# Honouring Our Strengths:

*A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*

Indigenous Services Canada
Services aux Autochtones Canada

## Description of the Cover

The tipi is one cultural structure among many that holds our sacred knowledge and cultural Indigenous evidence base. It is a structure with meaning, which by its design, holds teachings about living life and reflects the values that guide the implementation and interpretation of this renewal framework and its elements. *Honouring Our Strengths*, like the tipi, communicates a comprehensive circle of elements, with a strong cultural base that requires partnerships, programs, services, and infrastructure to come together to support stronger connections to family and community. It also recognizes that collaboration amongst partners is necessary to address social determinants of health and the environment around and within our communities. These strengths and the sense of shared identity will help to ensure that we move forward and yet stand strong as we embrace change for the future.

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# Executive Summary

First Nations people face major challenges such as high unemployment, poverty, poor access to education, poor housing, remote location from health services, the displacement of Indigenous language and culture, and social and economic marginalization; all of which continue to impact their health and well-being. In this context, substance use issues and associated mental health issues continue to be some of the more visible and dramatic symptoms of these underlying challenges. The use and abuse of substances has been consistently noted as a top priority by First Nations people and leadership. In fact, a national survey of First Nations communities (completed between 2008–2010) reported that alcohol and drug use and abuse was considered to be the number one challenge for community wellness faced by on-reserve communities (82.6% of respondents), followed by housing (70.7%) and employment (65.9%).[1]

The primary network in place to respond to First Nations substance use issues is the National Native Alcohol and Drug Abuse Program (NNADAP). NNADAP was one of the first programs developed in response to community needs. It evolved from the National Native Alcohol Abuse Program (a pilot project in 1974) to a Cabinet-approved program in 1982. This network of on-reserve addiction services has since evolved into 49 NNADAP alcohol and drug abuse treatment centres, more than 550 NNADAP community-based prevention programs, and since 1995, a network of National Youth Solvent Abuse Program (NYSAP) residential treatment centres which now includes 9 centres across Canada.[2] In the North, NNADAP funding is transferred to the Governments of Northwest Territories and Nunavut under the 1988 Northwest Territories Health Transfer Agreement and through the creation of Nunavut in 1999. Yukon First Nations receive funding for the prevention and treatment components of NNADAP, some through contribution agreements and some through their authority as self-governing First Nations. Northern First Nations and Inuit either attend an alcohol and drug treatment centre operated by the respective territorial government or are transported to the closest appropriate treatment centre South of 60, as per Non-Insured Health Benefits Program (NIHB) policy. In addition to NNADAP/NYSAP, First Nations also access substance use and mental health-related services from other sectors throughout the health care system both on- and off-reserve, as well as various other systems and sectors, including social services, child welfare, justice, housing, education, and employment.

These various systems of care are faced with increasingly complex needs: new drugs; more people reporting associated mental health issues; a rapidly growing First Nations youth population;[3] and growing prescription drug abuse concerns in some regions and communities. These factors have dramatically changed the landscape upon which systems were designed. With diverse systems and increasingly complex needs, a challenge for communities, regions, and all levels of government is to coordinate a broad range of services and supports to ensure First Nations have access to a comprehensive client-centred continuum of care.

In response to this need, in 2007, the Assembly of First Nations (AFN), the National Native Addiction Partnership Foundation (NNAPF)* , and the First Nations and Inuit Health Branch (FNIHB) of Health Canada oversaw a comprehensive, community-driven review of substance use-related services and supports for First Nations people in Canada. This review was led nationally by the First Nations Addictions Advisory Panel (see Appendix A for a list of Advisory Panel members), which was responsible for both guiding the process and developing a national framework. The review was also informed by the First Nations and Inuit Mental Wellness Advisory Committee's *Strategic Action Plan for First Nations and Inuit Mental Wellness*, which was developed in 2007 to provide national strategic advice on efforts related to First Nations and Inuit wellness. From 2007 to 2011, the review included a wide range of knowledge-gathering and consensus-building activities, including regional addiction needs assessments; a national forum; a series of research papers; regional workshops; and an Indigenous knowledge forum. These activities directly engaged community members, treatment centre workers, community-based addiction workers, health

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

administrators, First Nations leadership, Elders, provincial service providers, researchers, and policy makers to develop and shape a renewed approach for community, regional, and national responses to substance use issues among First Nations people in Canada. *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* was developed based on this process of engagement and feedback.

*Honouring Our Strengths* outlines a continuum of care in order to support strengthened community, regional, and national responses to substance use issues. It provides direction and identifies opportunities to ensure that individuals, families, and communities have access to appropriate, culturally-relevant services and supports based on their needs at any point in their healing process. This vision is intended to guide the delivery, design, and coordination of services at all levels of the program. This approach recognizes that responsibility for a strengthened system of care includes individual responsibility for managing one's own health, communal responsibility among First Nations people, and a system-wide responsibility that rests with individuals, organizations, government departments, and other partners. The focus of the framework is on addressing substance use issues; however, it also considers the important roles mental health and well-being play in all aspects of care, including prevention, early identification, intervention, and follow-up. In addition, it recognizes that community development and capacity building are central to more self-determined substance use and mental health services and supports.

The continuum of care outlined in this framework consists of six key elements of care. These six elements respond to the needs of individuals, families, and communities with a wide range of substance use issues. They are also designed to meet population needs throughout the life-span and across unique groups (e.g., women, youth, and those affected by mental health issues). These elements are as follows:

- **Element 1:** Community Development, Universal Prevention, and Health Promotion: Element 1 includes broad efforts that draw upon social and cultural systems and networks of support for people, families, and communities. These supports, including formal and informal community development, prevention, and health promotion measures, provide the basis for a healthy population and are accessible to the broader community.
- **Element 2:** Early Identification, Brief Intervention, and Aftercare: Element 2 is intended to respond to the needs of people with at least moderate levels of risk with respect to a substance use issue. Services and supports in this element help to identify, intervene, and support those in need of care with the goal of intervening before substance use issues become more severe. These services may also provide ongoing support to those who have completed more intensive services (such as active or specialized treatment).
- **Element 3:** Secondary Risk Reduction: Element 3 seeks to engage people and communities at high risk of harm due to substance use issues and who may not be receiving support (e.g., Personal: physical injuries, becoming a victim of sexual assault/abuse, domestic abuse, car accidents, suicide, and HIV and/or Hepatitis C infections; or Community: crime, lost productivity, increased needs with unmatched resources for health, child welfare, and enforcement). These services and supports seek to reduce the risk to individuals and communities through targeted activities that engage people at risk and connect them with care that is appropriate for their needs.
- **Elements 4:** Active Treatment: Element 4 is focused on people with substance use issues that are moderate to severe in their complexity. This element involves more intensive services than those found in the previous element, and may include a range of supports (e.g., withdrawal management, pre-treatment, treatment programming, aftercare, and case management) provided by various service providers. These can be community-based or they may be part of outpatient programs. Having an aftercare stage or a second phase of care that provides active support and structure makes it easier for clients to slowly return to the community for longer-term recovery work.
- **Element 5:** Specialized Treatment: In contrast to Element 4, Element 5 provides active treatment for people whose substance use issues are highly complex or severe. People who require care in this element often have highly acute and/or complex substance use issues, diagnosed mental health disorders, mental

illness, and other conditions like as Fetal Alcohol Spectrum Disorder (FASD). Specialized services usually required can include medically-based detoxification and psychiatric services, as well as culturally-based interventions.

- **Element 6:** Care Facilitation: Element 6 involves active and planned support for clients and families to find services in the right element, transition from one element to another, and connect with a broad range of services and supports to meet their health and social needs (e.g., cultural supports, housing, job training, jobs, education, and parenting skills). Whether through formal case management or other forms of community-based or professional support, care facilitation involves efforts to stay connected with clients, especially when various service components are not well integrated.

Six key supports to the continuum of care have also been identified in the framework. These include: workforce development; governance and coordination of and within the system; addressing mental health needs; performance measurement and research; pharmacological approaches; and accreditation.

While the framework is first intended to influence change in the current NNADAP and NYSAP programs, it is also an evidence-based framework to guide the design, delivery, and evaluation of substance use and mental health programs that serve First Nations populations in other jurisdictions. These include provinces, territories, First Nations self governments, and transferred health programs within First Nations communities. This framework benefits from extensive engagement with First Nations people across Canada through the

FIGURE 1: ELEMENTS OF CARE

| ELEMENT OF CARE | ELEMENT 1<br>Community Development, Universal Prevention, and Health Promotion | ELEMENT 2<br>Early Identification, Brief Intervention, and Aftercare | ELEMENT 3<br>Secondary Risk Reduction | ELEMENT 4<br>Active Treatment | ELEMENT 5<br>Specialized Treatment |
|---|---|---|---|---|---|
| POPULATION SERVED | Everyone | People at moderate risk | People at high risk | People with moderate issues | People with severe issues |
| SERVICE & SUPPORT COMPONENTS | Community Development<br>Universal Prevention<br>Health Promotion | Early Identification<br>Brief Intervention<br>Referral & Case Management<br>Risk Assessment & Pre-Treatment Support<br>Aftercare | Community-based Supports<br>Outreach<br>Risk Assessment & Management<br>Screening, Assessment, Referral & Case Management | Screening, Assessment & Referral<br>Withdrawal Management & Stabilization<br>Treatment Planning & Pre-Treatment Care<br>Case Management<br>Specialized Treatment Programming<br>Discharge Planning & Aftercare | Coordination of Care<br>Cultural Competency<br>Community-Level Capacity & Support |
| ELEMENT 6: Care Facilitation | | | | | |

networks of the three partners to this process: the AFN health technicians and First Nations political system; the NNAPF networks of NNADAP and NYSAP workers; and the Health Canada First Nations and Inuit Health Regional Program Advisors.

*Honouring Our Strengths* has the benefit of a team tasked with guiding, advocating, and supporting its implementation. The NNADAP Renewal Leadership Team is a national committee with broad, cross-Canada representation from areas such as prevention, treatment, culture, youth, policy, health, nursing, public health, and research who will guide the implementation of the framework's renewal opportunities. Facilitating and influencing change, where change is possible, is critical to maintaining the momentum that has been generated through the regional needs assessments and in the development of this framework.

# Introduction

## >> PROCESS OF RENEWAL

*Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* outlines a comprehensive continuum of services and supports, inclusive of multiple jurisdictions and partners, to strengthen community, regional, and national responses to substance use and associated mental health issues among First Nations people in Canada.

There is currently a range of federally-funded mental health and addictions programs in place for First Nations and Inuit communities that are aimed at improving their physical, social, emotional, and spiritual well-being. These programs include: Building Healthy Communities; Brighter Futures; NNADAP—Residential Treatment; NNADAP—Community-based Services, and NYSAP. Other programs that were not included in the process of renewal are the Indian Residential Schools Resolution Health Support Program (IRS-RHSP); and the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). These programs vary in their scope, application, and availability, but generally provide community-based services to First Nations people living on-reserve and Inuit living in the North.

First Nations substance abuse prevention and treatment services have continued to evolve throughout their history. In the beginning, NNADAP services were largely based on the Alcoholics Anonymous model, with the main difference being the infusion of First Nations cultures. Over time, many treatment centres have moved toward the use of other therapeutic interventions, such as cognitive behavioural approaches, while also strengthening their culturally-specific interventions and incorporating more mental health-focused services. In addition, since the NNADAP network was further expanded in 1995 to include NYSAP treatment centres, communities have had access to a range of highly innovative and effective treatment programming for First Nations youth.

NNADAP and NYSAP's many successes over the years can be largely attributed to First Nations ownership of the services, as well as the creativity, dedication, motivation, and innovation of NNADAP workers. NNADAP centres and workers have continued to show their commitment to strengthening the program by pursuing accreditation and certification, respectively. Through the creation of community NNADAP worker positions, NNADAP has contributed to the development of local leadership. In addition, many former NNADAP workers have gone on to pursue post secondary education and have moved into high level positions within the community, as well as taking on roles in the public and private sectors. The *NNADAP Storybook: Celebrating 25 Years* also demonstrates the significant impact NNADAP has had within First Nation communities.

NNADAP has been reviewed several times during its long history. Most recently, the *1998 NNADAP General Review* generated 37 recommendations, including the need for communities, regions, and all levels of government to better coordinate services and supports to meet the needs of First Nations communities. Since 1998, some of these recommendations have been addressed, while others are

informing current renewal efforts. Since the review, the urgency and complexity of issues facing communities have increased. Prescription drug abuse has emerged as a major issue in many communities, and the recognition of the unique treatment needs of certain populations (e.g., youth, women, and people with mental health issues), has also become more defined. Likewise, the number of people who specifically identify their trauma and associated substance use issues as being linked to Indian Residential Schools and child welfare experience has also increased. There is broad recognition of the need for strong health promotion, prevention, early identification and intervention services within the context of community development for the rapidly growing First Nations youth population.

Based on these and other emerging needs, the process of renewal developed as a result of a partnership between the AFN, NNAPF, and Health Canada. It has been led nationally by the First Nations Addictions Advisory Panel, which included addictions researchers, health professionals, Elders, and First Nations community representatives, who both guided the process and were tasked with developing this national framework. Significant guidance and support has also been received from regional networks including AFN Regional Health Technician Network, NNAPF regional networks, and Health Canada First Nations and Inuit Health Regions and their partners. Renewal officially began in 2007 and has involved a wide range of activities aimed at informing a strengthened systems approach to community, regional, and national service delivery. These activities have included regional addiction needs assessments; a national forum to identify key renewal directions; a series of research papers; and an Indigenous knowledge forum. Activities have involved community stakeholders and those most directly involved in providing services to clients at a local level.

Announced in 2007, the National Anti-Drug Strategy (NADS) represents the most significant investment in NNADAP since its creation in the 1980s. Under the NADS, the Government of Canada committed $30.5 million over five years, and $9.1 million ongoing, to improve the quality, accessibility, and effectiveness of addiction services for First Nations and Inuit. Funding provided by the NADS is supporting the development, enhancement, renewal, and validation of on-reserve addiction services, including NNADAP and NYSAP. NADS funding has provided an opportunity to support services in targeted areas to better respond to the current and emerging needs of First Nations individuals, families and communities.

More information on the renewal process, including the regional needs assessments, research papers, and NNADAP Renewal National Forum, is available on the NNADAP renewal website—http://www.nnadaprenewal.ca

## >> PARALLEL INITIATIVES

Within Canada, mental health and addiction issues have gained considerable attention in recent years. Consequently, there are a number of parallel initiatives that have provided direction and support to the NNADAP Renewal Process. The ongoing implementation of *Honouring our Strengths* will benefit from co-ordinating with, and building upon, these parallel initiatives. These include but are not limited to:

### The National Anti-Drug Strategy (2007):

The NADS encompasses prevention, treatment, and enforcement. In 2007, the Government of Canada committed $30.5 million over five years, and $9.1 million ongoing, under the Treatment Action Plan of NADS to enhance addiction services for First Nations and Inuit populations. The NADS investment provided the opportunity for renewal, as well as support for ongoing implementation efforts.

### First Nations and Inuit Mental Wellness Advisory Committee's (MWAC) Strategic Action Plan (2007):

This action plan was developed by a national committee established to provide advice to Health Canada on issues relating to First Nations and Inuit mental wellness, including mental health, mental illness, suicide prevention, Indian Residential Schools, and substance use issues. MWAC's Strategic Action Plan advocates a holistic approach, recommending that individual and community efforts towards health and wellness should take into account the inter-relationship of mental, physical and social well-being. The NNADAP Renewal Process has been informed by, and is consistent with, this approach.

**The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005):**
This framework was developed following two years of Canada-wide consultations spearheaded by Health Canada, its federal partners—Public Safety and Emergency Preparedness Canada, and the Department of Justice Canada—and the Canadian Centre on Substance Abuse. It emphasizes that a range of approaches are necessary to address substance use issues, and identifies 13 priorities for action, including alcohol, treatment, youth, First Nations and Inuit, workforce development, Fetal Alcohol Spectrum Disorder, and offender-related issues.

## Key Concepts

Three terms found throughout this report are defined here; however these definitions may not capture all realities for all people.

### 1) Substance Use Issues

"Substance use issues" is used to describe a broad range of issues and concerns related to, and resulting from, substance use. This includes problematic use (e.g., substance abuse and potentially harmful use, such as impaired driving, using a substance while pregnant, or heavy episodic/binge drinking) and substance addiction or dependence (e.g., substance use disorders, as defined by diagnostic classification systems, such as the DSM–IV). These issues are typically experienced by individuals, families, and communities alike, and their impact may be physical, psychological, emotional, behavioural, social, spiritual, familial, or legal in nature.

### 2) Services and Supports

"Services and supports" is used to convey a broad range of interventions or responses—provided by NNADAP/NYSAP, Elders, cultural practitioners, health care, public health, social service, justice or other sectors or providers—to address substance use issues or to reduce their associated risks. These interventions or responses include proactive responses to care provided from various systems, such as prevention, health promotion, intervention services, and aftercare, and also extends to a wide range of support functions and resources. It recognizes that both formal services and individual, family, community, and other cultural supports are often critical to supporting individuals throughout their healing journey. A fundamental challenge for any system of care is to integrate this broad range of interventions or responses.

### 3) Determinants of Health

"Determinants of health" are factors both connected to, and affecting health, which often fall outside the realm of health programming. They are sometimes described as the "root causes" of poor health, that include general social and economic factors, such as income, education, employment, living conditions, social support, and access to health services. Understanding the impact and relationship between these factors supports a more holistic view of health. However, in addition to social and economic factors, First Nations health is widely understood to also be affected by a range of historical and culturally-specific factors. These additional factors are sometimes referred to as First Nations or Aboriginal-specific determinants of health and include loss of language and connection to the land; residential school abuses; systemic racism; environmental destruction; and cultural, spiritual, emotional, and mental disconnectedness.

A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (NTS) (2007):
This approach is the product of a cross-Canada working group established to improve the quality, accessibility, and options available to address harmful substance use—which is one of 13 priority areas identified by the National Framework for Action. The NTS provides general principles and key concepts for building a comprehensive continuum of care, and focuses on addressing risks and harms related to substance use including an emphasis on community-based prevention and treatment initiatives. Engagement of families and a continuum of care responding to the needs of all individuals adversely affected by substance use problems are also featured.

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada (2009):
This document establishes the framework for Canada's first ever mental health strategy. The report was developed by the Mental Health Commission of Canada, and sets out seven goals for what a transformed mental health system should look like: one enabling all Canadians the opportunity to achieve the best possible mental health and well-being. The NNADAP Renewal Process has been informed by, and is consistent with, the principles of this approach. It may also help to inform the Mental Health Commission's ongoing strategic planning efforts.

# Guiding Principles

A systems approach depends not only on ensuring the system contains all the right "parts", but must be guided by a set of overall principles informed by the cultural realities of First Nations people. The following principles were established based on the guidance of cultural practitioners and Elders at the NNADAP Renewal Indigenous Knowledge Forum, and based on a series of regional confirmation workshops for the framework:

- **Spirit-Centred**—Culture is understood as the outward expression of spirit and revitalization of spirit is central to promoting health and well-being among First Nations people. System-wide recognition that ceremony, language and traditions are important in helping to focus on strengths and reconnecting people with themselves, the past, family, community and land.
- **Connected**—Strong connections are the basis for holistic and integrated services and supports. Healthy family, community, and systems are built on strong and lasting relationships. These connections exist between Indigenous people, the land, and their culture, as well as relationships between various sectors and jurisdictions responsible for care delivery.
- **Resiliency-focused**—While trauma contributes substantially to both addictions and mental health, there is a need to recognize, support, and foster the natural strength and resilience of individuals, families, and communities. These strengths provide the foundation upon which healthy services, supports, and policies are built.
- **Holistic Supports**—Services and supports that are holistic consider all potential factors contributing to well-being (e.g., physical, spiritual, mental, cultural, emotional, and social) over the lifespan, and seek to achieve balance within and across these areas. This involves recognition that individual well-being is strongly connected to family and community wellness; and that a comprehensive, integrated continuum of care is necessary to meet the needs of First Nations people.
- **Community-focused**—Community is viewed as its own best resource with respect to the direction, design, and delivery of services. Adopting a community-focused lens will help to both ensure that diversity within and across communities is respected, and enhance overall system responsiveness to factors that make each community unique.
- **Respectful**—Respect for clients, family, and community should be demonstrated through consistent engagement, at all levels, in the planning and delivery of services. This engagement must also

uphold an individual's freedom of choice to access care when they are ready to do so, as well as seek to balance their needs and strengths with the needs of their families and communities.

- **Balanced**—Inclusion of both Indigenous and Western forms of evidence and approaches to all aspects of care (e.g., service delivery, administration, planning and evaluation) demonstrates respect and balance. It is also important to maintain awareness that each is informed by unique assumptions about health and well-being and unique worldviews.
- **Shared Responsibility**—Recognition of the individual, shared, and collective levels of responsibility to promote health and well-being among First Nations people. This begins with individuals managing their own health and extends to families, communities, service providers, and governments who all have a shared responsibility to ensure services, supports, and systems are effective and accessible, both now and for future generations.
- **Culturally Competent**—Cultural competence requires that service providers, both on- and off-reserve, are aware of their own worldviews and attitudes towards cultural differences; and include both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To achieve this, it is also necessary for indigenous knowledge to be translated into current realities to meaningfully inform and guide direction and delivery of health services and supports on an ongoing basis.
- **Culturally Safe**—Cultural safety extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people.

# Environment

As of 2011, there are 630 First Nations communities in Canada. These communities vary considerably and range from larger reserves located close to major urban centres, to very small and remote reserves. Some of these communities are self-governing and exercise control over their health programs; are economically well off; enjoy general good health and high levels of participation in education and community life; and are continuing to pass on their cultural knowledge, language, and traditions to the next generation. However, many communities face major challenges, such as high unemployment, poverty, low levels of education, poor housing, and considerable distances from health and social services.

Substance use issues, including heavy drinking, drug use, and related harms (e.g., violence, injuries, and family disruptions) are consistently identified as priority health concerns by First Nations. Results from the 2008–10 First Nations Regional Longitudinal Health Survey indicated that respondents believed that alcohol and drug use and abuse was the number one challenge to community wellness faced by on-reserve communities (82.6% of respondents), followed by housing (70.7%) and employment (65.9%).[4]

For some First Nations, the use and abuse of substances offers a means of coping with, and providing a temporary escape from, difficult life circumstances and ongoing stressors. Many of these challenges are rooted in the history of colonization which has included: criminalization of culture and language; rapid cultural change; creation of the reserve system; the change from an active to a sedentary lifestyle; systemic racism; and forced assimilation through residential schools and child-welfare policies. These experiences have affected the health and well-being of communities, and have contributed to lower social and economic status, poorer nutrition, violence, crowded living conditions, and high rates of substance use issues. Regardless of their social, economic and/or geographic status, these issues and their historical contexts must be understood as ones faced by First Nations communities.

Several generations of First Nations children were sent to residential schools. Many of the approximately 80,000 former

students alive today are coping with disconnection from traditional languages, practices, and cultural teachings. Others suffer from the after-effects of trauma stemming from physical, sexual, and emotional abuse endured as children in residential schools or through the child welfare system that also removed First Nations children from their families and communities. Because they were removed from daily contact with their parents/family, community, and traditional lands at a young age; many lack a connection to a cultural identity and the parenting/family skills that would have allowed them to form healthy attachments with their own children.

Taking into account the legacy of colonization, a process of decolonization has emerged as a priority for First Nations communities and leadership. Decolonization refers to a process where First Nations people reclaim their traditional culture, redefine themselves as a people, and reassert their distinct identity. It has involved grieving and healing over the losses suffered through colonization; the renewal of cultural practices and improved access to mental wellness resources; and First Nations leaders and communities calling for healing, family restoration, and strengthened communities of care. There have also been calls for a parallel process of raising a consciousness within Canadian society so that stigma and discrimination against First Nations people can be eliminated, both on the personal and the structural levels of society. These efforts to provide effective healing programming and to reclaim cultural identity are recognized as keys to revitalizing communities and reducing the extent of alcohol and substance abuse.

Many First Nations communities aspire to achieve wellness, which is a holistic view of health that promotes balance between the mental, physical, emotional, and spiritual aspects of life. This view of health, sometimes referred to as mental wellness, includes a secure sense of self, personal dignity, cultural identity, and a feeling of being connected. Many First Nations people have reported little success with, and may in fact avoid, services that do not value their way of knowing, particularly with respect to health and wellness.

Likewise, there is a common view that culture is vital for healing, although how culture is defined and practiced varies across communities. Culture is intimately connected to community wellness and is often described as a way of being, knowing, perceiving, behaving, and living in the world. It is recognized as being dynamic because the beliefs, values, customs, and traditions that are passed

on between generations continue to be relevant to current realities. Expression of culture may take on many different forms including: language; methods of hunting, fishing and gathering foods; arts and crafts; ways of relating to each other; knowledge that informs family, community, and governance structures; the gathering and use of traditional medicines; traditional diets; as well as spiritual journeying, drumming, dancing, singing, and healing ceremonies. Within these various expressions of culture, some First Nations people see culture as distinct from spirituality. However, for others, traditional Creation Stories of First Nations people in Canada set out the primary foundation for defining culture with an understanding that spirit is the central and primary energy, cause, and motivator of all life. It follows then that the use of cultural practices to address substance use issues, and the role of spirituality within these practices, must be determined by individuals, families, and communities themselves.

# Who is Affected?

## >> INFANTS AND CHILDREN

Through the regional needs assessments, many First Nations communities expressed significant concern over how many First Nations children are exposed to alcohol and drugs at an early age. A Quebec-based survey on substance use patterns among First Nations revealed that one-third of the people surveyed who had used inhalants started using them at the age of 10 or younger and 58% began using them when they were aged 11 to 15. Alcohol and marijuana were also used at an early age compared with amphetamines, cocaine, heroin, and prescription medications. The first use generally occurred (about 60%) in the 11 to 15 age group and slightly more than 20% said they first used alcohol at the age of 10 or younger.[5] In addition, the regional needs assessments indicated that, while data is limited, Fetal Alcohol Spectrum Disorder (FASD) continues to be a concern in some First Nations communities.

The role of early childhood development in future health is well known.[6] During the early years of life, children develop important attitudes and resiliency skills. Thus, it makes sense to provide children with the tools and support they will need to make healthy lifestyle choices. There is a range of ways to use prevention and health promotion to help reduce the chance that children will develop a future substance use or mental health issue. The focus will be on lowering risk factors (e.g., problems at school, abuse, family neglect, psychological disorders, low degree of bonding with parents, and lack of connection with traditional culture and life ways), while promoting protective factors (e.g., pride in cultural identity, speaking a traditional language, school success, literacy skills, access to high school, recreational activities, and ties to a supportive adult or Elder). By dealing with these issues early in childhood, the risk of future problems will be lowered.[7]

## >> YOUTH AND ADOLESCENTS

A high level of concern exists when it comes to youth. Aboriginal youth are the fastest growing population in Canada, with a projected annual birth rate growth that is nearly three times higher than non-Aboriginal Canadians. In 2006, the average age of Canada's Aboriginal population was 27 years, compared with 40 years for non-Aboriginal people, a gap of 13 years.[8] Between 2002–03, more than one in four (27.2%) First Nation youth reported sad, blue, or depressed feelings for two weeks in a row. This same study revealed that 21% of First Nations youths had thoughts of suicide, while 9.6% have attempted suicide.[9] According to the 2008–10 First Nations Regional Longitudinal Health Survey (RHS), 51.1% of First Nation youth (12–17) reported heavy drinking (five or more drinks on an occasion) at least once per month in the past 12 months, and 10.4 % of youth engaged in heavy drinking at a rate of at least once per week in this past 12 months.[10] Previous surveys have revealed that First Nations are more likely to both use all types of illegal drugs and to start using substances at a much younger age than non-Aboriginal Canadians. The highest risk group for both drinking and drug use among Aboriginal people is young males aged 18–29.[11]

There is a significant body of research that demonstrates the effectiveness of prevention, outreach, early identification and intervention services targeted at youth and adolescence as a cost-effective means for reducing substance use issues later on.[12] These approaches focus on lowering risk factors, while promoting protective factors. Because many services—especially mental health and addictions services—are not usually designed for youth, mental health and addiction health workers are seldom trained to specifically work with this population. In fact, youth are among the least-served segment of the population and rarely seek out formal mental health and addictions services that exist in their communities.

## >> ADULTS

Among the First Nations adult population, alcohol is still the most common substance of abuse. Although abstinence from alcohol is common among First Nations, so is heavy drinking. The RHS 2002/2003 showed that almost three times as many First Nations adults reported heavy drinking on a weekly basis (16%) than did the general population (6.2%).[13, 14] The survey also found that 7.3% of the adults surveyed said they use illegal drugs, more than double the rate among mainstream Canadian adults. In addition, alcohol was a noted as a factor in 80% of suicide attempts and 60% of violent events.[15] While alcohol abuse among First Nations has been a concern for a long time, some communities are reporting increasing use of illegal and prescription drugs. Although the extent of prescription drug abuse is not well known, First Nations in some provinces have described it as a high priority issue, while others have said it is an emerging concern.

## >> OLDER ADULTS/SENIORS

Older adults/seniors make up the smallest group of First Nations people, and are often one of the most under-served groups given that many services target the needs of younger adults. Although research data is very limited for this population, some regions have stated that more attention is required on this population, particularly with respect to alcohol and prescription drug abuse. This population may have a unique

set of risk factors for developing a substance use issue. For instance, older adults/seniors are significantly more likely to have direct experience with residential schools (as opposed to intergenerational) and to have lost a child due to removals through the respective child welfare system. The regional needs assessments revealed that many older adults still find talking about their residential school experience difficult. They also indicated that they did not easily recognize prescription drug abuse or gambling as problems.

## >> FAMILIES

When children grow up in an environment where their cultural identity is oppressed and substances are abused frequently, they may come to see alcohol and other substance abuse as "normal" and therefore become more likely to repeat those behaviours in adulthood. A family environment characterized by intergenerational trauma, grief and loss will also be characterized by an erosion of cultural values visible through inadequate child rearing, disengagement from parental/family responsibilities, violence, abuse, and the problematic use of substances are all risk factors that contribute to alcohol and drug abuse. Parenting programs and other supports for families could help to address this need with a more holistic approach that would include child and parent well-being through the provision of family healing programs and traditional parenting programs for families and extended family members.

Families have a responsibility to provide children with an environment where they feel loved, nurtured, safe, and connected to their spirit, community, and culture. First Nations definition of family goes beyond the nuclear family and recognizes that children have a wide range of caregivers apart from parents (including older siblings, extended family, and clan family). For First Nations people, identity comes from family and, by extension, community and traditional land and clan systems. These supports and connections have the capacity to promote a secure sense of self pride in culture and fulfillment of cultural identity, and play a significant role in preventing or delaying the onset of substance use issues and mental health disorders.

## >> GENDER

Many First Nations women's health issues are adversely affected by gender-based social status and roles imposed through colonization. First Nations women face high rates of family violence, single parenting, sexual harassment, inequality, sexual exploitation and poverty. The impacts of these issues contribute to their mental health and substance use issues and have a major impact on the lives of their children, families and communities.[16] Women also face unique barriers to accessing services and may be deterred from doing so due to stigma, discrimination, a fear of losing their children, or a lack of women-centred programs. Lack of childcare, housing, income support, and transportation are some of the more common barriers for women that need to inform service delivery and planning. In the past, many services were aimed mostly at the needs and realities of men. It is important that services and supports acknowledge the role of sex and gender, including the unique experiences of women with substance use and mental health issues, in service design and delivery. There is now a movement toward offering services that are women-specific, in consideration of past/current trauma and the barriers that many women seeking services face; or at the very least, services that are adapted to reflect the needs and realities of women.

While there is a need for women-centred services, it remains very important to continue to have programs that are designed and developed to address the needs of men of all ages. Men are also dealing with the impacts of poverty, violence, sexual abuse, and loss of culture and language, and require programming that supports them in addressing these underlying issues as part of their recovery. The stigma around various types of physical and sexual abuse can be just as significant for men as for women, making gender-specific programming critical for many individuals. As well, traditional cultural teachings may also play an important role in restoring gender defined strengths and purpose in family and community.

## >> MENTAL HEALTH

Colonization and residential schools have contributed to First Nations experiencing mental health and substance use issues at much higher rates than the general population in Canada. In 2002–2003, 30% of First Nations people who

were surveyed said they had felt sad, blue, or depressed for two or more weeks in the past year.[17] Recent data also suggests that First Nations people are two times more likely to seek help for a mental health issue than other Canadians.[18] This number is likely to rise if more services become available in rural and remote communities. In 2005–2006, antidepressants were the number one type of therapeutic drug issued under Non-Insured Health Benefits Program (NIHB), at a cost of $17.5 million, while anti-anxiety medications ranked sixth, for a total of $5.5 million.[19] NIHB data also show that depression and anxiety are two of the more common mental health issues faced by First Nations.

The links between substance use and mental health issues are complex. It is generally known that someone with a mental health issue is more likely to use substances to self-medicate, just as a person with a substance use issue is more likely to have or develop a mental health issue. Likewise, it is generally recognized that people with co-occurring mental health conditions have poorer treatment outcomes; are at a higher risk for harm; and have the most unmet needs.

### >> PEOPLE WITH UNIQUE NEEDS

Although anyone may be affected by substance use issues, the risk and course of these issues vary for different people. Services and supports must adapt or be targeted toward unique population needs to maximize their appropriateness and effectiveness. As well, some persons may also face additional risks and barriers. Examples of populations with unique service needs include, but are not limited to:

- two-spirited, gay, lesbian, bisexual, and transgendered people;
- people with disabilities;
- people with mental health issues;
- individuals living with HIV/AIDS or Hepatitis C;
- persons with cognitive impairments or acquired brain injuries;
- youth and adults who are FASD affected;
- marginalized individuals, such as those who are homeless; and
- persons in conflict with the law.

It is recognized that for these populations they may not be able to feel fully connected or engaged in community life. Due to this disconnect, they may not be the focus of prevention efforts, or have access to treatment services. In addition, they may experience distinct barriers that impact on their ability to access services; services may not be responsive to their unique needs; and their community may not be fully accepting or welcoming in supporting their recovery. In some cases, people belonging to these populations need to migrate to urban centres to obtain proper services or for the support and safety that may be lacking within their home community. A systems-wide goal to address the needs of all populations is required to remove barriers, combat stigma, and ensure proper services and full community participation.

# Other Considerations

### >> TOBACCO ABUSE

Tobacco-related illnesses and diseases are urgent issues in First Nations communities where smoking rates are more than double those for the rest of Canada. According to the 2008–10 First Nations Longitudinal Health Survey, 43% of First Nations adults are daily smokers, with an additional 13.7% self-identifying as occasional smokers.[20] In comparison, 17.1% of the larger Canadian population are daily smokers.[21] As well, over half of daily smokers are between the ages of 18–29,[22] and the majority of on-reserve First Nations people who smoke started between the ages of 13 and 16.[23]

Currently, stop smoking programs (tobacco cessation) within First Nations communities receive limited funding from various federal programs. Some funding support from provinces is also offered through community partnerships with provincial agencies. The focus of available community efforts have been on prevention, cessation, and education. Some communities have also chosen to promote smoke-free environments and have banned smoking in public spaces (e.g., health and social services offices, band offices and sometimes treatment centres). In addition, some treatment centres provide support for clients with tobacco cessation in addition

to overcoming other chemical addictions, although there is a common view within many other treatment centres that it is too much to expect from clients for them to abstain from everything all at once.

## >> PROBLEM GAMBLING AND OTHER ADDICTIVE BEHAVIOURS

A process addiction can be defined as a process or activity that has become compulsive or destructive to a person's life. Process addictions differ from substance addictions because they are not a physical addiction in the way that alcohol or other substances can be. In contrast, process addictions involve a psychological addiction, which can still be very harmful and may require counselling, treatment, or other supports. There are a wide range of process addictions. The most common process addictions are sex addiction, compulsive gambling, internet addiction, shopping addiction, and compulsive eating.

For many Aboriginal communities, addictions to gambling are a growing concern across all age groups. Unfortunately, older adults seem to be more likely to get involved in problem gambling, often finding refuge from being lonely and isolated. During community focus groups, some people said that family members are often aware of problem gambling but feel helpless. Gambling can be seen as a way to fill a social void for many people because it provides a social outlet. As a result, many people are not keen to view gambling as a form of addiction. Gambling addictions are not usually part of current NNADAP programming. However, some treatment centres have chosen to provide specific programming for gambling addictions. Programming may include awareness, counselling, or support groups. Often these services are offered as an extra service rather than as part of the core program.

# Overview of the Systems Approach

## >>SUMMARY OF THE SYSTEMS APPROACH

This systems approach to addressing care is inclusive of the full range of services, supports, and partners who have a role in addressing substance use issues among First Nations people. This includes First Nations community-based services and supports (such as NNADAP, community cultural supports, and social support networks) but also other related partners and jurisdictions (e.g., housing, education, employment, and federal correctional services). It is recognized that no single sector or jurisdiction can support individuals and their families alone. A systems approach provides a framework through which all services, supports, and partners can enhance the overall coordination of responses to the full array of risks and harms associated with substance use among First Nations.

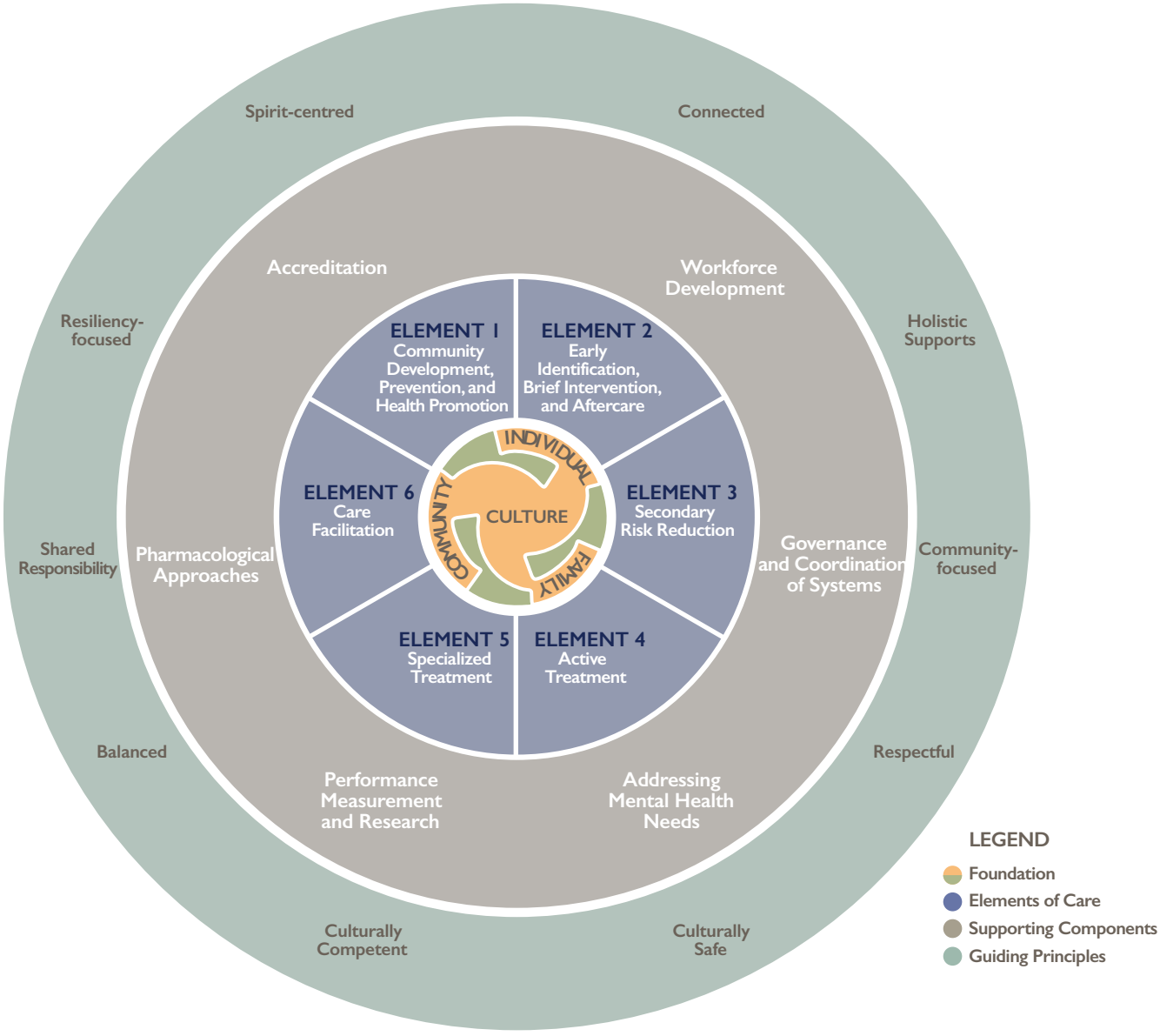
The elements of care described in *Honouring Our Strengths* reflect a continuum of care approach that considers a range of services, supports, and partners who have a role in addressing substance use issues among First Nations. This approach aims to support a strengthened, systems-wide response for First Nations communities and people who are at risk of, or directly affected by substance use issues throughout the lifespan. This approach focuses on:

- Matching people affected by substance use issues to the kinds of services and supports they need at any point in their care journeys; and
- Co-ordination among partners and sectors to provide effective, client-centred and culturally safe services and supports.

The six elements of a continuum of care are intended to respond to the needs of individuals, families, and communities with a range of substance use issues. The elements are also designed to meet the needs of specific population groups (e.g., women, youth, and people with co-occurring mental health issues). The elements of care are as follows: Community Development, Universal Prevention, and Health Promotion; Early Identification, Brief Intervention, and Aftercare; Secondary Risk Reduction; Active Treatment; Specialized Treatment; and Care Facilitation. Six key supports to the continuum of care have also been identified in the framework: workforce development; governance and coordination of and within the system; addressing mental health needs; performance measurement and research; pharmacological approaches; and accreditation. The elements and key supports outlined in this model are described in more detail in the sections that follow. Each of the sections is organized into four parts:

1. **Description:** providing a summary and rationale for the section, including a description of the target population, key components, and/or key partners. This outlines what services and supports would ideally look like.
2. **Key Components:** providing further definition of the key services and supports specific to each element.
3. **Current Status:** providing an overview of current services and supports available with an emphasis on strengths and challenges.
4. **Renewal Opportunities:** identifying opportunities to strengthen the current system in line with the description and key components while supporting identified strengths and targeting challenges within the current system.

FIGURE 2: SYSTEMS MODEL



# ELEMENTS OF CARE

*Health and well-being must be pursued in the context of the community in which First Nations people live and remain connected throughout their lives.*

*First Nations communities, with services and supports that are responsive to their needs and culture, are the primary means for promoting healthy connections between individuals, families, and communities.*

# Element 1

## Community Development, Universal Prevention, and Health Promotion

### >> DESCRIPTION

The services and supports in Element 1 are broad efforts focused on promoting and strengthening the well-being of individuals, families, and communities. A healthy community with strong social supports helps to establish a foundation for all aspects of the continuum of care. In periods of stress, where substance use issues mostly occur, social support networks can provide essential care and encouragement for personal, family, and collective healing.

The three main components of Element 1 involve:

- community development;
- universal prevention; and
- health promotion.

People who may provide Element 1 services and supports include but are not limited to community members such as parents, family, and friends; staff from all community programs; and leaders in the community, both formal and informal.

### >> KEY COMPONENTS

#### Community Development

Community development describes the intentional actions taken by a community to increase their overall health and wellness. Community development strategies work best when they are community-driven, long-term, planned, empowerment-based, holistic, build ownership and capacity at the community level, and take into account the broader social and economic context. This context may include the influence of education levels, living and working conditions, poverty, awareness of culture and traditional language, social environments, history of colonization, and access to health and well-being services.

Capacity within community is an important foundation to effectively plan, implement, and evaluate community development activities. Community capacity includes the practical, team-building skills of facilitating community consensus; leadership skills; cultural resources and knowledge; health and wellness knowledge and expertise to provide mental health promotion, addictions treatment and prevention.

#### Universal Prevention

In harmony with community development, universal prevention approaches are aimed at the general public or a population within a region or a community (e.g., youth, pregnant women, or older adults) with the specific goal of promoting healthy behaviours and preventing, reducing, or delaying substance use or abuse. Effective prevention initiatives focus on strengthening protective factors and minimizing risk factors. These initiatives are positive, proactive and offered to everyone, no matter what their risk status.

Collaboration is required on these initiatives between various health and social services, departments, and agencies. Examples of universal prevention in action may include:

- drug education programs in schools;
- community-based cultural practices;
- parenting or family programs;
- media campaigns; and
- alcohol or drug policies and strategies within a community.

These efforts are often most effective when based on Indigenous value systems and culture, plan for future generations, and combined with other health and social strategies or frameworks at the community level.

### Health Promotion

Health promotion is a process of empowering people to increase control and improve their health and its determinants. These efforts help people engage in safer and healthier lifestyles, create conditions that support such lifestyles, and restore healthy and supportive family and community dynamics. They can also advance skills, knowledge, changes in attitude, or community environment to help people engage in safer and healthier lifestyles.

Specific to substance use and mental health issues, health promotion may be paired with universal prevention programming in a variety of ways. This may include a range of approaches to build self-awareness, self-esteem, healthy boundaries, and effective assertiveness skills. These skills and approaches may serve as key protective factors among individuals, families, and communities to reduce, delay, or prevent future substance use or mental health issues. They may also build awareness among youth and families of cycles or patterns of behaviour (e.g., addiction, or physical, emotional, or sexual abuse) that are key risk factors for these issues. Awareness is often an important first step in breaking these patterns of behaviour, both in the present and intergenerationally.

Health promotion may also include long-term planning to ensure future generations are adequately supported. It can also contribute to healthy public policy development; help to create supportive environments; and, where appropriate, lead to re-orienting or re-focusing health services. Community health promotion can enhance community development efforts that are based on local needs identification and community- or region-wide inter-agency planning (e.g., needs assessments based on participatory approaches). This kind of community health promotion targets issues in a multi-dimensional, holistic fashion as communities become the focal point of decision making and operations for health services.

### Alkali Lake (Esketemc First Nation) Community-based Holistic Healing

There are a number of examples of First Nations communities who have developed holistic approaches to community-based healing. One of the more dramatic examples is Alkali Lake (Esketemc First Nation) near Williams Lake, British Columbia. In reaction to high rates of alcohol addiction, with nearly all of the community seen as dependent, the community engaged in an ongoing healing process to transform health and social conditions, promote individual and community wellness, and revitalize traditional teachings and practices. Guided by continued leadership, commitment and support, this process started with one sober person and expanded to 95 percent of community members indicating that they were clean and sober. Throughout the process, sober community members worked to eliminate the bootlegging of alcohol through collaboration with the RCMP. As well, a voucher system was established with stores in Williams Lake for food and other necessities, where some of the community's heaviest drinkers received these in place of social assistance funds.

## >> CURRENT STATUS

Community development efforts vary considerably from one community to the next. At present, a majority of First Nations community development efforts are focused on economic development. However, there is a growing recognition among government departments and communities that efforts benefit significantly from including a focus on mental health and well-being.

The intergenerational impacts of residential schools can sometimes contribute to mental health issues, which can hinder collective action. Despite these challenges, there are examples where communities, in partnership with their leaders, have implemented community development projects that target either mental health or addiction issues. These projects often focus on individual, family, and community well-being within the broader context of social determinants of health. Such projects promote community interconnectedness and

cultural identities through traditional teachings and ceremonies. However, the significance of this approach may not be recognized by the communities themselves or by research bodies and policy-makers.

A wide range of community workers, including NNADAP workers, Brighter Futures coordinators, suicide prevention workers, Community Health Representatives (CHRs), youth workers, and teachers, have a role in delivering prevention, health promotion, and community development in First Nations communities. As key parts of the health system, some of these individuals have a passion for, and understanding of, prevention work. That being said, many workers also find it hard to create time and space for prevention, health promotion, and community development activities as they are overwhelmed with crisis response, treatment needs, and other demands, which often take priority over these activities. Subsequently, workers tend to provide basic supports to clients in the form of counselling, as well as transportation to and from treatment facilities.

NNADAP community-based addiction workers vary in their capacity to carry out prevention roles. In some cases, workers are mostly qualified to do counselling but they may not have formal qualifications to develop or carry out prevention programs. As a result, an ongoing concern for NNADAP community-based addiction workers is that training and certification activities are not geared toward prevention. Instead, these actions focus on personal development in the field with little emphasis on population level responses, community development, and public health/prevention theory and practice. In general, NNADAP workers receive limited training each year to advance their knowledge of addiction issues and to enhance their prevention skills and approaches.

While workers in some communities clearly know what their roles are, well-developed resources and job descriptions are not common across the system. An additional challenge is the fact that community prevention funding for NNADAP is often used for wages, whereas Brighter Futures and Building Healthy Communities funding is often focused on program activity dollars. This has led to calls for strengthened collaboration at the community level and greater integration of program dollars at regional and national levels.

Current prevention efforts, where they exist, are mostly focused in schools. In many cases, school interventions are limited to public speakers, participatory events, and reading material distribution during National Native Addictions Awareness Week. As well, there are some examples of community awareness raising and support offered in the form of community workshops and events.

Many communities have raised concerns about the lack of support for prevention and health promotion, both in terms of leadership not acknowledging their importance, and funding limitations. For example, some communities support by-law policies that create dry communities. However, when such by-laws are passed, bootlegging is common and enforcement is a significant challenge. In general, by-laws are usually not effective unless they are coupled with a broader wellness approach which addresses the complex social and health conditions that lead to substance use and mental health issues.

The community context where prevention and health promotion activities occur can be affected by many challenges that threaten implementation. One of the main challenges is the difference in capacity of each community. While some communities have set up an integrated, comprehensive approach to prevention, many do not have the capacity to support a range of such activities. This is particularly the case in smaller, rural/remote communities that only have funding for one part-time addictions worker. The lack of more comprehensive prevention activities is often due to a lack of knowledge, resources, or a coordinated plan to support culturally relevant, community-based prevention and health promotion activities.

## >> RENEWAL OPPORTUNITIES

### Community Development

- A system-wide approach to community development to promote the local control of services and support and include a strong focus on mental wellness within communities. Such an approach would be designed and directed by community members

and leadership and include a focus on First Nations-specific social determinants of health. It would also focus on improved collaboration with other communities, community programs, as well as multiple levels of government and other federal departments (e.g., Aboriginal Affairs and Northern Development Canada, given its central role in supporting communities when it comes to many determinants of health).

- A process for collecting and sharing successes, challenges, and lessons learned from local community development activities. This would allow for useful regional knowledge exchanges to occur through the sharing of experiences, hopes, and needs across regions. Such an approach would take time and investment, but would be an effective way to build processes which can nurture and expand healthy community development.
- Coordination of services in the community, including partnerships with police, justice, child welfare, housing, education, job and training, social assistance, health, cultural programs and community governance, which would help to ensure a multi-faceted, community-wellness focused approach. Means to support this collaboration could vary and may include multidisciplinary mental wellness teams and leadership roundtables composed of local program managers.
- Ongoing community discussions about culture in order to define its role in service design and delivery and within broader community development efforts. These discussions could help to inform dialogue between a community and other individuals (e.g., service providers) and organizations (e.g., provincial and federal departments) directly involved in community wellness so as to ensure that cultural differences are respected in all dealings.
- Consider how to build a continuum of care beyond prevention and residential treatment. This approach could involve learning more about the kinds of mental health and addictions services which could be available in a given community, per this framework.
- Ongoing engagement and support of parents and families within communities, especially those who have school-age children. Parents and families need support and assistance from service providers, Elders and community leadership to maintain an environment of inter-generational wellness and support. Part of this would involve including more and better

activities for youth (e.g., sports and recreation activities) within the community. As well, school staff may require more training to work with parents, families, and health and social service providers in order to offer a network of observant and engaged role models for youth.

- Chances for youth to meet and engage with each other and with other generations through holistic outlets such as art, sports, dancing, drumming, or learning their Indigenous language. Intergenerational activities and sports have been found to be a good way to share values and ideas, as well as to promote healthy behaviours. Youth can be given support to develop and lead activities or programs they feel would benefit them.
- Mobilization and support of community volunteers to provide community development activities, including recreation, community events, and general activities that help to strengthen community support, promote wellness, and transmit knowledge.

### Tribal Journeys—West Coast of British Columbia

Tribal Journeys has become a movement embraced by international coastal First Nations communities. For two weeks each summer, canoe families (all ages) from up and down the coast make a drug- and alcohol-free journey to a host community. The journey has profound therapeutic value and promotes a healthy lifestyle, not just during the journey, but in the months leading up to it. Spiritual, emotional, social, physical, cultural, and mental challenges are supported by Elders and knowledge keepers such as canoe builders, skippers, traditional food gatherers, cooks, and paddlers. Team meetings allow people to speak of their emotions during the trip. Skipper meetings recognize the skills of those who know the water and embrace the longing of others to learn. In each First Nations community, the visitors are fed as they rest overnight. The success of these tribal journeys is based on a strong cultural foundation that embraces both the past and a modern world. Family involvement allows for intergenerational healing, and relationship building that spans decades. Families and friends celebrate in sobriety, a practice that reflects strong ancestral processes.

## Universal Prevention and Health Promotion

- A clearly stated strategy for universal prevention and health promotion, with defined outcomes and indicators that feed into ongoing policy and program development. This strategy would require a vision or indicators of community wellness and set out a vision for the types of services and supports required to achieve that vision. Key components of this approach would:
  - focus on preventing/reducing possible substance use issues through a whole community/multi-level approach, within a broader public health framework;
  - prevent multiple problem outcomes (e.g., substance use issues, suicide, and mental health issues) through a multi-component, community wellness-based approach (e.g., as school, policy, parent, and media programs or self-care/management tools);
  - reduce developmental risk factors and strengthen protective factors;
  - include a range of health promotion activities that seek to build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, and, where appropriate, re-orient health services;
  - include a focus on addressing and de-normalizing the inherited effects of colonialism—lateral or community violence, guilt, shame, etc.—in fostering a transition to healthier lifestyles built on a strong cultural foundation;
  - draw on mainstream and Indigenous knowledge;

  - build capacity within communities, with an empahsis on supporting communities in need through shared learning and mentorship;
  - opportunities for communities to dialogue on effective strategies for prevention and health promotion;
  - harmonize or link existing addiction, prevention—related, and mental health promotion—based services and funding;
  - prioritize the health and well-being of children and youth;
  - target prevention activities for high-risk groups (see Element 2); and
  - include secondary risk reduction services and supports to people who are actively using alcohol and other drugs (see Element 3).
- Community-driven alcohol policies that focus on promoting health, regulating alcohol supply, reducing instances of driving while intoxicated, reducing environmental risk factors, and broad-based actions to change drinking-related norms and values. These policies will require continuous monitoring and must evolve with both the available evidence, and the values and norms within the community.
- Self-care and management tools and resources that help people manage their own health and wellness. This many include sharing information to help individuals and families make informed choices about health and wellness services and could also include a range of self-management tools (e.g., books, correspondence courses, computer programs and websites).
- Support for families and others who are either close to, or have been impacted by, someone with a substance use issue. This may include family based-programming, cultural supports, or "co-dependency"—focused mutual aid groups (e.g., Co-dependents Anonymous or Adult Children of Alcoholics). These forms of support can help individuals adopt healthier behaviours, set boundaries, build self-esteem, support a loved one's recovery from addiction, and help individuals and families recognize and break patterns of behaviour.
- Strengthened collaboration between prevention and health promotion approaches with treatment, pre- and post-treatment, and community-based intervention services at all levels. The goal would be to create a balance between the needs of community-wide prevention and treatment with support efforts to help promote and sustain healthy behaviours within communities.
- Coordination and cost sharing of prevention and health promotion activities with provincial services. This would support new ways of working at the provincial level and provide ways to exchange knowledge on prevention and health promotion models.

## First Nations Health and Social Services Resource Center (FNHSSRC)—Kahnawake, Quebec

In the community of Kahnawake, Quebec the First Nations Health and Social Services Resource Center (FNHSSRC) was created with the objective of providing information to community caregivers promoting the health and well-being of Aboriginal families. Bilingual newsletters are published quarterly with information pertaining to the Native Alcohol and Drug Abuse Prevention Program (NNADAP) projects in the Quebec region. Among the many resources available are DVD documentaries, pamphlets, documents, and conference dates provided by outside agencies to the Centre. Subjects include mental health, bullying, child abuse, family violence, FASD, suicide, tobacco, AIDS and sexually transmitted infections, and teen pregnancy. An extensive data base lists the materials and clients are able to order on-line or by telephone. An extensive list of resources is available from the Center's catalogue found on their website.

# Working to Prevent Prescription Drug Abuse

## >> CURRENT STATUS

Prescription drug abuse (PDA) has emerged as a critical issue in many parts of Canada, both on- and off-reserve. The problem use of prescription drugs can be defined as the use of a drug for something other than its intended medical purpose. Often, abuse involves using a drug to get high and misuse is defined as not using a drug in the way it was prescribed.

There is limited surveillance data available to completely capture the extent of the use or prevalence of PDA in First Nations communities, particularly as it relates to illicit supply sources (thefts, organized crime, family members procuring or using another family member's prescription, and internet supply). However, First Nations in some regions have described prescription drug abuse as a high priority issue, and others have said it is an emerging concern. According to the 2002–03 First Nations Regional Longitudinal Health Survey the use of substances without a prescription (including codeine, morphine and opiates) had the second highest frequency of use, after marijuana, with 12.2% of the population reporting the use of these drugs over the past year.

The availability of prescription drugs in First Nations communities can be attributed to the following main sources: Non-Insured Health Benefits Program (NIHB); Provincial drug plans/cash payments; and illicit supply.

For this reason, while NIHB data is important in establishing the extent of PDA in First Nations communities, it has its limitations. For example, NIHB data does not capture drug claims paid through other provincial plans, paid by cash, or purchased on the Internet. In some communities, the issue is illicit supply of prescription drugs, either through organized crime or individual users.

Prescription drug abuse has been a target of both NNADAP and several community-based pilot projects funded by Health Canada. The pilot projects raised awareness of prescription drug abuse through various means, including promotional materials, workshops focusing on youth, community and cultural events, and social activities. Specific examples of community interventions to increase awareness of PDA include going door to door to educate community members about healthy prescription drug use and the disposal of unused or expired medications; a public notice in the health centre that medical doctors will not prescribe any form of narcotic drug, and that counselling, treatment plans, and referrals to resources would be offered to individuals seeking help with chemical dependencies; engaging elders to be champions in supporting young mothers with prescription drug misuse issues while teaching them how to prepare nutritional, traditional and affordable meals; and implementing "train-the-trainer" workshops to increase capacity within the community.

Results of the pilots showed that certain key elements are important for successful interventions at the community level; the development of steering or advisory committees to guide prevention efforts at a community/regional level; support from chiefs in council; collaboration with police, schools, family services and health centres; community consultations; use of the mass media; multidisciplinary team approaches; and showing people how much of a problem it is, using local data.

The evidence indicates that, as with all addictions, a comprehensive approach is needed to address prescription drug abuse. Current activities to address PDA are underway in five key areas:

1. Multi-sectoral collaboration—partnerships with addictions programming, policing, nursing, and schools.
2. Research and Surveillance—tracking patterns of use as well as research into best approaches to prevention and treatment.
3. Demand reduction—prevention initiatives to help reduce the demand for prescription drugs, particularly among youth. The work related to prevention

is very similar to that which is described in Element 1 for all substances, however it has been noted that often there is a need to highlight the risks associated with using prescription medication in ways other than how they were prescribed.

4. Supply reduction—prevention initiatives looking at both legitimate and illicit supply. To address supply reduction, NIHB has several strategies, including warning messages to pharmacists about repeat prescriptions; giving pharmacists details on a client's drug therapy history; trend analyses of both client and program level prescription drug use; and the creation of an independent advisory committee to provide input, evaluation, and recommendations for client safety.
5. Treatment—as described in Elements 4 and 5.

## >> RENEWAL OPPORTUNITIES

### Multi-sectoral collaboration

- A multi-faceted approach to address the issues of prescription drug abuse, including exploration of traditional medicine and alternative therapies; improving access to counselling services; reducing peer pressure; and putting in place education and prevention strategies aimed at youth, doctors, pharmacists, dentists, police and the general public.
- Focus on long-term success by linking prevention work with structural change at all levels to shift social norms from reliance on prescription drugs. The findings of community-based pilot projects provide a number of examples of approaches that have worked well in communities.
- Infrastructure to support collaboration among the First Nations and Inuit Health Branch staff, NNADAP staff, doctors, pharmacists, police and band councils to lessen "double doctoring." This includes raising awareness of First Nations health issues within bodies such as the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians, the Canadian Medical Association, and medical schools. It may also include development of an early warning system for prescription drugs use/abuse in First Nations communities.

### Surveillance/Research

- Strengthened evidence base regarding the incidence and prevalence of PDA, including sources of illicit supply.

### Prevention

- Partnering with justice, social, and other sectoral partners at the national level to coordinate development of community-based prevention programming for youth.
- Cooperative approaches with physicians and pharmacists to support appropriate prescribing at the community level.
- Set NIHB coverage limitations for clients identified with PDA problems.
- Expansion of NIHB Prescription Drug Monitoring for clients at risk.

### Treatment

- Support for community-based workers, particularly specialized training and clinical supervision.
- Strengthened access to appropriate counselling services at the local level where possible, in partnership with doctors and pharmacists.
- Support for local health services and treatment centres to ensure appropriate use and collaborative approaches to pharmacological therapy, such as methadone.
- Development of alternate approaches to treatment for those who are uncomfortable with harm reduction practices (e.g., methadone) and for rural and remote areas.

Ongoing engagement and care for those who are either at risk of developing substance use issues or who have already accessed more intensive services is central to a system of care.

Reducing and preventing potential issues requires that care providers, associates across the social determinants of health families, and other community members, are equipped with the skills and knowledge to identify, briefly intervene, and support those in need of care.

# Element 2

## Early Identification, Brief Intervention and Aftercare

### >> DESCRIPTION

The service and support components in Element 2 help to identify, intervene with, and support those who are either at risk of developing a substance use issue or who are currently engaged in problematic or risky substance use. Element 2 also provides ongoing support to individuals and families who have accessed more intensive services in the past (such as active or specialized treatment).

These approaches must be strongly tied to the services, supports, and activities described in Element 1, as they will assist in both identifying and supporting individuals who require help. The key components of Element 2 include:

- targeted prevention;
- early identification;
- brief intervention;
- referral and case management;
- risk assessment and pre-treatment support; and
- aftercare.

People who may be well placed to provide Element 2 services and supports include: primary care and emergency health staff (e.g., doctors, nurses, nutritionists, health centre staff, and CHRs); NNADAP community-based addiction workers; cultural practitioners; social service workers; maternal child health home visitors; FASD mentors; law enforcement or correctional workers; staff at urban Aboriginal friendship centres; an a range of community and social supports (e.g., family members, teachers and friends).

### >> KEY COMPONENTS

#### Targeted Prevention

Targeted prevention is aimed at specific populations showing early signs of a substance use issue or at risk of developing a problem. These approaches reduce risk factors, promote protective factors, limit disability, prevent future addiction issues, and promote community and cultural connections.

Focusing on high risk populations will help to ensure funding can be targeted to those who are at the greatest risk for substance use, as well as a range of health, social and other problems, which may impact the general health and well-being of the community. There is a growing understanding of the importance of focussing on risk factors, particularly among young people. Key high-risk populations include individuals:

- with a mental health issue or disorder;
- with a parent who is or has been alcohol or drug addicted;
- who have been physically, sexually or emotionally abused;
- who are involved with a gang;
- who are lesbian, gay or bisexual; and
- who have experienced childhood traumas or family disturbances, including former residential school students and their families.

Examples of targeted prevention include community support programs targeting at-risk families or communities, youth specific interventions, targeted health education, and social marketing programs to reduce stigma and discrimination.

#### Early Identification

Early identification involves a range of approaches to screen people who have or may be at risk of having a substance use issue (and in some cases a mental health issue). Screening is a process for determining the possible presence of a substance use (or mental health) issue; the level of risk to an individual, family, or community; and whether or not a more comprehensive assessment is required (see Element 4 for more information on comprehensive assessments). Screening can be done by a wide range of individuals, such as primary care professionals, child welfare workers, police, friends and family, and in a range of settings (e.g., schools, recreation centres, or workplaces).

Early identification of substance use and mental health issues may lead to early treatment and self-management, and is important for reducing current or potential addiction or mental health issues.

### Brief Intervention

Brief intervention is a time-limited supportive conversation between a substance user and someone they trust and respect. These conversations can be structured or unstructured in nature; vary from a five minute discussion with a friend to a series of hour-long, structured conversations with a health care professional or Elder; and aim to help the person set goals for healthier behaviours related to their substance use.

Key mechanisms for achieving this can include personalized feedback on substance use patterns and the effects they may be having in a client's health or life. Brief interventions are mostly offered by health or social service providers who know the person. It can also be used by others, in other settings, such as in nursing stations or emergency rooms, and by teachers, school counsellors, or parents and other family members. By dealing with substance use and mental health issues through early identification and brief interaction it may be possible to stop them before they become more severe and complex.

### Referral and Case Management

It is important that care providers know where to refer clients when it is clear that the client's substance use issue requires more intensive support (see Elements 4 and 5). This may involve referring the client for a more comprehensive assessment or directly to treatment services should the situation warrant it. This may also require a care provider to take the role of a case manager or to provide linkages to case management services to ensure appropriate navigation of available services and supports. Case management is discussed in more detail in Element 6.

### Risk Assessment and Pre-treatment Support

Risk assessment and pre-treatment support is necessary for many clients with moderate to high substance use issues who are in need of treatment. These services provide an opportunity for the provider to assess an individual's readiness and motivation for treatment, along with any potential risk factors or patterns of behaviour that may lead to future substance use involvement or issues.

Risk assessment and pre-treatment support can address potential barriers to participation in treatment and help enhance a client's motivation. Support may also help clients prepare for the upcoming treatment process and can involve looking at a client's holistic needs, working with other service providers and sectors, as well as the person's community and social supports. For example, a youth who is at risk of a substance use issue may be far more likely to accept support from a school teacher or sports coach than those of an unfamiliar NNADAP worker.

### Aftercare

Many people who receive intensive treatment services may require life-long, holistic support from a range of service providers as well as community and social supports. This post-intervention support is often referred to

## Nemi'simk, Seeing Oneself—Nova Scotia

"Nemi'simk, Seeing Oneself" was a community-based, collaborative project designed to provide adolescents in partnering Mi'kmaq communities in Nova Scotia with tailored, brief interventions for alcohol misuse. By integrating Aboriginal and Western scientific knowledge, the project developed a brief intervention for substance abuse among Aboriginal adolescents who were engaging in risky drinking behaviour. The interventions occurred across two 90-minute sessions and were delivered by trained school facilitators. Participants in the tailored interventions showed decreased rates of drinking frequency, binge drinking, alcohol-related problems, and increased rates of abstaining from alcohol.

as aftercare. The purpose of aftercare is to help people and their families or other loved ones along their healing journey and to return to positive community life. Aftercare services and supports may be provided by:

- a variety of health and other professionals (e.g., NNADAP workers, mental health, housing, human resources, and social service providers, cultural supports) working both on- and off-reserve;
- community-based support groups for both the person in recovery (e.g., Alcoholic Anonymous and Narcotics Anonymous, sweat lodge ceremonies, or other traditional ceremonies) and family members or other individuals close to people with a substance use issue (e.g., Co-dependents Anonymous or Adult Children of Alcoholics); and
- a wide range of approaches using technology (e.g., telephone/video conference calls, or Internet-based links to health professionals and support groups).

Effective aftercare involves being aware that an initial intervention, such as treatment, is a first step in a long-term recovery process. Adopting a long-term approach to care often requires a focus on relapse prevention and strong case management supports. This approach will help to ensure continued engagement with a client and use community, cultural and social supports, as well as services in key social determinant of health areas (e.g., housing, employment, education, and living conditions).

Support from family, peer networks, and friends, as well as access to housing, education, work, and opportunities to celebrate cultural identity, help support a person to be productive and connected to their community. Effective aftercare strategies could include follow up by treatment providers; additional supports for people with co-existing mental health conditions; "safe" living conditions to support recovery; and support for people moving to urban centres or other communities.

## >> CURRENT STATUS

Increased access to targeted prevention, early identification, and intervention services is required within many First Nations communities. As with universal prevention and health promotion (see Element 1), those best placed to provide these services and supports are often not appropriately trained or find it hard to create time and space to engage in activities with a preventive focus.

Services that reach out to people with, or at risk of developing, a substance use issue are recognized as necessary within all aspects of community life. It is also apparent that funding and training opportunities are needed to ensure service providers and community members are comfortable enough to provide these types of services and supports.

Many of the current screening and assessment tools have a narrow focus on limitations of the client and what is missing in their lives. Although there is a shift toward screening and assessment tools that focus on client strengths, to date, many of these tools have been used mostly with youth. People also recognize that in many cases, current screening, assessment, and referral processes are too

time-consuming, flawed, or restrictive. The NYSAP has developed a more comprehensive screening and assessment approach, as well as tools that take into account a person's own strengths based on cultural identity and resilience.

Aftercare services represent a significant gap within addictions programming, both on- and off-reserve. As with prevention, granting time and space for aftercare can be hard to do. What gets in the way for community workers are high workloads and other, often more pressing concerns. Sometimes a lack of available, accessible, and affordable training or cultural resources can be a barrier to the delivery of aftercare. In the absence of available services, many clients must rely on support groups, family, and community to stay on their healing journey. In some cases, someone returning to a community may not have these supports or may still need more support for a wide range of problems linked to substance use issues.

## >> RENEWAL OPPORTUNITIES

### Early Identification and Intervention

- In harmony with universal prevention activities (see Element 1) and secondary risk reduction services and supports (see Element 3), development of a coordinated, long-term approach to targeted prevention focussing on specific populations whose levels of risk are significantly higher than average, either immediately or over a lifetime. This may involve a wide range of approaches, including:
  - youth-specific interventions, such as programs for personal development; cultural ceremonies celebrating puberty and rites of passage; peer education and outreach initiatives; anti-gang initiatives; and school-based early identification and intervention;
  - targeted interventions for other key populations, including pregnant women, two-spirited, gay, lesbian, bisexual, and transgendered people;
  - home and community support programs targeting at-risk individuals or families, such as family trauma-based services, or services and supports for single parents;
  - targeted health education, such as information on specific substances of use or abuse, including the effects of heavy drinking, the identification of the impacts of colonization on health behaviours, and the promotion of culturally informed healthy living;
  - cultural ceremonies that help individuals to identify their spirit name and clan family; and
  - targeted social marketing programs, such as sobriety promotion or anti-drug campaigns.
- Screening tools for substance use and mental health issues that are basic, evidence-informed and culturally safe. These tools would provide a wide range of community members and health professionals with a series of screening questions that could be used with each client to find out whether a substance use issue is present and determine if a more comprehensive assessment is needed.
- Development of holistic and culturally safe early identification and brief intervention tools to support people with substance use issues. These tools may be standardized and should:
  - recognize client, family and community strengths;
  - be easily adapted to meet the needs of different regions and populations;
  - include consideration of associated mental health issues;
  - be flexible enough to meet the diverse needs of regions and communities; and
  - be supported by guidelines, training and/or workbooks that would help community members, service providers, and other care providers, both on- and off-reserve, to help clients set goals for substance use behaviours. For more discussion on screening and assessment, see Element 4.
- Development of such tools and approaches will require collaboration with a wide range of workers providing services to First Nations communities (e.g., NNADAP workers, community members, cultural practitioners and clinical consultants) in order to identify existing opportunities for new screening, assessment, and brief intervention tools. It may also require that support staff get the correct training to perform the data entry and quality assurance checks required in all data entry.
- Where possible, early identification services could be paired with case management (see Element 6) and

## Video Conference AA Meetings—Shamattawa First Nation, Manitoba

Since June 2010, Shamattawa First Nation, with the support of Selkirk Hospital, has been hosting regular Alcoholics Anonymous (AA) meetings that are broadcast to a range of communities through video conference technology. These meetings provide ongoing support to the Thompson Addictions Foundation of Manitoba, along with many surrounding rural communities that do not have access to local support groups. The practice of video conference AA meetings has since expanded and there are now four other First Nations communities hosting meetings. These communities have made use of tele-health and video conferencing services in local nursing stations. This practice is being actively pursued in the Manitoba Region as a way of assisting community members to attend AA meetings without having to travel from their home communities.

secondary risk reduction supports (see Element 3). For example, when individuals with substance use issues are identified, basic assessment would also point out secondary harms and would provide guidance to case managers to make appropriate referrals. This may mean that coordination with a range of other services and supports will need to occur.

### Aftercare

- Recognition of aftercare as a priority is an essential part of the overall continuum of services. Partnerships among communities, treatment centres and a wide range of health, justice and social service workers are required in order to collaborate on the development of a strategy to support an aftercare model at the community level. Such a model would recognize that recovery is an ongoing process and that clients require continued, holistic support.
- Ensuring community-based efforts have support from more specialized services and that referral guidelines are clear and well understood.
- An effective and comprehensive aftercare model could include the following:
  - training for community workers and community members in relapse prevention;
  - strong collaboration with other linked services (such as cultural and clinical services to treat psychiatric illness);
  - a focus on family members and other close to people with substance use issues;
  - flexible approaches that offer clients support both on- and off-reserve;
  - strong case management support to ensure easy access to services;
  - community and technology-based models of peer support (use of the internet, phone or video);
  - transitional, safe and recovery housing;
    support for education, skill development, and employment;
  - ongoing check-ins (recovery management) by service providers and support networks; and
  - more access for clients to less intensive outpatient or community-based programs in support of both intervention and relapse prevention. For more information on aftercare (see Element 4).

People who are involved in substance use that may be putting themselves or others at risk (e.g., binge drinking, driving while intoxicated, and using substances in high risk environments) require a range of culturally safe services and supports.

These services and supports include actively engaging people in a wide range of settings and helping connect them with care responsive to their needs, priorities, and motivations to change. Meanwhile, other initiatives may involve community wide response to environmental factors.

# Element 3

## Secondary Risk Reduction

### >> DESCRIPTION

The services and support components in Element 3 are intended to respond to the needs of people at a high risk for negative consequences linked to substance use. Their risky behaviours may put themselves or others at risk, and result in a range of negative consequences that include but are not limited to: violence, injuries, sexual victimization, school dropout, domestic abuse, gang involvement, driving while intoxicated, suicide, needle sharing, HIV infection, having a child with FASD, job loss, family break up, child apprehension, and community crime.

Services and supports in Element 3 seek to actively engage people in a wide range of settings and help connect them with care. Some individuals who have a substance use issue may not be willing, ready, or appropriate for certain more intensive services. Likewise, services may not be suited to the needs of these clients, particularly those services that require complete abstinence. Providing support and secondary risk reduction increases the chance that those at risk will experience some form of change and lower their levels of risk and harm.

The key components of an effective approach to secondary risk reduction include:

- community-based supports;
- outreach;
- risk assessment and management; and
- screening, assessment, referral and case management.

People who may be well placed to provide Element 3 services and supports include community-based mental health and addiction workers; cultural practitioners; social service workers; maternal child health home visitors; FASD mentors; law enforcement workers; correctional workers; off-reserve outreach workers; staff at urban Aboriginal friendship centres; and a wide range of community and social supports (e.g., family members, Elders, teachers and friends).

### >> KEY COMPONENTS

#### Community-based Supports

The general community is in a good position to provide secondary risk reduction, whether through informal or formal means.

Within many communities, there is a great deal of knowledge and experience about well-being and recovery. Individuals who remain well-connected to their community through group events, (e.g., gatherings, feasts, and Indigenous ceremonies), and through connections to family and the land may be less likely to engage in risky substance use and therefore face fewer secondary risks.

Likewise, there are a number of formal risk reduction activities that a community can take on, such as drinking and driving reduction campaigns; alcohol and drug abuse screening by health professionals; and alcohol management or control policies. These approaches may be formalized in risk reduction plans that take into account the unique needs of a given community, and outline a range of services and supports to best meet the needs of those at risk.

#### Outreach

Outreach refers to a range of community-based activities that serve to improve health and reduce substance abuse risks for people and families that may not usually receive or access such services at fixed locations. Most of the time, outreach involves connecting with people who use substances, rather than waiting for them to come to the services. Effective outreach often involves helping a client determine what life changes they feel ready and able to make, and helping them connect with a wide range of health and social supports. This may include a range of approaches to provide/enhance skills, knowledge, resources, and support that individuals need to live safer, healthier lives.

Outreach may occur in a wide range of situations, including primary care, recreational activities, community gatherings, talking circles, cultural teaching events, or in a person's home.

### Risk Assessment and Management

Risk assessment is a part of care planning. It involves engaging with clients and social and community supports, as well as sharing information and protocols among services. After risks have been identified, risk management plans are developed with clients and their supports, and put in place to prevent immediate harm. For example, if there are concerns about harm to children around a mother's substance use, social services would normally be involved in any further risk assessments. In this case, secondary risk reduction programs or services could create immediate outreach plans to meet the client's unique needs. This might involve screening, brief intervention, referral, (e.g., support offered through mentorship programs for mothers-at-risk or through social and cultural support networks).

### Alcohol Regulatory Policies— Mattagami First Nation, Ontario

In some Aboriginal communities, alcohol regulatory policies have been designed to support moderate drinking practices and reduce problems related to alcohol misuse. For example, in 1993 the Mattagami First Nation in Ontario implemented a policy for serving alcohol that required a Special Occasion Permit and Band approval for the use of a designated building such as the community hall. It attempted to balance between a "wet" and "dry" approach by requiring that, in addition to alcohol beverages, non-alcohol and low-alcohol drinks be available on the premises. Further, it required that all staff be trained and signs posted in the facility to indicate that intoxicated people would be denied alcohol service, minors were not allowed (or only until a specified time), and there would be no "last call." An evaluation of the policy showed it was effective in reducing alcohol service to youth and the number of fights at community events.

### Screening, Assessment, Referral, and Case Management

As with early identification, intervention, and aftercare (see Element 2), the desire to reduce the negative consequences linked to substance use requires an understanding of all the factors that play a role in the client's substance use behaviours. This can be done through screening, assessing, and referring clients to services and supports that match their needs, strengths, and readiness to change problem behaviours. There is also a need to respect each person's informed choice of what types of approaches may work best for them. A wide range of service providers and community members can provide such services, particularly when they have training and an awareness of available resources. As well, referrals may not always be to formal services. In some cases, they may connect people to cultural workers or other social supports. Coordination of these services and supports often requires a case manager to access the types of services needed and to ensure ongoing care (see Element 6 for more information on case management).

## >> CURRENT STATUS

Substance use issues and their negative consequences generate high social and financial costs to First Nations individuals, families, communities and society as a whole.

Secondary risk reduction programs are currently limited within many communities. This is particularly true for more isolated or remote communities. Approaches, where available, are typically delivered by NNADAP community-based addiction workers. In many cases, these services are often delivered independently of one another and without much coordination.

Applying risk reduction activities may be challenging in some community settings. Many communities have a strict

focus on abstinence and prohibition with respect to any psychoactive substance use. Often these approaches do not support less risky or reduced substance use required for many secondary risk reduction approaches. The support for strict abstinence within many communities could be a barrier to exploring a wider range of risk reduction supports and may require further discussion, particularly given the persistence of alcohol and drug-related harms.

Other issues identified in regional needs assessments relate to staffing, training, role clarity, program-specific policies, and financial resources. All of these can affect the degree to which secondary risk reduction services are organized within a community. While there are debates about secondary risk reduction as an approach to substance use issues, communities seem to agree that services in this element are much needed and they are open to finding ways to discuss potential strategies for reducing secondary harms.

## >> RENEWAL OPPORTUNITIES

A strengthened approach to secondary risk reduction services could include:

- Awareness of substance use-related costs and consequences of at the community level. This would help to support service delivery and planning at the community and regional levels in partnership with health units, nursing services, and provincial services.
- Completion of a community-based needs assessment on the services and supports for people with substance use issues. This may include finding out what kinds of services and supports exist for people at risk within a given community (e.g., people who are either not ready or not a good fit for treatment or those who have used services in the past and need more support), and what might need to be put in place.
- Development of a risk reduction plan based on findings from the needs assessment. These plans would be coordinated with universal prevention (see Element 1) and targeted prevention (see Element 2) activities and include an assessment of what is currently in place at the community level. These plans should include a wide range of partners such as primary care, police services, child and family services, schools, income support services, and the justice system. Examples of key risk reduction activities may include:

## The Circle of Life Program—Terrace, British Columbia

The Circle of Life Program runs out of the Kermode Friendship Centre in Terrace, B.C. It is open to First Nations women of child-bearing age with a focus on women who are currently using alcohol and/or drugs, who have a history of alcohol or drug misuse, who have given birth to a child with Fetal Alcohol Spectrum Disorder (FASD), who are themselves affected by FASD, or have a family member who is affected. The program is designed to empower all First Nations women within their child-bearing years to make healthier lifestyle choices and decrease the number of alcohol and/or drug exposed births in the community. The approach is to have peer mentors who understand and support First Nations women in developing and maintaining healthy life choices, connecting them with their personal support systems as well as community services. By the end of the three-year mentoring program, women will have developed skills to maintain a healthy life plan for themselves and their families. Some skills may include budgeting, parenting, family planning, social skills, assertiveness and maintaining a recovery plan. Circle of Life is a replication of the successful Birth to Three Project developed in 1991 by the University of Washington School of Medicine, and adapted for use with Aboriginal women.

- culturally-appropriate media and social marketing campaigns where communities collaborate with a range of health professionals to positively influence community norms and individual behaviour;
- neighbourhood watch/outreach programming to identify and support substance users who are putting themselves or their community at risk;
- alcohol management policies to control the availability of alcohol, moderate consumption, and encourage safe drinking practices;
- public health approaches that pair substance-use related prevention and health promotion strategies with programs that address other risky behaviours (e.g., safe sex, tobacco cessation, and healthy eating);
- identification of role models within communities who maintain healthy lifestyles, which may include living alcohol and drug free;
- targeted approaches, such as screening and brief interventions, for heavy episodic drinking (i.e., binge drinking);
- youth-specific approaches such as school-based programs, increased recreation activities, anti-gang programs, and cultural activities; and
- injection drug use services, where appropriate, such as needle exchange programs, methadone maintenance programs, and anonymous HIV/AIDS testing.

- A wide range of workers with the training and skills to support people at risk of secondary harms, so that clients at risk of negative consequences may be identified in a timely way.
- Partnerships with existing organizations and between community programs that now provide risk reduction services to First Nations clients. While formal relationships are not required, agencies with secondary risk reduction mandates, particularly for First Nations clients, could be excellent supports to NNADAP-based programs. Some examples include the Canadian Aboriginal AIDS Network; the Ontario Aboriginal HIV/AIDS Strategy; and the Healing Our Spirit BC Aboriginal HIV/AIDS Society.

*Supporting people with alcohol and drug addictions and those close to them requires that a range of client-centred, culturally competent approaches are available throughout the healing journey.*

*These services and supports build on individual, family, and community strengths; consider the holistic needs of clients; and are offered in a range of settings, such as communities, treatment centres, and on the land.*

# Element 4

## Active Treatment

### >> DESCRIPTION

The service and support components in Element 4 are intended to respond to the needs of people who are experiencing moderate to severe substance use issues. Element 4 includes a range of approaches, including counselling, education, group therapy and cultural approaches, which are often more intensive than those in other elements.

The goal of active treatment is to reduce the dependence on alcohol and drugs, as well as any negative health and social consequences linked to the use of such substances. Supporting people with alcohol and drug addictions and those close to them, active treatment also requires a range of client-centred, culturally competent approaches available throughout their healing journey. This often requires a range of treatment services and supports that assist individuals to achieve the ultimate goals of adopting healthier behaviours; enhancing their connection with family and community; and reducing addictive or compulsive behaviours and patterns.

Key components of an effective approach to active treatment include:

- Screening, assessment and referral;
- Withdrawal management (including medical management of withdrawal) and stabilization;
- Treatment planning and pre-treatment care;
- Case management;
- Specialized treatment programming; and
- Discharge planning and aftercare.

Services and supports for active treatment are generally provided in outpatient, day, evening, or residential settings, or on the land by health and social service professionals, as well as Elders and cultural practitioners. These individuals include but are not limited to addiction counsellors; NNADAP community-based workers; psychologists; social workers; case managers; cultural practitioners; staff at urban Aboriginal friendship centres; and for some services (e.g., withdrawal management) nurses and doctors.

### >> KEY COMPONENTS

#### Screening, Assessment and Referral

Early identification and intervention through effective screening is an important first step in client care, and is typically done by a health professional or someone who has a trusting relationship with the individual. The goals of screening are to find out if someone has a substance use or mental health issue—including whether or not they are at risk—and to determine if a more comprehensive assessment is needed (see Element 2).

At the assessment stage, the client and health care worker work through a structured set of questions or criteria to define the nature and severity of the problem(s), as well as the client's strengths, supports, resources, readiness to change, and mental health status. Assessment is typically carried out by a trained professional at a community, regional, or treatment centre level. A primary goal of assessment is to determine if a client is in need of additional support and to refer them to the appropriate source. It is important to match the client's level of need with appropriate intervention options. Effective assessment is grounded in a therapeutic relationship that builds a rapport, enhances motivation, and develops a collaborative treatment plan. See Element 2 for more information on screening and assessment.

#### Withdrawal Management and Stabilization

When a person is addicted to drugs or alcohol and discontinues use, they will experience withdrawal symptoms that may be felt psychologically, physically, or, in some cases, both. Withdrawal symptoms vary considerably from one client to the next based on factors like the type of substance a person is addicted to; the length and frequency of use; and associated health issues. Whether or not medical support is required is often determined after an assessment by a qualified medical professional. For instance, people who have been taking large amounts of opioids (e.g., heroin, OxyContin®), pain medications, or alcohol either alone or together may need medically monitored withdrawal management services. In the

majority of cases, people with mild withdrawal symptoms from alcohol or drugs and people using cocaine, marijuana, opioids, or methamphetamine require little to no medical support and often do not need to be hospitalized for detoxification.

Withdrawal management (detoxification or "detox") and stabilization refer to processes of support that help people withdraw from the use of alcohol or other drugs. These services are an important first step in a long-term recovery process in which timely access to culturally appropriate services is necessary. Withdrawal management and stabilization services may include:

- Medical approaches (e.g., offered by provinces, typically either in hospitals or detoxification centres);
- Non-medical or minimally medical approaches, such as cultural, social, mobile, or home detoxification, which can be offered within communities, on the land, or within a home. Depending on symptoms, these may involve check-ins with primary care staff and medication; and
- Stabilization supports for people experiencing persistent psychological effects after successfully withdrawing from a substance (e.g., post-acute withdrawal syndrome). This may involve ongoing monitoring, assessment, case management, and treatment planning; and can be offered in a range of settings including recovery houses, residential treatment centres, or through outpatient, day or evening programming.

### Treatment Planning and Pre-treatment Care

Treatment planning involves setting goals and objectives, and choosing a full set of staged, integrated treatments for each problem. The plan is matched to the client's needs, readiness, preferences and personal goals, and should be connected to broader care planning efforts (see Element 6). It should also consider their cultural, community, and family supports and relationships, and also involve developing hope and motivation, as well as focusing on non-chemical stress management techniques. It is crucial that the client takes an active role in this process and has a chance to be directly involved in setting their course for treatment. Access to community and agency

## The Native Alcohol and Drug Abuse Counselling Association of Nova Scotia (NADACA)—Eskasoni, Nova Scotia

NADACA provides a wide range of services to 13 communities in Nova Scotia, as well as Labrador, Prince Edward Island and New Brunswick. Services include community outreach field workers, school-based education, and prevention programs. Within the province of Nova Scotia, NADACA offers treatment for drug and alcohol misuse at the 15-bed Mi'Kmaw Lodge, located in Eskasoni, and the 7-bed Eagle's Nest Recovery House in Shubenacadie. Eagle's Nest provides a transitional program to help recovering individuals continue in a substance-free environment beyond the first stages of treatment at Mi'Kmaw Lodge. One-on-one counselling is the basis of the NADACA programming, with upwards of 20 certified counsellors employed to cover the 12 Bands in Nova Scotia. As part of a total recovery program, NADACA introduces clients to a range of options, such as job training and counselling, AA, and skills upgrading. NADACA outreach workers provide opportunities for children and youth to engage in positive experiences in their communities through such activities as boys and girls clubs, martial arts, swimming and ballet. A diversion program is offered at both treatment centres, which help clients in post-treatment by providing many opportunities to engage in positive behaviours such as cultural programming, tickets to entertainment and other venues. Through programming, such as those for children and youth, the treatment centres have come to be viewed as places of healing, not of sickness.

supports and resources is necessary for pre-treatment care. It is essential for referral workers to work closely with community and treatment workers, and other available agencies and resources, in order to support the client's preparation for treatment.

### Case Management

Case management is a client-centered approach where a service provider (such as a referral worker, Elder, or case manager) or a team of service providers coordinates various health and social services to meet the special needs of each client. It may also involve multidisciplinary partnerships to support the client from pre-treatment to aftercare. To learn more about case management, see Element 6.

### Treatment Programming

Treatment programs offer clients a range of services and supports aimed at helping clients stop or reduce an addiction to alcohol and/or drugs, and to improve their overall quality of life. Treatment may occur in a variety of settings (e.g., residential centres, direct counselling in the community, outpatient, day, or evening programs), or land-based healing programs. It may also consist of a variety of approaches and models, and vary in its intensity, specialization, and duration.

Specific approaches to treatment need to include an awareness of, and sensitive responses to a client's needs, including possible mental health issues, age, gender, substance(s) of use and abuse, language, culture, and co-morbid conditions. The approach to treatment may involve the use of medications, behavioural therapy (such as individual or group counselling, cognitive behavioural therapy), or a range of culturally-based activities.

### Discharge Planning and Aftercare

After a client has completed a treatment program, it is important to build on the strong foundation set by the treatment process. This process of continuing care and support is a period of less intensive treatment usually referred to as aftercare. Aftercare is often set up during discharge planning at a treatment centre, but may also be part of care planning efforts initiated at any point during a client or family's healing journey.

Discharge planning is a process that guides such things as a return to the community and family; access to case management services; connection with services in key social determinant of health areas (e.g., housing, employment, education, living conditions, and social support); or a referral to a more intensive and specialized program when a client is leaving a structured treatment experience. It is also important that discharge planning begins when a client first enters a treatment centre to provide time to arrange necessary post-treatment supports. It involves making sure that ongoing support networks exist in the form of peer groups (e.g., going to 12-Step meetings or linking to community resources) and, if necessary, transitional housing. For more information on aftercare, see Element 2.

## >> CURRENT STATUS

Addiction treatment services for First Nations populations are mainly provided through community-based addiction workers and a national network of treatment programs managed by First Nations organizations and communities. Residential treatment centres, while governed at the local level, are national resources and many centres accept referrals from all parts of Canada. There are also multi-disciplinary teams in some communities offering mental health and addiction services.

The extent to which workers are able to respond to the treatment needs of clients varies. There is also a growing complexity of client needs, which includes higher rates of concurrent disorders, illegal drug use, and prescription drug abuse. The ability and capacity of local workers to meet the complex needs of clients is directly linked to:

- Access to educational institutions where they can obtain and develop basic qualifications;
- Ongoing support and training;
- Clinical supervision; and
- Appropriate referral networks.

Other factors include high workloads, stressful working conditions, and low wages.

In all regions, factors that have an impact on workers' capacity and ability affect whether and how a client's needs can be met at the local level. This is most true

for youth or clients with more complex needs, such as those with complex mental health and addiction issues. Community-based addiction workers are the ones most likely to refer clients living on-reserve for treatment. However, the level of interaction and communication between community-based addiction workers and treatment centre workers before, during and after treatment is described as limited. A similar problem exists for off-reserve referral sources such as friendship centres, social workers, counsellors and psychologists.

The lack of a consistent and streamlined approach to client assessment and referral has been consistently recognized as a challenge by both communities and treatment centres. In some cases, different, and incompatible, assessment and referral tools are being used. As well, some assessment tools require training or fees for use, which create barriers to their consistent use. Through the regional needs assessments, both communities and treatment centres alike have called for a more standardized approach to reduce duplication of efforts and ensure that clients are matched with services appropriate to their needs and strengths.

In general, community-based addiction workers report that they devote large amounts of time to the referral process, while treatment centre staff report feeling frustrated by being sent "inappropriate" clients both from communities and provincial services.

All of the 58 First Nations addiction treatment centres provide culturally-relevant inpatient, outpatient, and day treatment services for alcohol and other drugs. Most of these use a number of treatment approaches—often a blend of cultural and mainstream—as well as life-skill and self-care techniques. Programs can vary in length but are usually between 29 and 42 days. At present, 10 programs provide specific programming for families while 12 are directed at youth. Nine focus mainly on solvent abuse and 17 are gender-based. These treatment centres are accessible either on an ongoing basis, or for certain clients, when needed.

Given the often chronic nature of addiction issues, characterized by high risk of relapse, one treatment episode is usually not enough. Most people who access treatment require multiple treatment attempts and ongoing post intervention support.

Limited access to provincially-based detoxification services has been a recognized barrier to effective client care. Where detoxification services are available, some communities have reported concerns with the cultural appropriateness of these services, as well as difficulties accessing them due to long wait lists.

In some cases, ensuring appropriate access requires clarification of funding responsibilities for these services between federal and provincial levels of government. In cases where medically based withdrawal management is not being offered by provinces, some communities

## *Caring for the Circle Within—Kwanlin Dün First Nation, Yukon*

Caring for the Circle Within was a pilot project hosted by Kwanlin Dün First Nation at Jackson Lake Healing Centre in 2010 that is designed to address the spiritual, mental, emotional and physical needs of participants dealing with issues associated with substance abuse, the effects of Indian Residential Schools, grief and loss issues, violence, and trauma. The goal of Caring for the Circle Within is to provide a supportive, land-based, holistic, and compassionate environment, which includes both traditional and modern healing approaches, in order to foster balance and self-empowerment. This intensive land-based program offered a camp experience as a core part of its design and a central part of the healing process. Participants in the program have reported that the time on the land builds confidence, teaches them new skills, and fosters pride in local culture and traditional ways. A key success factor of the program is the participation of Elders and other community members in all aspects of programming.

have expressed interest in providing withdrawal management in their community. This is a highly complex area of service, requiring a comprehensive approach to ensure client safety.

As with community-based addiction workers, treatment centres are facing higher numbers of clients with ever more complex needs. Some centres have been working to set up specialized programs to respond to these needs, such as prescription drug abuse and mental health issues. The ability of treatment centres to respond to more complex client needs is directly related to their access to specialized training, clinical supervision, and often access to other psycho-medical supports. As long as difficulties accessing these specialized supports continue, the capacity to assume more complex cases will remain limited. The same is true at a community level.

For the most part, treatment programs for prescription drug abuse are based on what is known about addiction treatment in general where behavioural treatments combined with medications have proven effective. Although methadone is used in the treatment of prescription drug abuse, increased training, services and supports are needed. In some cases, tension exists in communities on the question of methadone as a treatment option. Often methadone is provided without complementary psychosocial services to address the other needs and goals of clients. In many communities, abstinence is seen as the only valid way to deal with addictions. Some of this resistance to methadone is based on a misperception of pharmacological approaches, along with examples of inappropriate assessment and prescribing and inadequate complementary supports. Many treatment centres do not take clients on methadone. When they do, the client needs to be stabilized on a specific dose and closely monitored. Reasons why some treatment centres do not take methadone clients include, but are not limited to:

- Limited access to a doctor who is authorized to prescribe the medicine;
- Limited access to a qualified pharmacist that can prepare and dispense methadone;
- Condition that the client must be stabilized enough to qualify for take-home doses or "carries", since this removes the need to travel every day for the daily dose of methadone;
- Uncertainty regarding the effect of methadone on treatment participation;
- Limits on the amount of "carries" that a pharmacy will dispense, so travel to the pharmacy must continue; and
- Client travel to medical services is not a service normally provided.

Unless treatment programs are able to provide medication for people in treatment, the coordination and provision of the necessary supports for dose management present a barrier to client participation in needed care.

Treatment centres range in size from 5 to 30 beds. The centres are based in remote, rural, and urban settings. The physical state of treatment centres has been flagged as a concern in many regions with some centres having limited funding to do basic maintenance, let alone major renovations. In recent years, some limited funding supported building maintenance. However, this funding was reported to be less than what was needed.

In some communities, inpatient facilities have been re-profiled to outpatient centres. This has been done in response to community needs. However, this has resulted in re-profiled programs becoming regional/local in scope, rather than national resources. In other regions, no shift to outpatient treatment centres has happened and "the centre" has been identified as a safe place for clients to go, especially when their communities are not.

Detailed information on how all the treatment centres are used is limited; available data shows major variations in bed occupancy rates, ranging from three-month long waiting lists to centres that are running well below capacity. Per bed costs also vary widely, particularly when economies of scale, travel costs and operating costs associated with treatment are included.

While treatment centres are consistently identified as important resources to support the wellness of the population, there is also growing recognition that this must be supported by effective services at the community level.

## >> RENEWAL OPPORTUNITIES

### Screening, Assessment and Referral

- Standardized mental health and addiction assessment tools. Such tools would be comprehensive, culturally safe, and easily adapted to meet the unique needs of different regions and populations.
- Cultural assessment tools developed to learn about a client's spiritual, community, or cultural needs. These tools would help to raise awareness and assess the strength of a client's spiritual connection to family, clan and community.
- Streamlined electronic referral systems that may include online bookings. This would help referral workers to quickly find out which programs have available beds/spots.
- Standardized referral packages that include screening tools, such as:
  - an observational checklist and ready-made screening questions about the client's emotional health, diagnosis, prescriptions, and ability to live in a group or be part of an intensive group process;
  - a form for the client to identify the mental, physical, emotional, and spiritual healing resources that are accessible in their home community;
  - a standardized medical form that includes vital statistics, dental care needs, as well as information on psychoactive medications (prescribed by a psychiatrist or doctor and approved by the centre before a client is admitted);
  - a brief mental health screening tool; and
  - cultural assessment tool(s).
- Basic information for community and referral workers on the correct way to offer pre-care services and supports, as well as treatment planning.
- Where available, a liaison with drug diversion courts and mental health diversion courts. Opportunities with these specialized referral routes include decreasing periods of incarceration. Liaisons should include "front end" interface with drug diversion courts as well as post-treatment planning and follow-up.

### Withdrawal Management

- Collaboration with medically based withdrawal management (detoxification services) available off-reserve. This would include better coordination and information exchange between services, and a focus on key service gaps (e.g., for youth and women). Inter-agency memoranda of understanding and protocols for culturally safe withdrawal management may need to be developed.
- A system-wide approach to non-medical or minimally medical (e.g., visiting a doctor or accessing a nurse while home detoxing) withdrawal management within communities and treatment centres. This approach would include protocols that are easily adapted to each community's needs and resources. It would take into account problem severity, substance(s) being

used, health risks, and, as needed, culturally based medicines, ceremonies and supports. It would include the need for stabilization, pre-treatment supports and limited medical supports, where required.

- Consideration of stabilization services and supports for people experiencing persistent psychological effects after successfully withdrawing from a substance (e.g., post-acute withdrawal syndrome). This approach would look at including a variety of post-withdrawal management and pre-treatment programming for clients who are not able to or do not want to immediately access more intensive services, and could be offered in a range of settings, such as recovery houses or through outpatient, day or evening programming. These services are crucial for transitioning an individual from withdrawal management when appropriate services are not available.

### Treatment Planning and Pre-treatment Care

- A coordinated approach to treatment planning and pre-treatment care for clients and their families. This approach would be linked to community-based resources, such as recovery houses or outpatient, day or evening programming, as well as stabilization and case management supports. Such an approach would seek to identify key people to support individuals in early recovery and to assist with strength-based treatment planning. It may also consider the needs and available supports for children or other dependents when their parent(s) or primary care provider(s) might need to leave home to access treatment.
- Pre-treatment check-ins for clients who are awaiting admission to a treatment facility. This type of support can make them more "treatment ready," and increase their likelihood of successfully treatment.

### Case Management

- Community-centred case management approaches that involve multidisciplinary and multi-jurisdictional teams or partnerships to support clients from pre-treatment through to aftercare. For more information about case management see Element 6.

### Treatment

*Strengthened Care Approaches*

- Standardized intake approaches at centres, aligned with the standardized universal referral packages discussed earlier, and including (as needed), medical and mental health screening and assessment.
- Approaches to care must be flexible and responsive to client needs at all levels of treatment. They must

also reflect a client's own Indigenous strengths and connections to culture. An emphasis on ways to strengthen the client's involvement in the treatment process will allow better outcomes to occur. Ways to do this include looking at how a client's involvement and treatment success are impacted by the design of the environment; the staffing model; cultural competencies; a focus on the client's strengths; and the support of family and community.

- A system-wide approach to clinical supervision, especially when it comes to co-occurring mental health issues, for both treatment centres and community-based workers. This approach could include in-person support on a rotating basis to First Nations communities and support through the use of technology (e.g., video conferencing, e-mail, or a 24-hour telephone line) for workers to receive clinical supervision, advice, and guidance.
- Exploration of opportunities to develop manual-based treatment approaches, based on clinical, best practice evidence that can be tailored to community or cultural needs.
- Treatment centre admission policies that support access for clients based on their stage of readiness for change, mental health or addiction pharmacological needs, or unresolved issues with the justice or child welfare systems.
- Recognition of the importance of family and the need to work with families before, during and after a client's stay in treatment to maximize successful outcomes. This is most relevant for youth, but is important for all clients.
- NIHB medical transportation policies, in line with practice-based evidence on client outcomes, to provide access to the services that are the best fit (not just the nearest), and that support a client's return home should they not complete treatment. Such policies would also support a return to treatment even where there has been a previous attempt, and provide support, where appropriate, for family to be involved in treatment.

### Tsow-tun Le Lum Treatment Centre—British Columbia

Tsow-tun Le Lum Treatment Centre is a residential treatment centre on Vancouver Island in British Columbia that receives funding from both NNADAP and Corrections Canada. In addition to the centre's six-week addiction program, it also offers a five-week trauma program for individuals who have survived physical, emotional, and sexual abuse, including former residential school students and their families. The centre takes a client-centred and strength-based approach to services and is widely recognized for its use of both mainstream and traditional therapeutic models. Services include a mental health therapist, who provides services to clients and clinical supervision and support to staff; a resident Elder who provides traditional healing and counselling 24/7; and other traditional and spiritual approaches integrated into all aspects of care. The traditional spiritual supports are continually acknowledged by clients in post-treatment evaluations as a key strength and essential part of the program.

### Enhanced Support for Cultural Practices

- A culturally competent system-wide approach that supports cultural practices within treatment programs, through policy, program design and service delivery.
- NIHB policies that support a cultural role in health and healing, by:
  - providing professional fees for cultural practitioners comparable to other approved NIHB service providers;
  - covering travel cost, including cultural practitioners and Elders visiting treatment centres to provide cultural support; and
  - acknowledging the community's right to define what a cultural practitioner is and "sanction" specific cultural practitioners.

- Further research on the extent and kinds of treatment approaches that are most likely to help First Nations people, families, and communities defeat prescription drug abuse, including research into non-drug, culturally based forms of treatment.
- Development of cultural protocols to guide relationships between cultural practitioners and communities/treatment programs. These protocols would focus on the dynamics between cultural practice and program requirements and between cultural practitioners and other program staff and clients. Protocols may set out the following:
  - what the treatment program expects and cultural practitioners expect, as well as the roles and responsibilities of each;
  - confirmation of the skill and knowledge base of cultural practitioners; to help create a better understanding of how their role parallels that of mental health professionals; and
  - standards of practice that set out such things as client rights, including the right to choose to be part of cultural practices; conflict resolution and grievance processes; scope or limitations of practice; named healing methods; diversity of practice; screening and assessment; resources and materials to support cultural practices; research, training, and information management; and record keeping and compensation.

### Enhanced Collaboration and Knowledge Exchange

- Collaboration with primary care services to better serve clients with other health issues (such as chronic pain, tuberculosis, or diabetes as well as expectant mothers). This will include stronger relationships with nurses and doctors, and may also involve dieticians and other health workers.
- Knowledge exchange opportunities on effective approaches, as well as better access to details on practices from other parts of Canada or the world. This may include meetings or teleconferences among service providers; online discussion forums; a database tool that includes updates on clinical information about addictions which is accessible to the whole network; or development of a "community of practice."

### Expanding and Strengthening the Continuum

- System-wide goals to address the needs of all populations are required to remove barriers, combat stigma, and ensure proper services and full community participation.
- Ongoing efforts to expand and strengthen the continuum of services and supports in First Nations communities, seeing residential treatment as just "a step" in a range of services. These efforts will require continued dialogue among communities, service providers, regional bodies, and national representative and funding organizations on questions of program design and configuring services. Key aspects of the discussions may include:
  - alternatives to residential treatment, including community-based approaches, land-based programs, outpatient services, day/evening programs;
  - lower threshold services to serve clients who either are not ready to abstain or have moderate substance use issues;
  - responsiveness of services to different language and cultural group needs;
  - community-based treatment options for rural and remote communities, including the use of mobile treatment or multidisciplinary teams; and
  - best use of existing resources, including a system-wide approach to addressing treatment centres that operate below capacity, as well as consideration of how to strengthen the capacity of programs in order to intake clients on a continuous basis.
- Strengthened approach to services and support for specific groups based on regional and national needs. Such an approach may include but is not limited to:
  - gender-specific services;
  - youth-specific services;
  - family-centred services; and
  - mental health-centred services
- Increase multidisciplinary support for NNADAP/NYSAP staff and provide specialized services more often. This would include case management processes and policy development, clinical supervision, direct service delivery, and training. It would also support strong links with crisis intervention and

centre-based addictions services, specialized mental health services, and justice services.
- Efforts to improve physical structures through more capital funding to treatment centres, and through spaces within buildings that allow for cultural practices, such as rooms with fans or vents so smoke can escape, larger group spaces, more offices, and areas for physical activity.

### Discharge Planning and Aftercare

- Stronger relationships between treatment centres and referral workers (or communities) in all phases of client treatment, as defined and supported by policy development. Treatment centre counsellors could use tele/video conferencing to connect the client with the local care worker as part of the aftercare/discharge planning process. Other opportunities to support these linkages include networking forums for addiction workers each year and cross-training opportunities.
- Better recognition of social determinants of health in discharge planning and aftercare through greater collaboration with social services and an increased focus on life skills, emotional intelligence, or job training, both within programs and as a key aspect of aftercare planning.
- Stronger support for relapse prevention, especially as based on the Marlatt model within treatment that focuses on both immediate determinants of use (e.g., high-risk situations, outcome expectations, and coping skills), covert antecedents (e.g., lifestyle factors, urges, and cravings), and seeks to strengthen family, community and cultural supports.
- Development and support for community-based peer support programs to assist individuals and families in recovery.
- Using new electronic approaches to support clients (e.g., e-mail, social media, hotlines, an anonymous online discussion forum for aftercare), and providing "booster" or refresher programs for former clients at risk of relapse.

## Nelson House Medicine Lodge—Culture and Ceremony

"Paving the red road to wellness," the vision of the Nelson House Medicine Lodge (NHML), truly guides the daily, weekly and seasonal resurgence of Cree culture and tradition to the benefit of clients, staff and community of this Northern Manitoban alcohol and drug treatment centre. Cultural activities include daily smudging observances, sacred songs and prayer, traditional teachings, weekly sweat lodge ceremonies and substantive seasonal undertakings, all drawing on the direction of Cree Elders. The NHML is a 17-week, 21-bed inpatient NNADAP alcohol and drug treatment program serving adult clients of either gender, most often native but occasionally non-native. Clients, staff, board members, and the community at large participate in spring, summer and fall fasting camps; medicine gathering; an annual winter round-dance which honours those who walk in sobriety; and the Sundance. The board, staff, and clients played a huge role in the reintroduction of the Sundance in Nelson House after a 130 year absence. By paving the red road to wellness, the NHML eases and enriches cultural and identity reclamation for their clients and community members as a primary means of promoting mental wellness as a way to a healthier, happier life.

*People with highly complex service needs, including individuals with severe addiction and/or mental health or chronic health issues, require effective screening, assessment and referral; culturally competent services; and ongoing support and monitoring throughout their healing journey.*

*Those who access these care options, whether within or outside of the community, benefit from strong connections to support networks, such as family and community.*

# Element 5

## Specialized Treatment

### >> DESCRIPTION

The service and support components in Element 5 are intended to provide specialized treatment for people whose substance use issues are complex and severe. People with highly complex service needs, including individuals with severe addiction and/or mental health and chronic health issues, require effective screening; assessment and referral; culturally competent services; and ongoing support and monitoring. Those who access these care options, whether within or outside of the community, benefit from strong connections to their support networks, such as family and community.

The kinds of services provided in Element 5 are the same as those outlined in Element 4, but usually with significantly greater levels of intensity and professional specialization (e.g., psychiatric intervention and medically-based detoxification).

The key components needed to support an effective approach to specialized treatment are:

- coordination of care;
- cultural competency; and
- community-level capacity and support.

Services and supports for specialized treatment are generally provided in acute care or specialized care settings. Doctors, psychiatrists, psychologists, social workers, and cultural practitioners are the primary service providers, and often provide support through strong case management services and supports.

### >> KEY COMPONENTS

#### Coordination of Care

Coordination of care efforts, such as case management and multi-disciplinary teams, that facilitate collaboration among care providers in a manner that is culturally competent are important for supporting clients with complex needs. This collaborative approach is essential given the range of services often required by clients in this element.

#### Cultural Competency

Cultural competence requires service providers to have knowledge of, and openness to, the cultural realities of the clients they serve. It also requires that service providers are aware of their own worldviews and attitudes toward cultural difference, including how these may influence the type of care that is provided.

To support cultural competence within the system, it is necessary for Indigenous knowledge to be translated into current realities so that cultural principles and knowledge meaningfully inform and guide the direction and delivery of health services and supports on an ongoing basis.

#### Community-level Capacity and Support

Capacity and support must be in place for community based workers to ensure that clients with highly complex needs get the support they need in time. This element allows trained service providers who have the required resources and tools to effectively screen and refer clients with complex needs to addiction and mental health assessments, specialized services and aftercare. This component also involves making sure that community members are aware of and understand the health problems that commonly occur along with substance use issues, and the types of supports that are available.

Collaboration among service sectors (e.g., the justice and education systems) and service providers is also important. A strong network that works together will make it easier for a client to move through the assessment, referral, treatment, and post-treatment phases of care. However, communities may need to find and use innovative ways to provide intensive services and supports. An example might be tele-psychiatry. It can be linked to primary health care services to effectively provide the client with the medical-based care needed, and a variety of cultural healing approaches and supports within communities.

## >> CURRENT STATUS

Federal, provincial, and First Nations governments all play an important role in supporting First Nations people who require specialized services. Most of these services, however, are delivered and funded by provincial governments. As well, it is not uncommon for clients in need of specialized services to only get access to them when they are involved with the justice system.

When provinces shifted away from institutional care and towards community-based models of service, this impacted First Nations communities. The need for specialized, more intensive services remains a significant concern both within the NNADAP/NYSAP system and in other social and health systems across Canada. For example, limited beds in psychiatric hospitals mean that long waiting lists are often to be expected when attempting to find the appropriate services for someone with highly complex needs.

In many cases, clients with complex needs require support from a range of care providers, both within and outside their home community. This type of support often requires information exchange and coordination between various care providers and, in some cases, jurisdictions. Navigating through these separate systems of care is a challenge that those who provide services and supports to clients frequently face. As well, clients living in remote communities may suffer limits or delays in care if there is reduced access to primary health care and social service providers who play a critical role in assessing and referring people to specialized services.

Although community-level resources for people with complex needs are often inadequate, there are some communities with access to more specialized services. In general, however, most of these services are offered off-reserve. The concern with off-reserve services is that they may not be culturally safe and the client may lack the support that comes from community, family and cultural networks.

### Keewaytinook Okimakanak Telemedicine and K-Net—Ontario

The Kuhkenah Network (K-Net) provides information and communication technologies, telecommunication infrastructure and application support to First Nations communities across north-western Ontario, as well as in other remote regions in Canada. K-Net recently partnered with Keewaytinook Okimakanak (KO) to provide First Nations access to the Ontario Telemedicine Network for clinical, educational, and administrative services. KO Telemedicine (KOTM) is a complete telemedicine program, connecting remote First Nations communities with health service providers. This technology has helped facilitate access to psychiatric services and supports. KOTM also includes an education program, which provides access to education sessions, training and support for community front-line workers and health staff, and supports the sharing of knowledge for and among addictions workers through online access. The service also includes Elder visitations, which feature an Elder presenting teachings such as traditional medicine and storytelling through video conferencing to community workers and members. K-Net is a program of Keewaytinook Okimakanak, a First Nations tribal council established by the leaderships of Deer Lake, Fort Severn, Keewaywin, McDowell Lake, North Spirit Lake and Poplar Hill bands to provide a variety of second level support services for their communities.

In addition, clients with complex needs are also referred to NNADAP/NYSAP centres when they should not be. Although this is not ideal, many centres do their best to manage clients' complex and concurrent needs so that the client will not be discharged before addiction treatment is complete.

## >> RENEWAL OPPORTUNITIES

### Coordination of Care

- Enhanced access to culturally safe and specialized services for clients within federal and provincial correction systems. Efforts could also be made to

link clients with appropriate community services and supports (e.g., family, community and cultural) when they are released. This will help to ensure continuity of care and successful reintegration into community life.

- Approaches to screening, assessment, referral and case management that ensure strong linkages between services and supports amongst communities and provincial and federal partners.
- Policies and formal agreements designed to coordinate the range of services and supports necessary for clients accessing specialized services across jurisdictions. These measures will help to reduce service gaps, make roles and responsibilities clear, and increase resources to meet client needs. Examples of such policy tools include inter-agency memoranda of understanding or agreements.

### Cultural Competency

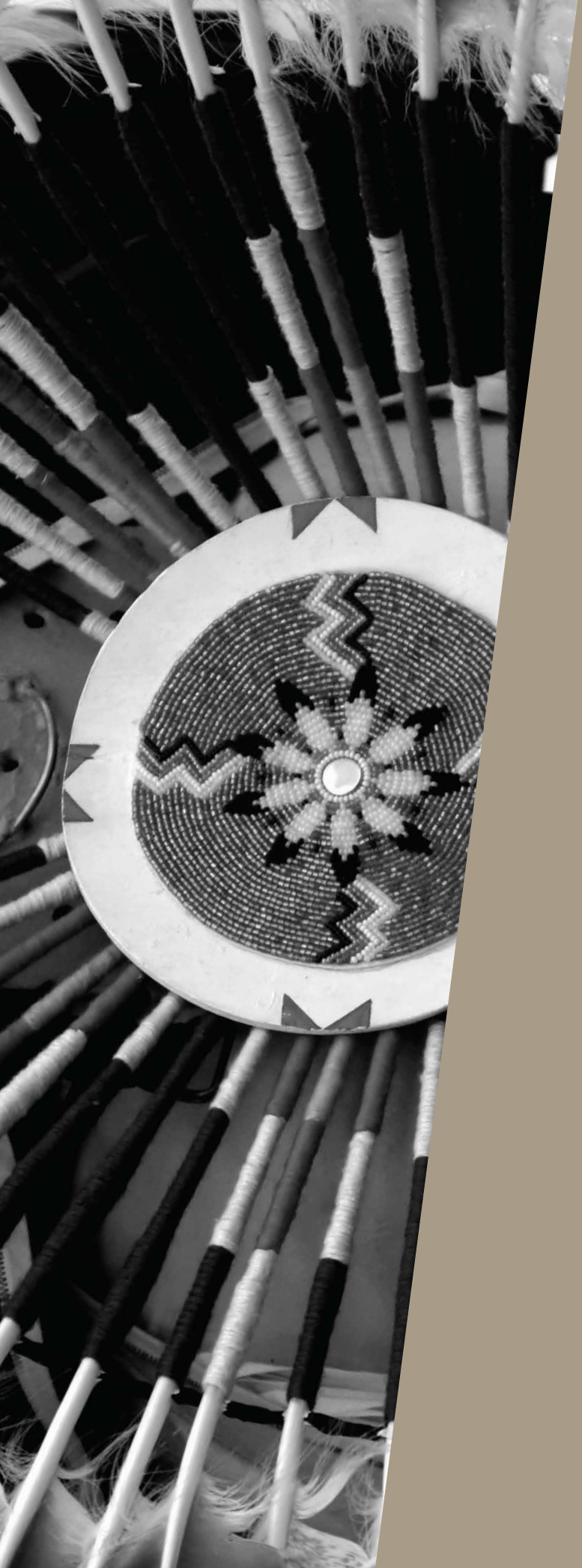
- First Nations' world views, an understanding of cultural practices and traditions, and the history of intergenerational trauma could be included in treatment and care plans. For example setting out the role of intergenerational trauma in concurrent mental illnesses. This would enhance both a client's comfort level when receiving care outside the community and treatment outcomes.
- Greater cultural competency among specialized service providers can lead to culturally safe care. For example, the Royal College of Physicians and Surgeons of Canada has a framework on cultural competencies that could be used or adapted to local contexts. It sets out core cultural competencies in a First Nations context for undergraduate, postgraduate, and continuing education medical studies.
- Cross-cultural training between NNADAP/NYSAP workers and mainstream service providers, with an emphasis on ensuring that the services and supports they provide are culturally competent and culturally safe. Training could be provided within provincial education services and through training courses in collaboration with NNADAP/NYSAP treatment centres and First Nations communities.

### Community-level Capacity and Support

- The promotion of community awareness and education (with a focus on mental health and illness) in order to reduce stigma and to inform clients about how services can be accessed.
- The promotion of community-centred case management and the capacity for outreach that would involve multidisciplinary and multi-sectored teams or partnerships. Clients with complex, long-term needs and changing priorities require a team-based approach. It is most helpful to set up a long-term support system that draws on services from a number of sectors in a coordinated and strategic way. It would also help to use the limited care that can be provided within the community setting without fully exhausting it.
- Policies, services, and supports that foster culturally safe care for First Nations people who have highly complex needs. This may mean that funding and payment models would need to be adjusted to include Indigenous elements of care within care plans.
- The presence of primary health care services—and ideally specialized health services—within the community. This is very important, especially when it comes to effective assessment and referrals. Where a lack of resources limits services at the community level, solutions such as online, mobile, or tele-services (such as tele-psychiatry) could be explored.

## Anishnawbe Health Toronto—Ontario

Anishnawbe Health Toronto offers specialized services to status and non-status First Nations, as well as Inuit and Métis people. Most of the clients are supported by social assistance and must have stable housing, including long-term shelter accommodation, to qualify. The walk-in intake is open five days a week, during which screening for substances, gambling and mental health issues is conducted. Referrals to detox, mental health services or a residential program are part of the intake service. A unique treatment plan is developed for each client, utilizing both individual and group counselling, and clients are able to choose among traditional healers or traditional counsellors. Culture plays a large role throughout treatment, such as traditional teachings and ceremonies as well as a traditional sweat lodge. Medication management is provided by an on-site psychiatrist, as well as a nurse for longer term injection medication. A psychologist performs assessments weekly. Clients participate in training and education sessions, such as life skills, cooking on a budget, self-care and self-esteem, art therapy, physical activity and healthy communication skills. To assist clients after their discharge from the program, an "aftercare circle group" is held once a week. All services are provided at no cost to the client and no provincial health identification is required.



*An effective system of care requires coordination between a wide range of services and supports for individuals and families throughout the healing journey.*

*This system of care provides collaborative and consistent communication, as well as planning and monitoring among various care options specific to a client's holistic needs. It relies upon a range of individuals, including service providers, case managers, friends, or families to provide ongoing support to facilitate access to care.*

# Element 6

## Care Facilitation

### >> DESCRIPTION

People and families at higher risks of developing substance use issues may benefit from a range of services and supports during their lives. The types of services and supports will change over time but may include:

- Formal mental health and addiction services;
- Community and family supports;
- Cultural supports; and
- Services and supports to meet other needs such as housing, jobs, education and parenting skills.

Care facilitation can refer to formal case management or it can involve other forms of community-based, professional, or social support. No matter what it looks like, an effective system of care requires coordination between these various services and supports for individuals and families throughout the healing journey. This system of care provides collaborative and consistent communication, as well as planning and monitoring among various care options specific to a client's holistic needs. It relies upon a range of individuals to provide ongoing support to facilitate access to care.

Key components of effective care facilitation include:

- Social and cultural supports;
- Assessment and planning;
- Collaboration and information sharing;
- Advocacy; and
- Ongoing follow-up.

The people who are well-placed to provide care facilitation include any service provider involved in the client's care (such as NNADAP community-based addiction workers, case managers and staff at urban Aboriginal friendship centres), as well as community members (including Elders and cultural practitioners) who can support clients and their families in accessing the care they need during their healing journeys.

### Tui'kn Case Management Model—Eskasoni First Nation, Nova Scotia

Eskasoni First Nation was the first Aboriginal community in Atlantic Canada to establish a multidisciplinary, multi-departmental case management team. Following a series of tragic events within the five Cape Breton First Nations communities, and with funding from both government and communities, these efforts were expanded to the surrounding communities of Membertou, Potlotek, Waycobah and Wagmatcook—known as the Tui'kn Partnership. The Tui'kn case management model is an approach to mental health and addictions that helps individuals, families and their communities restore and sustain balance and well-being. Through the creation of community-based multidisciplinary teams, the five communities have established a mechanism for the delivery of a streamlined, accessible, time efficient, coordinated, and gap reducing mental health/health/well-being/addiction service delivery model of holistic care. By creating these teams, what once would have taken individuals from multiple agencies several months to accomplish on behalf of their mutual clients can now be addressed in an efficient, coordinated, collaborative, and time sensitive manner.

### >> KEY COMPONENTS

#### Social and Cultural Supports

Social and cultural supports are an essential component of an individual or family's healing journey. These supports can not only provide an essential source of encouragement and care but may also help identify care options, navigate services, and maintain connections between various other supports and care providers. This kind of support includes family, friends, and community members.

#### Assessment and Planning

Once a client has been screened and assessed (See Elements 2, 3 and 4), a range of individuals can help to develop a unique care plan grounded in the individual's or family's strengths, values, and goals, based on available resources and services. Care plans map out key services

and supports throughout an individual's care journey, which often take place at various stages. This plan may outline a range of formal and informal services and supports, including those care options that address key social determinant of health areas (e.g., housing, employment, education, living conditions, and social support). Care plans should be reviewed frequently with clients and adapted as their needs change (e.g., with the addition of an aftercare plan post-treatment).

### Collaboration and Information Sharing

Through relationship-building and information/resource sharing with clients, their families, and other community services, this component makes it possible to establish meaningful partnerships within the community. It can allow providers to make the best use of limited resources and supports, enhance community and individual capacity, and remove or reduce delays and needless duplication. This approach may be something as simple as frequent meetings between health and social service providers or the identification of one worker within the community who is solely responsible for wellness-based case management. To support access to both on- and off-reserve services, it may be necessary to have regionally-based case management support as well.

### Advocacy

This component involves speaking out on behalf of the clients and their families in order to enhance the continuity, accessibility, accountability, and efficiency of resources and services available to them. Advocacy can happen at individual and community levels. It can also have an impact on policy development to improve prevention, health promotion, early identification, and treatment services.

### Ongoing Follow-up

This component provides ongoing review and recognition of what the client has achieved. It may involve adjustments to goals and changes to care plans, as needed, to serve and support the client during the healing process.

## >> CURRENT STATUS

Mental health and addictions systems are fragmented and require enhanced coordination. Services and supports vary between communities and are offered by different levels of government, with often limited collaboration. Informal care facilitation is well-established in many communities. Often, community and family members assume key roles in supporting care. However, given the complex and fragmented nature of the services available and the limited awareness of available services, finding care for their family members can often be a challenge.

More formal care facilitation (e.g., case management) is not currently available in many communities or at the regional level. This often means clients are not aware of the services available to them including housing, job training, education, and community and cultural supports. Communities that do provide case management often find that the practice is uncoordinated and lacks effective communication and information sharing.

Workers often lose contact with clients after the client leaves a treatment centre. As well, uncoordinated service delivery can mean that clients must wait longer to get and benefit from services.

Sharing client information among service providers has raised concerns about privacy in First Nations communities. The proper ways to share information are often not in place. In smaller communities, where everyone knows each other, keeping information private can be hard to do.

## >> RENEWAL OPPORTUNITIES

- A well-defined system-wide approach to care facilitation, available at both community and regional levels. These approaches should:
  - rely on evidence-based and culturally-relevant screening and assessment tools;
  - seek to coordinate with relevant health and social services, based on the needs of clients and their families;
  - respect existing confidentiality and privacy acts;
  - promote access to training and resources for individuals who provide care facilitation;
  - foster a system of support for the client within their social, family, and community;
  - promote the development of partnerships with specialized services from other communities, provinces, or other jurisdictions; and

## Sakwatamo Lodge—Melfort, Saskatchewan

Sakwatamo Lodge has an Elder aftercare network to support the continuum of care for clients that complete their program and are returning home to their communities. Clients upon returning home are connected to their community NNADAP worker for access to various aftercare programs. Clients are also connected to this network of Elders to provide them additional support in the areas of culture, tradition and the transition to a healthy lifestyle. Elders provide the client with culturally sensitive knowledge, wisdom and participate in a variety of ceremonies to strengthen the client's resolve and decrease the likelihood of recidivism. These Elders have been trained in the various areas of addiction and have worked with Sakwatamo staff prior to becoming a part of the aftercare network.

  - include a focus on support for family members and other loved ones.
- Case managers from allied services who refer people to NNADAP services could receive cultural competency training, provided by a First Nations institute as this becomes increasingly more common across provincial health authorities.
- Standardized assessment tools and placement criteria would also contribute to increased information sharing and the use of available resources, such as referring people with the most severe issues to the most intensive treatment settings.
- A full and coordinated referral system that allows for referrals between on-reserve and off-reserve resources, and among mental health, addictions, and primary care services. This kind of system would also recognize the important role that community and family members play in care facilitation. The referrals would identify potential risks, drug use, client history (e.g., personal medical and impacts of colonization through intergenerational trauma), and other issues facing the client from a strengths-based perspective (especially cultural identity), to facilitate collaboration, information sharing, and care planning with all available supports.
- Increase awareness within communities of the range of available services and supports, including the eligibility criteria for accessing these services. Increased awareness of these services will help family and other social supports refer individuals to appropriate screening, assessment or intervention settings. This may involve something as simple as the development of a pamphlet that would be available within public areas.

# SUPPORTING THE CONTINUUM OF CARE

*The foundation of quality care for clients is: a qualified workforce with the appropriate skills and knowledge, supported by a healthy work environment, competitive wages and benefits, and opportunities for worker development.*

# Workforce Development

## >> DESCRIPTION

A qualified workforce plays a vital role in the quality of care clients receive. A comprehensive strategy for human resource management supports hiring and recruitment and offers practical options for professional development. It sets the stage for employee satisfaction and retention. A strategy will help ensure the right mix of staff with appropriate qualifications and training is on hand to provide supports and services on an ongoing basis.

The key components of an effective approach to workforce development include:

- cultural knowledge and skills;
- recruitment;
- education and training;
- worker certification;
- worker retention;
- wages and benefits; and
- personal wellness.

## >> KEY COMPONENTS

### Cultural Knowledge and Skills

The skills and experience needed in a First Nations addictions system extend beyond clinical or counselling skills. The NNADAP and NYSAP programs were built upon the foundational belief that Indigenous-specific cultural practices drawn from an Indigenous worldview would provide the best route back to wellness. A strong basis in community and culture, and an understanding of cultural healing practices are important in both community and treatment centre settings.

### Recruitment

Recruitment involves attracting, screening, and selecting qualified people for employment. The ability to attract qualified candidates is often directly linked to how a candidate views the organization and the pay and benefits provided. It is easier for organizations to recruit staff if: they have well-administered human resource policies and practices that balance recognition of western and traditional cultural qualifications; they have appropriate salaries and benefits; and the organization involves staff in decision making. Where the available pool of qualified candidates is limited (e.g., in rural and remote communities), ensuring staff have the capacity and opportunity to increase their qualifications over time through well planned recruitment and retention planning is essential.

### Education and Training

Ongoing training and/or education is a requirement in the addictions field because of work complexity at the community level and the ongoing developments in the fields of prevention and treatment. With greater challenges and more diversity in services and programs, the capacity of service providers must also evolve. Specialized training, cultural competency, and multidisciplinary training are becoming more important if not necessary to help inform the workforce of emerging addiction and mental health issues. For specific or special needs groups, such as youth and women, workers often require targeted training and education to meet client needs.

### Worker Certification

Certification is recognized as a key activity that enhances the skills of addiction workers. Certification involves an independent third-party assessing and acknowledging a person's level of knowledge and skill based on a set of pre-determined standards. Some advantages to being certified include better professional recognition and job mobility, as well as higher staff satisfaction and retention.

### Worker Retention

Retention is the result of having appropriate human resource measures in place. It also depends on whether an organization can create a positive and supportive work environment. Although many factors can have a direct impact on retention rates, staff satisfaction with their job, a healthy relationship with a supervisor and competitive wages are often said to be the most important factors. For supervisors, both paying recognition to staff and engaging workers in policy development/decision making may also encourage retention.

## Standardized Salary Grid—Alberta

In 2004, the Alberta region developed a standardized salary grid to provide First Nations communities and treatment centres with a streamlined approach to salaries within the addiction workforce. A committee composed of staff from FNIHB, NNADAP treatment centres, and community-based programs developed an incentive-based salary funding model by streamlining job descriptions into a single, standardized wage scale. As a result of this work, extra funds were given to treatment centres based on staffing levels and salaries, plus a remoteness factor. Funding to community-based programs was based on the Community Workload Information System (CWIS). Other groups/organizations, such as the Regional Addictions Partnership Committee of Manitoba, the Treatment Directors of British Columbia and the Youth Solvent Addiction Committee, have also developed standardized salary grids.

### Wages and Benefits

Wages and benefits for the addictions workforce in communities and treatment centres are based on two factors: availability of funds and employer policies and practices (e.g., standardized job descriptions or salary grids). This is part of human resource management that is administered at the community level. In terms of benefits, an Employee Assistance Program can provide support that will help with the stresses of providing complex services at the community level and can reduce employee burnout.

### Personal Wellness

*Psychological Safety*

Psychological safety refers to a workplace culture that promotes healthy mental wellness. Having healthy workplace policies, a trusting atmosphere, and resources for employee assistance will encourage psychological safety and allow employees to feel comfortable. Using employee surveys and feedback, addictions organizations can enhance employees' psychological safety.

Acknowledging and addressing vicarious trauma is one way an organization can promote and sustain the psychological safety of their staff. Vicarious trauma can be defined as a personal reaction to frequent exposure to the traumatic experiences of clients, especially when the discussions involve violence and physical abuse. Vicarious trauma generally happens over time and, if it is not addressed, can have a negative impact on the employee's work and personal life. Due to the nature of their work, helping professionals are at an increased risk of experiencing vicarious trauma. Common signs include anger, depression, fatigue, and problems with relationships.

*Self-care*

Both the employee and employer are responsible for self-care. It is critical for staff to manage stress and essential to have a self-care plan. A good self-care plan considers the physical, mental, emotional and spiritual needs of a worker.

Many centres within the NNADAP/NYSAP network use yearly personal wellness plans in annual performance appraisals to ensure that self-care is part of the workplace. Workshops, training events and professional development opportunities can promote self-care for staff.

## >> CURRENT STATUS

The NNADAP/NYSAP workforce includes approximately 1,500 treatment centre and community workers. While they bring passion and dedication to their work, they can also be overlooked and not appreciated for the role they play in the system.

Community addiction workers are employed through their community. Their salary is generally set by funding authorities and available resources. Communities hire workers and set salaries using a variety of means, (e.g., wage scales and job descriptions). In most regional needs assessments, salaries were found to be one of the

most important barriers to hiring and retention. Limited resources and policy issues often make it hard for communities to set aside resources each year for salaries.

The on-reserve addictions workforce ranges from workers with formal education (like post-graduate degrees) to some staff with more limited addictions training and others still with cultural knowledge, skills and community sanctioning to conduct ceremonies with relevance to addictions treatment and prevention. All workers face the challenge of keeping up with emerging and complex addiction issues. During the last decade, both the addictions workforce and employers have acknowledged the importance of training and certification as a key way to meet standards and to provide effective, high-quality, culturally relevant addictions treatment and prevention services.

Training is a key requirement for workers to maintain certification. Unfortunately, prevention or treatment training does not occur in a systematic manner and is not consistent across all regions. Access to career development can be limited or lacking in smaller communities.

Despite differences across regions, most of the workforce at the community and treatment centre level has addictions training, certification training, a degree, or diploma. Treatment centre staff access to clinical supervision and support is also increasing.

In general, hiring and retention are common problems in addiction programs. Isolation and lack of community supports are also issues of concern. High staff turnover remains a significant problem, with skilled and experienced workers moving to the provincial system or leaving this work altogether. The reasons range from inadequate salaries and high workloads, to stressful working conditions and a lack of cultural supports.

## >> RENEWAL OPPORTUNITIES

- A national addictions workforce strategy that respects local governance could provide guidance and support to employers for all aspects of human resources related to the addictions workforce.
- Competency-based job descriptions and training may help to support both worker development and better services for clients. Generic job descriptions can be a useful tool for multiple employers.
- The huge demands on addiction workers make it critical that a healthy work environment exists. A process for collecting and sharing strategies that promote worker wellness may provide additional support to both community and treatment centre staff. This process may include strategies for:
  - developing wellness plans for staff;
  - identifying opportunities for workers to voice their opinions on decisions;
  - developing and reviewing healthy workforce policies;
  - providing regular events/awards to recognize workers;
  - ensuring employees have formal ways to provide and receive feedback; and
  - creating plans for employee development.
- Enhanced networking among workers as a means for regional information exchange and networking forums to:
  - share effective approaches;
  - enhance service coordination; and
  - encourage formal and informal supportive professional networks.

### Cultural Knowledge

- Identification of ways to link cultural knowledge, skills, and community-based cultural practices. This will be important for raising cultural competency within mental health and addiction services.
- Recognition of cultural knowledge and skills in qualifications for mental health and addictions services.
- Compensation of cultural knowledge and skills in setting salaries/wages.
- Provision of, or allowance for, cultural knowledge and skill development through culturally based professional development and psychological safety strategies.

### Recruitment and Retention

- A key to longer term recruitment could be greater advancement opportunities through:
  - laddered approach to career building, which may lead to degrees or post-secondary education;
  - distance education programs;
  - support for education through bursaries or scholarships;
  - supervised clinical training;
  - activities to promote a psychologically safe workplace;
  - culturally appropriate professional support through an Employee Assistance Program, which includes access to Elders and cultural practitioners; and
  - orientation programming for new staff that is critical in supporting the engagement of new employees.

### Education and Training

- An ongoing focus on education and training of workers, especially with respect to emerging issues (e.g., prescription drug abuse), target populations (e.g., women, youth, and people with co-occurring mental health issues), and essential skills and competencies (e.g., evidence-based prevention and health promotion strategies). This training can be supported through an approach to clinical supervision, either at community or regional levels, and may be enhanced through a mix of video-conferencing and distance education along with training and flexible work options.
- Emphasis on addiction and mental health training for a range of other care providers who may also be involved in client care. This may include family and community members, other community service providers, primary care and other medical staff (e.g., nutritionists and dental teams), and off-reserve service providers. This training could focus on signs of substance use or mental health issues; available services and supports; community and cultural considerations; and specific considerations for their area of practice.
- Partnerships between communities and cultural knowledge societies/Elders, regional training bodies, schools, universities, and provincial, territorial, or federal government agencies would help to ensure that supports are in place for workers seeking education. As well, training programs available within education institutions are required to provide courses and education necessary to complement workforce competencies.
- Partnerships with certifying bodies and schools/universities to ensure training and certification standards are accessible and culturally-relevant for the First Nations addictions workforce.

### Certification

- Respond to the need and demand for culturally responsive certification standards for NNADAP and NYSAP workers.

### Wages and Benefits

- More information and analysis are needed before regional and community salary scales and job descriptions endorsed by First Nations leadership can be applied to the addictions workforce. These scales could reflect both clinical and cultural competencies, and may draw upon certification data as key criteria within scale development.

## Manitoba Clinical Supervision Approach

In response to a recommendation from the Manitoba Regional Needs Assessment, Health Canada's Manitoba Region, with the support of the Manitoba First Nation Addiction Committee, entered into a contract with a therapist for clinical support and training for the region's four NNADAP treatment centres. Since 2009, the therapist has provided both direct clinical supervision and training and has coordinated workshops and information sessions, all based on specific needs identified by each centre. Training and information has included such topics as the support of clients with prescription drug issues and children with FAS/FAE. Partnerships with related organizations have been facilitated as a result of these activities, leading to increased collaboration and information exchange.

*The development and maintenance of holistic community-based addictions services and supports, which are informed by First Nations culture, values, and tradition, are central to a community's health and well-being.*

*These services and supports are enhanced when they are controlled and defined locally, and benefit from collaboration between and among governing bodies and service providers.*

# Governance and Coordination of Systems

## >> DESCRIPTION

Strong governance and coordination among and within systems are vital to developing and maintaining a continuum of care in a First Nations community.

The responsibility for the governance of on-reserve addiction prevention and treatment services often rests with First Nations chiefs and councils, treatment centre boards of directors, tribal councils, and First Nations self-government structures. Specific to mental health and addictions, governing groups are responsible for two main functions: 1) making sure that needs are being met through systems design and policy; and 2) supporting accountability in all aspects of service delivery.

Key components that support both the governance and coordination of systems include:

- Community-driven addiction services;
- Inter-jurisdictional relationships and collaboration; and
- System level partnerships and linkages.

### Alberta Region Co-Management Committee—Alberta Region

Since 1996, the Alberta Region Co-Management Committee has helped to ensure that Alberta First Nations are full partners with Health Canada with respect to community health administration. This group represents the majority of communities within the Region, and those without membership possess observer status at Committee meetings. The Co-Management Committee is comprised of six sub-committees which link to clusters of FNIH health programming: Non-Insured Health Benefits; Mental Health and Addictions (NNADAP and NYSAP); Children and Youth; Prevention Programs; Health Protection; and Governance and Capital. All sub-committees are co-chaired by a First Nation representative and FNIH ensuring full partnership and collaboration on all decisions. Through this committee, First Nation leadership and FNIH participate as equal partners in the administration of health programming for Alberta communities.

## >> KEY COMPONENTS

### Community-driven Addiction Services

A stable and progressive addictions service must be driven by First Nations communities and embody their cultures, values and traditions.

### Inter-Jurisdictional Relationships and Collaboration

An effective addictions system requires the development/maintenance of inter-departmental and inter-jurisdictional relationships and collaboration. This kind of collaboration helps to understand:

- The impact of social determinants of health and their role in service delivery and continuity of care for clients (e.g., mental health, corrections, child welfare);
- Coordination and transition between services and supports (e.g., between provincial detox and community-based services); and
- How services can be responsive to the unique needs of First Nations people and communities (cultural competency).

It is important that the link between accountability and communication be clearly defined and actively supported. Collaboration requires a clear understanding of the roles and responsibilities of on-reserve governing bodies and service providers, as well as those of regional, provincial, and national service providers.

### System-Level Partnerships and Linkages

Key opportunities for collaboration exist among governance bodies, health providers, and social service providers. In some cases, this collaboration is facilitated through community health boards or advisory committees that coordinate health services including NNADAP/NYSAP services or a regional NNADAP organization that represents all First Nations communities.

Establishing stronger links among addiction networks, community-based representatives, community-based programs and other key partners at the community level (e.g., research, political policy, and advocacy organizations) provides an opportunity to promote the interests of First Nations at regional and national levels. Regional and national networks can provide opportunities for knowledge development and exchange; a forum for contributing to the evolving addictions field; and ongoing advocacy for programming. All of these are vital in supporting community-based addictions systems.

## >> CURRENT STATUS

Diversity exists in governance structures for First Nations people, at all levels. Depending on the community, these may include: band councils, self-government, regional tribal councils, and provincial/territorial organizations, as well as national Aboriginal organizations representing women, urban Aboriginals, addiction, and mental health. These issues can present unique challenges when adapting governance and service needs for such a diverse client base.

Community decision makers and leadership have significant roles in reducing substance use issues within a community. Without clearly defining governance structures, the roles can be unclear between a First Nations community governance body and the addictions or mental health service, especially with respect to who is responsible for setting policies and standards.

The level of integration and collaboration between community addictions services and off-reserve or provincial services varies widely. In some regions, collaboration is formal and well-established, while others have little or no collaboration. This is the case for detoxification services in particular.

Several regions currently have forums where regional working groups or committees may network, identify needs and challenges, and advise on regional and/or provincial actions. As well, the National Native Addictions Partnership Foundation serves as a national advocate in advancing First Nations and Inuit culturally based addictions services.

### Summit on Addictions Among the First Nations of Quebec: Mobilizing Around Real Change—Trois Rivières, QC

From February 1–3, 2011, the Assembly of First Nations of Quebec and Labrador (AFNQL), and its regional commissions and organizations, held a summit that focused on ways to address substance abuse and addictions, with the theme "mobilizing for real change." Organizing this Summit was a priority for the First Nations of Quebec and Labrador chiefs, who had observed that their populations were poorly informed as to the magnitude of the situation and the available solutions. Faced with a real emergency that required action, the First Nations Chiefs chose to hold an event that would not only present the existing situation regarding addictions, but also encourage participants to explore possible solutions and make concrete commitments. The Summit brought together almost 400 First Nations people for the two-day gathering. In addition to workshops and plenary discussions, attendees participated in presentations by inspiring personalities who work in the fight against addictions.

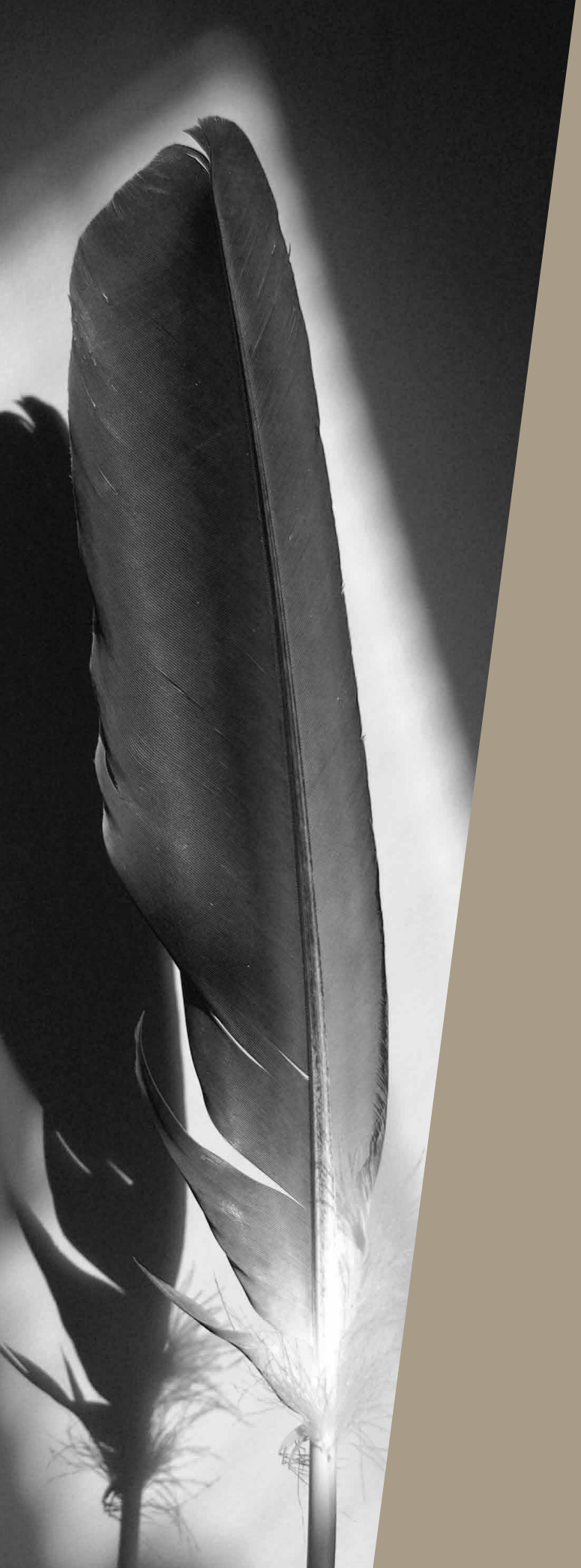
NNADAP/NYSAP currently partner at the national level with the:

- Assembly of First Nations;
- Inuit Tapiriit Kanatami;
- National Native Addictions Partnership Foundation;
- First Nations and Inuit Mental Wellness Advisory Committee; and
- National Native Mental Health Association.

Some NNADAP representatives are part of mainstream addictions systems through the work of the *National Framework for Action* governed by the Canadian Centre on Substance Abuse and other partners (e.g., National Treatment Strategy Leadership Team, National Advisory Group for Workforce Development, and the National Treatment Indicators Working Group). There are, however, wide differences in the organization of, and support for, regional networks and mobilization. The way that each network informs national and federal policy and systems also varies.

## >> RENEWAL OPPORTUNITIES

- Recognition, respect, and support for the idea that healing is connected to self-determination.
- Recognition of the major role that all aspects of governance, system coordination, and service delivery play in each client's or family's experience with accessing and using services, and ultimately, in positive client outcomes.
- Recognition of the important roles local control and cultural continuity play in community health and well-being. This may include:
  - indicators of how self-government is being achieved;
  - use of the courts to obtain First Nations title to lands;
  - degree of local control over health, education, and police services;
  - community facilities aimed at preserving culture;
  - local control over child welfare;
  - community capacity across determinants of health; and
  - women's involvement in governance.
- Recognition of Indigenous society, and support for communities (where desired) by promoting traditionally-based governance structures, customary land ownership, and internal reconciliation and healing. These are seen as vital to social cohesion based on the linked obligations and responsibilities that form the basis for Indigenous societies.
- Governance training for health boards and treatment centres. Such training would focus on good governance practices, workplan development and ways to enhance collaborative relationships among key partners (internally, as well as those that are inter-departmental, inter-jurisdictional, and system wide.)
- Networks for support, advocacy, knowledge development, and information exchange. These networks could also function within system-supports to ensure that changes to policies and laws truly reflect the needs of NNADAP/NYSAP addictions and mental health services and support issues around changing community needs.
- Active monitoring of changes to laws that have an impact on the addictions field (such as taxation, laws on illegal drugs, privacy laws, labour standards, Youth Criminal Justice Act, and Child Welfare).
- Clear and consistent communication should guide and then inform policy and service delivery, which may include measures to increase communication capacity both within and across communities.
- Promoting First Nations leadership involvement in reducing substance use issues by:
  - being role models for healthy living;
  - offering political/governance support to ensure competent staff with fair compensation in service delivery;
  - respecting and safeguarding treaty and Aboriginal rights, helping to set up links to multi-level services to ensure gaps are filled;
  - supporting the need for cultural competency in services both within and outside of First Nations communities and organizations; and
  - setting up methods to manage grievances and service complaints.



*Serving clients and communities with mental health and addiction needs requires a range of community and medical supports which make use of both cultural and mainstream approaches to care.*

*The foundation of this approach includes worker competency with mental health issues, capacity to meet specialized needs, and strong connections among care providers.*

# Addressing Mental Health Needs

## >> DESCRIPTION

It is generally understood that substance use and mental health issues are strongly linked and often occur together. For instance, mental health issues can lead to the use of substances as the person tries to cope with, or numb, distress. As well, substance use can lead to mental health issues, such as depression and anxiety.

The terms *concurrent disorders or co-occurring disorders* refer to a combination of a mental health disorder and a substance use disorder. Common mental health issues include mood, anxiety, and personality disorders, and post-traumatic stress. People with co-occurring issues tend to have poor general health (known as co-morbidity).

To prevent substance use issues, it is vital to take a holistic approach to mental wellness with a focus on strengths, resiliency and recovery. There are many system approaches to ensure that the mental health needs of clients with substance use issues can be addressed. Some are through referrals, cooperation, and collaboration among addiction and mental health services both on- and off-reserve; others involve using specialized mental health supports that are part of existing addiction services; and some comprehensive services exist to more fully address all of a client's and community's mental wellness needs.

An awareness of the frequent co-occurrence of mental health and addiction issues has significant implications for both addiction treatment and prevention. In many cases, it is best to address issues at the same time, through integrated or collaborative approaches.

Key components of an effective approach to addressing mental health needs within an addictions system include:

- strong referral and case management networks;
- centres able to deal with concurrent disorders;
- supports for community-based mental wellness;
- Indigenous approaches to mental health; and
- medical assessment and medication support when necessary.

## >> KEY COMPONENTS

### Strong Referral and Case Management Networks

For clients who require both mental health and addiction services, these services may not always be provided "under one roof." However, services and supports could also be made available through strong connections among services from various elements of care. For example:

- community-based mental health and addictions aftercare could follow intensive treatment at a provincial mental health facility or acute care services in a community;
- ongoing community-based mental health counselling, including family counselling, could follow NNADAP/NYSAP treatment;
- connections with primary care services could be made within and outside the community with respect to supporting and managing mental health issues; and
- a visiting Elder/psychologist and a NNADAP prevention worker could work along with a client and their family in a community.

In all of these examples, it is important to have mechanisms in place to support collaboration. Some of the mechanisms include culturally specific assessments, standardized assessments, well-defined protocols for case management, and a shared understanding of the relationship between the mental health and addiction issues for that client. As well, a shared understanding of the importance of culture and community as supports to well-being can help service providers work together to meet a client's needs. This can broaden the network of supports available for that client.

### Centres able to Deal with Concurrent Disorders

Existing addiction services can safely and effectively meet the needs of some clients with concurrent disorders, particularly those that are less severe. This may be the case if the addiction service has well-trained staff with access to

clinical supervision and specialized cultural supports to provide support to individual client cases. Access to medical supports outside the centre is needed for cases using drug-based approaches to help a client manage a mental health condition. However, it may not be necessary or feasible for all centres to have the capacity to manage specialized concurrent disorders. What is more practical is for every centre to have some level of competency with respect to mental health issues, and to have specific centres within the regional and national continuum of services that can provide specialized concurrent disorder treatment, based on need.

### Supports for Community-based Mental Wellness

Strong community-level supports designed to be flexible and to meet the mental wellness goals of a community can eliminate the need for more acute services for some clients. For instance, when it comes to diagnosis, research suggests that for youth, early diagnosis and intervention for a mental health issue can reduce its severity and thus reduce the chance that the client will develop a substance use issue later in life.

Community-level supports can also provide assistance to other clients before they access specialized services and/or help them with their well-being when they return home. The latter may involve in-community supports, (e.g., multi-disciplinary teams to help provide aftercare for families). For many people, stigma is often a major barrier to accessing services which reflects the need for trustful relationships. Mental health supports help to encourage community members to access counselling or specialized services.

Networks and links to provincial services are essential, especially for clients with concurrent disorders and other acute mental health issues. Access to community-based, culturally appropriate supports for mental wellness are just as important. This includes prevention, health promotion, early identification, intervention, and follow-up activities and supports that are connected to, and coordinated with community development efforts.

### Indigenous Approaches to Mental Health

Providing cultural or Indigenous approaches along with mainstream clinical approaches is often necessary to reflect the diversity of client needs. The specific cultural approaches used and the right balance between the two must be determined by clients, families, or communities themselves. Consideration of these approaches must also respect diversity within the First Nations community and adapt to varied approaches to care. For instance, some cultural practitioners are trained in ceremonial practices for assessment and diagnoses, and in the use of natural medicines, which can be an important way to improve the well-being of those dealing with

## Dilico Anishnabek Family Care—Ontario

In response to growing needs and demands, Dilico has conducted extensive research into how best to refine its services to meet the needs of those with concurrent disorders and prescription drug addictions, and to be able to offer gender-specific treatment services. This research has led the centre to make provisions for concurrent disorders in the centre's mission, screening, assessment, treatment planning, program content, discharge planning, staff competency and training in an effort to become a "concurrent disorder capable" program. Changes in service provision have included a strong case management focus; medication being accepted as part of the provision of care; and clinical support and consultations routinely accessed. It also included efforts to strengthen pre-treatment support services and aftercare to enhance the continuum of care to better support clients with more complex needs.

both addictions and mental health issues. Based on a client's preferences, their strengths, and their needs, the role of Indigenous medicines and ceremonies should be seen as part of, not separate from, other aspects of support and care.

### Medical Assessment and Medication Support

For many clients a medical assessment is required to rule out physical illness that may cause or play a role in mental health symptoms, and to identify mental health issues. Key factors in knowing whether a mental health diagnosis is needed relate to the severity of a client's symptoms; the distress the symptoms cause; and the degree to which they affect how the person functions in the world. This can include being able to make and maintain relationships and friendships; to work in some way; and to take care of oneself and/or others. Based on a medical assessment, medication may be prescribed to manage symptoms of mental illness and improve client safety.

In addition to doctors, nurse practitioners can also play an important role in the administering and prescribing of medication. In some regions, they can renew prescription medications used to treat mental health issues (e.g., depression, anxiety disorders and schizophrenia), while in other regions they can both prescribe and renew medications. This can affect whether clients with mental health needs can get new prescriptions on-reserve. However, an ongoing concern for many communities, particularly those that are rural and remote, remains access to medical assessments, prescribed medication, and complementary psychological, social, and cultural support.

## >> CURRENT STATUS

Mental health and addictions have historically been viewed and treated as separate conditions with separate systems of care. Sometimes integrating mental health and addiction systems has raised the concern that by trying to address mental health issues within addictions programming, the focus and expertise on addictions will be lost. Although structural issues related to systems integration may be complex, the need for stronger collaboration between mental health and addictions services is essential in addressing the needs of clients. This is consistent with client and community requests for more effective, holistic, and client-centred services.

The high co-occurrence of mental health and addiction issues requires strong collaboration between and within services, screening, referral, assessment, and treatment methods. Collaboration between addictions and mental health services is taking place in some First Nations communities. However, the supports needed for integrated treatment plans often do not exist. Some of those supports include culturally specific assessments, standardized assessments, protocols in place for case management and information sharing, and the correct screening tests for mental health conditions.

Currently there are limited specialized mental health services available. Mental health services are limited

and fragmented and often delivered by multiple sectors. These gaps in available mental health services can be found both on- and off-reserve. While an established system of on-reserve addiction services exists across the country, on-reserve mental health services are underdeveloped with little or no coordination existing between the two systems. In addition, access to provincial mental health services is limited due to long waiting lists. These services may not be culturally appropriate or safe, and may not exist at all for certain populations, such as youth.

A challenge within the system occurs when clients are not only unable to access more specialized services, but where there are no specialized mental health services, or when long waiting lists prevent access to treatment, the local supports available to clients are inadequate to meet their needs.

The number of addiction treatment centres that can address concurrent disorders is increasing. In all cases, this has involved staff receiving specialized training, clinical supervision, and access to other psycho-medical supports. Where there is limited access to these supports or difficulty in recruiting and retaining qualified staff, the capacity to work with more complex cases will remain a challenge. The same is true at the community level, where community-based prevention workers need more support and training to meet the needs of clients with concurrent disorders.

An emerging area that many centres and community workers have had to deal with is the use of mental health medication. There is a significant body of research supporting the idea that people with concurrent disorders have significantly better outcomes when they are *appropriately* medicated while receiving addiction interventions at the same time, and that medication or counselling alone is less effective. Determining the appropriateness of medication often requires monitoring by a qualified medical professional.

Currently, some NNADAP centres have policies restricting mental health medication; however, many others have adapted their services to accommodate clients taking mental health medication. These centres have reported that the accreditation process has been particularly helpful in providing guidance on protocols and policies for medication management.

There are examples of community mental wellness supports, funded through programs such as Brighter Futures or Building Healthy Communities; however, they are generally described as insufficient to fully address a community's needs or are not carried out in a systematic or deliberate fashion (see Element 1 for more information on community wellness approaches).

Multi-disciplinary, community-based mental wellness teams provide a variety of culturally safe mental health and addictions services and supports to First Nations communities, including mobile clinical services; access to specialized mental health services; community development; and traditional/cultural programs. The mental wellness team concept supports an integrated approach to service delivery (multi-jurisdictional, multi-sectoral) to build a network of mental wellness services for Aboriginal people living on and off reserve. Mental wellness teams are owned, defined and driven by the community and include traditional, cultural, and mainstream clinical approaches to mental wellness services, spanning the continuum of care.

## >> RENEWAL OPPORTUNITIES

- Incorporating cultural or Indigenous approaches along with mainstream clinical approaches into mental health and addictions services is important to reflect the diversity of client needs.
- Mental health and addictions workers must be culturally competent and have cross-disciplinary training and access to networking. In particular, workers could be trained in basic counselling skills, case management, family counselling and basic knowledge of addiction and mental health issues.
- A long-term approach to community-based coordination of mental wellness services, supports, and workers. This may involve:
  - development of community-based wellness plans, inclusive of mental health, addictions, and community development;
  - implementation of multi-disciplinary teams, adapted to community needs and inclusive of

both mainstream and cultural practitioners, within and across communities; and
  - identification of a wellness coordinator within each community tasked with providing leadership on all mental health, addiction, and community development activities. Such a worker would require a range of skills and competencies and may also provide direct service delivery.
- Stronger screening and assessment to help addictions workers better identify client needs, and then find the "best fit" with available services. A key avenue for this may include standardized assessment tools or approaches, along with relevant training.
- Flexible funding options at a community level to support stronger mental health supports (both Indigenous and clinical), will help to meet the needs of clients with concurrent disorders, as well as their family's needs.
- A systematic approach is needed to support NNADAP and NYSAP treatment programs to become more capable in addressing the needs of clients with concurrent disorders. This will ensure a dual focus on mental health and addiction issues throughout the treatment process, in policies and procedures (e.g., for medication and psychiatric emergencies), as well as in screening, assessment and referral; intake procedures; and treatment sequencing and analysis.
- Access to appropriate services needs to be supported by referral networks that allow addiction workers and other community workers to easily refer clients to more specialized resources, such as physician services and acute mental health services. As well, having ongoing links to community resources will help workers better support clients when they return home.
- Specialized treatment services for youth who would benefit from more development and new approaches to care.
- Medical transportation policies that allow for access to the right kind of care based on the needs of the client and support a return to treatment, even where there has been a recent attempt at treatment.

## Nuu-chah-nulth Tribal Council Mental Wellness Team—British Columbia

Nuu-chah-nulth Tribal Council provides multidisciplinary support to 14 First Nations communities on Vancouver Island. The Quu'asa Mental Wellness Team is a partnership between a range of health professionals and community support staff such as nurses, infant development workers, clinical counsellors, cultural healers, external support services, and the RCMP. The team coordinates client-driven, culturally sensitive, strength-based treatment for both mental health and addictions. Cultural healers and the multidisciplinary team coordinate ceremonies by working collaboratively with the community, and planning and consulting with health professionals about culturally sensitive healing approaches. The Quu'asa workers provide support, information, and mentorship on cultural healing and prevention in communities, at public urban centres, in the workplace, and on a one-to-one basis. Trained cultural healers lead gatherings and ceremonial and cultural healing events and are included in case conferencing. The program has been operating for several years and has shown positive results in reducing youth suicide, addictions and in promoting mental health.

*Ensuring an effective system of care requires culturally-relevant research and ongoing tracking of program results, including not only data on individual substance use but also all factors which contribute to wellness for First Nations.*

*This approach combines opportunities to share knowledge and support addictions programs to better meet the needs of clients and communities.*

# Performance Measurement and Research

## >> DESCRIPTION

Performance measurement and research are both relevant to the development and delivery of effective programs and services. They make it possible to develop approaches that best meet the needs of clients while getting the most value from available resources. Performance measurement is an important way to demonstrate to clients, communities, and stakeholders that the work being done in addictions programs is having a positive impact on the well-being of First Nations communities. Coordinated research activities are vital to building a stronger evidence base and understanding why what is being done works within particular contexts, from a First Nations perspective. It can also make a case for changes that may need to be introduced.

Key components of a strengthened approach to performance measurement and research in a First Nations addictions system are:

- population health information;
- integrated performance measurement system;
- research strategy; and
- knowledge exchange.

## >> KEY COMPONENTS

### Population Health Information

Population health information includes both health status (outcome measures) and indicators of the need for health care (socio-economic measures). Socio-economic measures include determinants of health data which can be used to conduct needs-based planning and inform future programming that focuses on improving overall health.

### Integrated Performance Measurement System

Integrated performance measurements can be an effective way to determine where change may be needed within an organization. Key elements of an integrated performance measurement system include tracking and reporting of activity data (e.g., service availability and rates of use, results data, and client outcomes). This is generally done by using a systematic approach to record keeping, such as a case management or an electronic system. It is also important to observe this data alongside defined human resource indicators, such as staff turnover, staff grievances, staff attendance and staff satisfaction to link the impact on client care and service outcomes.

### Research Strategy

A well-defined research plan identifies and funds research in areas most important for client and community wellness. Specific research is necessary for demonstrating the impact of cultural interventions. It is important that both the research plan and any research projects recognize cultural knowledge and the values of a community with respect to the principles of community-controlled and community-owned research.

Research may also support the development of new treatment approaches, or measures to improve care for the community (e.g., for certain kinds of addictions, or clients with specialized needs); or may include research on other variables that have an impact on access to and impact of care received. Meaningful program reviews usually address both performance measurement and research plans.

### Knowledge Exchange

Knowledge exchange helps with the transfer and integration of research findings and information among the areas of research, policy, and practice at a community, regional, and national levels. Knowledge exchange supports the development of new approaches to care and helps to refine services at all of these levels through methods including face-to-face meetings, conferences and web-based forums.

## Nimkee NupiGawagan Healing Centre (NNHC)—Ontario

NNHC partnered with the Canadian Centre on Substance Abuse (CCSA) and Carleton University to identify indicators of client length of stay. The research project confirmed the use of indicators to monitor client engagement in the four-month gender-based treatment program for youth aged 12 to17, with the goal of improving treatment outcomes. This research highlighted the many factors that influence client engagement, retention and completion of treatment. Further research is needed into program length and length of client stay to standardize the indicators and their meaning for making informed clinical decisions. This is important given that the average rate of completion of treatment nationally for youth is at approximately 50 percent, while Nimkee NupiGawagan Healing Centre has been able to achieve a client completion rate of 100 percent annually over three years and 90 percent ongoing.

### >> CURRENT STATUS

Population-level data specific to First Nations in support of monitoring or addictions-related program planning is limited. Canadian population-level research on substance use often does not include on-reserve populations and often does not use large enough samples to identify First Nations living off-reserve.

Concerns identified during previous efforts to obtain population-level data on substance use among First Nations have included low levels of participation; lack of cultural sensitivity in the survey tools and interpretation of results; and culturally biased diagnostic tools. There are also sensitivities around the use of this type of data, especially about how to reflect a holistic understanding of wellness. The most credible source of population-level data available is through the First Nations Regional Longitudinal Health Survey, which is the only First Nations governed, national health survey in Canada. It collects information based on both Western and traditional understandings of health and well-being.

Research specific to First Nations addictions programs often includes partnering with local, regional, national and international bodies, and is guided by Ownership, Control, Access, and Possession (OCAP) principles. Community processes and cultural protocols must be respected with research providing a benefit to the community.

Some First Nations communities have developed indicators that focus on wellness rather than illness and they may develop health information at a collective level of family or community, rather than at the individual level.

Without complete data, it is difficult to make a correct assessment of service gaps, needs, and priorities, or to make recommendations on the best way to allocate resources.

There is no defined set of indicators to guide data collection and performance measurement within the on-reserve addictions system. In some cases, a lack of awareness exists when it comes to the benefits of data collection or the need for infrastructure to support it. A basic electronic system for data collection is under development but until it is fully implemented, a large gap in performance measurement data will remain both in treatment centres and in communities.

Many research and information gaps have been identified in the current renewal process. The Renewal Process recognizes the need for an improved evidence base to inform programming. Both the process, along with an emerging research base, has helped to validate Indigenous knowledge and traditional practices within addiction services. However, there are no consistent definitions for Indigenous knowledge or Indigenous evidence. Little has been written or documented within the NNADAP and NYSAP regarding the structure, process, and outcomes of culturally based

programming or culture's role in mental wellness. These areas require significant attention and support from the research community.

Wide-ranging research is needed for the development of a First Nations-specific evidence base and has been identified as a priority. There is a high level of interest in confirming the effectiveness of existing approaches through research. This will help to identify preferred treatment modalities for different populations (e.g., women and youth) and specific substances (e.g., methadone and prescription drugs) in a First Nations context. There has also been very limited research to date on substance use and abuse prevention in First Nations communities. Regional needs assessments and research forums revealed a high level of interest in research on culture's role in healing and on ways to integrate Indigenous and mainstream therapeutic approaches. Some communities have said they feel "researched to death," but the most common barriers to research that people named were access to funding, culturally competent researchers, and community involvement in defining research projects. The views on approaches to research in communities are as varied as the areas to be explored through research. For example, there is a need to define relevance and significance from a community perspective, not only from a clinical perspective.

Finally, opportunities for knowledge exchange to support the integration of evidence-based strategies are also viewed for the most part as limited. There is interest in having more opportunities for knowledge exchange where service providers can discuss and share what is working for their clients. There also seems to be interest in discussing research on certain programming areas, and receiving information on specific topics, such as clinical treatment information to support clients with prescription drug issues.

## >> RENEWAL OPPORTUNITIES

### Population Health Information

- A strengthened approach to gaining population level data is essential for understanding of the level of substance use issues, their patterns and changing demographics, and regional issues. This will help to support needs-based planning, improved national surveillance, and data sharing. The development and use of this data should build upon findings from available population-level information, such

as the *First Nations Regional Longitudinal Health Survey*, and must be done in partnership with communities.

### Integrated Performance Measurement

- Well-designed and ongoing processes at the community/treatment centre level that support a systematic approach to collecting and managing client and program level information.
- A data management system or systems at the community/treatment centre levels, which supports the collection and reporting of key performance measurement information at the community, regional and national levels. As this system or systems evolve, there may be opportunities to coordinate with provincial data systems.
- Ongoing capacity development and training opportunities to ensure a robust system of performance measurement that is developed with and is meaningful to communities.
- Ongoing analysis of performance measurement data at all levels to inform system design and delivery.

### Research Strategy

- A coordinated research strategy is needed to ensure that First Nations-specific research is conducted in a systematic and sustainable manner as part of the wider on-reserve addictions system. This strategy could help to improve:
  - understanding of "what works" for addiction prevention and treatment with First Nations;
  - planning, implementation and evaluation of programs;
  - workforce development;
  - policy areas, such as the integration between addictions and mental health programming; and
  - the identification of priority areas for research such as prevention strategies, treatment modalities, and research on specific populations, such as women and youth, with a focus on specific substances and the recipe for treatment "success."

  This strategy would draw upon priorities identified through the NNADAP Renewal Process, as well as research engagement activities carried out by the National Native Addictions Partnership Foundation (NNAPF), and seeks to partner with a wide range of research organizations, such as the Canadian Institute on Health Research.

- The approach to all research outlined in the strategy also needs to reflect indigenous cultures and values. Key components of this approach include:
  - making use of Indigenous research methods;
  - ensuring research is *founded* upon cultural knowledge with culturally relevant mainstream approaches *incorporated*, where appropriate;
  - developing Indigenous knowledge and models of practice;
  - building of Indigenous research partnerships and dissemination of results by Indigenous researchers;
  - ensuring research is informed by data from the First Nations Regional Longitudinal Health Survey; and
  - providing two-way knowledge exchange with communities.

- Strengthened community capacity to develop and support effective, evidence-based programming. This may involve shared learning and mentorship, support and training from regional networks, better research information from across the on-reserve addictions system, and greater incentives to work with best practices.

### Knowledge Exchange

- Support for information sharing and mentorship between communities that are doing well and those that may have more challenges.
- A planned approach to knowledge exchange that supports networks and processes and that would review research and performance measurement data. The goal would be to improve program efficiency and effectiveness. Some networks could involve:
  - a wide cross-section of partners from both mainstream and cultural practitioners, while others could be Indigenous-only;
  - partners involved in all aspects of the system, such as universities, researchers, policy developers, private companies, mental health and addictions workers, program directors and Elders; and
  - support for knowledge translation to ensure that the results of research are shared and discuss how useful data could be made available to people.

The processes to support these networks could vary, and would likely include videos, websites, brief reports, and regional and national networking meetings, as well as conferences and specific training events. Priority areas for knowledge exchange are the same as with research, namely promising Indigenous and cultural approaches to addictions and wellness. Indigenous and cultural approaches to addictions and wellness.

- Peer reviews and external reviews, for example the accreditation process, can provide a snapshot of where an organization is in its quality improvement process.

## Aboriginal Women Drug Users in Conflict with the Law: A Study of the Role of Self-Identity in the Healing Journey

There is limited research on how women's healing is impacted by the stigma linked with drug abuse, criminal involvement, and being of Aboriginal descent in Canada. Guided by the existing literature and practice-based expertise, the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse and the University of Saskatchewan undertook a collaborative study in this area. With initial funding from the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, over 100 narratives of women across the country were shared about their healing journeys at NNADAP treatment centres, including women who completed NNADAP treatment. The study established that healing from drug abuse must address the need for women to re-claim (and for some to claim for the first time), a healthy self-identity as an Aboriginal woman. This includes understanding the negative impacts of stigma. NNADAP treatment providers also offered insight on their roles in women's (re)constitution of their identity and its impact on healing. The goal of the study was to contribute original knowledge in the treatment field that can assist in improving the burden of ill health experienced by Aboriginal women in Canada. A key knowledge translation tool developed from the study's findings is a song and music video titled *From Stilettos to Moccasins* and a corresponding health intervention workshop. Prioritizing the often silenced voices of women with the lived experience, these products convey the interconnection between the negative impacts of stigma and the resilient benefits of a cultural identity.

*Training, support, and information-sharing are central to ensuring a safe and appropriate approach to medication in support of addiction recovery in First Nations communities.*

*This approach places an emphasis on collaboration between a range of individuals, including clients, medical service providers addiction workers, and cultural supports to ensure that clients get the care they need.*

# Pharmacological Approaches

## >> DESCRIPTION

Medications can be central to treating addiction issues and support addictions recovery. When appropriately prescribed and administered, they can increase the chance that a client with addictions will, over time, reduce their substance use or achieve sobriety. Prescription medications are sometimes used in the treatment of addictions either as a substitute for the substance of abuse, or to help the person reduce or stop their abuse. Medications can also be central to treating mental health issues (see the Addressing Mental Health Needs section of this chapter for more information on the use of medications for mental health issues).

The correct use of pharmacotherapy can be a valuable part of treatment for those clients who need to include medication in their healing journey. Key components of pharmacotherapy include:

- Medical assessment;
- Follow-up and monitoring;
- Coordination of care; and
- Multi-disciplinary team approaches.

Service providers include individuals qualified to prescribe medication such as physicians, and in the case of some medications, nurse practitioners. Non-prescription medications may be recommended by various health care providers, including nurses and pharmacists, or specialized cultural practitioners. Community-based addictions workers can also have an important role for clients on medication by providing routine follow-ups and monitoring side effects.

## >> KEY COMPONENTS

### Medical Assessment

The vast majority of assessments are done by primary care providers in the communities such as general physicians and nurse practitioners. A medical assessment is required to determine a client's need, suitability, and fitness for a particular medication. A client's need relates to a review of the client's symptoms and whether or not symptoms could be relieved or controlled by medication. Suitability relates to a person's tolerance of the medication given their condition or diagnosis, and their fitness relates to whether they can safely take the medication without severe physical side-effects.

### Follow-up and Monitoring

A person who is being prescribed medication needs to have ongoing follow-up with the appropriate health care provider. Symptoms and side-effects must be monitored and it is vital to determine the client's tolerance level of medication to ensure proper dosage. This ongoing monitoring by a health professional may also be an opportunity to determine what additional services are necessary.

### Coordination of Care

Some clients may need to be stabilized on a medication so that they can enter treatment (e.g., clients experiencing mental health issues). In these cases, community-based services may need to offer strong case management support to clients and link them with appropriate services, and assist them with making well-informed choices. Coordination of care includes physicians that provide pharmacological aspects of service working with the client and/or other health care providers.

Medication can be coordinated with the client's broader treatment plan to ensure they complement other approaches to healing such as traditional and complementary medicine.

### Multidisciplinary Team Approaches

A multidisciplinary team approach to care is often most effective when addressing all aspects of the client's needs. This enables knowledge exchange between medical professionals and other service providers to ensure coordinated care plans, particularly for clients on medication. It facilitates long-term partnerships among physicians, advanced practice nurses, pharmacists, and communities in supporting addiction workers as part of a holistic approach. It links continuity of care, follow-up supports, supervision, and consultation for the person's day-to-day

## Siksika Pain Management Approach—Alberta

Siksika First Nation represents an example of a successful model of collaboration through their Chronic Pain Clinic. This clinic brought together a multidisciplinary team (physician, counsellor, pharmacists, orthotist and Elder) to work collaboratively with community members struggling with chronic pain by assessing individuals and making recommendations for treatment options. This included assessing proper usage of medication and making recommendations such as the use of alternative methods to help clients manage their pain. Members of the multidisciplinary team identified feeling more comfortable and gaining skills in working with chronic pain and medication use through the strong support from Elders.

care providers. It can also ensure that prescribing physicians are aware if the client is using traditional medicines, so as to reduce possible drug interactions. A team approach also facilitates the inclusion of Elders and other cultural supports.

### >> CURRENT STATUS

There is much sensitivity around the use of prescription medications in First Nations communities. Some is rooted in the history of colonization, dominance of medical thinking, language and treatment, and a poor understanding by the medical system of the complex issues faced by First Nations people, families, and communities; and the cultural processes needed to support and empower them. This reinforces the belief that pharmacotherapy services are not always culturally safe. There is also growing awareness of the preventative and curative treatment value of Indigenous and complementary medicines, (e.g., to ease stress, anxiety and depression, to help build coping skills, and build resilience). It is also recognized that not all approaches have to involve medication.

Pharmacotherapy, however, can be a useful addition to other forms of treatment, and certain prescription drugs can help people to resist urges during their first year of abstinence. Opiate replacement therapy, such as methadone and the buprenorphine/naloxone combination (Suboxone®), has been shown to be very helpful to clients, their families and their communities when there are clear management plans in place. A client's overall health can improve while on these medications because with symptoms or cravings controlled, clients may be more likely to access health services and live healthier lifestyles. Their risk for contracting diseases like Hepatitis C and HIV is lower and they are more likely to have better relationships with family and friends.

Both opiate replacement therapy, such as methadone and Suboxone®, and naltrexone (Revia®, lowers a person's craving for alcohol), can be very useful in helping clients to complete an addiction treatment program. Completing a treatment program is one of the most important factors for long-term sobriety. Medications such as those listed above help clients dealing with withdrawal symptoms, support them to enter treatment at an early stage, and may increase the chance that they will complete treatment. For these reasons, it is recognized that medication is important for managing the physical aspect of addictions. Other aspects of treatment can address the emotional, spiritual and mental health needs to ensure a holistic approach.

Supports are limited for clients who are using medications and who also wish to access NNADAP treatment services.

- Treatment staff lacks specific training in how to deal with clients using medications as part of their addiction recovery.
- Treatment staff needs more support from physicians who have knowledge regarding addiction medications.

## >> RENEWAL OPPORTUNITIES

- Information on pharmacotherapy for service providers to provide more clarity about the scope of practice, screening, protocols, and when/how to seek assistance from a health professional and specialized cultural practitioner. Training and knowledge translation activities at all levels will help to build awareness of pharmacological and traditional medicine approaches to treatment, as needed.
- Training for addictions workers, nurses, doctors, and CHRs in mental health disorders would increase knowledge of the most up-to-date treatments (both behavioural and pharmacological). This will then allow NNADAP workers to inform physicians of a mental health or addiction issue that might require a pharmacological approach.
- Training for doctors and others able to prescribe medication on the factors that influence substance use and mental health issues among First Nations people, including potential cultural differences in understanding and treating these issues, as well as specific considerations for providing pharmacological support. This may involve coordination with professional and/or licensing organizations, in addition to other partners in prevention, provincial, and local health authorities.
- Recognition of the role and usefulness of team-based approaches including Elders and cultural supports as part of a multidisciplinary team. This would allow knowledge exchanges between medical professionals and other service providers to ensure coordinated care plans, and also promote information sharing, dialogue, and teamwork to address the stigma and fears linked to the use of medication.
- Involving clients themselves to be a part of the team and promote sharing and dialogue among physicians, communities, families, and clients with the goal of creating a safe setting for addressing challenges.
- Treatment centres' access to physicians, pharmacists and mental health professionals who are familiar with addictions so they can provide input into the development of policies and programming, as well offer support in the treatment of individual clients.

### Oromocto First Nation Methadone Maintenance Treatment Program—Oromocto, New Brunswick

Oromocto First Nation could not even begin to heal until the epidemic drug abuse in the community had been addressed. Every household and program on the reserve was affected, as over 85 percent of the community was addicted to drugs, and most were injecting. The Oromocto First Nation was a community in crisis due to opiate addiction; however, the community recognized the situation and desperately wanted a methadone maintenance treatment (MMT) program on reserve. This pharmacological approach to the treatment of addictions was the first MMT program on any First Nation in Atlantic Canada. In addition, traditional culture, such as drum making, was integrated with Western medicine into this strategy. As well, individual counselling and primary health care were provided to the community.

*National standards for treatment centres and community-based health services that reflect First Nations culture are essential to promoting quality services, and ensuring the safety of both clients and addiction workers.*

*This approach helps to meet and maintain standards of care, which encourage continuous quality improvement of addictions services.*

# Accreditation

## >> DESCRIPTION

Accreditation is a quality improvement process focusing on client safety and quality of work life, whereby addiction treatment centres are assessed against national standards of excellence. These standards measure clinical, operational, and governance-based performance. They provide a clear picture of strengths, areas for improvement, and levels of risk within an organization. The accreditation process is based on how well an organization complies with national standards and it measures the quality of services that clients receive.

In general, most accreditation processes consist of a three-year cycle that begins with an organizational self-assessment against standards of excellence. The next step usually involves a peer review that is done by external reviewers. They interview staff at all levels of the organization/health service, including governance, management, staff and organizational partners, as well as clients and their family members.

Key components of a strong accreditation approach are:

- Assessing organizational readiness;
- Choosing an accreditation body/organization;
- Conducting self-assessment and evidence gathering;
- Peer review;
- Report and recommendations; and
- Follow-up and continuous improvement.

## >> KEY COMPONENTS

### Assessing Organizational Readiness

The first step in an accreditation process is to gather information to find out how ready the organization is for accreditation. This generally involves the organization's board of directors and staff having a discussion about the potential risks and benefits of accreditation. For accreditation to be successful, organizational consensus must exist at the very start of the process. Readiness also explores the organization's capacity related to policy, planning and measurement of specified indicators throughout the organization, defined processes for service delivery, and linkages with partners.

### Choosing an Accreditation Body/ Organization

It is important to research all the options available for accreditation since many bodies may provide accreditation in a given field. Organizations need to seek out an accreditation body that will be responsive to their needs, as well as Health Canada accreditation policies. Some important factors are costs, level of detail in the standards, reporting time lines and the process requirements.

### Conducting Self-assessment and Evidence Gathering

Once an organization selects an accreditation body, it will need to take some time to understand the standards structure and how processes will be measured within this structure. During this phase of the process, time is needed to gather policies, practices, and evidence that support organizational ratings based on a set of standards.

### Peer Review

A peer review is generally set up after the organizational self-assessment has been sent to the accreditation body. One to three reviewers will visit the organization to gather more evidence. During this part of the process, they may conduct interviews with staff, board, clients, and former clients.

### Report and Recommendations

Quality in addictions programming is assessed by examining structure, process, and outcomes. *Structure* involves having the resources and infrastructure that are needed to conduct tasks, such as having the human, financial and program resources to provide care, as well as the facilities, governance, standards, and policies in place. *Process* involves the delivery of health services, namely how it is done, inputs-tasks-outputs and the care itself. *Outcomes* involve the results, such as client satisfaction, staff satisfaction, effective care, efficient use of resources and measurement of the extent to which services impact client health.

Using information from the organization's self-assessment, combined with information gathered and verified during the peer review, the accreditation body provides a report on its findings. This report usually comes in the form of recommendations for continuous quality improvement. Depending on the accreditation body that is used, the time between peer review and the report can vary from a few days to many months.

### Follow-up and Continuous Improvement

In this phase, an organization works to implement the recommendations and makes changes to policies, practices or environmental supports based on the recommendations of the report. The process may include a re-visit from the accreditation body or the submission of follow-up evidence of how the organization has worked to address certain recommendations.

## >> CURRENT STATUS

Accreditation is being provided for treatment centres within NNADAP/NYSAP and community based health services inclusive of NNADAP by one of three main accreditation bodies:

- Accreditation Canada (AC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Canadian Accreditation Council (CAC))

Health Canada has an accreditation framework document that outlines some key features of accreditation. This outline informs programs for which accreditation is mostly voluntary, and provides details on incentive supports for programs that begin the accreditation process and meet the criteria.

The accreditation process is initiated by a First Nations treatment centre or community-based substance use-related service within a broader community health service and is managed by a non-government accrediting body. Centres may receive funding from Health Canada to engage in the accreditation process with an eligible accreditation body.

Among First Nations addictions programming, awareness of accreditation and its benefits has grown as more organizations feel proud of their success and have met standards of excellence. What started as a grassroots movement has gained force and is now seen as the model for many NNADAP/NYSAP treatment centres. The success of accreditation to date is largely due to the desire of First Nations services to provide a high level of quality health services to their clients.

Some of the challenges linked to accreditation relate to the higher costs and workload for centres and their staff during the accreditation process. Some centres question whether accreditation programs which are mostly focussed on health care services are relevant. For example, a focus on client safety within the context of a community health and residential addiction treatment centre is very different from in acute health care settings. If accreditation is going to be seen as useful, the standards must be relevant for community services. In addition, there are concerns about the fact that program funding for accreditation does not cover the entire cost of compliance with accreditation recommendations.

Although accreditation addresses all structures, it does not replace evaluation of specific programs. For example, accreditation does not prescribe the best approach to offering any health care service or to addiction treatment (namely the evaluation of a specific theory or of a cultural approach to health service delivery). It does, however, ask how the organization uses its knowledge of best practices to guide its service delivery and how the organization monitors and measures effectiveness.

## >> RENEWAL OPPORTUNITIES

- Support for treatment centres to bear the costs of compliance with accreditation standards. This support must be fair, scalable, adaptable, and sustainable. It must include both the implementation of accreditation and compliance with recommendations stemming from this process.

- Accreditation standards that have meaning to First Nations culture can provide a holistic framework within the accreditation process, and cultural relevance needs to be integrated into assessments.
- Having standards that can accommodate First Nations holistic health and healing practice requires ongoing improvements to the accreditation processes and standards. This will help to ensure that these standards are more tuned into the operations and realities of First Nations addictions facilities and programs.
- Ongoing evolution of the accreditation process will ensure that the process meets the best standards possible in an ever-changing sector. The standards must be a benchmark of excellence.
- Support for knowledge exchange among centres specific to accreditation will help to ensure that practice-driven success can be shared broadly. This may include a national program resource centre or a centre of excellence that promotes accreditation champions. The goal would be to further support accreditation within First Nations communities and organizations.

## Accreditation at Wanaki Centre, Quebec

The Wanaki Centre is an 11-bed adult inpatient treatment centre located in Maniwaki, Quebec. This Centre offers a culturally based residential treatment experience to First Nations speaking either English or French. Wanaki Centre has been accredited since 1999, and the accreditation experience has been a very positive one. Accreditation has helped to ensure staff continuously focuses on and assesses the quality of care being provided to their clients. The most significant change attributable to accreditation has been in the management and observation of client medications. This has included a pre-treatment contact component to services, during which an inventory of medications is made and the client is asked if they know what the medication is and why they are taking it. The medication inventory is updated when the client arrives at the centre, and all client medication becomes the responsibility of one member of the clinical team. Wanaki Centre has obtained the services of a pharmacist at no cost who meets with clients upon their arrival for treatment, reviews their medication and answers any questions. Reconciliation of client medication inventories is done continuously. Clients are also observed taking their medication and any reactions are noted and monitored. As well, an incident report process has been introduced to track errors in medication administration, resulting in improved quality in client medications. These reports are reviewed every morning by the clinical team members.

# MOVING FORWARD

# Moving Forward

*Honouring Our Strengths* outlines a vision for a comprehensive continuum of services and supports to guide community, regional, and national responses to substance use issues among First Nations people in Canada. This vision recognizes that a strengthened system of care is the shared responsibility of various jurisdictions (community, province, federal), as well as a wide range of care providers including family and community members, community service providers, primary care and other medical staff, and off-reserve service providers. Within this vision, the emphasis is on ensuring that people, families, and communities have access to a range of effective, culturally-relevant care options at any point in their healing journey. Culture, family, and community are seen as the foundation of this approach; along with the important role that First Nations-specific social determinants of health play in revitalizing communities and reducing the extent of substance use issues. This approach also recognizes the connection between mental health and addiction issues, and that an integrated approach to programming at a system level is required to best meet the needs of clients and communities.

Renewal presents a significant opportunity for partners at all levels to initiate discussion on the vision for change, as well as how to support and facilitate this change. These discussions must acknowledge the important roles not only of community, provincial, federal, and territorial governments but also of regional and national organizations. They must also acknowledge the important role individuals, families and communities have in supporting each other and implementing a strengthened, systems-based approach to care. Realization of this vision will require ongoing commitment, collaboration, and sustained partnerships. Commitment and collaboration will, in turn, depend upon effective leadership throughout the system.

The NNADAP Renewal Leadership Team was formed in 2010 to exercise leadership in guiding the implementation of *Honouring Our Strengths*. In support of this goal, the Leadership Team will work with various networks and jurisdictions to facilitate open dialogue on renewal; advocate for additional resources; establish linkages and help to inform related efforts; and oversee a range of implementation activities to support a system-wide, strengthened approach to service delivery and planning. Membership of the team includes broad, cross-Canada representation from areas such as prevention, treatment, culture, youth, policy, health, nursing, public health, and research. Similar to the First Nations Addictions Advisory Panel, the Leadership Team is supported by national renewal partners—AFN, NNAPF, and Health Canada. As guided by the Leadership Team, the national partners in renewal have a responsibility to work creatively within available mechanisms to: raise awareness and gather information on areas of need within the system; work strategically with a wide range of partners to enhance this system; advocate for the resources required to make the vision of the framework a reality; and track and communicate progress on implementation to partners.

While it is recognized that full implementation of all aspects of the system that the framework describes will depend on increased resources, there are existing opportunities to positively influence change; optimize the use of existing resources; and leverage partnerships to better meet the needs of First Nations. For instance, with direction from the regional needs assessments and support from the National Anti-Drug Strategy investment, many communities and regions have already begun strengthening their services and supports in response to community needs.

The strength of the renewal process to date has been its connection to a wide range of regional and national First Nation health and wellness networks. These networks have provided guidance to the renewal process, shaped the vision for the framework, and supported engagement with First Nations communities. Key networks include, but are not limited to: the AFN First Nations Health Technicians Network; the NNAPF Board of Directors and their regional networks; Regional Addiction Partnership Committees, including advisory groups, co-management committees, and tripartite organizations; the Youth Solvent Addiction Committee; and Health Canada First Nations and Inuit Health regional offices and regional addiction/wellness consultants. These networks will continue to be essential in their ongoing support and leadership of the process. This may include using the framework as a tool at both regional and national levels to initiate conversations with major healthcare providers, other service providers, and jurisdictional partners to

enhance collaboration and build partnerships in order to ensure the needs of First Nations people are being met.

While the Leadership Teams, regional networks, and national networks all play an important role in facilitating implementation, it is important to note that solutions for renewal must come from First Nations people, who own the vision of the framework. They must guide its implementation. Many First Nations people, service providers, Elders, youth, and cultural practitioners have already demonstrated that change is possible through their selfless acts and continued efforts to promote wellness within communities and among their people. Renewal provides an opportunity to build upon these efforts and begin changing systems. Such change often begins with a small group of people who create collective ownership for change and which then transforms into communities of solutions.

In accordance with the belief that change is everyone's responsibility, implementation of the framework must empower individuals, communities, and organizations to see their role and capacity in influencing this renewed approach to care. This will involve the development of tools or guides to support uptake of the renewal vision, including its use as a best-practice framework to guide the design, delivery, and coordination of addictions and mental health services at community and regional levels. It will also involve establishing ongoing feedback and engagement mechanisms facilitated through networks, the Leadership Team, and the renewal national partners—AFN, NNAPF and Health Canada.

While *Honouring Our Strengths* provides a comprehensive vision for the renewal of First Nations substance use-related services, it is recognized that the framework must be viewed as a living document, which can be adapted or revised based on the evolving Indigenous and mainstream evidence-base, as well as the changing needs and realities of First Nations people. Over time, this will require integrating programs for tobacco abuse, problem gambling, and other addictive behaviours. It will also involve efforts to expand and evolve a fully integrated mental wellness [24] continuum of services and supports, which will require additional resources and significant engagement with First Nations communities and leadership.

The opportunities that exist to strengthen the system of care are great. Many First Nations cultural teachings indicate that the Creator gave everyone tomorrow to make a difference, and with this promise of tomorrow comes responsibility. It follows then that everyone involved in the vision of this framework has a decision to make. How everyone chooses to manage the responsibility for "tomorrow" is dependent upon our answer to the question: "what difference will we collectively make?" Our shared vision for the future cannot be created with or bound by limitations, such as the lack of funding or barriers that may be encountered in facilitating change. The collective vision of the change we seek must be fuelled by courage to include all possibilities beyond our imagination. Courage is a vital characteristic of leadership, and is necessary to ensure we are ready when the timing is right: to be strategic in taking risks, to create new pathways, and to continuously seek answers to the unknown. In fact, it is in that which is yet unknown where we will find the answers that are there waiting for us. The vast numbers of youth which make up the First Nations population rely upon those in front of them on this path to the future to ensure the footprints we leave every day will lead them to their freedom from the harms of drugs, alcohol and the ongoing legacy of colonization. Every moment and every effort counts. We must "honour our strengths" with the belief that change is possible through our collective efforts.

# Endnotes


1 First Nations Information Governance Centre (FNIGC). (2011). *Preliminary Report of the Regional Health Survey: Phase 2 Results—Adult, Youth, Child*. Ottawa, ON: FNIGC. Please note that at the time this report was produced preliminary findings from the Regional Health Survey (RHS) were available. These findings were used wherever possible. Where the data was incomplete, data from the 2002/3 regional health survey was used. For the most current RHS data, please consult the First Nations Information Governance Centre at: http://www.fnigc.ca/.

2 The number of NNADAP and NYSAP centres and community programs are as of February 2011. Please note that these numbers are subject to change. Contact Health Canada for the most current numbers.

3 Statistics Canada. (2008). *Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census*. Catalogue no. 97-588-XIE.

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19 Health Canada. (2007). *Non-Insured Health Benefits Annual Report: 2005–2006*. Ottawa: Author.

20 First Nations Information Governance Centre (FNIGC). (2011). *Preliminary Report of the Regional Health Survey: Phase 2 Results—Adult, Youth, Child*. Ottawa, ON: FNIGC.

21 Statistics Canada. (2010). Health Indicators Maps. Catalogue no. 82-583-XIE, Vol. 2010, No.1.

22 First Nations Information Governance Centre (FNIGC). (2011). *Preliminary Report of the Regional Health Survey: Phase 2 Results—Adult, Youth, Child*. Ottawa, ON: FNIGC.

23 Environics Research Group. (2004). *Baseline study among First Nations on-reserve and Inuit in the north*. Ottawa: First Nations and Inuit Health Branch, Health Canada.

24 According to the Mental Wellness Advisory Committee Strategic Action Plan, Mental wellness is defined as "a lifelong journey to achieve wellness and balance of body, mind and spirit. Mental wellness includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness. Mental wellness must be defined in terms of the values and beliefs of Inuit and First Nations people"; Mental Wellness Advisory Committee. (2007). *First Nations and Inuit Mental Wellness Strategic Action Plan*. Ottawa; Mental Wellness Advisory Committee.

# Appendix A:

## First Nations Addictions Advisory Panel

The First Nations Addictions Advisory Panel (FNAAP) was a time-limited body of community, regional and national mental health and addiction representatives tasked with developing *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada*. The Panel included members of the AFN's Public Health Advisory Committee, and was supplemented by addictions researchers, health professionals, Elders and First Nations community representatives. In addition to developing the Framework, the Panel also provided support to regions to complete their regional needs assessments.

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