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A realist evaluation of the aboriginal alcohol and drug worker program for urban aboriginal people

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A REALIST EVALUATION OF THE ABORIGINAL ALCOHOL AND DRUG WORKER PROGRAM FOR URBAN ABORIGINAL PEOPLE

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Abstract

Thesis title: A realist evaluation of the Aboriginal Alcohol and Drug Worker Program for urban Aboriginal people.

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Background: There is limited research evaluating addictions programs for Aboriginal people in urban contexts. **Objective:** The current project aimed to fill this gap by conducting an evaluation of the Aboriginal Alcohol and Drug Worker Program (AADWP), offered at Friendship Centres in Ontario. **Methods:** A realist approach was used to evaluate the AADWP. Client-targeted focus groups and staff questionnaires were conducted to develop preliminary theories regarding how, for whom and under what circumstances the program helps or does not help clients. Individual interviews were then conducted with clients and caseworkers to test these theories. **Results:** Mechanisms through which clients achieved their goals were related to client needs, trust, cultural beliefs, willingness, self-awareness, and self-efficacy. Clients' goals related to sobriety status, renewing relationships, cultural connection and mental health. Client, staff and setting characteristics were found to moderate development of mechanisms and outcomes. Results were congruent with existing literature.

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for Urban Aboriginal Adults

Introduction

Over half (53%) of First Nations, Inuit and Métis populations in Canada are located in urban areas (Statistics Canada, 2006). More specifically, in Ontario, 80.4% of these populations live in urban areas (Statistics Canada, 2006). Although rates of substance use problems will vary by urban Aboriginal community, the prevalence of substance use problems is often higher than the general population (Aboriginal Healing Foundation, 2007; Health Canada, 1998). For example, the prevalence of lysergic acid diethylamide (LSD) and marijuana use is four times higher for urban First Nations and Métis people in comparison to non-Aboriginal people in Manitoba (Health Canada, 1998). Rates of substance use among First Nations, Inuit, and Métis populations is difficult to understand without considering the unique history of First Nations, Inuit and Métis Peoples, especially regarding the historical trauma and cultural genocide endured by these populations (Connors, 2007). Appreciating the distinctive history of First Nations, Inuit and Métis Peoples not only aids in understanding the development of substance use problems among these populations, but it also provides insight regarding treatment approaches (McCormick, 2000).

Program evaluations are rarely conducted in the context of addictions even though substance use problems are complex and often difficult to treat. Moreover, evaluations of treatment approaches targeting substance use problems among First Nations, Inuit and Métis populations are even more sparse (Gray, Saggers, Sputore, & Bourbon, 2000), despite higher rates of such problems among these populations. The Aboriginal Alcohol and Drug Worker Program (AADWP), which serves clients in nine cities in Ontario (i.e., Hamilton, Fort Frances,

Fort Erie, North Bay, London, Georgian Bay, Thunder Bay, Sioux Lookout, and Sault Ste. Marie), is one such program that has targeted substance use problems among urban Aboriginal populations (Ontario Federation of Indian Friendship Centres, 2010). The AADWP, despite being in operation for 18 years, has only been evaluated at the administrative level and, therefore, it is unclear if or how the program is helping clients.

The current study evaluated the AADWP using a realist methodology and participatory approach to research. Realist methodology is used to comprehensively evaluate a program by asking how, for whom and under what circumstances the program works or does not work (Pawson, 2006). Participatory action research is an approach that is commonly used when working with communities, as it emphasizes a collaborative process with the communities involved (Cornwall & Jewkes, 2010; Minkler, 2000; Reilly, Doyle, Bretherton, & Rowley, 2008). Using primarily qualitative methods, the study seeks to understand how, for whom and under what circumstances the program works or does not work for clients accessing the AADWP.

Literature Review

Aboriginal Peoples in Canada

Aboriginal Peoples are the descendents of the first residents of North America. Aboriginal Peoples of Canada include First Nations, Inuit, and Métis people (Constitution Act, 1982). First Nations People may or may not be registered under the Indian Act and, therefore, may be considered "Status" or "non-Status Indians", respectively (Isaac, 1995). Having "status" means that one obtains certain rights such as exemption from paying provincial taxes and paying for post-secondary education (Hare & Barman, 2000). A First Nations person may be considered a "treaty Indian" if one's ancestors signed treaties in Canada (Smylie, 2000). Being a "treaty

Indian" means that one has certain rights outlined in the numbered treaties signed between 1871 and 1922, such as the right to live, hunt, and fish on reserve land. A First Nations person may be a "treaty Indian" in addition to a "Status Indian" and, therefore, obtain both "Status and "treaty" rights (Smylie, 2000). Alternatively, a First Nations person may be either a "treaty Indian" or a "Status Indian" and, therefore, obtain either "treaty" *or* "Status" rights (Isaac, 1995; Smylie, 2000). The Métis are people whose ancestry comprises First Nations women who intermarried with European men in the 17th century (Métis Nation of Ontario, 2010; Smylie, 2000). Inuit historically lived above the tree line in Canada. There are currently four Inuit specific regions in Canada. These regions are Nunavut (east of the Northwest Territories), Inuvialuit (western Arctic), Nunavik (northern Quebec), and Nunatsiavut (northern Labrador; Smylie, 2000).

In addition to differences between such groups, there are many differences *within* each group including, but not limited to, language and cultural traditions. For example, First Nations People do not all speak the same language. In fact, there are over 30 different languages (including English) that are spoken by First Nations People (e.g., Mohawk, Anishnawbe, and Cree; Battiste, 2000). Métis People speak English, French, or Michif. Michif is a combination of French, Cree and Ojibway (Vizina, 2005). French-speaking Métis traditionally excelled at canoeing and as navigational guides, whereas English-speaking Métis excelled at animal husbandry (Vizina, 2005). Inuit primarily speak Inuktitut, which has many different dialects. As well, a major cultural difference among this group is the hunting strategies that are used to gather food. For example, in Nunavik and Nunatsiavut, Inuit travel inland during the fall season in order to track herds of caribou for hunting. In contrast, Inuit who reside in central Arctic live inland all year round to track caribou (Pauktuutit Inuit Women of Canada, 2006). In addition to

traditional cultural differences within each Aboriginal group, there are also individual differences regarding the extent to which members choose to identify with their traditional or more contemporary culture. The differences between and within Aboriginal groups as outlined above are in no way exhaustive; however, they should be considered throughout this literature review. It should be noted that distinguishing between these three groups is not common within the literature; therefore, this literature review will state the terms used in the research being discussed.

Historical Trauma among First Nations Inuit and Métis Peoples

In order to understand the high prevalence of substance use problems among First Nations, Inuit and Métis Peoples (Aboriginal Healing Foundation, 2007), one must first understand the impact of historical trauma, endured by these populations from the colonization by Canada. Historical trauma was primarily enacted by the attempted cultural genocide on the part of the Canadian Government (Connors, 2007). Cultural genocide is the deliberate act of destroying the cultural heritage of a nation for political, ideological, ethnical, or racial reasons (Connors, 2007; Leenaars, Brown, Taparti, Anowak, & Hill-Keddie, 1999). The Indian Act and subsequent legally-mandated residential schools can begin to highlight this trauma via cultural genocide.

The Indian Act was passed in 1876, and is a set of policies that reflect the distinctive place of First Nations People in Canada. The Indian Act was marked with disparities in legal rights for First Nations People (Indian and Northern Affairs Canada, 1996). Examples of legal disparities included being restricted from managing their own land, or even practicing their own traditional ceremonies. These policies were a direct attack on First Nations culture, as the goal was to assist in the "civilization" of this population through assimilation. Such conditions were in place for over 75 years and have had significant multigenerational impacts, as it prevented oral

traditions, languages, as well as other cultural values to be passed on to future generations (Indian and Northern Affairs Canada, 1996). Presently, such provisions have been removed from the Indian Act; however the damage of such policies has had a lasting, multigenerational impact on First Nations culture.

From the policies that surrounded the Indian Act came the development of the residential school system, which impacted First Nations, Inuit and Métis Peoples. Residential schools are perhaps the most infamous and influential act of cultural genocide among the First Nations, Inuit and Métis populations in Canada. Residential schools were created to "civilize" First Nations, Inuit and Métis Peoples (Morgan & Freeman, 2009), or more candidly, to "get rid of the Indian problem" (pg. 332), by assimilating these populations to mainstream European society via the education system (Hare & Barman, 2000). Between 1874 and 1986, hundreds of thousands of First Nations, Inuit and Métis children were taken from their families/communities and forced to attend a residential school (Aboriginal Healing Foundation, 2003). Residential schools aimed to assimilate First Nations, Inuit and Métis populations by teaching them the "European way" and forbidding the practice of their own cultural traditions (Indian and Northern Affairs Canada, 1996). More specifically, the goal was to obliterate Aboriginal languages, traditions, and beliefs through socialization into the European way of life (Indian and Northern Affairs Canada, 1996). This was attempted by teaching First Nations, Inuit and Métis children to be ashamed of their identity and culture (Aboriginal Healing Foundation, 2003).

Any education that First Nations, Inuit and Métis children received through the residential school system was interrupted by mistreatment, neglect and abuse of children, which was often used as punishment for continuing to practice components of First Nations, Inuit or Métis culture (e.g., speaking their language; Hare & Barman, 2000). Such physical, emotional

and sexual abuse has been shown to be related to poor coping strategies, mental health problems and substance abuse (Aboriginal Healing Foundation, 2007), which provides insight as to why substance use problems are so highly prevalent among these populations.

One of the many consequences of the historical trauma via cultural genocide is a clash of First Nations, Inuit and Métis worldviews and European ways of life, or what has been termed as "jagged worldviews" (Little Bear, 2000). According to Little Bear (2000), First Nations, Inuit and Métis Peoples do not have a fully "Aboriginal" worldview, nor do they have a fully European worldview. First Nations, Inuit and Métis Peoples see the world through a jagged puzzle, consisting of fragments of both Aboriginal and European worldviews, failing to fit together in a cohesive manner (Little Bear, 2000). Such "jagged worldviews" continue to be passed on intergenerationally and provide a lack of culture for First Nations, Inuit and Métis Peoples to look toward as a coping strategy (Connors, 2007). There is evidence that the clash of worldviews, which has stemmed from historical trauma, is at the heart of many issues among First Nations, Inuit and Métis Peoples, one of which includes the high prevalence of substance use problems (Battiste, 2000; McCormick, 2000).

Such historical trauma has also contributed many adverse social determinants of health for Aboriginal populations in Canada, which also influences substance use problems. These adverse social determinants of health include, but are not limited to high rates of poverty, unemployment, family violence and suicide (Smylie, 2001). Historical trauma and social determinants of health are both very interconnected and should always be considered when examining high rates of substance use problems among these populations.

Substance Use Problems among First Nations, Inuit and Métis Populations

According to Statistics Canada (2006), 53% of First Nations, Inuit and Métis people live in

urban areas across Canada. As well, 80.4% of these populations reside in urban locations, in Ontario (Statistics Canada, 2006). In comparison to the majority urban population in Canada, urban First Nations, Inuit and Métis people have lower education, lower income, more single-parent headed families, and a higher prevalence of health problems (Smylie, 2001; Statistics Canada, 2006). In addition, there are higher rates of substance use problems among First Nations, Inuit and Métis populations (Aboriginal Healing Foundation, 2003; Aboriginal Healing Foundation, 2007; Indian and Northern Affairs Canada, 1996; Smylie, 2001).

The National Native Alcohol and Drug Program Review reported that alcohol and drugs are one of the major health concerns among First Nations people (Health Canada, 2005). According to a report by Health Canada (2003) among First Nations reserve communities in Canada, 73% and 59% of this population described alcohol use and drug use, respectively, to be a "major problem" within their communities. Therefore, over half of the on-reserve First Nations population in Canada were found to view alcohol and drug use as major problems in their communities at this time. As well, this report found that fewer First Nations people reported consuming any alcohol in comparison to the general population; however, the proportion of First Nations people reporting weekly heavy drinking was double that of the general population (16% versus 7.9%, respectively; Health Canada, 2003).

Health Canada (1998) reported the prevalence of substance use for particular provinces and territories and found a high substance use rate among First Nations, Inuit and Métis populations. In the Northwest Territories, heavy drinking was reported by 33% of Inuit and Dene (a First Nations group that historically inhabited in the boreal and Arctic regions of Canada; Dene Nation, 2006) communities, in comparison to 16.7% of non-Aboriginal people (Health Canada, 1998). As well, in the Northwest Territories, use of marijuana or hashish was

greater for First Nations, Inuit and Métis populations than the non-Aboriginal population (27.3% versus 10.8%, respectively; Health Canada, 1998). Alcohol and drug abuse has been identified by the Pauktuutit Inuit Women's Association (2002) as one of their most prevalent "mental heath" problems.

There is even less information available on the prevalence of substance use among *urban* Aboriginal people. In Manitoba, self-reports of marijuana, non-medical tranquilizers, non-medical barbiturates, LSD, phencyclidine (PCP), other hallucinogens and "crack" cocaine use were higher for urban First Nations and Métis people when compared to urban non-Aboriginal people (Gfellner & Hundleby, 1995). It was found by the National Association of Friendship Centres in 1985 that urban Aboriginal respondents reported severe levels of substance abuse across age groups, with alcohol as the principal substance (as cited in Aboriginal Healing Foundation, 2007). According to the *National Framework to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada* in 2005, Aboriginal people with substance use problems are over-represented in urban areas, with the most significant substance use problem being the use of inhalants, as this often begins in very early childhood (Canadian Centre on Substance Abuse & Health Canada, 2005).

The impact that the high prevalence of substance use problems has on First Nations, Inuit and Métis populations is widespread and multifarious. Alcohol use is the primary cause of death for almost twice as many Aboriginal people, in comparison to non-Aboriginal people (Aboriginal Healing Foundation, 2007). It should be noted that, unfortunately, it is unclear whether such rates apply equally to First Nations, Inuit and Métis populations, since the Aboriginal Healing Foundation does not discuss these groups separately. In addition, death due to illicit drug use among Aboriginal populations is three times that of the non-Aboriginal

population (Aboriginal Healing Foundation, 2007). A representative from the Royal Canadian Mounted Police identified alcohol-related legal offenses as the second of the top three issues in Aboriginal communities in Canada (Inspector Shirley Cuillierrier, as cited by the Aboriginal Healing Foundation, 2007).

In addition to the impact that alcohol and drug use has on the adult Aboriginal population, it has a significant impact on Aboriginal children. As reported in *No Safe Haven: Children of Substance Abusing Parents* conducted by the National Centre on Addiction and Substance Abuse in 1999 (as cited in Aboriginal Healing Foundation, 2007), children of parents who have problems with alcohol and/or drug abuse are three times more likely to be physically and/or sexually assaulted than children of parents who do not have problems with addiction (Aboriginal Healing Foundation, 2003). As well, such children of addicted parents are more than four times more likely to be neglected than children of parents who are not addicted to a substance (Aboriginal Healing Foundation, 2007). Many repeat the patterns of alcohol and drug use as they grow into adulthood, contributing to the multigenerational nature of substance use problems among First Nations, Inuit and Métis Peoples.

In addition to adverse physical implications of substance use problems, high rates of alcohol and drug use are commonly reported as major contributors to mental health problems among Aboriginal populations (Jacobs & Gill, 2002; Perkins, Sanson-Fisher, Blunden, Lunnay, Redman, & Hensley, 1994; Teasdale, Conigrave, Kiel, Freeburn, Long, & Becker, 2008). Jacobs and Gill (2002) examined substance use in relation to mental health among urban First Nations, Inuit and Métis populations in Montreal. They found that a very large proportion of those who had substance use problems suffered from additional psychological distress (e.g., 28.8% of those who abused substances reported depressive symptoms in comparison to 7.6% of those who did

not abuse substances). Such results are similar to those found in studies conducted by Regier et al. (1990) and the Canadian Centre on Substance Abuse (2009), which involved non-Aboriginal populations. Regier et al. (1990) demonstrated that individuals with a substance use problem are at an increased risk of having a concurrent mental disorder and vice versa. More specifically, of the clients involved in their study who had an alcohol or drug use disorder, 37% also had a mental illness. In addition, of those clients who had mental illnesses, 29% also had a drug or alcohol use disorder (Regier et al., 1990). More recently, over half of the individuals in the general population with a substance use problem were shown to have a co-occurring mental health problem (Canadian Centre on Substance Abuse, 2009). In addition, up to 20% of those with a mental health problem were found to be suffering from a concurrent substance use problem (Canadian Centre on Substance Abuse, 2009). Even though these studies (Canadian Centre on Substance Abuse, 2009; Regier et al., 1990) did not include First Nations, Inuit and Métis populations, results parallel the findings from Jacobs and Gill (2002), who included Aboriginal populations. Therefore, such rates may generalize to both populations, highlighting the importance of considering mental health problems when examining substance abuse in First Nations, Inuit and Métis populations.

The effect of substance use problems on First Nations, Inuit and Métis communities makes it difficult for such communities to move toward self-determination, which is a goal of many Aboriginal communities (Asch, 2002). The healing of First Nations, Inuit and Métis populations will strengthen the voices of community members and empower them to become in control of their own future, rather than this future being, in many ways, controlled by the Canadian government.

Treatment of Substance Use Problems

Due to the high prevalence of substance use problems among First Nations, Inuit and Métis populations, effective treatments that are designed to meet the needs of these populations are necessary (McCormick, 2000). Within the general population, there are numerous challenges associated with treating a substance use disorder. For example, there is no one treatment for substance use disorders that has been identified to consistently show promising effects (Siqueland & Crits-Christoph, 2002). Treatment is complicated by many factors, including the type of substance used (Siqueland & Crits-Christoph, 2002), motivation (Lash & Burden, 2006), gender (Brady, Grice, Dustan, & Randall, 1993) and co-occurring mental illnesses (Mueser, Noordsy, & Drake, 2008). The facilitation of treatment becomes even more complex when the methods used are not culturally sensitive or appropriate for the individual. The treatment of substance use problems among the general population is difficult (Mueser, et al., 2008); however, the jagged worldviews, that so many First Nations, Inuit and Métis people experience, add even more potential challenges to the treatment process. Successful interventions need to be specific for the target Aboriginal population, as it has been suggested that there are vast differences between Aboriginal and mainstream service providers' beliefs regarding the causes and solutions of substance use problems (McCormick, 2000). As well, treatments should be flexible in order to adjust to different cultural experiences within First Nations, Inuit and Métis populations (Aboriginal Healing Foundation, 2008).

Program Evaluation in the Context of Addiction for Aboriginal Populations

Even though substance use problems are so highly prevalent, have such adverse impacts, and are challenging to alleviate among First Nations, Inuit and Métis populations, there is little research examining the treatment of substance use problems among these populations. Gray et

al. (2000) conducted a review of evaluated alcohol misuse interventions targeting the Aboriginal Australian population and concluded that there is a significant need for more rigorous evaluation studies in partnership with Aboriginal community organizations. As well, Chouinard and Cousins (2007) discussed the need for culturally competent evaluations of programs targeting Aboriginal communities and highlighted the importance of appreciating the culture and context in such evaluations. Finally, evaluations of substance abuse programs targeting First Nations, Inuit and Métis populations in Canada are lacking in the published literature. Some insight can be drawn from evaluations conducted with Aboriginal populations from other countries or from those program evaluations targeting Aboriginal people in Canada with issues other than substance use problems, as some are available. For example, Gray et al. (2000) found that, in a review of 14 evaluations of alcohol misuse interventions targeting Aboriginal Australian populations, the impact of most of these alcohol interventions were limited for clients. Such limited effectiveness was linked to inadequate resources (Gray et al., 2000). As well, Gone (2009), examined a healing lodge for historical trauma among First Nations people and found that focusing on "wholistic" healing was key for client success. Although these evaluation studies contribute insight regarding what is helpful for program implementation in Aboriginal contexts, they are rare and either do not include Aboriginal populations residing in urban locations in Canada or are not specific to substance use treatment programs. Due to this gap, it is unclear what is effective for First Nations, Inuit and Métis populations residing in urban locations in Canada with substance use problems. Therefore, the rates of such issues among these populations remain high.

With these challenging circumstances, some Aboriginal community organizations in Canada are responding to the need for more accessible, appropriate services to address the

disproportionate burden of substance use problems experienced by First Nations, Inuit and Métis populations. The Aboriginal Alcohol Drug Worker Program (AADWP) is one such program that operates in Ontario and offers treatment to First Nations, Inuit and Métis individuals living in urban areas.

The Aboriginal Alcohol and Drug Worker Program

The AADWP is a culturally- and community-based program aimed at decreasing the negative effects of addictions for urban Aboriginal individuals, families and communities (Ontario Federation of Indian Friendship Centres, 2010). The program promotes an alcohol and drug abuse-free lifestyle. The AADWP is culturally-based by providing traditional ways of healing including, talking circles, which is a group of individuals who come together to discuss topics in democratic and non-confrontational ways, Sweat lodges are also made available, which can be best described as a meditation ceremony, offering healing that is individualistic, but grounded in relationships and spirituality (Ontario Federation of Indian Friendship Centres, 2010). Referrals to healing lodges are also available to clients, which are facilities that offer traditional healing approaches in order to address the impacts of sexual assault and physical, mental and emotional abuse, as well as family dysfunction (Ontario Federation of Indian Friendship Centres, 2010). Social gatherings are available for urban Aboriginal people suffering from drug and alcohol problems through the AADWP. As well, referrals to other treatment centres are made through the program, sometimes to mainstream programs such as Alcoholics Anonymous and/or Narcotics Anonymous. Information, support and education are provided to clients to aid in changing one's lifestyle and move toward recovery. Other aspects of the program include assessments, education, prevention, aftercare supports and relapse prevention.

The objectives of the AADWP are to promote healthy lifestyles and alternatives to drugs and alcohol (Ontario Federation of Indian Friendship Centres, 2010). The program also seeks to increase knowledge and sensitivity in the area of addiction. Reports from clients emphasize the ability of the program to reconnect them with their culture and empower them to improve their overall quality of life (Ontario Federation of Indian Friendship Centres, 2010). The aim of the present study was to evaluate how, for whom, and under what circumstances the AADWP works or does not work, which was done using a realist evaluation. More specifically, contextual factors influencing the effectiveness of the program, mechanisms through which the program is helping or not helping and outcomes that clients hope to achieve were evaluated in order to answer these questions.

Realist Evaluation

The main purpose of the present study was to provide evidence regarding how for whom and under what circumstances the AADWP helps or does not help urban First Nations, Inuit and Métis populations achieve their goals when accessing treatment through the program. As proposed by Health Canada (1998) in a discussion of *Evaluation Strategies in Aboriginal Substance Abuse Programs*, program evaluations should incorporate the physical, mental, emotional and spiritual needs of clients accessing the program. In addition, the evaluation should not merely focus on one aspect of the program; rather it should include the staff, the curriculum, and the program philosophy. Finally, the context in which change arises needs to be taken into account, as this has not been considered in past evaluation strategies involving Aboriginal populations (Chouinard & Cousins, 2007). Such recommendations were incorporated into the present evaluation of the AADWP. Conducting this research in a culturally-appropriate manner and taking direction from the collaborating community organization (the Ontario

Federation of Indian Friendship Centres) were also important goals of this project. These goals follow the current ethical guidelines for conducting research with Aboriginal Peoples in Canada (Canadian Institutes of Health Research, 2008).

Following the recommendations listed above, a realist evaluation was an appropriate evaluation method. In a realist evaluation, the synthesis of research is viewed as a process of theory testing and refinement (Pawson, 2006). Programs and services are complex interventions and are located in complex social systems. Therefore, realist evaluations do not seek to provide simple answers to the complex questions that stem from programs and services (Pawson, Greenhalgh, Harvey & Walshe, 2005). In using a realist methodology to evaluate a program, the primary aim is not only to understand whether the program works or does not work; rather, the aim is to gain a deep, detailed and practical understanding of the program and the process by which it works or does not work (Kazi, 2003; Pawson et al., 2005). This type of understanding is of much more use when attempting to implement the program in other locales, which is a goal of the partnering organization, the Ontario Federation of Indian Friendship Centres.

A realist evaluation seeks to identify social program/intervention theories, or "mechanisms", that improve or impede program outcomes, while also taking into consideration the context of the program in its effectiveness (Pawson & Tilley, 2008). A mechanism refers to the ways in which (or pathways through which) effects (outcomes) are brought about. Contexts refer to the conditions under which the operation of mechanisms and outcomes are activated. Pawson and Tilley (2008) proposed a formula to describe the theories that stem from realist evaluations: outcome = mechanism + context. This means that a program has a desirable outcome (or works) only if the program provides the relevant ideas and opportunities (mechanisms) to individuals who meet the relevant social and cultural backgrounds (context;

Pawson & Tilley, 2008). In summary, the realist approach attempts to decipher 'why', 'when', and 'how' an intervention works or does not work (Pawson et al., 2005; Pawson & Tilley 2008).

A realist evaluation can draw upon practitioners' and communities' prior knowledge including personal and social experiences in order to trace the pathway of what works or what does not work (Kazi, 2003; Pawson & Tilley, 2008). In this way, a realist evaluation involves an analysis of the outcomes, mechanisms, and contexts that make up a particular intervention or service. Therefore, the main research goal is to identify the specific mechanisms as they interact with different contexts to produce certain outcomes in relation to the AADWP. From this, conclusions can be drawn on how the AADWP works/does not work, as well as for whom and under what circumstances. Although this method of evaluation deviates from traditional experimental approaches to evaluations, it is aligned with the recommendations outlined by the Canadian Institutes of Health Research (2008), Chouinard and Cousins (2007), and Health Canada (1998), for culturally-appropriate research with Aboriginal populations. As well, Pawson and Tilley (2008) and Tilley (2000) argue that evaluation strategies, in general, should begin to deviate from traditional experimental methodologies.

Tilley (2000) criticizes traditional program evaluations for using cause-and-effect experimental methods to thoroughly evaluate a program, as it is difficult for such methods to take into account the influence that the many underlying mechanisms and contexts have on outcomes. As well, traditional methods of evaluation are usually designed to focus on external causation, meaning that attention is directed at whether the program works via external and observable outcomes, rather than why it works via underlying mechanisms (Kaneko, 1999). Therefore, traditional experimental methods of program evaluation are simply not as capable of taking mechanisms into consideration. Finally, many traditional experimental program

evaluations do not take contextual factors into consideration. Traditional program evaluations merely describe the potential of a phenomenon in the right condition and under the right circumstances (or under "controlled conditions"; Kaneko, 1999; Pawson & Tilley, 2008), which would, therefore, lack applicability to other conditions and circumstances. However, including all possible contexts and circumstances in an experimental evaluation would be unrealistic, to say the least, and would require mass amounts of resources to recruit participants in control and experimental conditions to test each possible mechanism under each potential circumstance (Tilley, 2000). Both Pawson and Tilley suggest that the purpose of evaluation research is to further the development of public policy (Tilley, 2000) and traditional cause-and-effect research methodology often fails to accomplish this goal due to its limits regarding causation and context.

A realist evaluation also has the key benefit of being consistent with Aboriginal values and knowledge. The realist approach recognizes different types of knowledge, including knowledge contained within community reports, policy documents, and experiential knowledge of key stakeholders, including community leaders and Elders (esteemed members of an Aboriginal community). As well, a realist evaluation values the local context and culture, which is consistent with theories of First Nations, Inuit and Métis knowledge (Battiste, 2000; Smylie, Martin, Kaplan-Myrth, Steele, Tait, & Hogg, 2003).

Participatory Action Research (PAR)

In addition to the recommendations put forth by Chouinard and Cousins (2007) and Health Canada (1998) for evaluating programs targeting First Nations, Inuit and Métis populations, both sources recommend using an approach to research called participatory action research (PAR) when working with First Nations, Inuit and Métis populations. As well, and most importantly, the Canadian Institutes for Health Research (2008) recommends this approach in their

"Guidelines for Conducting Health Research with Aboriginal Peoples". Therefore, this study will use the PAR approach. PAR is not a research method; rather it can be described as creating a community-engaged context in which knowledge development and social change can occur (Cornwall & Jewkes, 2010; Minkler, 2000; Reilly et al., 2008). The primary aim of PAR is to improve health and decrease health inequalities through collaborating with, and involving the communities who, in turn, take actions to improve their own health (Baum, MacDougall, & Smith, 2006). PAR is different from traditional research because it aims to produce change and improvement to a situation through action (Minkler, 2000; Reilly et al., 2008). Such action toward change is pursued through a reflective cyclical process of data collection, such that data are collected, there is reflection or discussion of data between both the researchers and community, action is carried out based on such reflection, and the cycle repeats (Cornwall & Jewkes, 2010; Israel, Schulz, Parker, & Becker, 2001; Reilly et al., 2008). PAR provides an agenda of how those being researched will be highly involved in the research process. This means that such individuals will be considered regarding all aspects of the project including how they will be affected by the research and adequate reciprocation/compensation, throughout the entire process (Israel et al., 2001; Kelly, 2005; Reilly et al., 2008). PAR involves the evaluation of the social, political and/or cultural conditions that are influential in constructing the identities and actions of individuals or communities (Israel et al., 2001; Reilly et al., 2008).

The PAR approach promotes balance in relationships and power between academic research team members and First Nations, Inuit and Métis partner organization, community participants and decision-makers (Chouinard & Cousins, 2007; Evans, Hole, Berg, Hutchinson, & Sookraj, 2009). The PAR approach differs from many past studies, in which research was done on First Nations, Inuit and Métis people without their permission, in an exploitive manner,

and without considering the needs of the communities (Battiste, 2000; Humphrey, 2001; Reilly, et al., 2008). Using a collaborative approach helps to gain the trust of First Nations, Inuit and Métis people in order to gain from the valuable insights of these individuals. It also helps build capacity in such communities to take action to improve their circumstances (Cornwall & Jewkes, 2010). Collaboration exists from the initiation of the research project to the dissemination of the research findings (Israel et al., 2001; Reilly et al., 2008). Through implementing this approach in the present study, this project has been developed in partnership with the Ontario Federation of Indian Friendship Centres (OFIFC), and is consistent with their goals and future directions as an organization. As well, in addition to this thesis, a community report will be developed for the partnering organization to access.

Project Overview

This study realistically evaluated the AADWP. The objectives of this project were: (a) to gather empirical evidence and outline initial theories of how, for whom and under what circumstances the AADWP works/does not work in alleviating substance use problems for urban Aboriginal adults, (b) to evaluate and revise these theories, and (c) to synthesize these theories into coherent context-mechanism-outcome configurations (Pawson & Tilley, 2008).

Method

The present study consisted of two phases. Phase One was called the Theory Development Phase during which clients accessing the AADWP participated in focus groups and AADWP staff were given questionnaires to develop initial theories regarding how, for whom and under what circumstances the program works or does not work for clients. The second phase was called the Evaluation Phase, during which in-depth interviews were conducted with clients and staff. Each phase was conducted at two different Friendship Centre locations: Hamilton,

Ontario and Fort Frances, Ontario. These Friendship Centres were called the Hamilton Regional Indian Centre and the United Native Friendship Centre in Fort Frances. Hamilton is located at the west end of Lake Ontario and is considered one of Canada's major cities, having a population of 500,000 (City of Hamilton, 2011). Fort Frances is located in Northwestern Ontario, sharing a border with Minnesota, U.S.A. Fort Frances has a population of approximately 8,103 (Town of Fort Frances, 2011).

Epistemological Lens

The main lens through which data were collected and coded was through a realist perspective. The philosophical stance of the realist paradigm is that there is a true and external reality, that is, reality exists and is independent from the researcher. As well, any perceptions of reality must be triangulated to many different sources, in order to develop an accurate perspective (Sobh & Perry, 2005).

It is recommended that a realist researcher begin his/her study by looking to the literature to develop theories before collecting data. When using grounded theory, which is a common method of qualitative data collection, one does not create theories prior to testing, as it is a process of discovery and grounding a theory in reality (Corbin & Strauss, 1990). The absence of initial theories is the main way in which grounded theory and the realist paradigm differ. Aspects of grounded theory were used for the Theory Development Phase in the present study, as there are a lack of theories or evidence that was directly relevant to the evaluation of the AADWP from which to develop initial theories. As well, due to the extensive cultural considerations associated with this evaluation, it was more appropriate to look to community members to aid in the development of initial theories and lessened outsiders' biases. Although this aspect of grounded theory was used as a means through which data were collected during the

Theory Development Phase of the project, the questions asked and analysis were driven by the realist perspective (i.e., how, for whom and under what circumstances does the program work or not work?). As well, this phase included different perspectives from the program (clients, caseworkers, and other staff members of the Friendship Centre), which is an important aspect of a realist evaluation, called triangulation. The second phase of the study used the realist approach to collecting and analyzing data, as this phase aimed to test theories regarding how, for whom and under what circumstances the program works or does not work, which is the main facet of the realist paradigm. From this it is clear that the realist paradigm is the overarching lens through which data were collected, analyzed and interpreted.

Evaluation Plan

See Appendix A for the Evaluation Plan.

Participants

Theory Development Phase. A sample of five clients was recruited for the focus group conducted at the Hamilton Regional Indian Centre. A sample of 11 clients was recruited for the focus group conducted at the United Native Friendship Centre in Fort Frances. Inclusion criteria for clients were: 18 years or older and currently accessing the AADWP or had accessed the program in the past.

A sample of two staff members from the Hamilton Regional Indian Centre and four staff members from the United Native Friendship Centre in Fort Frances were recruited to complete a questionnaire during this phase. Inclusion criteria for staff members were: 18 years or older and involved in service provision for mental health, addictions, or other relevant community care through the Friendship Centres.

Evaluation Phase. A total of 27 participants (24 clients and three caseworkers) participated in the evaluation phase of the study (some participants were the same as those who participated in the Theory Development Phase) with varying demographic characteristics. Regarding clients, the mean age was 32.79 years (SD = 10.92, range = 21 to 59), with 38.5% of clients being male, 58.3% accessing the program through the United Native Friendship Centre in Fort Frances, and 80.8% identifying as being from First Nations descent. Clients were also asked to rate how much they followed Aboriginal culture and how much they followed Aboriginal traditions on a Likert-type scale (i.e., 1 = not at all and 5 = completely following the culture or traditions). On average, clients rated following Aboriginal culture as a 3 (SD = 1.20, range = 1 to 5) and Aboriginal traditions as a 2.65 (SD = 1.20, range = 1 to 5). Regarding caseworkers, the mean age was 52.57 (SD = 12.70, range = 38 to 60), with two being female, two being employed through the United Native Friendship Centre in Fort Frances, and two identifying as First Nations. Caseworkers were also asked to rate how much they followed Aboriginal culture and traditions. On average, caseworkers rated following Aboriginal culture as a 3.5 (SD = 0.71, range = 3 to 4) and traditions as a 3.5 (SD = 0.71, range = 3 to 4). See Table 1 and Table 2 for client and caseworker demographic variables, respectively.

Client participants were required to be 18 years or older and have sought services at the AADWP. Staff members were required to be 18 years or older and a present or past caseworker at the AADWP. Only AADWP caseworkers, rather than other staff members at the Friendship Centres, were included in this phase of the study because, in comparison to the previous phase where a wide range of perspectives were sought, in this phase the aim was to narrow responses to those directly involved in the program in order to refine and create the most accurate and representative model.

Materials

During the focus group (with clients) and the one-on-one interviews (with both clients and caseworkers), all responses were audio-recorded using a Roland Ederol R-09HR or a Sony ICD-UX71, which are high resolution audio recorders. The staff questionnaires were developed using software called NoviSystems. All qualitative data were analyzed using a qualitative analysis program called NVivo 8.0. This program organizes data by theme of response. All quantitative data were analyzed using SPSS. In addition, two flipcharts, black markers, an easel, and name tags were used during each focus group.

Procedure

Participant recruitment. Clients at the Hamilton Regional Indian Centre were recruited by the AADWP caseworker and those at the United Native Friendship Centre in Fort Frances were recruited by a staff member from the Aboriginal Healthy Babies Healthy Children Program (also located at the United Native Friendship Centre in Fort Frances). Staff members first identified interested clients, and then they described the study to clients and asked them if they wished to participate. If clients were interested in participating, the staff member informed them of when the focus group (for the Theory Development Phase) or interview (for the Evaluation Phase) would take place and gave them consent forms to review.

Staff members were recruited to complete the questionnaire (for the theory Development Phase) and participate in the interviews (for the Evaluation Phase) by the Health Program Manager from the Ontario Federation of Indian Friendship Centres or the Executive Directors (ED) of each of the Friendship Centre sites. The Health Program Manager or EDs first identified relevant staff members at the Friendship Centres, and then described the study to interested staff

members. Staff members are routinely asked to participate in program development and are familiar with the process.

Theory Development Phase. Once clients were recruited from both Friendship Centres (Hamilton Regional Indian Centre and United Native Friendship Centre in Fort Frances), the research team visited each site. At each site, clients were provided with food (clients at both sites were given the option of eating before or during the focus group). Both focus groups were conducted in a private comfortable room. Once introductions were made, clients were given a consent form. The content of the form was verbally summarized by someone from the research team and time was allotted for questions or concerns. Signed consent forms were collected and a copy was given to each participant (see Appendix B for the Client Consent Form: Focus Group). After the consent form process was completed, the focus group questions were asked (see Appendix C for Focus Group Questions). Audio recording began after the consent form process. Over the course of the focus group, notes were taken by a member of the research team on a large flipchart for all participants to see and all responses were audio-recorded. The focus group at each site took approximately 90 minutes. Upon commencement of each focus group all participants were given $25, as compensation for their time.

During the Theory Development Phase, staff members completed an online questionnaire, as this was deemed by the community as the most effective way to gather the staff's opinion on the AADWP. Although a focus group with staff was the preferred method of data collection, the community indicated it would interfere with the running of the programs at each centre. Once recruited, the Health Program Manager or the EDs sent the research team the names and email addresses of five staff members from the Hamilton site and five staff members from the Fort Frances site. These email addresses were entered into NoviSystems and, through

this software, an email was sent to each staff member, providing them with an internet link to complete the questionnaire. When staff members clicked on the link, they were taken to the first page of the questionnaire, which was the consent form (see Appendix D for the Staff Consent Form: Questionnaire). By clicking "next", they agreed to participate and began the questionnaire (see Appendix E for the Staff Questionnaire). Once each staff member completed the questionnaire, an email was automatically sent to the research team. Staff members were told to complete the questionnaire in their offices during work hours. If the questionnaire was not completed in 10 days, a friendly reminder was sent via email. The questionnaire took approximately 30 to 60 minutes to complete. Staff members were not compensated for participating in this phase of the study. Due to some technical difficulties with the questionnaire, a paper copy of the questionnaire was mailed out to participants (see Appendix F for the Mailed Staff Questionnaire) and they were provided with instructions regarding where to mail it back. The focus groups and questionnaires were transcribed and analyzed for themes and then theories were developed regarding how, for whom and under what circumstances the program works/does not work. From these theories, interview questions were developed in order to test the theories in the Evaluation Phase.

Evaluation Phase. Once the preliminary theories were created and the interview guides were developed to test such theories, the research team visited both Friendship centre locations (Hamilton and Fort Frances) to conduct in-depth interviews with clients and caseworkers. All interviews were conducted in a private comfortable room and participants at each location were provided with food. For client interviews, once the consent process was completed and clients agreed to participate in the study (see Appendix G for the Client Consent Form: Evaluation), the interview and recording began. Clients were asked to generate their own thoughts regarding

parts of the program, and regarding how, for whom and under what circumstances the program works or does not work. They were also asked to state whether they agreed with the research team's original model, as developed from the focus groups and staff questionnaires. Clients rated how important each part of the program, outcome, and pathway (also know as a mechanism) was for them on a one (not important at all) to five (very important) Likert-type scale. As well, they were asked to rate how important they thought each context was in impacting the AADWP on a one (does not impact the program) to five (highly impacts the program) Likert-type scale. It should be noted that, even though the present study is not an "outcome" evaluation, participants were asked about common client outcomes to relate mechanisms and contextual factors to client goals. This facilitated the development of context-mechanism-outcome (CMO) configurations, providing an in-depth understanding of the program.

After the first few interviews at the Hamilton location, which were conducted with clients, minor revisions were made to the Interview Guide to improve its clarity in response to feedback from participants (e.g., those around reintegration; see Appendix H the Interview Guide: Client Version 1 and Appendix I for the Interview Guide: Client Version 2). All responses were audio-recorded, which began after completion of the consent form process. The entire interview was approximately 60 to 90 minutes. Once the interview was completed, clients were compensated $25 for their time.

At each site, the staff interviews were conducted on the same day as the client interviews. The procedure was approximately the same for the staff interviews as the client interviews, with a few exceptions. The consent form and questions were slightly different (see Appendix J for the Staff Consent Form: Evaluation). Staff members were asked to answer the same types of

questions as outlined above; however, they were asked to refer to their clients, rather than themselves (see Appendix K for the Interview Guide: Staff). Staff members were not compensated for their time, as the interviews were completed during working hours. Once all interviews were completed, they were transcribed and analyzed to test the theories previously developed.

Qualitative Analysis Approach

Theory Development Phase. Responses collected during the client focus groups and staff questionnaires were analyzed using immersion/crystallization, editing, and legitimizing and corroborating. Immersion/crystallization is a common organizational style used in qualitative research (Crabtree & Miller, 1999). When using immersion/crystallization, the researcher immerses him/herself in the text and emerges after crystallizations, or reportable themes/theories have been decided (Crabtree & Miller, 1999). Editing is an organizational style that complements immersion/crystallization, and can be referred to as the way in which someone would immerse him or herself into the qualitative data. When using editing, the researcher enters the text (immersion) like an editor, rearranging portions of the text into different categories until a meaningful summary (or theories) have emerged (crystallization; Crabtree & Miller, 1999). The process of crystallization was finalized through corroborating and legitimizing, which is a critical step in qualitative analysis. This is where a research team meets to discuss findings in order to confirm and justify what has been found (Crabtree & Miller, 1999). The present research team met and had an iterative discussion about the theories that emerged through immersion/crystallization. Another two rounds of immersion/crystallization and corroborating/legitimizing took place with the lead student member of the research team (CD) and the lead faculty member of the research team (KM), until the crystallization of theories

was finalized. This process is common in qualitative research, as this type of research is a cyclical and interweaving process (Crabtree & Miller, 1999).

Evaluation Phase. Responses collected during this phase were analyzed in two different stages. During both stages, codebooks were used; however, the development of each codebook followed different processes.

Stage one analysis and reliability check. In the first stage of analysis, the codebook was developed *a priori*, which means that codes were developed and defined prior to examining the data. The codes were largely based on theories that had been developed from the initial phase of the study. The codes (also known as themes) mapped onto the interview questions that were asked during this study phase. For example, one interview question that was asked was, "When you came to the program, were your goals related to recovering from or gaining control over your addiction?" Therefore, the codebook had a corresponding code "Outcome Sobriety Example" (see Appendix L for the AADWP Evaluation Codebook: Stage 1).

Two members of the research team (the author, CD, and a trained volunteer research assistant, AP) completed the coding for participant interviews using NVivo 8.0. Coder 1 (CD) coded all 27 interviews and coder 2 (AP) coded 14 interviews. Reliability was calculated via percent agreement. Percent agreement was calculated for each code and for each participant in order to examine common discrepancies at either the code or participant level. When coding, both coders were required to identify a particular code in the same location of the interview. As well, at least 75% of the content coded had to overlap between each coder. If the content was overlapping by at least 75%, this was considered to be agreement between coders in the use of the code (Streiner & Norman, 2008). When disagreements could not be resolved between the

two coders, the faculty member of the research team (KM) served as a mediator and helped to resolve such discrepancies.

To determine a percent overlapping value for each individual participant included in the reliability analysis (14 participants), the number of codes that were found to be agreed upon were added to calculate a sum of "agreement" codes and were then divided by the sum of all codes for each participant. The same was done for each individual code. The percent agreement was examined for each individual participant and each code to determine if particular codes or participants had more versus less agreement in case certain codes needed to be redefined or were inadequate for use in certain interviewee circumstances. Minor revisions were made based on this information. The total percent agreement (across all participants and all codes) was determined by calculating the total number of codes that were found to be "agreement" codes and then dividing by the total number of codes used across all participants. The total percent agreement was 83.6% for this stage of coding. It should be noted that Cohen's kappa was considered for use in measuring inter-rater reliability; however, percent agreement already provided a measure of reliability at both the code and participant level. Kappa merely takes into consideration the likelihood of using particular codes by chance (Banerjee, Capozzoli, McSweeney, & Sinha, 1999). However, due to the way in which the data was collected and the necessity of taking percent overlap into account, using the kappa statistic would only serve to unnecessarily underestimate the reliability between each coder.

Before coding began, a few test interviews were coded to ensure that there were not any significant flaws in the coding scheme that would adversely affect reliability between the two coders. From this, the codebook was revised to increase coding clarity and ease. During the process of testing the codebook, a few coding guidelines were developed. The first guideline

concerned the weight attributed to responses. Participants' responses were only coded if they were able to elaborate on their responses, which was considered to be genuine agreement or genuine disagreement (e.g., genuine agreement: *Yes, I agree with a trusting relationship with the caseworker as a mechanism because I wouldn't be able to tell the caseworker anything that's going on with me if I didn't trust them*") versus mere agreement or disagreement (e.g., mere agreement: "*ya*", "*yes*", "*mmm-hmm*"). Mere agreement or disagreement statements do not hold as much weight as when participants are able to elaborate. This was in part because it was not easy to discern if mere agreement was due to genuine agreement with the concept presented or if participants were simply acquiescing to the interviewer's suggestion.

From this stage of coding and analysis, it was realized that those questions to which participants were asked to explicitly agree or disagree may not be entirely valid, as some interviewers deviated from the interview guide because of inadequate training or interviewer exhaustion. Because of this, many participant responses were questionable regarding whether participants understood the questions being asked or whether participants were simply acquiescing with interviewers' suggestions. From this, it became clear that those responses that were spontaneously generated would be given much more weight and were further coded in the second stage of analysis and reliability check.

Stage two analysis. Once all of the interview data were organized by question, the second stage of coding began. In this coding stage, portions of the interviews where participants were specifically asked to generate their own ideas of how, for whom and under what circumstances the program works were of interest and further coded using another codebook. Codes to be used during this stage of coding were developed by examining the interviews and using immersion/crystallization, editing, and corroborating and legitimizing. Legitimizing and

corroborating was conducted during the process of code development, in which the two coders met to discuss agreement with the developed codes and their definitions (see Appendix M for the AADWP Evaluation Codebook: Stage 2). Coder 1 (CD) completed the coding for all 27 interviews and coder 2 completed the coding for 14 interviews using NVivo 8.0, with inter-rater reliability of 85%, as calculated by percent agreement. Percent agreement was calculated in the same way as in stage one analysis.

Once all of the coding was completed, immersion/crystallization and corroborating/legitimizing were used to examine the parts, outcomes, mechanisms and contextual factors that respondents spoke about to determine which components of the model should remain and which components needed to be added, removed, or moved to another model location. Such qualitative analysis was conducted in combination with quantitative analysis (i.e., a Wilcoxon Signed rank t-test) to articulate and refine the model. Finally, immersion/crystallization was used to synthesize context-mechanism-outcome configurations regarding how, for whom, and under what circumstances the program works or does not work.

Results

Overview

Results are presented in three steps, mapping on to the study's objectives. The first phase involved theory development, with an examination of the program parts, client goals, mechanisms and contextual factors. The second phase involved evaluation or theory testing, with a focus on confirmation of the program parts, client goals, mechanisms and contextual factors. The final step of the results involved a synthesis of findings to contribute the final set of theories (context-mechanism-outcome configurations) and the final model for how, for whom, and under what circumstances the program works or does not work for clients. It should be

noted that the Initial Model and the Final Model Figures are presented in a way that is congruent with many Aboriginal cultures (i.e., in a circle).

Theory Development Phase Results

During the first phase of the study, theories were developed as relating to the components (or parts) of the program, clients' goals in the program, mechanisms by which clients achieved their goals and contextual factors that moderated the development of mechanisms and outcomes (see Figure 1 for the Initial AADWP Model as based on theories developed in the Theory Development Phase of the study).

Parts of the AADWP. The main elements of the program that were generated in the first phase of the study related to the caseworker, inclusion of culture and instrumental supports, each with corresponding components. Regarding the caseworker, participants reported that caseworkers completed assessments; provided direct, yet supportive one-on-one counselling; provided cultural resources; worked to ensure continuity of care (i.e., following-up with clients even when they access other programs or have finished with the AADWP); and provided referrals to inpatient and outpatient settings. Regarding the inclusion of culture part, participants spoke about the program following a wholistic model of healing by focusing on the balance between physical, mental, emotional and spiritual health. It should be noted that "wholistic" is used instead of "holistic" because the former spelling better represents the concept and is often used in Aboriginal contexts. Finally, regarding instrumental support (or daily support), the program provided help with employment, transportation, income, housing, and organizational skills. One client provided an example of the instrumental support that the program provided: "*Childcare and transportation are the most things that I would need. It's good that they help you.*"

Outcomes. The main outcomes clients aimed to achieve through the AADWP were related to substance use, mental health, renewing relationships, and reconnecting to their Aboriginal culture. As well, reintegration into one's prior community was thought to be an overarching (or macro) goal for many clients. Regarding substance use, participants spoke about clients wanting to be abstinent or wanting to reduce their substance use. With respect to mental health, participants spoke about wanting help around issues with anxiety and depression. Regarding renewing relationships, participants revealed wanting to get their children back into their care (i.e., regaining custody) and improving relationships with their significant others. With regards to reconnecting to Aboriginal culture, participants discussed clients' desire to learn about their culture and how clients appreciated having the chance to gain cultural knowledge through the program. Finally, with respect to reintegration, participants spoke about finishing external treatment, being released from a correctional facility, or generally achieving their goals around sobriety and how it was sometimes difficult to transition back into their previous environment while maintaining their progress. Clients hoped to effectively reintegrate back into their previous community (whether Aboriginal or not) while maintaining their achievements. The following is an example of a client being able to renew her relationships with her children and grandchildren through the program: "*Well, you know I've got my children and my grandchildren back. You know, I missed my grandchildren for five years because I wouldn't do it in front of them or let them see it. But now I've got all my life back. So it's a good thing.*"

Mechanisms. Six mechanisms were identified at this phase of the study. These included a treatment program for clients' needs, a trusting relationship with the caseworker, attendance of cultural events/increased cultural knowledge, attendance of external treatment programs, belief in a wholistic way of healing, and increased stability.

Treatment program for clients' needs. Participants reported that once clients were assessed by a caseworker, their needs were understood and treatment could be tailored to that individual in a one-on-one weekly session with the caseworker, rather than receiving generic addictions treatment in a group setting. When clients felt as though their caseworker understood their needs and was tailoring treatment to their needs, this was an important pathway through which clients achieved their goals because clients could work on what their self-identified issues were. One client spoke about how her caseworker was able to keep the counselling sessions focused on her, which was what she needed:

> *...some people get carried away. She will stop you and you go back and you work through that, where there are other counsellors that just let you, you know, verbal diarrhea, just blah, blah, blah, bah. You walk away three hours later thinking 'wow, I feel a lot worse than what I did when I walked in there because now I'm all emotional and don't understand a thing that just happened.*[1]

Establishment of trust between the caseworker and the client. Participants reported that direct, straightforward and client-centered one-on-one counselling allowed the caseworker to build rapport with their clients. Having rapport meant that clients trusted their caseworker and were able to be open and honest with them. When clients were honest with their caseworker, the caseworker was in a better position to help clients move towards recovery. The following client spoke about trusting her caseworker: "*I did counselling with her. I was seeing her once a week and I did feel better about talking to her because I wouldn't normally tell anybody but her what I was going through.*"

Attendance of cultural events/increased cultural knowledge. When a caseworker was able to provide cultural resources to clients, clients could attend cultural events and increase their cultural knowledge. From this, participants reported clients reconnecting to their Aboriginal

[1] The gender of caseworkers were changed to female in all quotes to protect the confidentiality of caseworkers

identity, which helped them develop a more concrete sense of self and ultimately lead clients to achieve their goals. The following is an example of a client who was working to develop this mechanism: "*The smudging, I've never heard of that before until this year, till I came to see her. Being Native and adopted at 5, I don't know anything. I am still learning about all of this…*"

Attendance of external treatment programs. Part of the caseworker's responsibility was to make appropriate referrals to external services for clients that present with problems that were not within the program's capacity. When such clients attended external treatment programs (e.g., detoxification centres), they returned to the program and began to move toward recovery. Participants reported that the absence of this mechanism made it difficult for clients to move toward recovery. One client spoke about how she was unable to attend an external treatment program (detoxification) through the caseworker at the AADWP. This created an obstacle in her progress:

> *It didn't help me get to treatment this time…I have actually had to argue with her just to go to treatment. The last time I went to go see her, she made me fill out all of my paperwork, I did everything, and then I went back there, she told me to come back a week later to find out what was going on. I went back a week later and she lost all the paper work…Anyways I just gave up, I said, fine I'm not going to go through you.*

Belief in a wholistic way of healing. The medicine wheel is the healing model adopted by the AADWP, emphasizing a balance between physical, mental, emotional, and spiritual health. The program promoted this model of healing and caseworkers used this in their approach to counselling. In turn, participants reported clients adopting this belief and working toward a wholistic way of healing. The belief in wholistic healing allowed clients to reach desired outcomes in all different areas of their life. The following is an example of a client who achieved a belief in a wholistic way of healing, which was helpful for her: "*What I learned in treatment is that your spirit has four things and you need to take care of that in order to live*

healthy and it's mental, emotional, it's physical and it's spiritual. And if we meet all four of those then we should live in a way that we are supposed to…"

Decreased chaotic lifestyles/increased stability. Many participants spoke about how clients' lifestyles were chaotic/unstable in the areas of employment, housing, and transportation. When the caseworker was able to provide instrumental support that addressed these needs, clients could reach stable lifestyles and progress toward desired outcomes. One client spoke about gaining stability through the program and how this was helpful: *"...I have a lot more money in my pocket and towards my kids, but I'm just starting right now. I just have to get there. You save money and you get back to regular routine."*

Contextual considerations. Contextual factors were divided into three main categories: clients, staff, and setting.

Client characteristics. The following client characteristics influenced the movement of clients toward mechanisms and desired outcomes: client age, willingness, complexity of presenting problems, the presence of external support, and trauma history. 1. When clients were younger versus older, they tended to have more pressing needs that would go above and beyond what the caseworker was willing or able to provide (i.e., younger clients needed more of the caseworker's time). 2. When clients were unwilling to change their maladaptive behaviours, this limited the effectiveness of the program. Caseworkers respected clients' autonomy and, therefore, clients would only be given effective help when they were ready to accept it. 3. Clients presenting with complex and/or severe problems (i.e., severe substance dependence or severe concurrent disorders) found it more difficult to move toward mechanisms and outcomes, as the program did not have the resources to help such clients. 4. Whether or not clients had an external support system in place (e.g., family and/or friends) influenced the eventual presence of

the above-mentioned mechanisms and outcomes. That is, high level of success was associated with the presence of external support. 5. Finally, if clients had a history of trauma, this affected their ability to trust their caseworker and many were not able to be as open and honest in reporting needs, especially surrounding trauma. The following quote provided an example of the importance of willingness: *"…It's up to the individual. If you want help, you take it. If you come here and you are like 'argh', that's up to you. Maybe you're not ready to give up your addiction…*"

Staff Characteristics. Seven staff characteristics were identified as influencing the effectiveness of the program: caseworkers' Aboriginal identity, cultural knowledge, length of time in caseworker position (long-term commitment), flexibility around lapses and abstinence, willingness to continue training, willingness to network with other services, and personal experience with addiction. 1. Mechanisms were more likely to develop and result in desired outcomes if caseworkers were from Aboriginal descent, as clients were better able to trust and identify with someone from their own cultural group. 2. As well, caseworkers were more likely to understand their clients' needs and better relate to clients if they were culturally knowledgeable and willing to share this knowledge with clients. 3. Long-term caseworkers were more likely to understand how the program works, understand the type of clients he/she would see and was a consistent counsellor for clients, allowing for trusting relationships to build. 4. Although the program was considered to be abstinence-based, caseworkers' decisions to be non-judgmental and continue to provide support when clients had lapses or did not have a goal related to abstinence was helpful in establishing rapport and in achieving desired mechanisms and outcomes. 5. Caseworkers also needed to be willing to continue their training. For example, caseworkers should be open to continue training in conducting appropriate and thorough

assessments in order for the above outlined mechanisms to lead to desired outcomes. 6. Caseworkers should also be willing to network with other services providers. From this, they could confidently refer clients to other services. In establishing networks, caseworkers could also collaborate with other service providers when difficult cases are present, which would help with client progression toward all outlined mechanisms and outcomes. 7. Finally, caseworkers were more likely to understand clients' needs and be more effective in establishing rapport when they had personal experiences with addiction because they were able to draw from these experiences during counselling. The following client provided an example of the importance of caseworkers having their own addiction experience: *"...and another thing is, she doesn't look down on you because she has been there…she knows exactly.*"

Setting characteristics. Three setting characteristics were identified as influencing the effectiveness of the program: positive staff environment, balanced administrative work, and location. 1. The staff environment should be supportive where staff feel valued and are able to access self-care. Such support should include physical, mental, emotional, spiritual, as well as financial. When the caseworker was content with his/her environment, this affected his/her ability to tailor treatment, establish rapport, provide cultural resources and provide external support. 2. Another contextual consideration related to the setting was the administrative responsibilities. When a caseworker was required to spend a lot of his/her time in administrative-related activities, he/she did not have as much time to spend working with clients, which limited his/her ability to be effective. 3. The organization and location of the Friendship centre should also be considered. For example, if the program was located in a building or was organized in such a way that created feelings of discomfort as related to confidentiality, or clients were unable to access the program because of where it is located, none of the mechanisms or

outcomes would be gained. These setting characteristics emerged through examining the focus group discussion and through an iterative qualitative process between members of the research team.

Evaluation Phase Results

During this phase, the aim was to revise the initial theories as outlined above to increase the accuracy and relevance of the final theories regarding how, for whom, and under what circumstances the program works or does not work. The model was revised in two ways. 1. By examining the components of the model with which participants agreed. This means that parts of the model were considered to be accurate when at least 25% of participants either spontaneously generated an originally proposed part *or* when participants' ratings of agreement to a model part were significantly greater than a neutral rating of three (on a scale from one to five). A Wilcoxon Signed Rank t-test was used to examine whether these ratings were significantly different from a rating of three (a neutral rating), as all variables of interest were not normally distributed (i.e., positively skewed). 2. Revisions were also made by examining interview responses that led to changes in the model (i.e., parts that were added, removed, or moved to a different section of the model). A portion was added to the model if generated by at least 25% of participants. Parts of the model were removed or moved to another location through an iterative, qualitative process of corroborating, legitimizing and crystallizing (see Figure 2 for the Final AADWP Model as derived from the Evaluation Phase of the study). It should be noted that disagreement statements were also examined. If at least 25% of participants explicitly disagreed with a part of the model *and* participants' ratings of agreement were not significantly greater than a neutral rating of three, this would also indicate removal of a part of the model. However, this never occurred and, therefore is not reported below.

Parts of the AADWP

Model agreement. The majority of the participants agreed with the caseworkers' responsibilities that were outlined in the previous model. More specifically, nineteen participants (70.3%) generated this information, which included: conducting intake assessments, providing one-on-one and weekly counselling sessions for problems with drugs and alcohol (one hour in length and not time-limited by number of weeks), making referrals to external treatment programs and to programs within the Friendship Centre, providing continuity of care, and providing cultural resources or referring clients to cultural resources. One client provided an example of the caseworker referring clients to other programs: *"... if there's something that she can't really help me with, then she will tell me, just maybe 'this is where to go.' Yeah so, which is good.*" All these program parts, as generated by participants matched the parts that were proposed in the original model as related to the caseworker (see Table 3 for participant rating statistics).

Model changes. Eleven participants (40.7%) generated information related to the caseworkers' approach to one-on-one counselling, all of which were not included in the original model and were, therefore, added to the final model. Such approaches included: providing cultural teachings, encouraging clients to identify their strengths and weaknesses, using a direct and client-centered style, encouraging clients to make decisions for themselves, focusing on a gradual movement toward recovery (i.e., "one day at a time"), teaching clients about acceptance, and providing education related to the physical and familial effects of substance misuse. One client provided an example of his caseworker teaching him about the harmful effects of substances: "*Oh, and the effects on your body; like she talked about my liver and my kidney and*

after so long, if you've been doing it for this, like this is what could happen to your body. Just stuff like that."

The only instrumental support that participants agreed as being provided by the program was the caseworker helping clients with organizational skills (i.e., planning their days and helping them to keep their appointments) and lending clients bus tickets once in awhile. The caseworker often indirectly provided instrumental support to clients by referring them to other programs within the Friendship Centre. Therefore, instrumental supports, other than help with organizational skills, were not found to be a direct part of the AADWP and were removed from the final model. As well, inclusion of culture was found to be integrated throughout the caseworker's interaction with clients and was, therefore, merged with the caseworker part of the model, instead of keeping it as a separate part of the program, as originally proposed.

Since the AADWP is so well integrated within the Friendship Centre, nine participants (33.3%) spoke about the help clients accessed through the Friendship Centre (rather than the AADWP) even when asked specifically about the AADWP. Therefore, it is important to note the services that clients reported accessing through the Friendship Centre when attending the AADWP. These included: help with education (e.g., attainment of a high school equivalent diploma), legal aid, help with housing, childcare and Alcoholics Anonymous meetings. One client in particular spoke about how he was able to achieve education from the Friendship Centre: "*…with my education, what I did was…at the Friendship Centre, the high school. So I just went downstairs and I asked them what I wanted to do there, wanted to get my GED, finish my school. So I went there and from there I just went on.*"

Outcomes.

Model agreement. Participants generated goals that matched many of the outcomes that were previously proposed. Twenty-seven participants (100%) generated goals related to substance use including clients wanting to reduce use, achieve abstinence, learn about the harmful effects of substance use, go to detoxification facilities, and stay out of trouble as a consequence of substance use. Twelve participants (44.4%) spoke about clients wanting help with renewing relationships, including getting their children back into their care, being a better parent, and/or preventing substance use from being passed on to their children. Three participants (11.1%) spoke about clients wanting to increase their cultural knowledge or connection with their Aboriginal culture. This did not meet the 25% threshold of agreement; however, this outcome was further examined from participants' rating scales, which had a median rating of 4 (SD = 1.30, range 1 to 5) and was significantly different from three (W_s = 199.5, z = 3.06, p = .002). Therefore, this outcome was included in the final model even though less than 25% of participants spontaneously generated this outcome. Eleven participants (40.7%) spoke about clients wanting help with their mental health including problems with anxiety, depression, low self-esteem, grief, anger and/or emotional instability. One caseworker in particular spoke about the goals her clients usually have:

> *The majority of them, I would say, were looking for help with drugs and alcohol. Um, they'd gotten to a point in their life where drugs or alcohol had interfered with their life and they were looking for help to make changes in whether they want to, um, abstain or whether they want to learn to cut down their drinking.*

Participants also agreed with the above outcomes when asked to rate the importance of each outcome (see Table 3 for participant rating statistics).

Model changes. Reintegration, which was proposed in the original model, was removed from the final model. Due to the way in which the question regarding reintegration was asked

and a lack of a clear operationalization of this term, data did not support nor refute the presence of this outcome and, therefore could not be reported.

It should be noted that many participants spoke about clients wanting instrumental support such as legal aid, gaining academic education, gaining professional training, getting their driver's license, owning their own home, and/or gaining employment. Participants spoke about clients having these goals in reference to the Friendship Centre, as much of these instrumental supports could be accessed through the centre and, therefore, are not considered to be goals that directly stemmed from the AADWP. These outcomes were not included in the final model.

Mechanisms.

Model agreement.

Treatment program for needs. This spontaneously generated mechanism was very similar to the "treatment program for your needs" mechanism that was originally proposed. A pathway that emerged from participants without explicit questioning was when clients felt as though their needs were being targeted/met during their one-on-one sessions, as mentioned by 13 participants (48.2%). For example, participants revealed that clients feeling as though the caseworker could target clients' changing needs and clients coming to the realization that the caseworker is doing what is best for them. The following is an example of a client feeling as though his caseworker is not giving him what he needed, which highlights the important presence of this mechanism: *"…It's pretty much the same. So, I don't really hear new things. Like once in awhile she will bring up new spirituality, I guess, but the drugs and alcohol is all the same…well, when they say the same thing, I guess, it's just repeating itself*".

Trusting relationship. Fifteen participants (55.6%) generated responses about clients developing a trusting relationship with their caseworker as a way in which they achieved their

goals. Participants spoke about the importance of clients being able to talk to their caseworker, and feeling unconditionally supported by their caseworker. This generated pathway was consistent with the "trusting relationship with caseworker" mechanism, which was proposed in the original model. The following is an example of a client who established trust with his caseworker: "*Yeah, yeah, it's staying with the same person for over so many years, I know like, they understand you and you, you feel safe to actually be able to talk to the same person and you, you trust them*" (see Table 3 for participant rating statistics).

Belief in a wholistic way of healing. No one spontaneously generated this mechanism. When explicitly asked, participants rated the importance of having a belief in a wholistic way of healing as a mechanism as a 5 (Mdn; SD = 1.19, range = 1 to 5), which was considered to be agreement with this mechanism, as this rating was significantly different from a neutral rating ($W_s = 276$, $z = 3.77$, $p < .001$). The following is an example of a client who had achieved a belief in a wholistic way of healing:

> *More than just looking at the alcohol or looking at the drugs, look at everything and how did you get to the alcohol and drugs. And what can I do to make it better? And which way are you going to make it better? Rather than just the alcohol and drugs. Because everybody's, like just isn't alcohol and drugs.*

Model Changes.

Some mechanisms were added to the model based on the number of participants that spontaneously generated them. As well, participants did not generate nor did they explicitly disagree with some mechanisms that were originally proposed. However, upon close examination of the data, it became clear that some of the originally proposed mechanisms were not underlying causal pathways, as previously thought and were, therefore, removed.

Willingness (added). Participants generated some important mechanisms that were not originally included in the model. One such mechanism is called "willingness/readiness to

change or accept help". This was originally proposed as a client characteristic, meaning that those clients who were unwilling to or not ready for change would have more difficulty progressing. However, from further examination of the data, it became clear that this was a mechanism for many clients, as many clients were able to gain such willingness through the program even though it was not explicitly targeted by the caseworker. Eight participants (29.6%) generated this mechanism. The willingness/readiness to change or accept help mechanism was demonstrated when clients were willing and ready to change, became invested in therapy and became persistent in and/or dedicated to achieving their goals. The following is a caseworker's example of the development of the willingness mechanism through the program: "*…because people [clients], they see… you're interested, you're, you know, people are going out of their way to help, then they stop taking advantage of that to accept the help. And when they do that, then they help, start helping themselves….*"

Self-efficacy (added). Another mechanism that was generated by 12 participants (44.4%) was the self-efficacy mechanism. The development of this mechanism was demonstrated when clients became confident in their ability to use skills that they had learned through the program. Skills gained were related to communication, parenting, and coping with triggers to substance use. The following is an example of a client who had developed the self-efficacy mechanism: *"…I can sit there and I can talk for a half an hour with my wife about what's going on with my daughter. Before, it would be a fight. And now we've learned, like lines of communication, um, we're both in this together. We're both parents…*"

Self-awareness (added). Fourteen participants (51.9%) generated a mechanism that was categorized as self-awareness. This was demonstrated when clients gained a better understanding of their addiction, realized what their triggers were, became more aware of their

environment, developed an understanding of what they actually wanted from treatment or what their goals were, and/or developed an understanding that their needs were a priority. The following is an example of a client who had gained self-awareness: "*Well, I've realized like, what my triggers are, that, what makes me want to do the drugs I was doing, and behavioural problems, like what was making me do it.*"

Attendance of cultural events/increased cultural knowledge (removed). One proposed mechanism that was removed from the model was attendance of cultural events or increased cultural knowledge. Clients did not talk about this as a mechanism; rather, they spoke about this in the context of outcomes both in the short and long term, which was captured under the "increased cultural knowledge/connection outcome". This was removed from the model as a mechanism.

Increased stability (removed). A similar finding was related to the "increased stability" mechanism, meaning that when clients gained stability in their lives around such things as employment, income, and housing, they were able to move toward their goals. Participants did not talk about stability as a mechanism; rather, it was discussed in the context of shorter and longer-term outcomes for clients and was related to instrumental supports being accessed through the Friendship Centre, rather than the AADWP. Stability was, therefore removed from the mechanisms portion of the model.

Attendance of external treatment programs (removed). As well, attendance of external treatment programs was not considered to be a mechanism by which clients achieved their goals, as was originally proposed. This is because, in this context, the underlying causal pathway would be changes occurring for clients throughout their external treatment access, rather than the mere attendance of such treatment. Highlighting the mechanisms of change through external

treatment programs could, therefore, not be measured through the present evaluation of the AADWP, as this would be too far removed from the program of focus. The attendance of external treatment programs mechanism was removed from the final model.

Context.

Model agreement. It should be noted that it was rare for participants to generate their own ideas of which contextual factors impacted the workings of the program, as they found the concept to be abstract and difficult to understand. Therefore, often times the "context generated" question was not asked by the interviewer; rather, the interviewer commonly skipped to the following questions, asking clients whether they agreed or disagreed to the contextual factors that were generated from the Theory Development Phase of the study.

Client characteristics. Two participants (7.4%) generated contextual factors regarding client characteristics that were thought to influence the workings of the program, which did not reach the minimum 25% threshold for agreement. However, when participants were explicitly asked to agree or disagree with proposed client characteristics (i.e., age of clients, complex/severe presenting problems, having an external support system, and the presence of a trauma history), they generally agreed to all characteristics as influencing the program. Participants rated these client characteristics as important, with a median rating of 4 (SD = 1.04, range = 2 to 5). This rating was significantly different from a neutral rating and, therefore, indicated agreement with client characteristics as impacting the program's effectiveness (W_s = 181, $z = 4.46$, $p < .001$). The following illustrates an example of how clients with more complex problems may need to be referred to external treatment programs, as revealed in this quote: "*...if it doesn't work for someone else, I would suggest going into a, um, um a program where you stay*

in there. I went to one in Kitchener…It was an eight month program, where you lived there and you go to all your meetings and that."

Staff characteristics. Regarding staff characteristics, the only staff characteristic that was spontaneously generated was the importance of caseworkers having their own personal addiction experience, which was generated by one participant (4.2%). This matched the previous model, but did not reach the minimum agreement threshold of 25%. However, participants agreed with proposed staff characteristics when directly asked. These included caseworkers having personal experiences with addiction, having long-term commitment to the program, being willing to network and collaborate with other programs, providing continuity of care, continuing training, and being from Aboriginal descent/communicating cultural knowledge. Participants agreed that when the above-mentioned characteristics were present, the program would be more effective for clients and gave a median rating of the importance of staff characteristics in impacting the program of 5 (SD = .66, range = 3 to 5). This rating significantly differed from a neutral rating ($W_s = 276$, $z = 4.46$, $p < .001$) and was considered to be agreement. The following client spoke about the importance of caseworkers having their own addiction experience: "*Yeah, I mean, for someone to have gone through the exact same thing, ah, I would trust someone in that position a lot better than someone who never has had a problem. I have a big issue with people telling me how it should be if they haven't experienced it themselves.*"

Setting characteristics. Regarding setting characteristics, 10 participants (37%) identified contextual factors related to setting characteristics, including the importance of the program's location. Clients from Hamilton spoke about the accessibility of the program as related to where it was located. One client in particular spoke about how he appreciated the program being located in the center of the city, which was very accessible for him. Another client from Fort

Frances spoke about how the program was located in an area where there were not many local external resources, such as detoxification centres. This client specifically spoke about a limited number of external resources to the program available for those who needed additional support in the area of domestic violence: "*Yeah. They don't have that or, if the women need a place to run to, from their spouse, they don't have that here*". These generated responses are in agreement with our previously proposed setting characteristics (see Table 3 for participant rating statistics).

Model changes.

Client characteristics. Willingness was originally proposed as a client contextual factor that influenced the effectiveness of the program (i.e., the program would be less effective for clients who are not willing or ready to change and/or accept help). Due to the way in which willingness was discussed by participants in the second phase and the potential of this factor to change over the course of treatment, willingness was included in the final model as a mechanism by which clients achieve their goals.

Staff characteristics. Participants were also asked about whether the caseworkers' flexibility around harm reduction would influence their progress. This means that if clients did not have goals to abstain from alcohol or drug use, their caseworker would use a harm reduction approach (i.e., reducing alcohol or drug-related harm without requiring the cessation of alcohol or drug use), rather than an abstinence-based approach. Due to the way in which this question was asked, data did not support nor refute the influence of this contextual factor on the program and, therefore, could not be reported. As well, a direct counselling style that was originally proposed, in the parts of the program portion of the model, was moved to staff characteristics and changed to "friendly and non-judgmental demeanour", as clients spoke about this approach in a way that was better captured by caseworkers' personal characteristics.

Setting characteristics. It should be noted that either due to inadequate training or interviewer exhaustion, questions relating to staff environment and balanced administrative work were rarely asked (i.e., one out of three interviews) and, therefore, there were not enough data to support nor refute these contextual factors. Since these results could not be confirmed by the Evaluation Phase, they were removed from the final model.

Context-Mechanism-Outcome Configurations: Final Model

Clients accessing the AADWP were able to achieve their goals around substance use, renewing relationships, certain mental health problems, and reconnecting with their Aboriginal culture through the following mechanisms: (a) when clients felt their needs were being met, (b) when clients established a trusting relationship with their caseworker, (c) when clients developed a belief in a wholistic way of healing, (d) when clients became willing or ready to change their behaviours, (e) when clients developed self-efficacy in their abilities to cope with their addiction, relationships, mental health problems, and cultural connectedness, and (f) when clients developed awareness of themselves and their environment. Without the development of these mechanisms, clients would be unable to progress toward their goals or such a progression may be delayed until these mechanisms develop.

Client characteristics. The establishment of the above-mentioned mechanisms and, therefore, clients' movement toward their ultimate goals will be less likely if certain client characteristics are present. 1. Younger clients may have more difficulty responding to the program, as they may be less mature and need more resources than the caseworker can provide. 2. Complex issues such as severe substance use problems or concurrent mental health problems may present challenges for clients, as the caseworker may need to refer clients with such presenting problems to external treatment programs (e.g., detoxification centres). 3. When

clients do not have (social) support that is external to the program (e.g., friends and family), this makes it more difficult for clients to move towards their goals. 4. Finally, the presence of a trauma history (i.e., experiencing varying levels of physical, emotional, and/or sexual abuse) makes it more difficult for clients to establish trusting relationships with their caseworker as well as other key mechanisms and, therefore, move toward desired outcomes.

Staff characteristics. The establishment of the mechanisms outlined above and, therefore, movement toward achievements of clients' ultimate goals will be more likely when certain contextual factors regarding the staff are present. 1. Having a friendly and non-judgmental demeanour and a sense of humour. The presence of these characteristics helps clients feel more relaxed, less formal, and may reduce the power imbalance when they attend counselling sessions. 2. Clients found it important for caseworkers to have their own addiction experience, as this made many clients feel as though their caseworker was able to understand them. 3. Clients appreciated long-term caseworkers, as it is easier to progress toward any of the above-mentioned mechanisms and outcomes when clients are able to see one consistent person throughout their time in the program. 4. It is also important for caseworkers to network with external services and be knowledgeable about the services offered to make appropriate referrals. This is especially important since the program heavily relies on referrals to detoxification centres. 5. Clients appreciated when caseworkers provided continuity of care/follow-ups (i.e., providing support for clients even when they were accessing services external to the program or had stopped attending the AADWP). This especially helps establish trust as well as all other mechanisms outlined above. 6. Clients thought that caseworkers should continue their training, as new approaches and strategies are always being developed and caseworkers should have up-to-date knowledge/skills in this area. As seen in the demographic characteristics collected at the

beginning of the staff interviews, 100% of the caseworkers were highly willing to continue their training. As well, the more experience caseworkers have in the area of treating addictions, the more effective they were thought to be. 7. Caseworkers being from Aboriginal descent represented an important staff characteristic for many clients. If caseworkers do not identify as Aboriginal, they should at least be knowledgeable about Aboriginal cultures. Caseworkers should also be willing to communicate their knowledge about Aboriginal culture to those clients who want this. All caseworkers reported high willingness to communicate such knowledge (see Table 2).

Setting characteristics. The establishment of the mechanisms outlined above and, therefore, clients' movement toward their ultimate goals will be more likely if the following contextual factors regarding the setting are present: accessibility and privacy, which are influenced by the program's location. The location of the program in the Friendship Centre influences clients' perceived privacy. This location puts clients at risk of feeling a lack of privacy because individuals accessing other programs through the Friendship Centre may become aware of those who attend the AADWP, compromising confidentiality. However, a significant benefit to the program being located in the Friendship Centre is that it is more accessible and there are numerous resources that clients can access while attending the program.

Program Recommendations

Participants spontaneously generated suggestions regarding the program. The following are ways in which 11 participants (40.7%) thought the AADWP could be improved: a decreased caseload for the caseworkers so that they could keep better track of their clients; providing educational presentations on the effects of drugs and alcohol, followed by a question and answer period; offering more cultural activities; increased availability of caseworkers (i.e., more than

once a week) for people who had been recently released from a correctional facility; a 24-hour service (such as a hotline); including significant partners in counselling sessions; having flexibility around incorporating cultural teachings during sessions for those who do or do not want this; and motivational speakers who had successfully completed treatment for their addiction. A caseworker from Fort Frances specifically spoke about the need for more cultural activities: "*Well, you know, the attendance of cultural events, more cultural knowledge, you know, I would really like to offer more sweats and more, you know, and do more cultural activities, but the lack of funding is a real hindrance.*"

Discussion

The purpose of this study was to empirically and realistically evaluate the Aboriginal Alcohol and Drug Worker Program (AADWP), which targets urban First Nations, Inuit and Métis adults with substance use problems. The major aim of the study was to answer the following questions: How, for whom and under what circumstances does the AADWP help or not help clients? By designing an evaluation study that takes into account the common goals that clients have, as well as the processes through and contextual factors under which clients achieve these goals, these questions were successfully answered.

The mechanisms by which clients were able to achieve their goals directly related to the caseworkers' responsibilities and counselling approaches. Common goals included: sobriety/gaining control over substance use, renewing relationships, reconnecting to one's First Nations, Inuit and/or Métis cultures and improving mental health. Key mechanisms included: (a) addressing clients' individual needs; (b) establishing a trusting relationship with the caseworker; (c) developing a belief in a wholistic way of healing; (d) developing willingness to change; (e) developing self-efficacy; and (f) developing self-awareness. Without such mechanisms, clients

would be unable to achieve their goals. Important contextual factors that moderated clients' pathways to their desired outcomes related to client characteristics (e.g., complexity of presenting problems), staff characteristics (e.g., personal experiences with addiction), and setting characteristics (i.e., program location). The program aids clients in reaching their goals through the above mentioned mechanisms and when favourable contextual factors are in place.

It is not surprising that sobriety/reduced substance use was the most commonly reported goal by participants. This finding was expected because of (a) the high prevalence of substance use problems among the First Nations, Inuit, and Métis populations in Canada (Aboriginal Healing Foundation, 2007; Health Canada, 1998) and (b) the major aim of the AADWP, which is to alleviate substance use problems (The Ontario Federation of Indian Friendship Centres, 2010). Mental health was another outcome that was expected to be important for clients, as First Nations, Inuit and Métis populations commonly experience co-occurring mental health problems in addition to problems with substance use (Jacobs & Gill, 2002). Mental health goals for those seeking substance abuse treatment will likely be apparent within the general population, as mental health problems also commonly occur concurrently with substance use problems for non-Aboriginal populations (Canadian Centre on Substance Abuse, 2009). Therefore, these results may apply to a context extending beyond Aboriginal populations. Although participants reported clients having goals related to mental health when accessing the AADWP and caseworkers used some strategies to alleviate mental health problems, it should be noted that clients were often referred by the caseworker to mental health treatment external to the AADWP. This speaks to the inability of the program to target complex presenting problems, which is why such problems were outlined as an important contextual factor. The AADWP can provide some

treatment for these clients; however, a strength of the program is knowing where resources fall short and when to refer clients.

Clients' reconnection to their First Nations, Inuit, and/or Métis culture was identified as a desirable outcome and was supported by participant ratings. This outcome is consistent with other substance abuse programs targeting Aboriginal populations. More specifically, a substance abuse program targeting Aboriginal populations called the Pisimweyapiy Counselling Centre in Nelson House, MB aims to "allow our people to embrace their own practices" and is designed to facilitate clients' reconnection to their Aboriginal cultures for healing purposes (Aboriginal Healing Foundation, 2008).

Even though the "reconnection to clients' culture" outcome was supported by participant ratings, few participants generated this outcome on their own. This is surprising because historical colonizing and assimilative tactics that have removed culture from First Nations, Inuit, and Métis Peoples have been cited as partially responsible for the high prevalence of substance use problems among these populations (Aboriginal Healing Foundation, 2008; Battiste, 2000). More specifically, it has been hypothesized that First Nations, Inuit, and Métis people may abuse substances because (a) many do not have a cohesive sense of identity and use substances to cope with this struggle and (b) many are not aware of their culture, which can guide them and help them cope with traumatic circumstances (McCormick, 2000). From examining this literature, a reasonable prediction would be that most clients that access the AADWP would be eager to get involved with cultural activities and gain cultural knowledge from their caseworker; however, fewer participants than expected generated this goal on their own.

There are a few reasons that can account for this lack of interest in cultural reconnection. 1. Caseworkers may not offer cultural teachings or referrals to traditional ceremonies in order to

respect clients' autonomy, as it is not always appropriate to provide such teachings or referrals before the client has initiated interest in this learning, within Aboriginal contexts (Brant, 1990). As well, some clients who access the AADWP have no connection to their First Nations, Inuit or Métis culture and, therefore, even if interested, they may be apprehensive about such reconnection or have no idea for what to ask. If available, caseworkers should make it clear that cultural teachings and ceremonies can be accessed by clients, but that it is up to the client to let the caseworker know if this is of interest. 2. Cultural resources may be inaccessible for clients. Clients may have issues with transportation required to attend cultural ceremonies or there may simply be a lack of cultural resources that are available for clients at certain Friendship Centre locations. In particular, a few participants in Fort Frances spoke about a lack of available cultural resources. This may be attributable to Fort Frances' less urban location and less overall external resource availability. It should be noted; however, that resource availability is beyond the capacity of the AADWP to address, as it is often difficult to implement Friendship Centres in central areas due to a lack of funding allocation. 3. Clients may simply not understand the potential benefits of reconnecting to their culture and, therefore, may remain ashamed or indifferent with regards to learning about their culture. Caseworkers should outline the potential benefits of clients reconnecting to their First Nations, Inuit or Métis culture while stressing respect for clients' decisions to forgo this reconnection. 4. Finally, it is also possible that some clients may not need such reconnection to their culture. Such clients may already be connected.

Yet another surprising finding related to outcomes was regarding the "renewing relationships" goal, as this outcome may not immediately come to mind. This outcome reflects the wholistic nature of the program and how it aids in many different aspects of clients' lives. This goal also speaks to the effect that colonization tactics have had on relationships within a

First Nations, Inuit, and Métis context (i.e., residential schools). From such tactics, relationships within First Nations, Inuit, and Métis communities have been fragmented (Hare & Barman, 2000). When participants outlined this as an important goal, it highlighted the lasting, intergenerational effects of historical trauma and how the AADWP is able to address this pressing issue. As well, the ability of clients to move toward this goal demonstrates the incredible resilience of First Nations, Inuit and Métis Peoples and is fitting with those resiliencies outlined in reports by the Aboriginal Healing Foundation (i.e., 2003). Renewed relationships could also be an important goal for people with substance use problems in the general population, as substance dependence has been shown to be associated with the alienation social networks (Kadden, 1995). Such relationships will, therefore, need to be repaired throughout the recovery process for non-Aboriginal populations, as well as for Aboriginal populations with substance use problems. Further, one of the 12 steps that people are expected to achieve when accessing Alcoholics Anonymous (a non-Aboriginal program) is making amends with those who they have wronged (Alcoholics Anonymous World Service, 1972), which also speaks to the importance of renewing relationships in the general context of substance use problems. This is yet another example of how the results of this study may apply to the larger population with substance use problems.

Not surprisingly, key mechanisms necessary for clients to achieve their goals were related to needs and trust. For many clients who access the AADWP, merely having someone listen to them, and express concern and effort regarding their needs is a significant change from their daily lives, as conflict and invalidation is common within relationships for many Aboriginal people (and should be cited within the context of historical trauma). Moreover, in addition to non-Aboriginal populations (Kadden, 1995), many clients in an Aboriginal context may have

alienated their healthy social network because of their substance use problems (McCormick, 2000) and, therefore, may not have any support or only have "support" that is untrustworthy or unreliable. As well, there is much shame around substance dependence, as highlighted in both Aboriginal (McCormick, 2000) and non-Aboriginal (Goldstein et al., 2009) contexts. Due to these circumstances, many individuals accessing the AADWP may be reluctant to share details regarding progress toward recovery and when they are struggling with their addiction. Therefore, clients feeling as though their needs are being met and that they can trust their caseworker are mechanisms necessary in order for clients to move forward. These mechanisms likely trigger thoughts of the therapeutic relationship between clients and caseworkers, as establishing trust and tailoring treatment to client needs are highly influential in the development of this relationship. By thinking about these mechanisms as they relate to the therapeutic relationship, it becomes clear why these mechanisms were so instrumental in client progress. The therapeutic relationship has been shown to be very predictive of desired counselling outcomes for clients with a variety of presenting problems and across many different treatment modalities (Horvath & Symonds, 1991; Martin, Garske, Davis, 2000). Although studies have not yet been conducted in the context of Aboriginal populations, highlighting this literature enhances understanding of the present findings.

A belief in a wholistic way of healing was also a key mechanism; however, this did not apply to all clients accessing the AADWP. Clients who were disconnected, yet interested in reconnecting to their First Nations, Inuit or Métis culture, could especially benefit from this mechanism. For those clients to which this mechanism is relevant, it would provide fundamental knowledge for eventually understanding who they are as Aboriginal people. This wholistic model is a foundational component of many Aboriginal cultures and can be applied in many

different contexts with regards to healing. This mechanism is in line with other programs targeting Aboriginal populations. More specifically, an Aboriginal program, Tsow-Tun Le Lum ("The Helping House") in the northern outskirts of Nanaimo, BC, is one such substance abuse treatment program that uses this wholistic model/worldview to help clients heal (Aboriginal Healing Foundation, 2008). In addition to the AADWP, clients who access Tsow-Tun Le Lum are also thought to benefit from the adoption of this model (Aboriginal Healing Foundation, 2008). As well, Gone (2009) outlined the importance of wholistic healing in effective treatments targeting First Nations populations suffering from historical trauma. Such a model will likely apply to issues that stem far beyond substance use problems.

The willingness mechanism was surprising as a resulting mechanism, as it was initially proposed as a contextual factor. It is especially interesting that this mechanism was found to arise for many clients since motivational interventions were not used at the AADWP. Such interventions could be described as conflicting with the "ethic of non-interference" as outlined by Brant (1990). This is one of the most important ethics of behaviour for "Native" people and states that positive relationships are fostered by discouraging coercion of any kind and promotes respect for every persons' independence. Restriction or interference of another individual's freedom is an undesirable behaviour in many Aboriginal contexts (Brant, 1990). Even though unwillingness is not targeted through the AADWP, many participants spoke about clients' progress toward willingness and readiness through accessing the program. Mechanisms are in no way mutually exclusive (Pawson & Tilley, 2008) and movement toward willingness in the absence of any coercion or motivational methods may be due to the highly valued and respected relationship that often develops between the client and the caseworker. Being able to attend a weekly session and engage in self-exploration with someone who is genuinely invested in the

client's well-being (which may be rare for many clients outside the program) could be the catalyst to developing this key mechanism.

The identification of the willingness mechanism fits with literature examining the importance of willingness in substance abuse treatment targeting other Aboriginal populations. More specifically, Fickenscher, Novins and Beals (2006) found that, among "American Indian" adolescents with substance use problems, willingness was a significant predictor of treatment completion in a Residential Substance Abuse Treatment Program targeting American Indian populations. This mechanism is also comparable to literature targeting the general population. More specifically, motivation has been found to be a predictor of treatment retention and engagement in substance abuse treatment targeting the general population (De Leon, Melnick & Hawke, 2000; Ryan, Plant, & O'Malley, 1995; Simpson & Joe, 1993), which are both very important in treatment success. Therefore, willingness fits with other Aboriginal as well as non-Aboriginal contexts, furthering the relevance and contribution of the present study.

Finally, self-efficacy and self-awareness were two mechanisms that were found to be instrumental in moving clients toward desired outcomes. When clients learned about their strengths, which was a counselling approach that most caseworkers used, they were able to better understand themselves, contributing to confidence in their ability to use the skills they learned in session and further increased their perceived ability to manage their addiction and their lives. As well, the work that was done during one-on-one counselling sessions was key to clients understanding their own individual weaknesses such as what their triggers were to using substances or becoming violent, etc. From this, clients became aware of what they needed to work on and developed their own goals, becoming an active participant in their own recovery. The development of self-efficacy and self-awareness may have also contributed to the

development of willingness, as clients may not have understood (a) that they had a problem when they first accessed the program or (b) the potential they had to progress and grow, which was often times explicitly outlined by the caseworker.

The self-efficacy mechanism is consistent with findings from Taylor (2000) who found that, among "American Indian" and "Alaskan Native" populations, general self efficacy (i.e., perceived control over bringing about change in one's life) was associated with lower alcohol use when accessing substance abuse programs targeting these populations. As well, the self-awareness mechanism is consistent with findings from Gone (2009) who examined therapeutic approaches and activities within Aboriginal programs that aimed to alleviate the impact of residential schools (which is highly related to substance abuse/dependence) for First Nations people in Canada. Gone (2009) found that self-awareness (i.e., looking into oneself) was necessary for desired long-term outcomes (e.g., continual self-growth). More specifically, in this study, clients spoke about how progress was tied to gaining greater self-awareness and self-understanding through the programs they accessed, which is very much in line with the findings of the present study. These mechanisms may also apply to substance abuse treatments targeting the general population, as Hasking and Oei (2004) found self-efficacy (more specifically, drink refusal self-efficacy) to be highly associated with decreased frequency and volume of alcohol consumption for non-Aboriginal participants accessing substance abuse programs. Finally, regarding self-awareness, Goldstein et al. (2009) discussed the common lack of self-awareness among individuals with many different disorders, including substance abuse, and how gaining such self-awareness is key to recovery. The applicability of the present findings to both Aboriginal and non-Aboriginal populations further strengthens the contribution of the present study.

Contextual factors came into play at the outcome and mechanism level. Contextual factors as related to client characteristics moderated the development of outcomes and mechanisms, as some client characteristics presented challenges relating to progress (i.e., younger clients, clients with complex problems, absence of external support and presence of a trauma history). It should be noted that all of these client characteristics are likely to be present for those accessing the AADWP, as the prevalence of such characteristics is very high within many Aboriginal populations and for those with substance use problems. Although such characteristics present challenges for caseworkers regarding their effectiveness in moving clients toward necessary mechanisms and desired outcomes, they do not necessarily lead to unresponsive clients. Such characteristics merely increase difficulty for client progress; however, such progression is still very possible. Since the program is not time-limited (i.e., by number of weeks), this provides clients with less favourable circumstances more time to work toward recovery and this is a definite strength of the program.

The consideration of client characteristics is consistent with available literature, as other studies have found client characteristics to affect their progress in substance abuse treatment. For example, Groh, Jason, Davis, Olson, and Ferrari (2007) found that having external support was predictive of client progress among a non-Aboriginal sample with substance use problems. Even though this study was not conducted with a First Nations, Inuit or Métis sample, the findings provide support regarding the impact of such client characteristics. Another example refers to clients with trauma histories, as it has been proposed that clients with substance use problems who have experienced trauma often view their substance use problem and trauma as inter-related (i.e., they use substances to cope with trauma). These clients may require treatment targeting both problems at once (Brown, Stout & Gannon-Rowley, 1998). Although this

proposal refers to the general population, this should be recognized within Aboriginal contexts, as what is called "Residential School Syndrome", is common among Aboriginal people. This syndrome is similar to Post Traumatic Stress Disorder (Brasfield, 2000) and is likely to present at substance abuse treatment programs targeting Aboriginal populations. These findings are in line with the present findings that highlight the consideration of client trauma histories as impacting client progress.

Staff characteristics also moderated the eventual development of mechanisms and outcomes, as participants found certain staff characteristics to be important for client progress (i.e., non-judgemental, own addiction experience, long-term commitment, connections with external services, providing continuity of care, continuing training, and Aboriginality/cultural knowledge). The program is likely to be very effective because the majority of the caseworkers were found to have most of these characteristics. In particular, one discrepancy was regarding long-term commitment, which became apparent when examining differences between the Hamilton Regional Indian Centre and the United Native Friendship Centre in Fort Frances. The AADWP at the Hamilton Regional Indian Centre, had a consistent caseworker who had been with the program for approximately 17 years. The AADWP at the United Native Friendship Centre in Fort Frances had just lost its caseworker (who had also been recently hired) at the Theory Development Phase and a new caseworker had just been hired at the Evaluation Phase of the study. The inconsistencies as related to the caseworker in Fort Frances was not as effective for clients and a few participants spoke about how it was difficult for clients to develop trust (a key mechanism) when there is a high caseworker turnover rate. The ability of the program to hire and retain a caseworker can have a significant impact on client recovery.

The findings presented regarding staff characteristics are consistent with literature examining the impact of therapist characteristics on client outcomes. For example, Vasquez (2007) highlighted the importance of the therapeutic alliance when delivering treatment and how psychologists may unintentionally disrupt this alliance with culturally different clients through their own unintentional biases toward their own culture. Even though this study is not specifically in reference to Aboriginal populations, it can still be used to contribute to understanding the present findings (i.e., the importance of caseworkers' Aboriginal heritage or cultural knowledge). Due to the importance of the therapeutic alliance, this may also help explain the importance of caseworkers being non-judgemental and having a friendly demeanour, as this would directly affect the development of the client-caseworker relationship. A final example is regarding caseworkers' own addiction experience. Within Aboriginal contexts, experiential knowledge is often considered to be more credible than formal training (Jack, Brooks, Furgal, & Dobbins, 2010), which may explain why caseworkers having their own addiction experience was so highly valued by participants. These studies provide examples of the importance of considering staff characteristics in substance abuse treatment programs and further strengthen the validity of the present findings.

Finally, even though the setting characteristics outlined may seem obvious, they should always be considered when conducting program evaluations. Accessibility to the Friendship Centre and having a private room for counselling sessions are necessary for triggering mechanisms. More than any other setting characteristics, accessibility issues were expressed by participants. Although public transit was helpful for those clients living in the city of Hamilton, some clients struggled with public transit issues (e.g., delays and inaccessibility). Clients accessing the program in Fort Frances raved about the transportation service "dial-a-ride", which

was implemented through the Friendship Centre. This transportation service was reliable in helping clients get to the Friendship Centre and clients did not have to pay for it. Clients from the Hamilton site may benefit from a similar service, as accessibility issues will inevitably affect client progress. Privacy is also an important consideration. The program being located in the Friendship Centre is helpful regarding accessibility, but also affects perceived privacy. The program should continue to be implemented within the Friendship Centre; however, greater care should be taken to ensure clients' privacy. Overall, the location of the Friendship Centre is an important consideration, as this will affect the availability of more versus less resources for accessibility, privacy, as well as referrals to external treatment programs. Gray et al. (2006) highlighted the link between limited program effectiveness and inadequate resources, which is often found in substance abuse programs targeting Aboriginal populations. It is likely that the AADWP could be more effective in helping clients achieve their goals if adequate resources were allocated to the program, especially to those locations that are less urban (e.g., Fort Frances), which is often accompanied by fewer resources.

It is important to note that this program is effective for clients partly because it is very well integrated into the Friendship Centre. The program is so well integrated that clients often do not distinguish between the other programs they access through the Friendship Centre and the AADWP. Clients come to the program with multifarious and complex needs and, therefore, having the AADWP in the same setting as legal aid, a schooling program, childcare, and help with housing and employment is very influential in helping clients achieve their goals. It also contributes to the wholistic and integrative nature of the AADWP.

The results of this study provide a synthesis of the above-mentioned outcomes, mechanisms, and contextual factors in order to create what is called context-mechanism-outcome

(CMO) configurations. The AADWP has been implemented for many years, helping many clients achieve their goals and now, the results of this program evaluation aids in understanding the process by which clients achieve their goals and the contextual factors that need to be considered. In other words, the present study provides insight regarding how, for whom, and under what circumstances the program works or does not work. From this evaluation, managers and caseworkers can understand the underlying, causal pathways through which clients achieve their goals and target such mechanisms during treatment. Perhaps such results can generalize to other substance abuse programs targeting both Aboriginal and non-Aboriginal populations, and treatments can be tailored to achieving the outlined mechanisms.

Recommendations for Substance Abuse Workers in Urban Aboriginal Contexts

From the mechanisms outlined above, it is clear that substance abuse workers in urban Aboriginal contexts, may increase their effectiveness by targeting the mechanisms outlined above. More specifically, workers should focus on conducting very thorough assessments in order to understand clients' presenting needs and target such needs. This will aid in the development of "treatment for clients' needs" mechanism. As well, training of workers in substance abuse contexts, should provide them with skills related to building rapport with their clients, in order for them to effectively develop trusting relationships, as this is a key mechanism as well. Furthermore, workers should spend time in counselling sessions teaching clients about the medicine wheel and wholistic healing, so clients can adopt such a belief and begin to work on healing many different aspects of themselves, rather than mere symptom reduction. This will aid in desired outcomes, as such a belief is a powerful mechanisms for many clients. A focus on needs and rapport building in treatment will also aid in clients' development of willingness or readiness to change. As well, culturally appropriate forms of motivational interviewing (MI; a

client-centered and non-coercive method to elicit intrinsic motivation) may be helpful for those clients who have more difficulty moving toward willingness to change, since this was also found to be an important mechanism. Finally, in counselling sessions, when workers focus on clients' strengths and weaknesses and teach clients different skills to use when faced with triggering circumstances to engage in maladaptive behaviours, this will help clients move toward self-efficacy and self-awareness and aid in clients' progression toward desired outcomes.

Strengths and Limitations

Strengths of this study include its rigour, incorporation of strategies to minimize potential biases, use of realist methodology and use of a participatory action approach. One way this study is considered to be rigorous is due to the wide net that was cast by collecting data from clients and staff members (from both caseworkers and staff from the Friendship centre in the first phase of the study). By collecting data from multiple sources, a wide range of responses were gathered and it was clear when saturation was reached. As well, theories regarding how, for whom, and under what circumstances the program works or does not work were developed from focus groups and questionnaires and tested during individual, in-depth interviews. Using different methods of data collection to develop initial theories and testing these theories is not a requirement of either quantitative or qualitative research. However, by implementing this method, final theories (CMO configurations) are more accurate, appropriate and helpful for the program of evaluation, in comparison to using one method of data collection and failing to confirm theories.

Another strength of this study relates to the recognition and appropriate action to control for potential biases in each and every step of the project. One way in which the potential biases were controlled was to approach the initial phase with an open mind and without extracting

theories from other program evaluations (that would not be culturally applicable). The AADWP is a unique and specific program and, therefore, knowledge of other program evaluations could have inappropriately influenced members of the research team as related to the questions asked and interpretation of responses. Another way in which potential biases were controlled was by including people on the research team who had previous experiences working with First Nations, Inuit and Métis people (i.e., in the areas of health, mental health, and legal aid). In having these experiences, the research team was better able to connect with the interviewees and better understand those examples or responses that were given by participants from more traditional Aboriginal backgrounds. Finally, during the coding and analysis stage of the study, potential biases were controlled by consistently legitimizing and corroborating the theories that were developed and, therefore, the final theories are not merely influenced by one person's experiences and/or perspectives.

Using realist methodology is yet another strength of this study. This is considered to be a strength because, when using this methodology, it is recommended that the researcher take culture into consideration, as this is a very influential contextual factor (Pawson & Tilley, 2008). Most clients who access the program identify more or less with their First Nations, Inuit, and/or Métis culture. By taking these cultures into consideration when collecting and analyzing the data, it allowed the research team to better understand the clients who accessed the AADWP, as well as the processes by which they were able or unable to achieve their goals. As well, a realist evaluation takes other contextual factors into account, which created an in-depth and wholistic understanding of the AADWP. This will be helpful for subsequent action to improve health circumstances on the part of the community (OFIFC) with which this project was conducted.

Lastly, this study is strengthened by the use of a participatory action research approach. In using this approach, the present research team collaborated with the community in which this project was conducted (OFIFC). Mutual respect was gained between the research team and the community, which was then translated to all of the clients and staff members from whom data were collected. The study could then be conducted respectfully and output can now be used for action to improve the program and contribute to decreasing substance use problems among First Nations, Inuit, and Métis people.

Although there are many more strengths, there are some limitations of the present study. The first relates to the length of the in-depth interviews. The interviews were a maximum of 90 minutes and most participants stated that this was very long for them. The length of the interview is a limitation because it compromised the interviewee's comfort level and created a risk of losing richness in their responses due to fatigue. Participant fatigue has been highlighted by Boksem, Meijman and Lorist (2005) who suggested that mental fatigue occurs after lengthy periods of mental activity and, in the context of research, this can deteriorate participant performance on measures in question. If this study were to be replicated, the interview should be a maximum of 60 minutes.

Another limitation relates to discrepancies when conducting the individual in-depth interviews. Due to the combination of training deficits and interviewer exhaustion, some sections of the interview guide were not followed and, therefore, some portions of the interview were conducted differently by different interviewers. This affected the validity of some of the responses. For example, the interview guide outlined that each interviewer was to ask each question and collect a response for each individual model part. The following dialogue provides an example of this:

Interviewer: "*Do you think that clients would gain more from the program if they had a support system*?"

Client: "*Yes, that is important*"

Interviewer: "*Do you think the program would be just as helpful if a client had a trauma history*?"

Client: "*It might make it more difficult for clients, but the program could probably help, overall*".

However, for some interviews, the interviewer asked all questions in a particular interview section and elicited a response from participants to all these questions at once. The following dialogue provides an example:

Interviewer: "*Does it matter if a client has a support system, a trauma history, or a complex presenting issue*?"

Client: "*Yes*".

For this example, it is difficult for the participants to disagree with any particular contextual factor, as they were being asked about all of them at once. When asking questions in this way, the risk of participants acquiescing to the interviewer's suggestion was much greater and potentially invalidated responses. To control for this issue, the codebook instructions (used for qualitative analysis) were revised, meaning that nothing was coded unless participants could elaborate on their responses. In this way it was clear (a) that participants understood the question and (b) to which question participants were responding during instances where individual questions were amalgamated. This issue was further controlled by only using those parts of the model that were spontaneously generated by participants or to which participants quantitatively agreed (via rating scales), rather than those to which participants were explicitly asked to agree,

as the risk of an invalid response was deemed to be too great, even though, from this decision some relevant data might not be used. As well, some questions were skipped by some interviewers, providing a lack of data to confirm some portions of the original model (e.g., balanced administrative work). Rather than reporting potentially inaccurate information, such characteristics were removed from the model and reasons for this exclusion have been noted throughout the thesis.

An additional limitation of this study is with regards to operationalization of some of the terms in the interview guide. Questions about reintegration were included, as this was a topic that came up in the Fort Frances focus group. This was with regards to the transition from a correctional facility or inpatient treatment facility to one's previous community and maintaining progress. From the analysis in the Theory Development Phase, this reintegration concept was thought to be a macro outcome for which everyone strives. However, due to the unclear definition that was presented to participants, only some were able to answer the question and responses were not strong enough to either support or refute this particular outcome. As well, the question related to caseworkers' acceptance of harm reduction was not clear for many participants. Because of this, participants had difficulty responding to this question and, as a result, the data were not of substance to report. Finally, when asking participants to generate their own ideas of contextual factors that impacted the program, this question was also somewhat unclear for many participants and, therefore, many were unable to answer the question. Because of this, few participants were able to generate contextual factors on their own.

A further limitation is also regarding the context portion of the interview. Since it was difficult for participants to generate their own ideas about the contextual factors influencing the program and many agreement statements were deemed as potentially invalid for use in the

analysis, in order to make conclusions about such factors, rating scales were the main means of confirming originally proposed contextual factors. There were rating scales for client, staff and setting characteristics; however, such context categories were not further broken down to include rating scales for individual context characteristics (e.g., clients having a trauma history, a complex presenting issue, etc). The rating scale questions that were related to contextual factors asked participants to rate overall client characteristics (rather than individual client characteristics), that impacted the program. The same was done for staff and setting characteristics. This forced participants to rate all client characteristics at once (and the same was done for staff and setting characteristics). If, for example, participants happened to disagree with a particular client characteristic, this would not be as well captured as would have been the case if rating scales were separated into individual client characteristics. Participants were given the opportunity to disagree with any of the proposed contextual factors throughout the interview and no more than 25% of participants disagreed with these factors. However, as previously mentioned, this opportunity was not consistently given, as some interviewers amalgamated the context questions, which also made it difficult for participants to disagree to individual contextual factors. If this study was to be replicated, interviewers should follow the exact interview guide and ratings scales should be specific to each individual contextual factor, rather than categorized by client, staff and setting characteristic.

A final consideration is regarding the use of a realist lens and qualitative methods. Although these were outlined above as strengths, there are limitations associated with these approaches to research that should be highlighted. Realist approaches are complex and multi-faceted and, it should be noted, that there are other perspectives through which program could have been evaluated. For example, constructivism approaches posit that there are multiple

realities that are constructed by individuals (Sobh & Perry, 2006). Critical theory views reality as being constructed via social, economic, political and cultural values and, from such values, realities are crystallized over time (Sobh & Perry, 2006). There is also a positivist lens, through which reality is considered to be real and apprehensible and researchers are considered to be objective. Quantitative methods often stem from a positivist approach (Sobh & Perry, 2006). Anyone who disagrees with the realist perspective may disagree with the results presented; however, such views cannot be empirically tested, as they stem from an individual researcher's own views and perspectives. Differences in epistemological approaches should be highlighted, as the reader should note potentially different views from which to collect, analyze and interpret both qualitative and quantitative data. Moreover, qualitative methods usually stem from the realist perspective; however, these methodologies have been critiqued for lacking scientific rigour, being highly subjective, and lacking generalizability (Mays & Pope, 1995). Although attempts were made to control for these issues by testing initial theories and consistently legitimizing and corroborating interpretation of data with other researchers, potential limitations associated with these methods should be considered when examining the present findings.

Future Research

Future research should evaluate other substance abuse programs targeting both urban and on-reserve First Nations, Inuit and Métis populations in order to improve upon those that are currently being implemented. Substance use problems are serious and highly prevalent issues among Aboriginal Peoples in Canada (Aboriginal Healing Foundation, 2007; Health Canada, 1998). It is important to understand the effectiveness of programs that have been implemented to alleviate these problems as well as what can be done to increase their effectiveness. Such

evaluations should be culturally specific and appropriate. As well, they should be conducted in collaboration with the community in which the evaluation will take place.

Future research should also aim to continue developing culturally specific programs for Aboriginal individuals with substance use problems. More specifically, there is a need for such programs to be even more targeted, meaning that they should be tailored to particular Aboriginal cultures (e.g., a treatment program that is specific to Métis individuals). It is difficult to target an entire population using cultural knowledge as a therapeutic tool, when there are vast differences within the culture.

Conclusion

From the present study, the underlying mechanisms that account for the Aboriginal Alcohol and Drug Worker Program's successes and drawbacks in helping urban Aboriginal clients with substance use problems can be understood. Clients are able to reach many different goals as related to their substance use, relationship issues, cultural reconnection and certain mental health problems through the program. By gathering responses from clients and staff members through focus groups, questionnaires, and individual interviews, a rich understanding of how, for whom and under what circumstances the program works or does not work for clients with substance use problems was obtained. This understanding is captured through synthesizing a final CMO configuration (also known as the final model) and will be communicated to the collaborating community. As well, these results may apply to non-Aboriginal populations and provide new avenues for future research.

Improvements to the AADWP can be made through examining program recommendations outlined throughout this thesis. As well, recommendations can be made and supported through citation of this study for the implementation of the AADWP into other

Friendship Centre locations across Ontario that currently have no such program. This will increase access for urban First Nations, Inuit and Métis people suffering from substance use problems. Finally, through collaboration with the OFIFC, capacity for this community organization to take action to improve adverse circumstances as related to substance use problems has been built. Overall, the present study will aid in decreasing the prevalence of substance use problems among urban First Nations, Inuit, and Métis people.

Table 1.
Client demographic characteristics as assessed in the Evaluation Phase (n = 24)

Characteristic	Mean	Standard Deviation	Range	N (%)
Location				
Fort Frances, ON				14 (58.3)
Hamilton, ON				10 (41.6)
Age (years)	32.79	10.92	21 - 59	
Gender				
Male				10 (38.5)
Female				14 (53.8)
Aboriginal Identity				
First Nations				21 (80.8)
Métis				1 (3.8)
Inuit				1 (3.8)
Non-Aboriginal				1 (3.8)
Children (#)	2.71	1.20	0 - 5	
Employment				
Employed				8 (33.3)
Unemployed				11 (45.8)
Student				4 (16.7)
Financial Support				
From Employment				2 (7.7)
From Other Sources (e.g., Ontario Works)				11 (42.3)
Relationship Status				
Single				13 (54.2)
Married/Common Law				7 (29.2)
Divorced/Separated				3 (12.5)
Times accessing the program	2.11	2.28	1 - 10	
Length of most recent access (mo)	44.23	67.62	1 - 252	
Culture Rating (from 1 to 5)	3.00	1.20	1 - 5	
Tradition Rating (from 1 to 5)	2.65	1.20	1 – 5	

Table 2.
Caseworker demographic characteristics as assessed in the Evaluation Phase (n = 3)

Characteristic	Mean	Standard Deviation	Range	N (%)
Location				
Fort Frances, ON				2 (66.7)
Hamilton, ON				1 (33.3)
Age (years)	52.67	10.92	21 - 59	
Gender				
Male				1 (33.3)
Female				2 (66.7)
Aboriginal Identity				
First Nations				2 (66.7)
Métis				0 (0)
Inuit				0 (0)
Non-Aboriginal				1 (33.3)
Length of time at the program (mo)	87.33	102.81	10 - 204	
Willingness to learn/be trained				
High				3 (100)
Medium				0 (0)
Low				0 (0)
Willingness to communicate cultural knowledge				
High				3 (100)
Medium				0 (0)
Low				0 (0)
Personal Addiction Experience				
Yes				2 (66.7)
No				1 (33.3)
Flexibility in providing support for those who experience lapses				
High				3 (100)
Medium				0 (0)
Low				0 (0)
Culture Rating (from 1 to 5)	3.50	0.71	3 - 4	
Tradition Rating (from 1 to 5)	3.50	0.71	3 - 4	

Table 3.
Participant ratings for each aspect of the model (n = 27)

Model Component	M	SD	Range	Mdn	W_s	*z*-score	*p*
Program Part							
Caseworker	4.78	0.54	3 - 5	5	351	4.82	< .001
Outcome							
Sobriety/Reduced Use	4.93	0.28	4 - 5	5	378	5.04	< .001
Renewed Relationship	4.70	0.62	3 - 5	5	325	4.72	< .001
Cultural Reconnection	3.96	1.30	1 - 5	4	199.5	3.06	.002
Mental Health	4.13	1.45	1 - 5	3	277	3.21	.001
Mechanism							
Treatment for Needs	4.69	0.89	1 - 5	5	335	4.39	< .001
Trusting Relationship	4.88	0.34	4 - 5	5	351	4.87	< .001
Wholistic Belief	4.32	1.19	1 - 5	5	276	3.77	< .001
Context							
Client	4.00	1.04	2 - 5	4	181	4.46	< .001
Staff	4.58	0.66	3 - 5	5	276	4.46	< .001
Setting	3.65	1.34	1 - 3	4	190	2.12	.034

Note. Mdn = Median; W_s = Wilcoxon Signed Rank T-Test

Figures

Figure 1. Initial AADWP Model

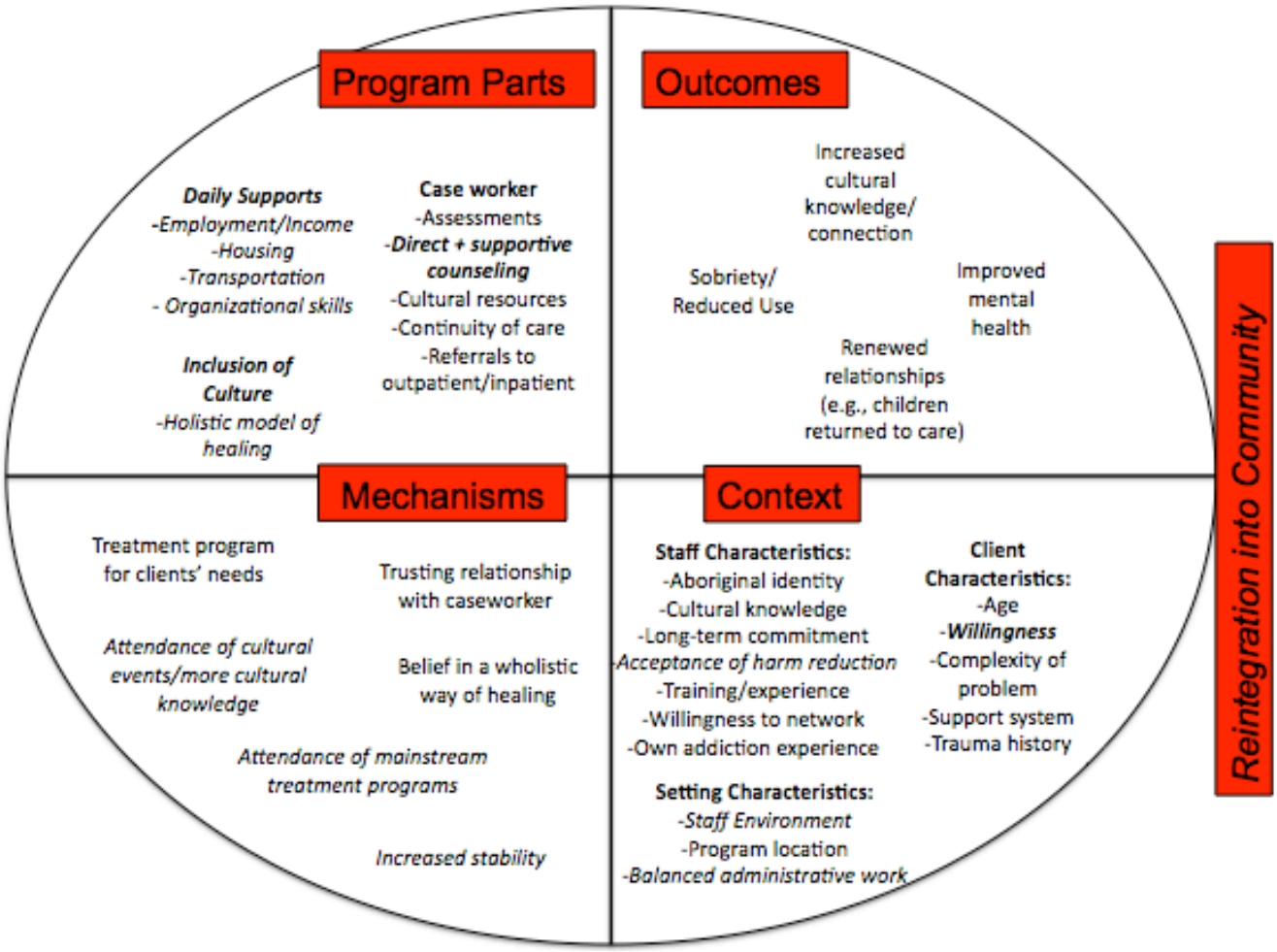


Figure 1. All italicized components of the Initial Model represent those components that were removed for the final model. All the italicized *and* bolded components of the Initial Model (except headings) represent those components that were not removed; rather they were moved to different portions of the model or simply changed to better represent participant responses in the Evaluation Phase. For an explanation of the Initial Model, see text under the Theory Development Phase Results.

Figure 2. Final AADWP Model

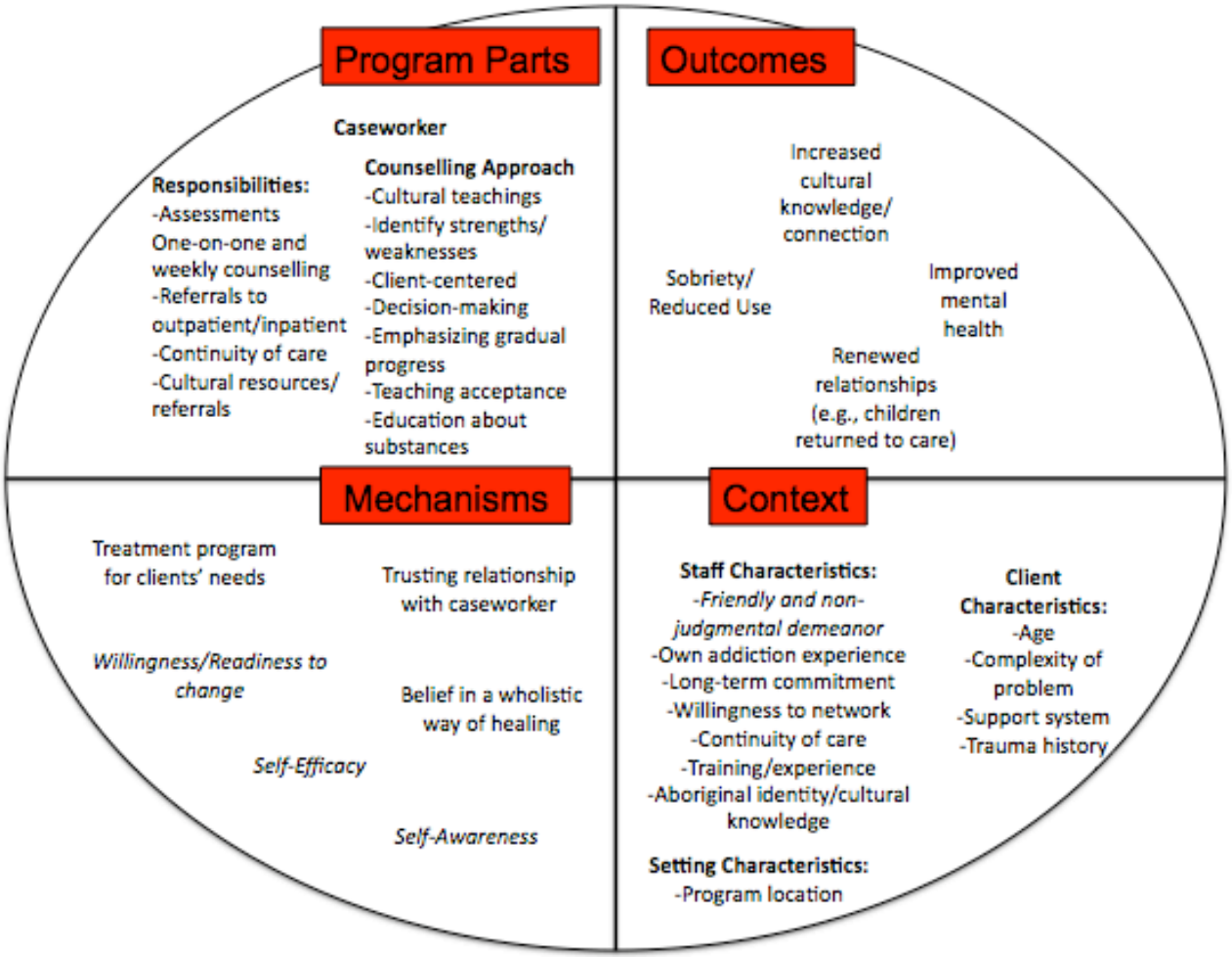


Figure 2. All italicized components of the Final Model represent the components that were added to the model through the Evaluation Phase. For an explanation these components please see text under Evaluation Phase Results. For an exaplanation of the CMO configurations please see text under the Context-Mechanism-Outcome Configuration heading in the Results section.

Appendix A

Evaluation Plan

Focusing the Evaluation (What are the Reasons for Evaluating this Program?)	• An evaluation has been identified as a need by the community (OFIFC) • Program has been functioning for many years, yet it is unclear *how* it is helping clients • Can provide information to improve the program and/or expand the program to other locations
Evaluation Participants	• Clients who have either accessed or are currently accessing the ADWP • Staff members of the Friendship Centre and/or the AADWP
What Type of Evaluation is Appropriate?	• Process Evaluation because we want to understand *how* the program is working or not working
What are the Evaluation Aims?	• To understand how, for whom and under what circumstances the program helps or does not help clients suffering from an addiction
What information is going to be collected? How is this information going to be collected?	• We will ask clients and staff members about what the parts of the program are, what are clients' goals, how do clients get to their goals, and under what circumstances to clients get to their goals? • We will conduct focus groups with clients and open-ended questionnaires with staff as well as in-depth interviews with both clients and caseworkers
What Resources are Available?	• We have financial resources and recruitment resources from the OFIFC • This project is currently funded by the Canadian Institutes for health Research • The Community Action Research on Aboriginal Health laboratory, through which the evaluation will be conducted, has additional funding through the Network Environments for Health Research
What is the Evaluation Timeline?	• Two years total **Phase 1: September 2010 to August 2010** • September to November 2009: Ethics submission and focus group question development • November to December 2009: Focus group completion • December 2009 to March 2010: Staff questionnaire development and collection • March to May 2010: Analysis of client focus group and staff questionnaire responses • May to August 2010: Development of initial theories regarding how, for whom and under what circumstances the program works or does not work and development of

	interview guide for next phase **Phase 2: September 2010 to August 2011** • September to October 2011: Refinement of interview guide • October to November 2011: In-depth interviews at Hamilton, Ontario and Fort Frances, Ontario • December to February 2011: Transcription of interviews and development of codebook for qualitative analysis • February to April 2011: Analysis of interviews and refinement of theories • April to June 2011: Report writing • July 2011: Analysis and writing is complete

Appendix B

Client Consent Form: Focus Group

RYERSON UNIVERSITY

O.F.I.F.C.

Consent Agreement
Evaluation of a treatment program for concurrent disorders in urban First Nations communities
Clients: Focus Group

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators:

Kelly McShane, Ph.D., C. Psych. (Supervised Practice) Assistant Professor Department of Psychology Ryerson University	Caitlin Davey, B.A. MA Student Department of Psychology Ryerson University (supervised by Kelly McShane)

Purpose of the Study: Provide a brief explanation of what the study is designed to determine or assess using language that is clear to the target audience. State the number of subjects being recruited for this study and the eligibility criteria used to identify prospective participants.

The purpose of this project is to evaluate the Aboriginal Alcohol and Drug Worker Programme (AADWP). The goal is to identify the strengths and weaknesses of the AADWP and understand how the program works to help people, who the program is able to help, and how to improve the AADWP. There will be 20 clients and 20 staff members of Friendship Centres who will be recruited to help develop the questions used in the evaluation and then 40 clients and 20 staff members will complete the evaluation. To be included, clients must be 18 years or older and have accessed either the AADWP, Mental Health program or another program at the Friendship Centre. For staff, any staff member of the Friendship Centres is eligible to participate.

Description of the Study: As part of this study, you will be asked to participate in a focus group with about 10 other clients. The focus group will last between 60 and 90 minutes and will take place at this local Friendship Centre. During the focus group, you will be asked a series of questions about how you think the AADWP program helps or doesn't help.

None of the procedures [focus group] used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis.

Risks or Discomforts: It is possible that during this study you will become uncomfortable because of the nature of the questions being asked or other peoples' comments. If you begin to feel uncomfortable, you may discontinue participating and leave the focus group altogether or take a break and return later.

Benefits of the Study: You may receive some benefits from being in this study by hearing others experiences in accessing treatment. We cannot guarantee, however, that you will receive any benefits from participating in this study. The findings of this study will be used to evaluate the AADWP, which is anticipated to benefit the community at large by assisting to improve the program.

Confidentiality: Confidentiality will be respected and no information that discloses your identity will be released or published without consent, unless required by law. Confidentiality cannot be guaranteed in the focus group as other participants are present. The focus group will be audio-taped and transcribed. The audio tape and printed transcripts will be kept in a locked file cabinet at Ryerson University. The files with the transcripts will be saved on computers that are password protected and audiotapes will be destroyed after we have confirmed all vital information (2-3 years). Only study staff will have access to these data. After 10 years, all information will be destroyed.

Incentives to Participate:
After completion of this focus group you will be given $25 as compensation for you participation. If, at any point in the interview, you don't want to answer a particular question, feel that you need to withdraw from the study, or take a break, you will still be given $25.

Voluntary Nature of Participation: Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with the Alcohol and Drug Worker Programme, Ryerson University, your local Friendship Centre, or the Ontario Federation of Indian Friendship Centres. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are allowed.

At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Kelly McShane, Ph.D., C. Psych. (Supervised Practice)
Assistant Professor
Department of Psychology
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
Phone: 416-979-5000, ext 2051 (after pressing 1)
Email: kmcshane@psych.ryerson.ca

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Alex Karabanow
Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
Phone: 416-979-5042

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Your signature below indicates that you have read and understand that you will be audiorecorded for only the purposes of this study. Your signature indicates that you agree to be audiorecorded and have been told that you can change your mind and withdraw this consent at any time.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix C

Focus Group Questions

The purpose of this group is to understand how First Nations people recover from concurrent mental health and addictions problems. The Aboriginal Alcohol and Drug Worker Programme (AADWP) could be a program that helps people recover. What would like to understand how the program works.

What parts of the program have helped you?
What other supports or program elements do you think would have helped?
    Probe: Addictions and Mental Health (anxiety, depression, anger, stress)

How did the parts of the program help you?

Thinking about other people in the community who have addictions and mental health problems, who would be able to get help through this program?
    Who would this program help?
    For example; different groups of people: youth, older adults, men and women.
    Who wouldn't get help from this program?

What was the program able to help you change or improve?
    What goals or outcomes has the program helped you achieve?
What was the program not able to help you change or improve?

Appendix D

Staff Consent Form: Questionnaire

Consent Agreement

Evaluation of a treatment program for concurrent disorders in urban First Nations communities
Staff: Questionnaire

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators:

Kelly McShane, Ph.D., C. Psych. (Supervised Practice) Assistant Professor Department of Psychology Ryerson University		Caitlin Davey, B.A. MA Student Department of Psychology Ryerson University (supervised by Kelly McShane)

Purpose of the Study:
The purpose of this project is to evaluate the Aboriginal Alcohol and Drug Worker Programme (AADWP). The goal is to identify the strengths and weaknesses of the AADWP and understand how the program works to help people, who the program is able to help, and how to improve the AADWP. There will be 20 clients and 20 staff members of Friendship Centres who will be recruited to help develop the questions used in the evaluation and then 40 clients and 20 staff members will complete the evaluation. To be included, clients must be 18 years or older and have accessed either the AADWP, Mental Health program or another program at the Friendship Centre. For staff, any staff member of the Friendship Centres is eligible to participate.

Description of the Study:
As part of this study, you will be asked to participate in a questionnaire conducted by a member of the research team. The interview will last between 30 to 60 minutes and will take place at this local Friendship Centre. During the questionnaire, you will be asked a series of questions about how you think the AADWP program helps or doesn't help clients.

None of the procedures [questionnaires] used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis

Risks or Discomforts

It is possible that during this study you will become uncomfortable because of the nature of the questions being asked. If you begin to feel uncomfortable, you may discontinue participating and leave the interview altogether, or take a break and continue later.

Benefits of the Study:
We cannot guarantee that you will receive any direct benefits from participating in this study. The findings of this study will be used to evaluate the AADWP, which is anticipated to benefit the community at large by assisting to improve the program.

Confidentiality:
Confidentiality will be respected and no information that discloses the identity of the study participant will be released or published without consent, unless required by law. The questionnaires will be kept in a locked file cabinet at Ryerson University. The files will be saved on computers that are password protected and questionnaires will be disposed of after we have confirmed all vital information (2-3 years). Only study staff will have access to these data. After 10 years, all information will be destroyed.

Incentives to Participate:
You will not be paid to participate in this study.

Voluntary Nature of Participation:
Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with the Alcohol and Drug Worker Programme, Ryerson University, your local Friendship Centre, or the Ontario Federation of Indian Friendship Centres. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty.

At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Kelly McShane, Ph.D., C. Psych. (Supervised Practice)
Assistant Professor
Department of Psychology
Ryerson University
350 Victoria Street
Toronto Ontario Canada M5B 2K3
Phone: 416-979-5000, ext 2051 (after pressing 1)
Email: kmcshane@psych.ryerson.ca

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Research Ethics Board (Alex Karabanow)
c/o Office of the Vice President, Research and Innovation
Ryerson University

350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix E

Staff Questionnaire

Introduction (Page 1)

Welcome to the Aboriginal Alcohol and Drug Worker Programme (AADWP) Survey for Staff Members!

Thank you for your participation in this survey. This survey seeks to understand how the AADWP works or doesn't work for clients who access this service.

Instructions (Page 2)

Instructions for completing the AADWP survey for staff members:

This survey will take you about 1 hour to complete. There are 10 questions in total.

In order to get to the next page (or question), just press the arrow button at the bottom of the page. You can go back to a question if needed (just press the back arrow at the bottom of the page).

All questions are open-ended and you can respond to them in point form.

You can complete as many questions as you would like, and then continue at a later time. You do not have to complete the entire survey at once. You can resume this survey at a later time.

You may also go back at a later time to change your answers

If you have any technological difficulties in completing the survey, please email cdavey@psych.ryerson.ca.

Thank you again for your participation!

Questions

The purpose of this group is to understand how First Nations people recover from concurrent mental health and addictions problems. The Aboriginal Alcohol and Drug Worker Programme (AADWP) could be a program that helps people recover. We would like to understand how the program works.

1. Think about all of the parts of the AADWP. Please list, in the box below, all of the parts of the AADWP that you can think of.

2. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
   a. What parts of the program worked for those clients? For example: Addiction, Mental health issues (anxiety and depression), etc.
   b. What parts of the program didn't work for your clients? For example: Addiction, Mental health issues (anxiety and depression), etc.

3. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
   a. How did the parts of the program help your clients?
   b. How come parts of the program didn't help your clients?

4. Thinking of all of the parts of the AADWP that you listed, and thinking about other people in the community who have addictions and mental health problems:
   a. Are there certain groups of people who would likely get the most benefits/help from the program? If so, who would these groups be and why would they benefit/be helped? For example; youth, older adults, men or women
   b. Who would not be helped/not benefit from this program and why?

5. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
   a. What was the program able to help change or improve in the lives of your clients? For example: What goals or outcome has the program helped your clients achieve?
   b. What was the program not able to help you change or improve in the lives of your clients? For example: What goals or outcome has the program not helped your clients to achieve?

6. Thank you for your participation in the AADWP survey for staff members. We are trying to understand how the AADWP work or doesn't work for your clients
   a. Is there anything else about the AADWP that you would like to share with us?

Thank you for responding to this survey!

If you have any questions please contact:

Dr. Kelly McShane
Department of Psychology
Ryerson Univeristy
350 Victoria Street
Toronto Ontario Canada
Phone: 416-979-5000, ext 2051 (after pressing 1)
Email: kmcshane@psych.ryerson.ca

By clicking forward you will save and close this browser

Appendix F

Mailed Staff Questionnaire

RYERSON UNIVERSITY

O.F.I.F.C.

Welcome to the Aboriginal Alcohol and Drug Worker Programme (AADWP) Survey for Staff Members!

Thank you for your participation in this survey. This survey seeks to understand how the AADWP works or doesn't work for clients who access this service.

Instructions

This survey will take you about 1 hour to complete. There are 10 questions in total.

All questions are open-ended and you can respond to them in point form.

Thank you again for your participation!

Once you are done, please mail the survey with the consent form in the self-addressed stamped envelope.

If you have any questions please contact:

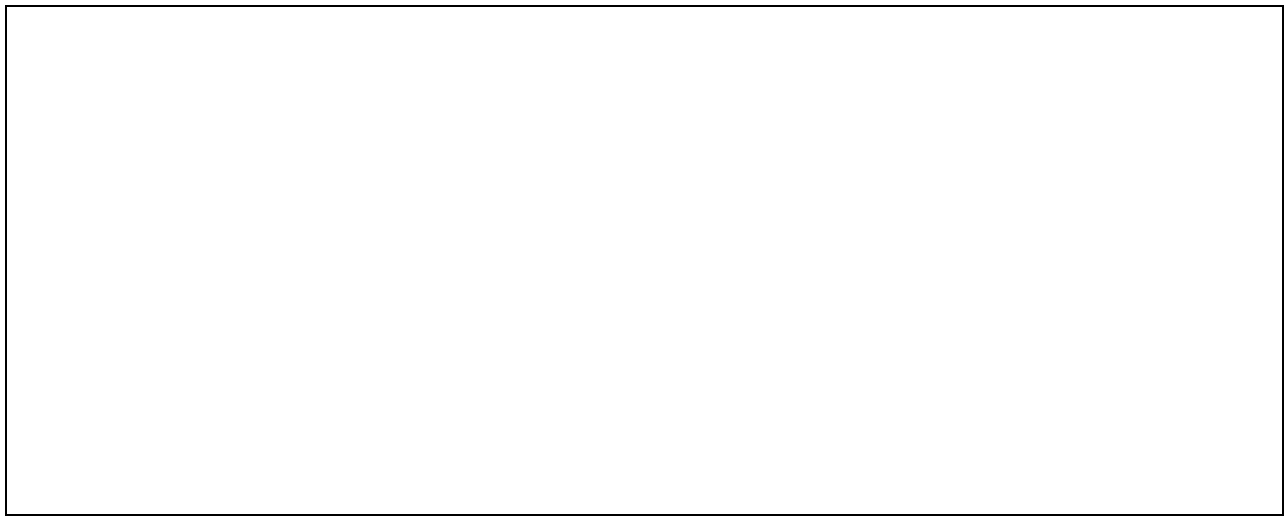
Dr. Kelly McShane
Department of Psychology
Ryerson University
350 Victoria Street
Toronto Ontario Canada
Phone: 416-979-5000, ext 2051 (after pressing 1)
Cell: 416-948-6255
Email: kmcshane@psych.ryerson.ca

Where is your Friendship Centre located (i.e., Hamilton or Fort Frances)?

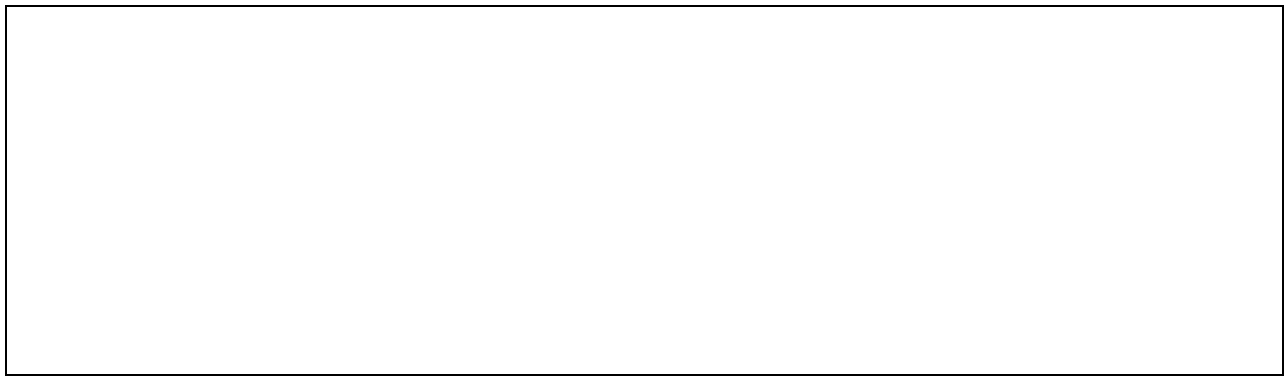
The purpose of this group is to understand how First Nations people recover from concurrent mental health and addictions problems. The Aboriginal Alcohol and Drug Worker Programme (AADWP) could be a program that helps people recover. We would like to understand how the program works.

1. Think about all of the parts of the AADWP. Please list all of the parts of the AADWP that you can think of.

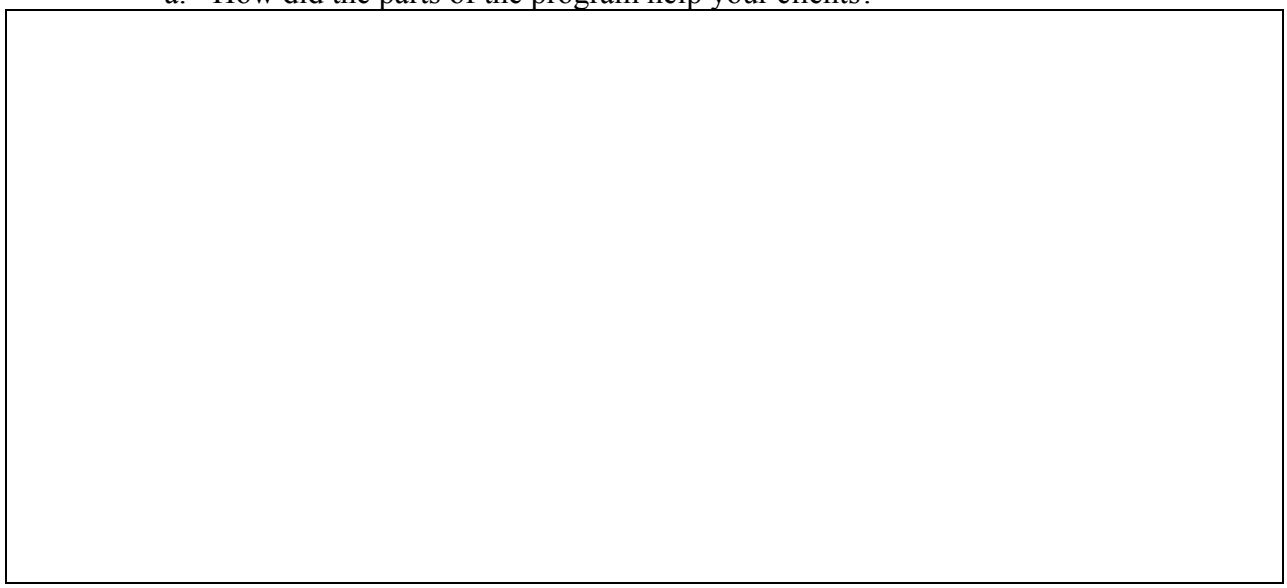
2. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
    a. What parts of the program worked for those clients? For example: addiction, mental health issues (anxiety and depression), etc.



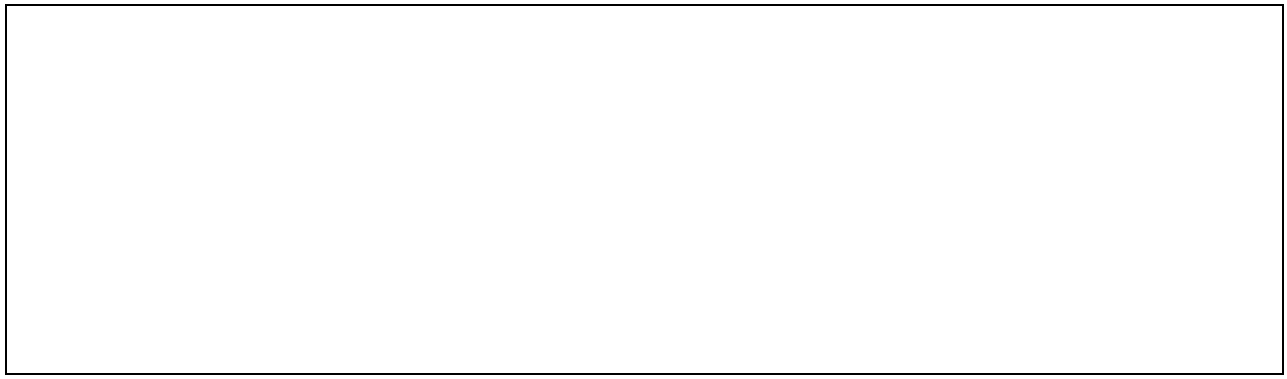
    b. What parts of the program didn't work for your clients? For example: addiction, mental health issues (anxiety and depression), etc.



3. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
    a. How did the parts of the program help your clients?



    b. How come parts of the program didn't help your clients?



4. Thinking of all of the parts of the AADWP that you listed, and thinking about other people in the community who have addictions and mental health problems:
    a. Are there certain groups of people who would likely get the most benefits/help from the program? If so, who would these groups be and why would they benefit/be helped? For example; youth, older adults, men or women, etc

    b. Who would not be helped/not benefit from this program and why?

5. Thinking about the parts of the AADWP that you listed, and thinking specifically of a few of clients you have worked with:
    a. What was the program able to help change or improve in the lives of your clients? For example: What goals or outcome has the program helped your clients achieve?

6. What was the program not able to help you change or improve in the lives of your clients? For example: What goals or outcome has the program not helped your clients to achieve?

7. Thank you for your participation in the AADWP survey for staff members. We are trying to understand how the AADWP work or doesn't work for your clients
    a. Is there anything else about the AADWP that you would like to share with us?

Conclusion:

Thank you for responding to this survey!

Please mail it with your consent form in the self-addressed stamped envelope.

Appendix G

Client Consent Form: Evaluation

RYERSON UNIVERSITY

O.F.I.F.C.

Consent Agreement
Evaluation of a treatment program for concurrent disorders in urban First Nations communities
Clients: Evaluation

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators:

Kelly McShane, Ph.D., C. Psych. (Supervised Practice) Assistant Professor Department of Psychology Ryerson University	Caitlin Davey, H.B.A. MA Student Department of Psychology Ryerson University (supervised by Kelly McShane)

Purpose of the Study:
The purpose of this project is to evaluate the Aboriginal Alcohol and Drug Worker Programme (AADWP). The goal is to identify the strengths and weaknesses of the AADWP and understand how the program works to help people, who the program is able to help, and how to improve the AADWP. There will be 20 clients and 20 staff members of Friendship Centres who will be recruited to help develop the questions used in the evaluation and then 40 clients and 20 staff members will complete the evaluation. To be included, clients must be 18 years or older and have accessed either the AADWP, Mental Health program or another program at the Friendship Centre. For staff, any staff member of the Friendship Centres is eligible to participate.

Description of the Study:
As part of this study, you will be asked to participate in an interview conducted by a member of the research team. In addition to the interviewer, there may be one other researcher present during the interview for training purposes. The interview will last between 60 and 90 minutes and will take place at this local Friendship Centre. During the interview, you will be asked a series of questions about how you think the AADWP program helps or doesn't help.

None of the procedures [interview] used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis.

Risks or Discomforts:
It is possible that during this study you will become uncomfortable because of the nature of the questions being asked. If you begin to feel uncomfortable, you may discontinue participating and leave the interview altogether or take a break and continue later.

Benefits of the Study:
We cannot guarantee that you will receive any direct benefits from participating in this study. The findings of this study will be used to evaluate the AADWP, which is anticipated to benefit the community at large by assisting to improve the program.

Confidentiality:
Confidentiality will be respected and no information that discloses your identity will be released or published without consent, unless required by law. The interview will be audio-taped and transcribed. The audio tape and printed interview transcripts will be kept in a locked file cabinet at Ryerson University. The files with the transcripts will be saved on computers that are password protected and audiotapes will be destroyed after we have confirmed all vital information (2-3 years). Only study staff will have access to these data. After 10 years, all information will be destroyed.

Incentives to Participate:
After completion of this interview you will be given $25 as compensation for you participation. If, at any point in the interview, you don't want to answer a particular question, feel that you need to withdraw from the study, or take a break, you will still be given $25.

Voluntary Nature of Participation:
Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with Ryerson University, your local Friendship Centre, or OFIFC. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are allowed.

At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Kelly McShane, Ph.D., C. Psych. (Supervised Practice)
Assistant Professor
Department of Psychology
Ryerson University
350 Victoria Street
Toronto Ontario Canada M5B 2K3
Phone: 416-979-5000, ext 2051 (after pressing 1)
Email: kmcshane@psych.ryerson.ca

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix H

Interview Guide: Clients Version 1

Ontario Federation of Indian Friendship Centres,
AADWP Evaluation Interview Guide
Clients

BOLD = Optional. You do not have to say everything that is bolded, but they are there for you if you need probes or explanations.

Demographic Information

Before we start talking about the Alcohol and Drug Program, I wanted to ask you a few questions. Some of these questions are personal and I want to remind you that you are free to skip any questions you do not wish to answer.

DOB:	Aboriginal Identity (FN, Métis, Inuit):
Location: Hamilton/Fort Frances?	Employment status:
How many children do you have?	Financial support:
For how long have you accessed the program?	Relationship status:
On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how much you follow your Aboriginal culture: 1 2 3 4 5 (circle one)	On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how traditional you are: 1 2 3 4 5 (circle one)

Traditional: Closely following Aboriginal traditions, rather than western traditions older clients may be more traditional than younger clients

Examples of following Aboriginal culture: This may be different depending on who we are interviewing (whether they are Métis, Inuit or of different Nations). We may want clients to define their own culture and whether or not they follow it closely.

Introduction- I want to start by asking you some general questions about your experience with the Alcohol and Drug program.

1. Can you describe what you wanted help with when you started with the Alcohol and Drug program?
    a. Were you looking for help with addictions?
    b. If not, what were your issues and concerns?
2. Can you tell me about how the Alcohol and Drug Program has helped you?
3. Can you tell me about how the Alcohol and Drug Program hasn't helped you?
    a. Were there any programs/services/skills that didn't help you?

Theory Questions- I want to now ask you some specific questions about how the Alcohol and Drug Program has helped you or not helped you and what specific things the Alcohol and Drug Program has helped you with or not helped you with.

Please use the diagram provided for the following questions

1. **Outcomes**

a. What were/are your goals in the program? Anything else? *Please note that they may have already said some of their goals in the beginning of the interview.*

b. *Take out diagram and cover up everything other than outcomes.* Here are our ideas of what client's goals are in the program. Some of what you have mentioned overlaps with what we

have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual outcome.*
c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*
d. *Hand them the rating sheet.* Please rate from 1 to 5 how important each outcome/goal is to you (1 being not important at all to you and 5 being the most important to you).

2. **Parts of the program**
a. We are wondering about the parts of the program. Can you tell me about what you do/have done in the program? **Describe your experiences in the program.** Anything else? *Please note that they may have already said some of their goals in the beginning of the interview.*
b. *Take out diagram and cover up everything other than parts of the program.* Here are our ideas of what the parts of the program are. Some of what you have mentioned overlaps with what we have. *Circle what already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual part.*
c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*
d. *Hand them the rating sheet.* Please rate from 1 to 5 how important each part of the program is to you (1 being not important at all to you and 5 being the most important to you).

Some items that may need clarification:

Assessments: This is where your needs are assessed. This is usually done by your caseworker. They will ask you questions about what is going on with you to understand your needs.

Directive and Supportive Counselling: Does your caseworker provide this? Is he/she straightforward or does he/she sugar coat things for you?

Cultural Resources: What I mean by "cultural resources" is your caseworker's knowledge about Aboriginal culture, his/her willingness to share this with you, and the availability of traditions and practices such as sweats and healing lodges.

Multi-Institutional Continuity of Care: This is when your caseworker would follow you from place to place/from program to program. If you have been to other services, outside of the alcohol and drug program or have been in a correctional facility and your caseworker continued to follow you from program to program or visits you in a correctional facility, this is providing continuity of care. It would also involve your caseworker seeing you even after you have a more stable lifestyle and have more control over your addiction if you need it.

Referrals to Outpatient/Inpatient: This is when your caseworker would suggest that you go to a different program because it would be able to help you better. It could be an

outpatient program, where you might attend once a week. It may also be an inpatient program, where you will live at that program for a while (detox, withdrawal).

Holistic model of healing: What I mean by holistic, in a general sense, is a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?

Daily Supports: Daily supports are what the program provides that is above and beyond treatment for addictions. Such things may include basic needs such as transportation to the centre, childcare, help with finding employment and housing. It also includes things like helping you organize your days.

Employment/income: Does the program help you find work? Do they help you out with finances at all?

Transportation: Does the program help with transportation?

Housing: Does the program help you find housing?

Organizational Skills: What I mean by this is being able to plan your days, and manage your time. You may get help from your caseworker by learning how to set an agenda or getting feedback on the plans that you make.

3. **Pathways**

a. Now I am wondering about the pathways to your goals. Pathways are how you get to your goals and they are how the program works because when you achieve your goals, this is a good thing! How do you think the program works?

b. How do you think the program doesn't work?

c. *Take out diagram and cover up everything other than pathways.* Here are our ideas of how the program works. **We think these are some of the pathways that lead to your goals.** Some of what you have mentioned overlaps with what we have. *Circle what already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual pathway.*

Treatment program for your needs: If your caseworker understands what you need and helps you with what you wanted and needed form treatment, then you have a treatment program for your needs. **If you got a program that assumes that your needs are the same as everyone else who has an addiction, this is not a program for your own needs because it is more generic**

- Which treatment do you think get/got?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Trusting relationship with caseworker: **When trust is gained, this means that you feel comfortable with your caseworker and you can be open and honest about what is going on with you.**

- Do you think you have/had a trusting relationship with your caseworker?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Attendance of cultural events/more cultural knowledge: **You will probably get a lot of information about cultural activities or events (smudging, sweats, etc.) from your caseworker. You will also probably get a lot of cultural knowledge from your caseworker if he/she has such knowledge and if they are willing to share this knowledge with you.**

- Have you accessed cultural resources? **If so, what did you access? If not, were there resources that weren't available to you?** Do you think your cultural knowledge has increased through the program?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Belief in a holistic way of healing: A holistic way of healing is something that the program uses when working with clients. **What I mean by a holistic way of healing, in a general sense, is working toward a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?**

- Do you have this belief? If so, did it come from the program or did you have it before going to the program?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Stability: **What I mean by stability is having a stable job, stable housing, access to transportation when needed, childcare, etc. and whether the program has helped with this stability. You would probably get this stability though the daily supports that the program provides (help with housing, employment, etc.)**

- Do you think you have gained more stability in your life from accessing the program? If so, what supports did/do you use? If not, were there supports that you needed that were not there?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some way this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Attendance of mainstream programs: What we mean by this is being referred by the Alcohol and Drug program to go to a mainstream program. *Be sure to differentiate between whether they*

have gone to a mainstream program on his or her own, or whether they have been referred by the program. Those programs that are attended through referrals are what we are trying to get at with this question because we want to know if people are getting appropriate referrals, whether the referrals go through, and whether referrals are available. **A "mainstream service" is a service that does not specifically target Aboriginal people, which might include Alcoholics Anonymous, detox, withdrawal management, and any other inpatient or outpatient clinics.**

- Have you accessed mainstream programs? If so, which ones have you gone to? If not, were there programs you needed that were not there for you?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some way this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

d. What do you think of the pathways we have proposed? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*

Other: *This section is for when someone comes up with an additional pathway. Decide on a definition of the pathway and then ask the following questions:*

- **How did/does this pathway help you? Could you list some way this pathway helped?**
- **How did/does this pathway not help you? Could you list some ways this pathway did not help?**

d. Please rate from 1 to 5 how important each pathway is to you (1 being not important at all to you and 5 being the most important to you)

e. *Hand them the rating sheet.* For each pathway, please rate from 1 to 5 how likely each pathway helps with each outcome (1 being not very likely and 5 being very likely).

4. **Reintegration into the community: Reintegration into the community is when someone is able to go back to their community as a sober individual and maintain their progress. Do you have a different understanding of this?**

a. We think that a lot of the outcomes we talked about relate to reintegration into community. What do you think of that?

b. *Hand them the rating sheet.* Please rate from 1 to 5 how likely you think that reintegration relates to each outcome (1 being not very likely to relate and 5 being very likely to relate).

c. We think that a lot of the pathways we talked about relate to reintegration into community. What do you think about this?

d. *Hand them the rating sheet.* Please rate how from 1 to 5 how likely you think that reintegration relates to each pathway (1 being not very likely and 5 being very likely)

5. **Context**

a. We are wondering about the context of the program. What about the context influences the program the most **(examples of context: what the staff is like, the program's location).**

b. Take out diagram and cover up everything other than context. Here are our ideas of what parts of the context impact the program. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is*

anything to be subtracted, cross it out of the diagram. Go through each individual contextual factor.
c. *Hand them the rating sheet.* Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Some items that may need clarification:
Staff Characteristics:
Aboriginal Identity: Whether they are First Nations, Inuit or Métis

Own addictions experience: If they have ever had an addiction

Long-term commitment: Whether the are in it for the long-haul, or whether they plan to leave after a year

Training/experience: Their willingness to be trained and their experience with working with people with addictions

Willingness to network: Do they have information about other programs and do they talk to other programs and educate them so other programs are more able to help.

Acceptance of harm-reduction: Harm reduction is focusing on safe use and decreased use, rather than no use. Are caseworkers flexible around these goals or do they expect that you will be abstinent?

Continuity of care: Following clients from program to program.

Client characteristics:
Age: Does it matter if someone is younger or older? Does age matter?

Willingness: If someone is or is not ready for change or willing to change.

Complexity of the problem: More than one mental illness going on, very severe problems

Support system: If client has a support system they would have friends and family that they can turn to.

Trauma history: Sexual, emotional, physical abuse, residential school survivor?
Setting:
Program location: geographical (whether you are in a bigger city vs. a smaller town) and the actual friendship centre – is it private, are there rooms for one on one session

Please rate from 1 to 5 how important each **outcome** is to you (1 being not important at all to you and 5 being the most important to you).

	Not important				Very

Outcome	at all				Important
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 to 5 how important each **program part** is to you (1 being not important at all to you and 5 being the most important to you).

Part of Program	Not important at all				Very Important
Caseworker	1	2	3	4	5
Inclusion of Culture	1	2	3	4	5
Daily Supports	1	2	3	4	5

Please rate from 1 to 5 how important each **pathway** is to you (1 being not important at all to you and 5 being the most important to you)

Pathway	Not important at all				Very Important
Treatment program for your needs	1	2	3	4	5
Trusting relationship with caseworker	1	2	3	4	5
Attendance of cultural events/more cultural knowledge	1	2	3	4	5
Belief in a holistic way of healing	1	2	3	4	5
Stability	1	2	3	4	5
Attendance of mainstream programs					
Other_____ _					

For each pathway, please rate from 1 to 5 how likely each **pathway** helps with each outcome (1 being not very likely and 5 being very likely).

Please rate from 1 (not likely) to 5 (very likely), how likely you think a treatment program for your needs helps with:

	Not				

Outcome	Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think a trusting relationship with your caseworker helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think attendance of cultural events/more cultural knowledge helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to	1	2	3	4	5

family, etc.)					
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think belief in a holistic way of healing helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think stability helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think attendance of mainstream programs helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (least likely) to 5 (most likely), how likely you think Other: _____ helps with:

Outcome	**Not Very Likely to help with**				**Very Likely to help with**
Sobriety and/or coping with addiction	**1**	**2**	**3**	**4**	**5**
Renewed relationships (children back in care, reconnection to family, etc.)	**1**	**2**	**3**	**4**	**5**
Connection to Aboriginal identity	**1**	**2**	**3**	**4**	**5**
Mental health (e.g., depression, anxiety)	**1**	**2**	**3**	**4**	**5**
Other: _____	**1**	**2**	**3**	**4**	**5**

Please rate from 1 to 5 how likely you think that **reintegration** is impacted by each **outcome** (1 not very likely to be impacted and 5 being very likely to be impacted)

Outcome	Not very Likely to be				Very Likely to

	impacted				be impacted
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

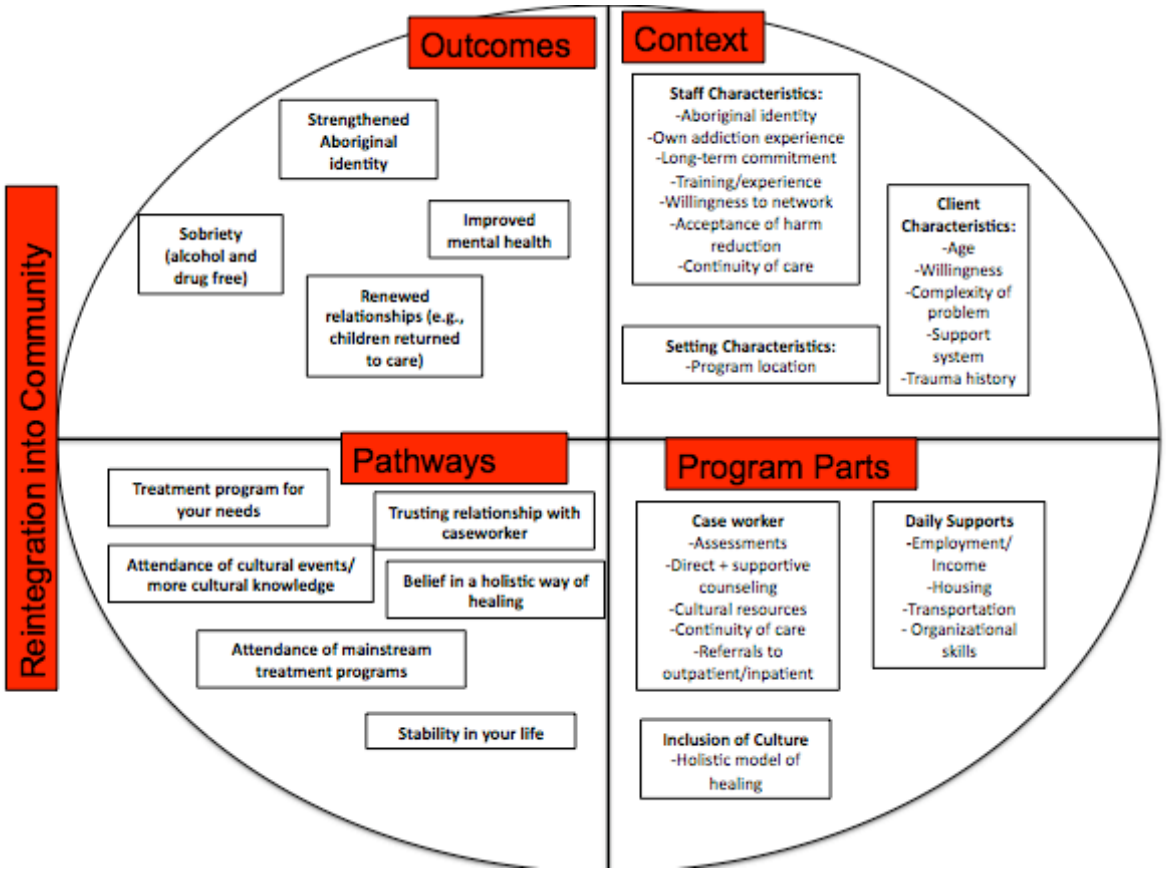
Please rate how from 1 to 5 how likely you think that **reintegration** relates to each **pathway** (1 being not very likely and 5 being very likely)

Pathway	Not important at all				Very Important
Treatment program for your needs	1	2	3	4	5
Trusting relationship with caseworker	1	2	3	4	5
Attendance of cultural events/more cultural knowledge	1	2	3	4	5
Belief in a holistic way of healing	1	2	3	4	5
Stability	1	2	3	4	5
Attendance of mainstream programs					
Other_____ _					

Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Context	Not important at all in impacting the program				Most important in impacting the program
Staff Characteristics	1	2	3	4	5

Client Characteristics	1	2	3	4	5
Setting Characteristics	1	2	3	4	5



Appendix I

Interview Guide: Clients Version 2

Ontario Federation of Indian Friendship Centres,
AADWP Evaluation Interview Guide
Clients

BOLD = Optional. You do not have to everything that is bolded, but they are there for you if you need probes or explanations.

Demographic Information

Before we start talking about the Alcohol and Drug Program, I wanted to ask you a few questions. Some of these questions are personal and I want to remind you that you are free to skip any questions you do not wish to answer.

DOB:	Aboriginal Identity (FN, Métis, Inuit):
Location: Hamilton/Fort Frances?	Employment status:
How many children do you have?	Financial support:
For how long have you accessed the program?	Relationship status:
On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how much you follow your Aboriginal culture: 1 2 3 4 5 (circle one)	On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how traditional you are: 1 2 3 4 5 (circle one)

Traditional: Closely following Aboriginal traditions, rather than western traditions. Older clients may be more traditional than younger clients

Examples of following Aboriginal culture: This may be different depending on who we are interviewing (whether they are Métis, Inuit or of different Nations). We may want clients to define their own culture and whether or not they follow it closely.

Introduction- I want to start by asking you some general questions about your experience with the Alcohol and Drug program.

4. Can you describe what you wanted help with when you started with the Alcohol and Drug program?
    a. Were you looking for help with addictions?
    b. If not, what were your issues and concerns?
5. Can you tell me about how the Alcohol and Drug Program has helped you?
6. Can you tell me about how the Alcohol and Drug Program hasn't helped you?
    a. Were there any programs/services/skills that didn't help you?

Theory Questions- I want to now ask you some specific questions about how the Alcohol and Drug Program has helped you or not helped you and what specific things the Alcohol and Drug Program has helped you with or not helped you with.

Please use the diagram provided for the following questions

1. **Outcomes**

a. What were/are your goals in the program? Anything else? *Please note that they may have already said some of their goals in the beginning of the interview.*

b. *Take out diagram and cover up everything other than outcomes.* Here are our ideas of what client's goals are in the program. Some of what you have mentioned overlaps with what we

have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go though each individual outcome.*
c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*
d. *Hand them the rating sheet.* Please rate from 1 to 5 how important each outcome/goal is to you (1 being not important at all to you and 5 being the most important to you).

2. **Parts of the program**
a. We are wondering about the parts of the program. Can you tell me about what you do/have done in the program? **Describe your experiences in the program.** Anything else? *Please note that they may have already said some of their goals in the beginning of the interview.*
b. *Take out diagram and cover up everything other than parts of the program.* Here are our ideas of what the parts of the program are. Some of what you have mentioned overlaps with what we have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual program part.*
c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*
d. *Hand them the rating sheet.* Please rate from 1 to 5 how important each part of the program is to you (1 being not important at all to you and 5 being the most important to you).

Some items that may need clarification:

Assessments: This is where your needs are assessed. This is usually done by your caseworker. They will ask you questions about what is going on with you to understand your needs.

Directive and Supportive Counselling: Does your caseworker provide this? Is he/she straightforward or does he/she sugar coat things for you?

Cultural Resources: What I mean by "cultural resources" is your caseworker's knowledge about Aboriginal culture, his/her willingness to share this with you, and the availability of traditions and practices such as sweats and healing lodges.

Multi-Institutional Continuity of Care: This is when your caseworker would follow you from place to place/from program to program. If you have been to other services, outside of the alcohol and drug program or have been in a correctional facility and your caseworker continued to follow you from program to program or visits you in a correctional facility, this is providing continuity of care. It would also involve your caseworker seeing you even after you have a more stable lifestyle and have more control over your addiction.

Referrals to Outpatient/Inpatient: This is when your caseworker would suggest that you go to a different program because it would be able to help you better. It could be an

outpatient program, where you might attend once a week. It may also be an inpatient program, where you will live at that program for a while (detox, withdrawal).

Holistic model of healing: What I mean by holistic, in a general sense, is a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?

Daily Supports: Daily supports are what the program provides that is above and beyond treatment for addictions. Such things may include basic needs such as transportation to the centre, childcare, help with finding employment and housing. It also includes things like helping you organize your days.

Employment/income: Does the program help you find work? Do they help you out with finances at all?

Transportation: Does the program help with transportation?

Housing: Does the program help you find housing?

Organizational Skills: What I mean by this is being able to plan your days, and manage your time. You may get help from your caseworker by learning how to set an agenda or getting feedback on the plans that you make.

3. **Pathways**

a. Now I am wondering about the pathways to your goals. Pathways are how you get to your goals and they are how the program works because when you achieve your goals, this is a good thing! How do you think the program works?

b. How do you think the program doesn't work?

c. *Take out diagram and cover up everything other than pathways.* Here are our ideas of how the program works. **We think these are some of the pathways that lead to your goals.** Some of what you have mentioned overlaps with what we have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual pathway.*

Treatment program for your needs: If your caseworker understands what you need and helps you with what you wanted and needed form treatment, then you have a treatment program for your needs. **If you got a program that assumes that your needs are the same as everyone else who has an addiction, this is not a program for your own needs because it is more generic**

- Which treatment do you think get/got?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Trusting relationship with caseworker: **When trust is gained, this means that you feel comfortable with your caseworker and you can be open and honest about what is going on with you.**

- Do you think you have/had a trusting relationship with your caseworker?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Attendance of cultural events/more cultural knowledge: **You will probably get a lot of information about cultural activities or events (smudging, sweats, etc.) from your caseworker. You will also probably get a lot of cultural knowledge from your caseworker if he/she has such knowledge and if they are willing to share this knowledge with you.**

- Have you accessed cultural resources? **If so, what did you access? If not, were there resources that weren't available to you?** Do you think your cultural knowledge has increased through the program?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Belief in a holistic way of healing: A holistic way of healing is something that the program uses when working with clients. **What I mean by a holistic way of healing, in a general sense, is working toward a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?**

- Do you have this belief? If so, did it come from the program or did you have it before going to the program?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some ways this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Stability: **What I mean by stability is having a stable job, stable housing, access to transportation when needed, childcare, etc. and whether the program has helped with this stability. You would probably get this stability though the daily supports that the program provides (help with housing, employment, etc.)**

- Do you think you have gained more stability in your life from accessing the program? If so, what supports did/do you use? If not, were there supports that you needed that were not there?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some way this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

Attendance of mainstream programs: What we mean by this is being referred by the Alcohol and Drug program to go to a mainstream program. *Be sure to differentiate between whether they*

have gone to a mainstream program on his or her own, or whether they have been referred by the program. Those programs that are attended through referrals are what we are trying to get at with this question because we want to know if people are getting appropriate referrals, whether the referrals go through, and whether referrals are available. **A "mainstream service" is a service that does not specifically target Aboriginal people, which might include Alcoholics Anonymous, detox, withdrawal management, and any other inpatient or outpatient clinics.**

- Have you accessed mainstream programs? If so, which ones have you gone to? If not, were there programs you needed that were not there for you?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help you? Could you list some way this pathway helped?
- How did/does this pathway not help you? Could you list some ways this pathway did not help?

d. What do you think of the pathways we have proposed? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*

Other: *This section is for when someone comes up with an additional pathway. Decide on a definition of the pathway and then ask the following questions:*

- **How did/does this pathway help you? Could you list some way this pathway helped?**
- **How did/does this pathway not help you? Could you list some ways this pathway did not help?**

d. Please rate from 1 to 5 how important each pathway is to you (1 being not important at all to you and 5 being the most important to you)

e. *Hand them the rating sheet.* For each pathway, please rate from 1 to 5 how likely each pathway helps with each outcome (1 being not very likely and 5 being very likely).

4. **Reintegration into the community:** Reintegration into the community is (1) reconnecting with one's community (whether it be Aboriginal or not Aboriginal) at large, as well as other people, events, organizations and (2) maintaining your progress around your goals of sobriety. Do you have a different understanding of this?

a. We think that a lot of what we have talked about today relates to reintegration into community. We are thinking of this as a major goal that people hope to get to. What do you think of that?

b. *Hand them the rating sheet.* Please rate from 1 to 5 how important reintegration is for you (1 being not important at all to you and 5 being the most important to you).

5. **Context**

a. We are wondering about the context of the program. What about the context influences the program the most **(examples of context: what the staff is like, the program's location).**

b. Take out diagram and cover up everything other than context. Here are our ideas of what parts of the context impact the program. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram. Go through each individual contextual factor.*

c. *Hand them the rating sheet.* Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Some items that may need clarification:
Staff Characteristics:
Aboriginal Identity: Whether they are First Nations, Inuit or Métis

Own addictions experience: If they have ever had an addiction

Long-term commitment: Whether the are in it for the long-haul, or whether they plan to leave after a year

Training/experience: Their willingness to be trained and their experience with working with people with addictions

Willingness to network: Do they have information about other programs and do they talk to other programs and educate them so other programs are more able to help.

Acceptance of harm-reduction: Harm reduction is focusing on safe use and decreased use, rather than no use.

Continuity of care: Following clients from program to program.

Client characteristics:
Age: Doe sit matter if someone is younger or older? Does age matter?

Willingness: If someone is or is not ready for change or willing to change.

Complexity of the problem: More than one mental illness going on, very severe problems

Support system: If client has a support system they would have friends and family that they can turn to.

Trauma history: Sexual, emotional, physical abuse, residential school survivor?
Setting:

Program location: geographical (whether you are in a bigger city vs. a smaller town) and the actual friendship centre – is it private, are there rooms for one on one session

Please rate from 1 to 5 how important each **outcome** is to you (1 being not important at all to you clients and 5 being the most important to you).

Outcome	Not important at all				Very Important
Sobriety and/or coping	1	2	3	4	5

with addiction					
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 to 5 how important each **program part** is to you (1 being not important at all to you and 5 being the most important to your clients).

Part of Program	Not important at all				Very Important
Caseworker	1	2	3	4	5
Inclusion of Culture	1	2	3	4	5
Daily Supports	1	2	3	4	5

Please rate from 1 to 5 how important each **pathway** is to you (1 being not important at all to you and 5 being the most important to you)

Pathway	Not important at all				Very Important
Treatment program for your needs	1	2	3	4	5
Trusting relationship with caseworker	1	2	3	4	5
Attendance of cultural events/more cultural knowledge	1	2	3	4	5
Belief in a holistic way of healing	1	2	3	4	5
Stability	1	2	3	4	5
Attendance of mainstream programs	1	2	3	4	5
Other_____ _					

For each pathway, please rate from 1 to 5 how likely each **pathway** helps with each outcome (1 being not very likely and 5 being very likely).

Please rate from 1 (not likely) to 5 (very likely), how likely you think a treatment program for your needs helps with:

Outcome	Not Very Likely to				Very Likely to

	help with				help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think a trusting relationship with your caseworker helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely your attendance of cultural events/more cultural knowledge helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to	1	2	3	4	5

Aboriginal identity					
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely your belief in a holistic way of healing helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think stability in your life helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely your attendance of mainstream programs helps with:

Outcome	Not Very Likely to				Very Likely to

	help with				help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (least likely) to 5 (most likely), how likely you think Other: _____ helps with:

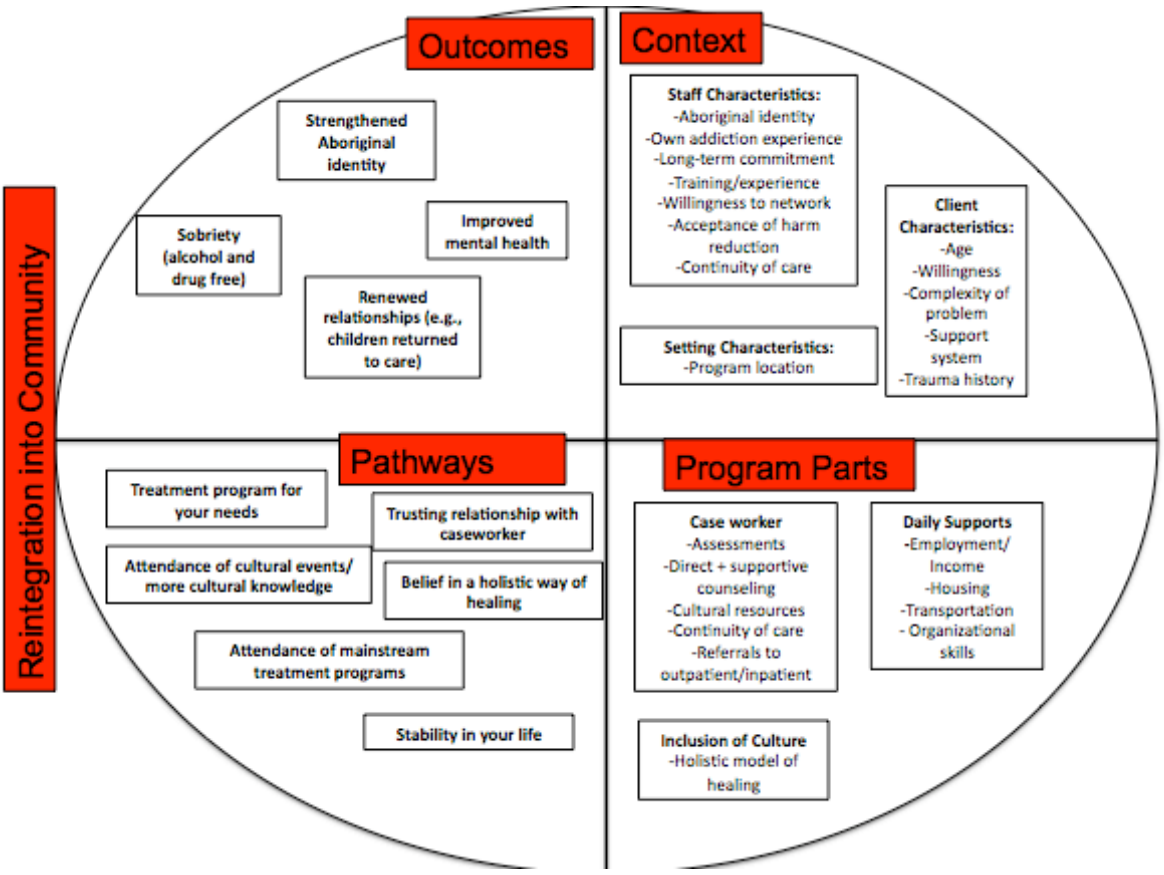
Outcome	**Not Very Likely to help with**				**Very Likely to help with**
Sobriety and/or coping with addiction	**1**	**2**	**3**	**4**	**5**
Renewed relationships (children back in care, reconnection to family, etc.)	**1**	**2**	**3**	**4**	**5**
Connection to Aboriginal identity	**1**	**2**	**3**	**4**	**5**
Mental health (e.g., depression, anxiety)	**1**	**2**	**3**	**4**	**5**
Other: _____	**1**	**2**	**3**	**4**	**5**

Please rate from 1 to 5 how important you think reintegration is for you (1 being not important at all to you and 5 being the most important to you)

	Not important at all				Most Important
Reintegration	1	2	3	4	5
Other_____ _					

Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Context	Not important at all in impacting the program				Most important in impacting the program
Staff Characteristics	1	2	3	4	5
Client Characteristics	1	2	3	4	5
Setting Characteristics	1	2	3	4	5
Other_____ ___					



Appendix J

Staff Consent Form: Evaluation

RYERSON UNIVERSITY

O.F.I.F.C.

Consent Agreement
Evaluation of a treatment program for concurrent disorders in urban First Nations communities
Staff: Interviews

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators:

Kelly McShane, Ph.D., C. Psych. (Supervised Practice) Assistant Professor Department of Psychology Ryerson University		Caitlin Davey, B.A. MA Student Department of Psychology Ryerson University (supervised by Kelly McShane)

Purpose of the Study:
The purpose of this project is to evaluate the Aboriginal Alcohol and Drug Worker Programme (AADWP). The goal is to identify the strengths and weaknesses of the AADWP and understand how the program works to help people, who the program is able to help, and how to improve the AADWP. There will be 20 clients and 20 staff members of Friendship Centres who will be recruited to help develop the questions used in the evaluation and then 40 clients and 20 staff members will complete the evaluation. To be included, clients must be 18 years or older and have accessed either the AADWP, Mental Health program or another program at the Friendship Centre. For staff, any staff member of the Friendship Centres is eligible to participate.

Description of the Study:
As part of this study, you will be asked to participate in an interview conducted by a member of the research team. The interview will last between 60 and 90 minutes and will take place at this local Friendship Centre. During the interview, you will be asked a series of questions about how you think the AADWP program helps or doesn't help clients.

None of the procedures [questionnaires] used in this study are experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis

Risks or Discomforts

It is possible that during this study you will become uncomfortable because of the nature of the questions being asked. If you begin to feel uncomfortable, you may discontinue participating and leave the interview altogether, or take a break and continue later.

Benefits of the Study:
We cannot guarantee that you will receive any direct benefits from participating in this study. The findings of this study will be used to evaluate the AADWP, which is anticipated to benefit the community at large by assisting to improve the program.

Confidentiality:
Confidentiality will be respected and no information that discloses the identity of the study participant will be released or published without consent, unless required by law. The interview will be audio-taped and transcribed. The audio tape and printed interview transcripts will be kept in a locked file cabinet at Ryerson University. The files with the transcripts will be saved on computers that are password protected and audiotapes will be destroyed after we have confirmed all vital information (2-3 years). Only study staff will have access to these data. After 10 years, all information will be destroyed.

Incentives to Participate:
You will not be paid to participate in this study.

Voluntary Nature of Participation:
Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with Ryerson University, your local Friendship Centre, or OFIFC. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty.

At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Kelly McShane, Ph.D., C. Psych. (Supervised Practice)
Assistant Professor
Department of Psychology
Ryerson University
350 Victoria Street
Toronto Ontario Canada M5B 2K3
Phone: 416-979-5000, ext 2051 (after pressing 1)
Email: kmcshane@psych.ryerson.ca

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information.

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University

350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix K

Interview Guide: Staff

Ontario Federation of Indian Friendship Centres,
AADWP Evaluation Interview Guide
Staff

BOLD = Optional. You do not have to say everything that is bolded, but they are there for you if you need probes or explanations.

Demographic Information

Before we start talking about the Alcohol and Drug Program, I wanted to ask you a few questions. Some of these questions are personal and I want to remind you that you are free to skip any questions you do not wish to answer.

DOB:	Aboriginal Identity (FN, Métis, Inuit):
Location:	Personal Experiences with addiction? (yes/no):
Willingness to learn/be trained (high/med/low):	Relationship status:
How long have worked for the program?	
Willingness to communicate your cultural knowledge to other clients and service providers (high/med/low):	Flexibility in providing support for clients who experience lapses (high/med/low):
On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how traditional you are: 1 2 3 4 5 (circle one)	On a scale of 1 to 5 (1 being 0% and 5 being 100%) rate how much you follow your Aboriginal culture: 1 2 3 4 5 (circle one)

Traditional: Closely following Aboriginal traditions, rather than western traditions older clients may be more traditional than younger clients

Examples of following Aboriginal culture: This may be different depending on who we are interviewing: whether they are Métis, Inuit or of different Nations. We may want clients to define their own culture and whether or not they follow it closely.

For the following questions, please think about the clients that you have seen to date:

Introduction- I want to start by asking you some general questions about your clients' experiences with the Alcohol and Drug program.

7. Can you describe what your clients wanted help with when they started with the Alcohol and Drug program?
    a. Were they looking for help with addictions?
    b. If not, what were their issues and concerns?
8. Can you tell me about how the Alcohol and Drug Program has helped your clients?
9. Can you tell me about how the Alcohol and Drug Program hasn't helped your clients?
    a. Were there any programs/services/skills that didn't help your clients?

Theory Questions- I want to now ask you some specific questions about how the Alcohol and Drug Program has helped or not helped your clients and what specific things the Alcohol and Drug Program has helped or not helped your clients with.

Please use the diagram provided for the following questions

1. **Outcomes**

a. What were/are your clients goals in the program? Anything else? *Please note that they may have already said some of their goals in the beginning.*

b. *Take out diagram and cover up everything other than outcomes.* Here are our ideas of what client's goals are in the program. Some of what you have mentioned overlaps with what we have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go though each individual outcome.*

c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*

d. *Hand them the rating sheet.* Please rate from 1 to 5 how important you think each outcome/goal is to your clients (1 being not important at all to your clients and 5 being the most important to your clients).

2. **Parts of the program**

a. We are wondering about the parts of the program. Can you tell me about what your clients do/have done in the program? Anything else? *Please note that they may have already said some of their goals in the beginning.*

b. *Take out diagram and cover up everything other than parts of the program.* Here are our ideas of what the parts of the program are. Some of what you have mentioned overlaps with what we have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual part.*

c. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*

d. *Hand them the rating sheet.* Please rate from 1 to 5 how important you think each part of the program is to your clients (1 being not important at all to your clients and 5 being the most important to your clients).

Some items that may need clarification, please use discretion in clarifying as some items may be sensitive for caseworkers:

Assessments: This is where your client's needs are assessed. This is usually done by the caseworker. They will ask clients questions about what is going on with the client to understand his/her needs.

Directive and Supportive Counselling: Do you provide this? Would you describe yourself as straightforward or do you try to sugar coat things for your clients? Or do you use a mix?

Cultural Resources: What I mean by "cultural resources" is your knowledge about Aboriginal culture, your willingness to share this with your client, and the availability of traditions and practices such as sweats and healing lodges through the program.

Multi-Institutional Continuity of Care: This is when you would follow your client from place to place/from program to program. If your clients have been to other services, outside of the alcohol and drug program or have been in a correctional facility and you continued to follow them from program to program or visits them in a correctional facility, this is providing continuity of care. It would also involve you seeing your clients even after they have a more stable lifestyle and have more control over their addiction.

Referrals to Outpatient/Inpatient: This is when you would suggest that your clients go to a different program because it would be able to help your client better. It could be an outpatient program, where they might attend once a week. It may also be an inpatient program, where they will live at that program for a while (detox, withdrawal).

Holistic model of healing: What I mean by holistic, in a general sense, is a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?

Daily Supports: Daily supports are what the program provides that is above and beyond treatment for addictions. Such things may include basic needs such as transportation to the centre, childcare, help with finding employment and housing. It also includes things like helping clients organize their days.

Employment/income: Does the program help your clients find work? Does the program help them out with finances at all?

Transportation: Does the program help clients with transportation?

Housing: Does the program help your clients find housing?

Organizational Skills: What I mean by this is clients being able to plan their days, and manage their time. You may help your clients by teaching them how to set an agenda or providing feedback on the plans that your clients make.

3. **Pathways**
a. Now I am wondering about the pathways to your client's goals. Pathways are how clients get to their goals and they are how the program works because when clients achieve their goals, this is a good thing! How do you think the program works for your clients?
b. How do you think the program doesn't work for your clients?
c. *Take out diagram and cover up everything other than pathways.* Here are our ideas of how the program works. **We think these are some of the pathways that lead to your clients' goals.** Some of what you have mentioned overlaps with what we have. *Circle what they already talked about and begin with one that you are sure they had mentioned. If unsure, ask to clarify! Go through each individual pathway.*

Treatment program for your clients' needs: If you understand what your clients need and help them with what they wanted and needed from treatment, then you have provided a treatment program for their needs. **If you provide a program that assumes that clients needs are the**

same as others who have an addiction, this is not a program for your clients' needs because it is more generic

- Which treatment do you provide?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some ways this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

Trusting relationship with caseworker: **When trust is gained, this means that your clients feel comfortable with you and can be open and honest with you about what is going on with them.**

- Do you think you have a trusting relationship with your client?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some ways this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

Attendance of cultural events/more cultural knowledge: Do you provide information about cultural activities or events (smudging, sweats, etc.)? **Do you share cultural knowledge with your clients?**

- Have your clients accessed cultural resources? **If so, what did your clients access? If not, were there resources that weren't available to your clients?** Do you think your clients cultural knowledge has increased through the program?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some ways this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

Belief in a holistic way of healing: A holistic way of healing is something that we think the program uses when working with clients. **What I mean by a holistic way of healing, in a general sense, is working toward a balance between mental, physical, emotional and spiritual health. Do you have a different way of understanding this?**

- Do you have this belief? If so, do you teach you clients about this? Do you think having this belief helps your clients?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some ways this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

Stability: **What I mean by stability is having a stable job, stable housing, access to transportation when needed, childcare, etc. and whether the program has helped with this**

stability. Clients would probably get this stability though the daily supports that the program provides (help with housing, employment, etc.)

- Do you think your clients have gained more stability in their lives from accessing the program? If so, what supports did/do your clients use? If not, were there supports that your clients needed that were not there?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some way this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

Attendance of mainstream programs: What we mean by this is your clients being referred by the Alcohol and Drug program to go to a mainstream program. *Be sure to differentiate between whether clients have gone to a mainstream program on his or her own, or whether clients have been referred by the program. Those programs that are attended through referrals are what we are trying to get at with this question because we want to know if people are getting appropriate referrals, whether the referrals go through, and whether referrals are available.* **A "mainstream service" is a service that does not specifically target Aboriginal people, which might include Alcoholics Anonymous, detox, withdrawal management, and any other inpatient or outpatient clinics.**

- Have you referred clients to mainstream programs? Have your clients accessed mainstream programs that you referred them to? If so, which ones have your clients gone to? If not, were there programs your clients needed that were not there for him/her?

Based on response please use judgment to decide which question(s) to ask next

- How did/does this pathway help your clients? Could you list some way this pathway helped your clients?
- How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?

d. What do you think of the pathways we have proposed? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram.*

Other: *This section is for when someone comes up with an additional pathway. Decide on a definition of the pathway and then ask the following questions:*

- **How did/does this pathway help your clients? Could you list some way this pathway helped your clients?**
- **How did/does this pathway not help your clients? Could you list some ways this pathway did not help your clients?**

d. Please rate from 1 to 5 how important you think each pathway is to your clients (1 being not important at all to your clients and 5 being the most important to your clients)

e. *Hand them the rating sheet.* For each pathway, please rate from 1 to 5 how likely you think each pathway helps with each outcome (1 being not very likely and 5 being very likely).

4. **Reintegration into the community:** Reintegration into the community is (1) clients reconnecting with one's community (whether it be Aboriginal or not Aboriginal) at large, as well as other people, events, organizations and (2) maintaining their progress around goals of sobriety. Do you have a different understanding of this?

a. We think that a lot of what we have talked about today relates to clients' reintegration into community. We are thinking of this as a major goal that clients hope to get to. What do you think of that?
b. *Hand them the rating sheet.* Please rate from 1 to 5 how important reintegration is for your clients (1 being not important at all to your clients and 5 being the most important to your clients).

5. **Context**
a. We are wondering about the context of the program. What about the context influences the program the most **(examples of context: what the staff is like, the program's location).**
b. Take out diagram and cover up everything other than context. Here are our ideas of what parts of the context impact the program. Do you agree with what we have here? What should be added or subtracted? *If there is anything to be added, write it onto the diagram. If there is anything to be subtracted, cross it out of the diagram. Go through each individual contextual factor.*
c. *Hand them the rating sheet.* Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Some items that may need clarification:
Staff Characteristics:
Aboriginal Identity: Whether they are First Nations, Inuit or Métis

Own addictions experience: If caseworkers have ever had an addiction

Long-term commitment: Whether caseworkers are in it for the long-haul, or whether they plan to leave after a year

Training/experience: Their willingness to be trained and their experience with working with people with addictions

Willingness to network: Do you have information about other programs and do they talk to other programs and educate them so other programs are more able to help.

Acceptance of harm-reduction: Harm reduction is focusing on safe use and decreased use, rather than no use.

Continuity of care: Following clients from program to program.

Client characteristics:
Age: Does it matter if someone is younger or older? Does age matter?

Willingness: If someone is or is not ready for change or willing to change.

Complexity of the problem: More than one mental illness going on, very severe problems

Support system: If client has a support system they would have friends and family that they can turn to.

Trauma history: Sexual, emotional, physical abuse, residential school survivor?

Setting:
Program location: geographical (whether you are in a bigger city vs. a smaller town) and the actual friendship centre – is it private, are there rooms for one on one session

Balanced administrative work: Do you spend all of your time doing paper work? Do you think that you have enough time to spend with clients?

Resources for staff training: Do you think that you have enough resources for your own training? If you needed training to keep up to date with your practice, would the program or OFIFC support that?

System/LIHN:
Collaborative approach to friendship centres: Do centres collaborate with each other as to how to best assess clients?

Culturally safe/competent: Does the system work to hire and train caseworkers to be culturally competent?

Treatment programs/centres: Treatment programs should be available through all centres: AADWP should to be accessible at all centre locations

Please rate from 1 to 5 how important each **outcome** is to your clients (1 being not important at all to your clients and 5 being the most important to your clients).

Outcome	Not important at all				Very Important
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 to 5 how important each **program part** is to your clients (1 being not important at all to your clients and 5 being the most important to your clients).

Part of Program	Not important at all				Very Important
Caseworker	1	2	3	4	5
Inclusion of Culture	1	2	3	4	5
Daily Supports	1	2	3	4	5

Please rate from 1 to 5 how important each **pathway** is to your clients (1 being not important at all to your clients and 5 being the most important to your clients)

Pathway	Not important at all				Very Important
Treatment program for clients needs	1	2	3	4	5
Trusting relationship with caseworker	1	2	3	4	5
Attendance of cultural events/more cultural knowledge	1	2	3	4	5
Belief in a holistic way of healing	1	2	3	4	5
Stability	1	2	3	4	5
Attendance of mainstream programs	1	2	3	4	5
Other_____ _					

For each pathway, please rate from 1 to 5 how likely each **pathway** helps with each outcome (1 being not very likely and 5 being very likely).

Please rate from 1 (not likely) to 5 (very likely), how likely you think a treatment program for your clients' needs helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think a trusting relationship with your clients helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think clients' attendance of cultural events/more cultural knowledge helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think clients' belief in a holistic way of healing helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5

Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think stability in clients' lives helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (not likely) to 5 (very likely), how likely you think clients' attendance of mainstream programs helps with:

Outcome	Not Very Likely to help with				Very Likely to help with
Sobriety and/or coping with addiction	1	2	3	4	5
Renewed relationships (children back in care, reconnection to family, etc.)	1	2	3	4	5
Connection to Aboriginal identity	1	2	3	4	5
Mental health (e.g., depression, anxiety)	1	2	3	4	5
Other: _____	1	2	3	4	5

Please rate from 1 (least likely) to 5 (most likely), how likely you think Other: _____ helps with:

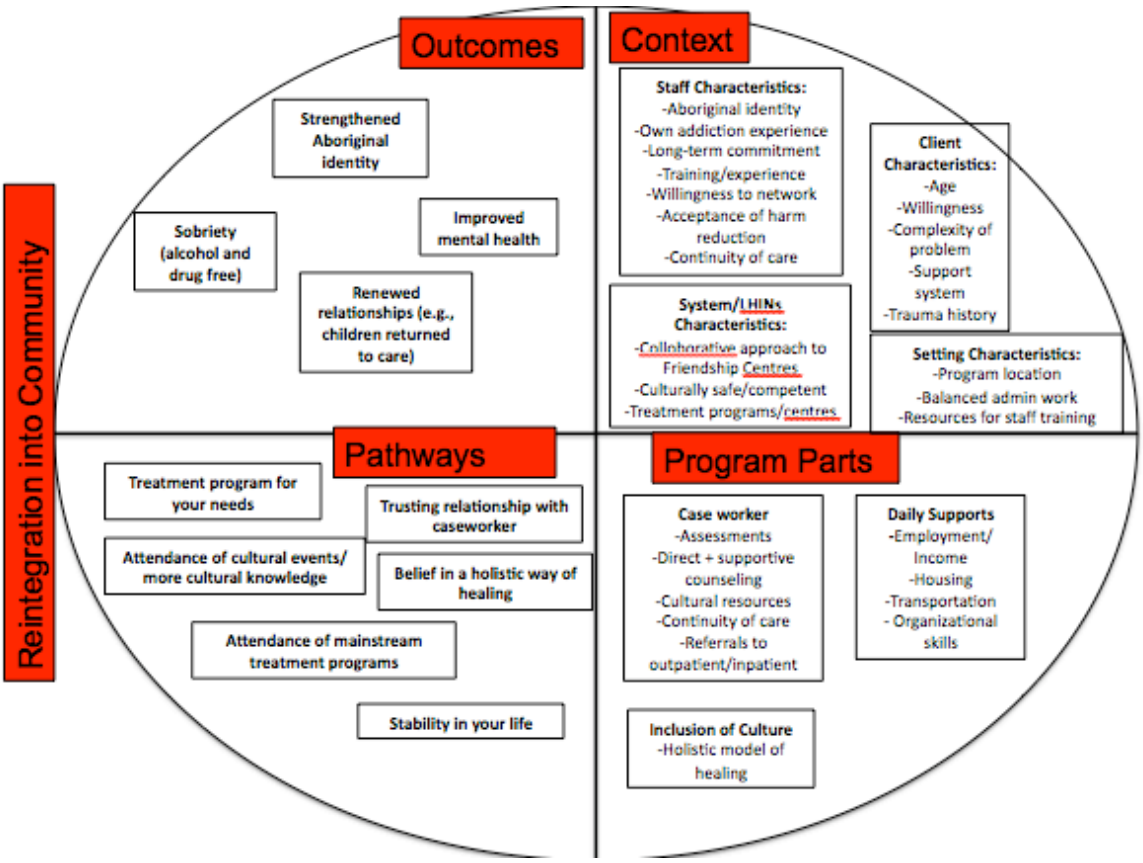
Outcome	**Not Very Likely to help with**				**Very Likely to help with**
Sobriety and/or coping with addiction	**1**	**2**	**3**	**4**	**5**
Renewed relationships (children back in care, reconnection to family, etc.)	**1**	**2**	**3**	**4**	**5**
Connection to Aboriginal identity	**1**	**2**	**3**	**4**	**5**
Mental health (e.g., depression, anxiety)	**1**	**2**	**3**	**4**	**5**
Other: _____	**1**	**2**	**3**	**4**	**5**

Please rate from 1 to 5 how important you think reintegration is for your clients (1 being not important at all to your clients and 5 being the most important to your clients)

	Not important at all				Most Important
Reintegration	1	2	3	4	5
Other_____ _					

Please rate from 1 to 5 how important each piece of the context is in impacting the program (1 being not important at all in impacting the program and 5 being the most important in impacting the program).

Context	Not important at all in impacting the program				Most important in impacting the program
Staff Characteristics	1	2	3	4	5
Client Characteristics	1	2	3	4	5
Setting Characteristics	1	2	3	4	5
Other_____ ___					


Outcomes
Context
Strengthened Aboriginal identity
Sobriety (alcohol and drug free)
Improved mental health
Renewed relationships (e.g., children returned to care)
Staff Characteristics:
-Aboriginal identity
-Own addiction experience
-Long-term commitment
-Training/experience
-Willingness to network
-Acceptance of harm reduction
-Continuity of care
Client Characteristics:
-Age
-Willingness
-Complexity of problem
-Support system
-Trauma history
System/LHINs Characteristics:
-Collaborative approach to Friendship Centres
-Culturally safe/competent
-Treatment programs/centres
Setting Characteristics:
-Program location
-Balanced admin work
-Resources for staff training
Reintegration into Community
Pathways
Program Parts
Treatment program for your needs
Trusting relationship with caseworker
Attendance of cultural events/ more cultural knowledge
Belief in a holistic way of healing
Attendance of mainstream treatment programs
Stability in your life
Case worker
-Assessments
-Direct + supportive counseling
-Cultural resources
-Continuity of care
-Referrals to outpatient/inpatient
Daily Supports
-Employment/ Income
-Housing
-Transportation
- Organizational skills
Inclusion of Culture
-Holistic model of healing

Appendix L

AADWP Evaluation Codebook: Stage 1

Code Name	Definition	When to use Code	When not to use code	Examples
General Wanted	When clients/staff describe what they or their clients wanted help with when they started with the program	Keywords: What did you/your clients want help with? It should be the very first question in the interview	Keywords: How, goals, outcomes	"I needed help with my addiction"
General Help	How they think the program has helped them or their clients	Keywords: *How* did this help you or your clients?	Keywords: Goals, outcomes, what did you or your clients want help with?	"It helped me get sober"
General Not Helped	How they think the program has not helped them or their clients or how they think the program could be improved	1) Suggestions of things to add to the program, 2) ways the program did not help them Keyword: How	Keyword: Goals, outcomes, what did you or your clients want help with? How did the program help you or your clients?	"I would like to see more guest speakers"
Outcome Generated	When clients or staff explain what their or their clients' goals were/are in the program	1) When they describe their or their clients' goals in the program, 2) when they add a goal to the "outcome" list	1) Do not use when goals are not the focus, 2) when asking clients or staff to agree or disagree with outcomes that we have come up with	"I mostly needed help with my alcohol use"
Outcome Sobriety Example	When a client or staff elaborates on whether they agree or disagree with sobriety/reduced use as an outcome/goal for them or their clients	1) When they describe an example of why this was their or their clients' goal, 2) how they or their client developed the	1) Do not use when they simply state that they agree or disagree with the goal	"My goal was to cut down on my alcohol use because I got in trouble with the law"

		goal (i.e., perhaps it wasn't the clients goal at first), 3) when they elaborate on whether they think this goal is important for them/their clients or others, 4) when they elaborate on how this goal is not applicable to them or their clients		
Outcome Aboriginal Example	When a client or staff elaborates on whether they agree or disagree with reconnection with their Aboriginal identity as an outcome/goal for them or their clients	1) When they describe an example of why this was their or their clients' goal, 2) how the they developed that goal (i.e., perhaps it wasn't the clients goal at first), 3) when they elaborate on whether they think this goal was important for them or for others or their client, 4) when they elaborate on how this goal is not applicable to them or to their clients	1) Do not use when they simply state that they agree or disagree with the goal	"My goal wasn't to reconnect with my Aboriginal identity because that doesn't interest me"

Outcome Mental Health Example	When a client or staff elaborates on whether they agree or disagree with mental health as an outcome/goal for them or their clients	1) When they describe an example of why this was their or their clients' goal, 2) how the they developed that goal (i.e., perhaps it wasn't the clients goal at first), 3) when they elaborate on whether they think this goal was important for them or for others or their client, 4) when they elaborate on how this goal is not applicable to them or to their clients	1) Do not use when they simply state that they agree or disagree with the goal	"My goal was not to improve my mental health because this was not an issue for me"
Outcome Relationships Example	When a client or staff elaborates on whether they agree or disagree with renewed relationships as an outcome/goal for them or their clients	1) When they describe an example of why this was their or their clients' goal, 2) how the they developed that goal (i.e., perhaps it wasn't the clients goal at first), 3) when they elaborate on whether they think this goal was important for them or for	1) Do not use when they simply state that they agree or disagree with the goal	"I want to get my kids back, so that I can have more stability in my life"

		others or their client, 4) when they elaborate on how this goal is not applicable to them or to their clients		
Parts Generated	When clients or staff explain what they/their clients have done in the program and what makes up the program	1) When they describe the program, 2) when they add a part to the "program part" list	1) Do not use when program parts is not the focus, 2) when asking clients/staff to agree or disagree to parts that we have come up with	"Well, I went to talk to the counsellor and I attended groups"
Parts Caseworker Example	When a client or staff elaborates on whether they agree or disagree with the caseworker as a part of the program and any subheading under the caseworker heading as a part of the program	1) When they describe an example of how this is a part of the program, 2) when they elaborate on whether they think the part is important for them or others, 3) when they elaborate on why that part is not applicable to them	1) Do not use when they simply state that they agree with the part	"Ya, I know that she does continuity of care because I kept seeing her when I went to jail"
Parts Supports Example	When a client or staff elaborates on whether they agree or disagree with daily supports as a part of the program and any subheading under the daily supports heading as a part of the program	1) When they describe an example of how this is a part of the program, 2) when they elaborate on whether they think that part is important for	1) Do not use when they simply state that they agree with the part	"I have never needed help with housing, but I know that they would help you with that"

		them or others, 3) when they elaborate on why that part is not applicable to them		
Parts Culture Example	When a client or staff elaborates on whether they agree or disagree with inclusion of culture as a part of the program and any subheading under the inclusion of culture heading as a part of the program	1) When they describe an example of how this is a part of the program, 2) when they elaborate on whether they think that part is important for them or others, 3) when they elaborate on why that part is not applicable to them	1) Do not use when they simply state that they agree with the part	"Ya, they have pow wows and stuff"
PathHelp Generated	When clients or staff explain how they think they or their clients have gotten to their goals	1) When they describe how they have gotten to their goals, 2) when they add a pathway to the "pathway" list	1) Do not use when pathways are not the focus, 2) when asking clients to agree or disagree to pathways that we came come up with	"I think I'm sober now because of persistence"
PathNotHelp Generated	When clients or staff explain how they think they have not gotten to their goals	1) When they describe how they have not gotten to their goals	1) Do not use when pathways are not the focus, 2) when asking clients to agree or disagree,	"I wasn't able to get to my goals because I couldn't trust my caseworker"
Path Needs Example	When clients or staff give an example or explain how the "Treatment Program for your Needs" pathway helped them or	1) When they elaborate on why they agree with this pathway, 2) When they elaborate on why/how this	1) If they only agree with the pathway and don't provide an example of how it helped, 2) if they state that the pathways is not	"It helped me because I learned what I need to focus on"

	their clients	pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	applicable, but do not elaborate	
Path Needs Disagree Example	When clients or staff give an example or explain why "Treatment Program for your Needs" is not a pathway	1) When they elaborate on why they disagree with this pathway as being a part of the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only disagree with the pathways and don't provide an example of why/how it didn't help,	"No, I would rather have group therapy. I don't need specific individualized treatment"
Path Trust Example	When clients or staff give an example or explain how the "A Trusting Relationship with your caseworker" pathway helped them or their clients	1) When they elaborate on why they agree with this pathway, 2) When they elaborate on why/how this pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to	1) If they only agree with the pathway and don't provide an example of how it helped, 2) if they state that the pathways is not applicable, but do not elaborate	"It helped me because I felt like I could tell Corene anything and it kept me coming back to get help"

		them or their clients		
Path Trust Disagree Example	When clients or staff give an example or explain why the "A Trusting Relationship with your caseworker" is not a pathway	1) When they elaborate on why they disagree with this pathway as being a part of the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only disagree with the pathway and don't provide an example of how it did not help	"Trust isn't important. You just have to put the work in"
Path Culture Example	When clients or staff give an example or explain how the "Attending Cultural Events/Increasing Cultural Knowledge" pathway helped them or their clients	1) When they elaborate on why they agree with this pathway, 2) When they elaborate on why/how this pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only agree with the pathway and don't provide an example of how it helped, 2) if they state that the pathways is not applicable, but do not elaborate	"It helped me because being involved in my culture is a healing method to me"
Path Culture Disagree Example	When clients or staff give an example or explain why "Attending Cultural Events/Increasing	1) When they elaborate on why they disagree with this pathway as being a part of	1) If they only disagree with the pathway and don't provide an example of how it helped	"It didn't help me because I don't want to know about my culture"

	Cultural Knowledge" is not a pathway	the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients		
Path Holistic Example	When clients or staff give an example or explain how the "Holistic Way of Healing" pathway helped them or their clients	1) When they elaborate on why they agree with this pathway, 2) When they elaborate on why/how this pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only agree with the pathway and don't provide an example of how it helped, 2) if they state that the pathways is not applicable, but do not elaborate	"It helped me because it helped me understand where my weaknesses are and what I need to work on"
Path Holistic Disagree Example	When clients or staff give an example or explain why "Belief in a Holistic Way of Healing" is not a pathway	1) When they elaborate on why they disagree with this pathway as being a part of the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they	1) If they only disagree with the pathway and don't provide an example of how it did not help	"It didn't help me because I don't care about spiritual health. I just want to focus on my addiction"

		elaborate on why that pathway is not applicable to them or their clients		
Path Mainstream Example	When clients or staff give an example or explain how the "Attending Mainstream Treatment Programs" pathway helped them or their clients	1) When they elaborate on why they agree with this pathway, 2) When they elaborate on why/how this pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only agree with the pathway and don't provide an example of how it helped, 2) if they state that the pathways is not applicable, but do not elaborate	"I was able to deal with things that the program could not help me with through mainstream programs"
Path Mainstream Disagree Example	When clients or staff give an example or explain why "Attending Mainstream Treatment Programs" is not a pathway	1) When they elaborate on why they disagree with this pathway as being a part of the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only disagree with the pathway and don't provide an example of how it did not help	"I got nothing from that program because it was insensitive to my culture"
Path Stability Example	When clients or staff give an	1) When they elaborate on	1) If they only agree with the	"It helped me to keep a job and

	example or explain how the "Increasing stability in your life" pathway helped them or their staff	why they agree with this pathway, 2) When they elaborate on why/how this pathway helped them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	pathway and don't provide an example of how it helped, 2) if they state that the pathways is not applicable, but do not elaborate	keep control over my addiction"
Path Stability Disagree Example	When clients or staff give an example or explain why the "Increasing stability in your life" was not a pathway	1) When they elaborate on why they disagree with this pathway as being a part of the model 2) When they elaborate on why/how this pathway did not help them or their clients, 3) when they elaborate on why that pathway is not applicable to them or their clients	1) If they only disagree with the pathway and don't provide an example of how it did not help	"I don't need stability because the program taught me how to deal with instability as it comes"
Reintegration	When clients or staff answer to the reintegration question			"I think it's more about renewing relationships"
Context Generated	When clients or staff explain what parts of the context influence the program	1) When they describe what parts of the context influence the program, 2)	1) Do not use when context is not the focus, 2) when asking clients or staff to agree or disagree	"Characteristics of other people in your life is another part of the context"

		when they add a part of the context to the "context" list,	to parts of the context that we have come up with	
Context Staff Example	When a client or staff elaborates on whether they agree or disagree with staff characteristics as an important contextual piece of the program and any subheading under the staff characteristics heading as influencing the program	1) When they describe an example of how this is influencing the program, 2) When they state and/or explain that a piece of the context would influence the program for others, 3) when they elaborate on why that part of the context as not applicable to them	1) Do not use when they simply state that they agree or disagree with that piece of the context as impacting the program	"I don't think it matters if the caseworker has their own addiction experience because it matters more about their experience in treating addiction"
Context Client Example	When a client or staff elaborates on whether they agree or disagree with client characteristics as an important contextual piece of the program and any subheadings under the client characteristics heading as influencing the program	1) When they describe an example of how this is influencing the program, 2) When they state and/or explain that a piece of the context would influence the program for others 3) when they elaborate on why that part of the context as not applicable to them	1) Do not use when they simply state that they agree or disagree with that piece of the context as impacting the program	"It doesn't matter whether someone is older or younger because everyone needs help"
Context Setting Example	When a client or staff elaborates on	1) When they describe an	1) Do not use when they simply	"I don't think that the program

	whether they agree or disagree with setting characteristics as an important contextual piece of the program and any subheadings under the setting characteristics heading as influencing the program	example of how this is influencing the program (for themselves or for others), 2) When they state and/or explain that a piece of the context would influence the program for others 3) when they elaborate on why that part of the context as not applicable to them	state that they agree or disagree with that piece of the context as impacting the program	would work as well in a smaller town"
Suggestions or Corrections	When a client or staff makes a suggestion of how to improve or clarify our model	1) When they suggests that we change the wording in the model, 2) suggest we change a definition that we have given, 3) when they add a whole other quadrant to the model	1) Do not use when they are adding to a quadrant of the model (this would go under ____generated, i.e., parts generated)	"It should be reconnection and not reintegration"

Appendix M

AADWP Evaluation Codebook: Stage 2

Code Name	When to use Code	Examples
Generated Outcome/Wanted Sobriety	When a clients/staff describe their or their clients' goals/needs were to abstain from, decrease use, maintain their progress, or increase their knowledge (i.e., what substance do to their body, how much is too much) around alcohol or drug use, referrals to treatment, resources to get to treatment, access to AA/NA meeting, or getting sober to stay out of a correctional facility	"I needed help with my alcohol use"
Generated Outcome/Wanted Mental Health	When a clients/staff describe their or their clients' goal/need was to manage their mental health issues, including issues with self-esteem, anger, grief, and emotional instability.	"I needed help with anxiety and anger"
Generated Outcome Personal Accomplishments	When a clients/staff describe their or their clients' goal was to better themselves, overall. This could be around holistic healing, wanting to accomplish things in life, being happy, develop the skill of acceptance or responsibility for their decisions and/or actions.	"Just to be happy" "Just to be able to accept that there are thing that I can control and there are things that I can control"
Generated Outcome Physical Wellness	When a clients/staff describe their or their clients' goal was to improve their physical health.	"Well, physical health because substance abuse makes people really sick"
Generated Outcome/Wanted Culture	When a clients/staff describe their or their clients' goal/need was to increase their cultural knowledge or connections.	"I appreciated that the caseworker taught me about my culture because I really wanted that"
Generated Outcome/Wanted Relationships	When a clients/staff describe their or their clients' goal/need was to renew relationships, reconnect with their family, be a better parent for their children, ensure that their substance use issues would not be passed on to children	"I needed to make things better for my family so we can get along better"
Generated Outcome/Wanted Instrumental Support	When clients/staff describes that they or their clients wanted help with instrumental support, which may or may not be accessed through the Friendship Centre's programs (other than the AADWP). For example: describing that they	"I got help with my court issues downstairs" "I wanted to get

	wanted help with their legal issues around domestic violence, or other violence charges, or help with legality around getting children back, their goal/need was to gain more education related to academics whether it be high school education, professional training, when a client describes that their goal was to gain more structure or stability - this could be around owning their own house, gaining employment, getting their driver's license	my GED and my driver's license" "I needed help finding housing"
Generated Parts Components	When clients/staff describe what the actual parts of the program are (what the caseworker does) such as assessments, counselling, providing cultural resources, referrals to treatment	"Well, she does assessments, she lets me know when and where sweats are going on"
Generated Parts Caseworker Approach	When clients/staff describe the caseworker's approach to counselling. That is, when they described a focus on strengths and weaknesses, the use of the medicine wheel, a holistic approach, how to deal with emotions such as anger and control, providing education around substance use and abuse as well as intergenerational trauma and culture, the caseworker's direct and supportive way of counselling, having respect for client's autonomy	"Ya she points out your strengths and weaknesses so that you can work on them"
Generated Parts Friendship Centre	When clients/staff describe parts of the larger Friendship Centre. That being, the availability of sweats and cultural teachings, daily supports, the availability of legal support, the availability of school/education, childcare. When clients or staff described things that helped that stem from other programs they have accessed at the friendship centre such as attending sweats or healing circles or AA at the Friendship centre that they accessed on their own	"Ya, they have sweats here at the centre" I got my welding license through the centre"
Generated Parts Program Recommendations	When clients/staff recommend that a part should be added to the AADWP program. For example, group outings, more cultural/traditional activities during counselling, more regular treatment for incarcerated individuals, continuity of care (follow-ups), group sessions	"It would be nice if they had movies like about the effects on drugs and alcohol and stuff"
Generated Parts FC Recommendations	When clients/staff recommend that a part should be added to the Friendship Centre. For example, a Youth Program, a Family program, Traditional ceremonies through the centre, youth program, support for families, guest speakers, movies, access to Al-Anon, 24-hour crisis help-line.	"They should have a Youth program because our youth need a lot of help"

Generated Path Needs	When clients/staff explain how the caseworker targeting or not targeting their or their clients' needs is or is not helpful. This could have to do with the caseworker referring them or not referring them to external treatment programs, taking the time or not taking the time to get to get to know their clients	"I needed to get to treatment and it didn't help me do that"
Generated Path Trust	When clients/staff explain how having or not having a trusting relationship/effective rapport with their caseworker or the Friendship Centre is or is not a helpful. This would include when client talks about whether or not they feel supported or feel comfortable being open with their caseworker and how this has or has not helped them. This code would also apply if the clients talks about how talking to the caseworker is helpful for them because you need trust to be able to talk to the caseworker	"I didn't trust the people who access the friendship centre, so I didn't go" "Just being able to talk to the caseworker helped me because I was able to get a lot of my chest"
Generated Path/Helped Willingness	When clients/staff describe how being or not being willing, ready, invested in therapy, or persistent is or is not a helpful. An example might be how they think about the session they had and sometimes come to a realization a week later about something that the caseworker pointed out in session	"She really makes you think. I will think and think about it and then a light bulb goes off and I finally get it" "You have to be willing to accept help. I wasn't at first, but once I started coming here, I realized that I needed it"
Generated Path/Helped Self-Efficacy	When clients/staff talk about how gaining or not gaining self-efficacy is or is not helpful. This could be around self efficacy in using skills (i.e., communication skills, parenting skills, acceptance (responsibilities, decisions, accepting that you need to work at your own pace, having patience) coping with triggers, changing environments, strength within themselves, feelings of empowerment	"Well I stopped hanging out with those people because they are a bad influence" "He helped me realize that I needed to go to treatment, so I packed up and went"
Generated	When clients/staff talk about how gaining or not	"Helped me figure

Path/Helped Self-Aware	gaining self-awareness is or is not helpful. This could be around, understanding your addiction, knowing your triggers, being aware of your environment and others around you, figuring out what you want from treatment, understanding that you need to take care of yourself as the first priority	out what I wanted help with"
Generated Path/Helped Sobriety	When clients/staff talk about how achieving sobriety/gaining control over their use has helped them achieve their goals. This may have led to them achieving more stability in their lives, renewing relationships, etc.	"You need sobriety to get stability"
Generated Path Stability	When clients/staff talk about how achieving stability in their lives has helped them achieve their goals. This may have led to them achieving sobriety/control over use, renewing relationships, etc.	"Stability and structure in my life has really helped me maintain my sobriety"
Generated Context Staff	When clients/staff generate staff characteristics that may influence the helpfulness of the program. Things like: working to create an informal dynamic where the client doesn't feel like there is a power imbalance, availability of the caseworker (e.g., on the phone or extended hours), age of staff (older having more experience), having personal addiction experience, being non-judgmental, lack of creativity (new strategies) for long-term clients	"I feel like I'm just talking to a friend"
Generated Context Setting	When clients/staff generated setting characteristics that may influences the helpfulness of the program. Things related to the program being aboriginal-specific, the location (e.g., approval of it bring in centre of Hamilton), accessible, friendship centre staff (outgoing, easy, good to clients), lack of nearby resources (Fort Frances lacks treatment centre and shelters for women), accessibility (e.g., having all programs in one building, transportation and waitlists for getting into treatment)	"I couldn't get access to transportation so I couldn't get here for my sessions" "There is nothing here in Fort Frances. You need to travel 3 hours just to get to treatment"
Generated Context Client	When clients/staff generated client characteristics that may influence the helpfulness of the program. This may include: complexity/severity of the problem, length of time in the program	"Some people are worse than other and have to go somewhere else"
Generated Context Other	When clients/staff talk about things related to external perspectives of the program such as its reputation and whether or not people know about	"Well, I think it matters what people think about

	the program	the program – like how good people think it is"
Outcome Substance Disagree	When a client/staff states that their or their clients' goals through the program were not around substance use such as to abstain from, decrease use, maintain their progress, or increase their knowledge (i.e., what substance do to their body, how much is too much) around alcohol or drug use, referrals to treatment, resources to get to treatment or access to AA/NA meetings. **This code would not be used if they talk about how it wasn't a goal before, but it is now, or if they say it isn't a goal now, but it would be in the future because these would be agreement statements**	"No, I needed help with my relationships"
Outcome Aboriginal Disagree	When a client/staff states that their or their clients' goals through the program were not around strengthening their Aboriginal identity. Perhaps they had no interest in learning about their culture. Perhaps it is a goal, but not through the program. **This code would not be used if they talk about how it wasn't before, but it is now, if they say it a goal isn't now, but it would be in the future, state that it isn't a goal now, but it would be in the future because these would be agreement statements**	"I'm not really interested in learning about my culture"
Outcome Mental Health Disagree	When a client/staff states that their or their clients' goals through the program were not around improving their mental health issues. They might talk about how issues with mental health are not a problem for them. This code would also be used if client expressed that they needed help with mental health issues, but it wasn't a goal through the program because the program doesn't help with that. **This code would not be used if they talk about how it wasn't a goal before, but it is now, or if they say it isn't a goal now, but it would be in the future, if they say that it was a goal for them and they were referred by the program to another program, or state that it isn't a goal now, but it would be in the future because these would be agreement statements**	"I don't have mental health issues" "The program doesn't help with that. I figured that out on my own somewhere else"
Outcome Relationships Disagree	When a client states that their or their clients' goals through the program were not around renewing relationships. They might talk about how issues with relationships are not a problem for	"My goal was more around dealing with my alcohol use"

	them. **This code would not be used if they talk about how it wasn't a goal before, but it is now, if they say it isn't a goal now, but it would be in the future, or state that it isn't a goal now, but it would be in the future because these would be agreement statements**	
Parts Caseworker Disagree	When a client/staff states that any part of the caseworker, as outlined in the model is not part of the program (i.e., assessment, direct and supportive counselling, cultural resources, continuity of care, referrals to outpatient/inpatient).	
Parts Culture Disagree	When a client/staff states that culture is not a part of the program, that being, the caseworker doesn't incorporate culture, but the FC incorporates culture or culture is not incorporated in any way, or the caseworker does not include a holistic model of healing	"I never got that from the caseworker, but I there are postings for pow wows all over the centre"
Parts Supports Disagree	When a client/staff states any of the daily supports proposed in the initial model (i.e., help with employment, income, housing, transportation, or organizational skills) are not a part of the program, that being, the caseworker doesn't provide, but the FC provide daily supports.	"The caseworker doesn't do that kind of stuff"
Context Client Disagree	When a client/staff states that the presence or absence of certain client characteristics does not influence the workings of the program (i.e., age, willingness, complexity of the problem, support system, trauma history).	
Context Staff Disagree	When a client/staff states that the presence or absence of certain staff characteristics does not influence the workings of the program (i.e., Aboriginal identity, own addiction experience, long term commitment, training, experience, willingness to network, acceptance of harm reduction, continuity of care).	
Context Setting Disagree	When a client/staff states that the presence or absence of certain setting characteristics does not influence the workings of the program (i.e., program location).	

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