National Treatment Gathering

Final Report

February 2024

THUNDERBIRD
PARTNERSHIP FOUNDATION

The Thunderbird Partnership Foundation would like to thank treatment centre workers and wellness workers from across the country who attended the National Treatment Gathering and contributed their vast experience and wisdom to the discussions. Sincere appreciation for wise guidance is also extended to Elder Leona Stevens, Elder Wes Whetung, and Dr. Bill Mussel.

We would also like to express sincere appreciation to First Peoples Wellness Circle and First Nations Health Managers Association for their valuable participation and leadership during the Gathering.

thunderbirdpf.org

1-866-763-4714

info@thunderbirdpf.org

The Thunderbird Partnership Foundation is a leading culturally centred voice across Canada on First Nations mental wellness, substance use and addictions. The organization supports an integrated and wholistic approach to healing and wellness serving First Nations and various levels of government, through research, training and education, policy and partnerships, and communications. Thunderbird strives to support culture-based outcomes of Hope, Belonging, Meaning and Purpose for First Nations individuals, families and communities. Thunderbird's mandate is to implement the Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (HOS) and the First Nations Mental Wellness Continuum (FNMWC) framework.

The Thunderbird Partnership Foundation is a division of the National Native Addictions Partnership Foundation Inc.

Executive Summary

Thunderbird Partnership Foundation (Thunderbird) held a National Treatment Gathering on February 6th, 7th, and 8th 2024, in Toronto, Ontario.

Over 100 participants from coast to coast attended the Gathering. Attendees included First Nations substance use treatment centre staff from the National Native Alcohol & Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) community mental wellness workers, Thunderbird Partnership Foundation Board Members along with partners such as First Peoples Wellness Circle (FPWC), First Nations Health Managers Association (FNHMA), and First Nations and Inuit Health Branch (FNIHB; Indigenous Services Canada (ISC)). Representatives from the Indigenous Certification Board of Canada (ICBOC), the Canadian Centre on Substance Use and Addiction (CCSA), Canadian Accreditation Council (CAC), and Accreditation Canada (AC) also took part in the event, which was supported by 21 Thunderbird staff.

Methodology:

The gathering was not a conference with speakers and workshops. Rather it was designed to engage experts in delivering addictions services across Canada, both in First Nations communities and in live-in treatment programs. Five topics were identified for discussion through world café processes, facilitated group break-out discussions, and table discussions in plenary. Some of these processes included an introductory presentation, Mentimeter survey, and report back. Discussion from the group was gathered through flip chart recording, and a note taker. Individual reflections were captured through sticky notes and a worksheet that was provided with instructions to participants for the world café session. The note taking template facilitated structure for developing this report.

Discussion Agenda:

The following topics were identified from emerging needs expressed by the workforce and by partners:

- Core Competencies for a Mental Wellness Workforce
- A National Standardized Treatment Curriculum
- Data, Quality, Indicators, Reporting, and Policy
- Culture in Virtual Care Environments
- Accreditation

This report provides a detailed overview of the presentations and discussions on these topics.

BACKGROUND

Core Competencies for a Mental Wellness Workforce

In 2022, Thunderbird Partnership Foundation and First Peoples Wellness Circle co-chaired a Northern Round Table with First Nations, Inuit, and Métis populations from northern parts of Canada. As part of the discussions, participants were asked to identify their priorities and one of the recommendations was to develop a National Mental Wellness Workforce Association. This recommendation emerged again from the first Indigenous Mental Wellness Summit held in 2022, and at that time it was supported by the federal Minister of Mental Health and Addictions, and the Minister for Indigenous Services, who were both in attendance.

The idea of a Workforce Association is closely linked to core competencies, which define the scope of work and the knowledge, skills, and behaviour required to do a particular job. These are meant to change over time in response to the environment. For example, there is a growing need to identify specific knowledge and skills needed to effectively support people who have challenges with opioids and methamphetamine.

OVERVIEW

The 39 core competencies presented for discussion to the participants in a world café are drawn from the key concepts of the First Nations Mental Wellness Continuum (FNMWC) framework and these 39 competencies are organized in the following themes:

- Substance Use/Mental Health
- Harm Reduction
- Trauma
- Culture
- Service Components
- Population Specific

The objective of the discussion groups was for participants to identify and shape core competencies based on their own work experience, their knowledge and skills, what they see in their communities and what people are asking questions about. The world café groups identified key knowledge, skills, and behaviors for the 39 core competencies.

Recommendations included having appropriate education and training in mental health and substance use, along with required knowledge about

- the importance of cultural knowledge and understanding of culture as foundation,
- Indigenous history and the effects of colonization and systemic racism,
- the Indigenous social determinants of health,
- intergenerational trauma and its effects,
- knowledge of toxic drug use and its effects,
- harm reduction,
- local communities,
- cultural healing interventions,
- early development and life stages,
- the range of available services and supports,
- ways to connect clients to required services and supports,
- specific treatment interventions,
- how to coordinate care, including continuing care, and
- the needs of different populations.

The recommendations also noted that skills required for the wellness workforce should include

- cultural training,
- Indigenous language training,
- the ability to connect clients to cultural healing interventions / practitioners and other needed services and supports,
- knowledge about conducting assessments,
- the ability to develop and implement treatment plans,
- listening skills,
- facilitation skills,
- the ability to provide various mental health and substance use counselling and therapeutic interventions,
- facilitating referrals and to coordinating care,
- the ability to work collaboratively,
- advocacy skills, and
- personal wellness skills.

In terms of behaviour, it was recommended that the wellness workforce needs to be humble, kind, understanding, non-judgemental, accepting, confident, supportive, and open to learning. They should also be knowledgeable about and involved with Indigenous culture and language. They need to be involved in community and to serve as positive role models for other staff and clients. The wellness workforce should be required to have reporting and documentation skills and be able support their own well-being and that of other staff.

Supervisors should have effective supervision and management skills. They should have a clear understanding of the vision, mission and strategic goals of the organization and local community. Supervisors should support culture enhancing practices and traditional knowledge. They must also ensure that appropriate policies and procedures are in place and updated regularly. Supervisors should be supportive of employees, communicate openly with them, promote staff wellness as a priority in the workplace, and have the capacity to supervise and support staff in the context of vicarious trauma. They must also provide ongoing staff education and training and show appreciation to and acknowledge the work of staff. Supervisors should also have the capacity to develop partnerships and to advocate for required funding.

A high-level more extensive synthesis of key themes relating to required knowledge, skills, behavior, and supervisor traits for all the six areas may be found on page 20 of this report.

National Standardized Treatment Curriculum

INTRODUCTION/OVERVIEW

The primary goal of this discussion was to identify the content of a standardized, trauma informed treatment program curriculum, based on participant work experience and what they think is most relevant.

Some of the topics that need to be discussed in relation to the development of a national curriculum are:

- What are programs doing currently?
- What type of wraparound services are needed?
- Who has specialized needs and how can those needs be met in a context of nationally based standards of care?
- What learning experiences, knowledge and skills can be shared, for instance, on the topic of substance misuse and mental health?
- How should this curriculum be delivered?
- How can it be integrated with and support the services you are already providing?

Key Findings

There was a large group discussion following the presentation and participants talked about the excellent work that treatment centres were currently doing to keep communities well, and it was agreed that a national curriculum should be developed based on their expertise. Several themes related to the development of a national curriculum emerged during the discussion, including the importance of

- flexible foundations – a national curriculum must include both national standards and be adaptable for diverse populations.
- focusing on treatment modalities other than just talk therapy, to support clients in processing their emotions, and incorporating these into national standards of care.
- defining wellness and focusing on facilitating wellness.
- engaging peers in the treatment journey.
- heart-centered approaches to care.

Other themes emerged about the need for

- worker training on trauma-informed care.
- teaching clients about trauma.
- counselors to do outreach activities to connect with clients, and to engage with, and support people who may be interested in treatment.
- pre-treatment programs.
- both personal and virtual support.
- continuing care/aftercare, ensuring that it is client based and client focused, and supporting what they need (i.e., clients being in control of their own after care) as well as identifying and addressing barriers to re-integration.

Participants broke into smaller groups and each group completed a document highlighting different elements of a national standardized curriculum. Following this, Mentimeter was used to generate word clouds with the most common themes appearing as the largest words most relevant to the topic.

Data, Quality, Indicators, Reporting and Policy

INTRODUCTION/OVERVIEW

Day two began with three presentations: one on quality and data quality; one providing an overview of the Addictions Management Information System (AMIS), which is used by many treatment centres; and one on changes to Indigenous Services Canada (ISC) reporting processes.

Carol Hopkins, Chief Executive Officer of Thunderbird Partnership Foundation, noted that Indigenous people have a natural way of thinking about the results that their work will achieve. This generates an ability to think about how to get to where they need to go, and what to do when adjustments are needed: it is both a way of doing and a way of being. Quality treatment may be defined differently based on the lens and the angle of the perceiver, whether that be a funder, a treatment centre, a client, families, or communities. This calls for a comprehensive quality framework, which allows for the collection of quality indicators in systematic ways. Indicators span across a variety of treatment areas, and they involve processes, perceptions and measurable outcomes using standardized tools, such as the DUSI (Drug Use Screening Inventory) and the NWA™ (Native Wellness Assessment).

AMIS is a national system, which includes competencies and client records, for NNADAP and YSAP treatment centres, and more recently community organizations. It supports referrals, information sharing and transfer processes, treatment planning and client follow-up. AMIS helps with screening and can assist clients to go to the centre that would suit them best.

AMIS system navigation is flexible, and AMIS has online support, various tools, tabs, and filters. It includes competency linkages to support organizational strategic planning and accreditation. AMIS is currently undergoing expansion at Thunderbird to include First Nation governed community organizations that offer mental wellness, substance use and land-based programming as part of their work.

Indigenous Services Canada (ISC) is in the process of making changes to outcome reporting processes. The data collected currently is primarily about outputs. It does not focus on outcomes, and there is a need for both quantitative and qualitative data in reporting. By September 2024, updates to data collection and reporting process will be proposed for 2025 – 2026, recognizing that this will be the beginning of a longer-term process.

In addition to being asked to discuss information provided above, attendees were also asked to think about the kinds of data they are currently collecting that could help them to tell a story about how their treatment centre runs and what kind(s) of data they could or should be collecting to help them build, change, or grow, and support policy change and advocacy.

Key Findings

Many key themes emerged across the discussion groups. Firstly, many treatment centres were using AMIS and and were generally positive in their views about it, though many also felt it did not fully capture everything they needed it to capture. Some of the benefits noted were that it generated reports easily (if all of the data has had been inputted) and was customizable.

Some of the challenges with AMIS involved the time commitment, the staff training required to use it, issues with the assessment tools (some staff did like the NWA and the DUSI for various reasons), an over-emphasis on quantitative data, and the lack of data for cultural components of care (e.g., number of Elders utilized, language instruction, ceremonies, and land-based treatments). In addition, AMIS did not fully capture all the actual services offered, such as community-based services and outreach services. It was also noted that AMIS reporting did not capture methamphetamine use, only opioids.

Funding and wage parity also emerged as significant issues. Many centres felt that the NNADAP funding levels were not where they needed to be and the inflationary increases since the 1970's were not adequate to cover increased population and needs. This has resulted in significant wage disparities compared to mainstream services.

Data that participants said they could or should be collecting to help them build, change, or grow, and support policy change and advocacy includes

- satisfaction levels of clients and staff,
- evaluation findings from board and program evaluations,
- quality assurance data using standards, governance, management, and resources,
- regular SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses (e.g., every three years).

Also important is critical incident reporting and risk mitigation data, enhanced Indigenous assignation standards, indicators for virtual programming, and development of policy committees for staff and boards. Additional data was around strength-based programming, about partnerships and potential partners, on wage parity for traditional healers and traditional wellness, along with the provision of outreach, prevention and stabilization services provided to advocate for additional funding.

Information about staff was also noted as important to collect, including age, gender education, First Nations status, length of employment, training, core competencies, personality traits, certification rates, staff self-care, turnover rates, and data from exit interviews. Information about how to build culturally based services with a strong team was also noted as important, along with details about the complexity of clients who need higher levels of care, the use of natural healing approaches, and information about funding (e.g., information required for applications to granting bodies and funders).

Culture in Virtual Care Environments

INTRODUCTION/OVERVIEW

The presentation focused on culture in virtual care environments. The onset of the pandemic required a shift to virtual services, which calls for the identification of best and wise practices. These should be developed in the context of the Indigenous Wellness Framework and support the four key outcomes: Hope, Belonging, Meaning and Purpose. There must be ethical guidelines for virtual service delivery, parameters for engaging Indigenous Knowledge (including engagement with Elders and Knowledge Keepers), a focus on culture as treatment, strategies for the use of equipment and platforms, identified staff competencies, an expanded community of practice, and continued advocacy (including advocacy for adequate funding). A prototype for a cultural resource hub is already being developed as a sharing platform for service providers.

Key Findings

Benefits of virtual care include opportunities to reach out to and connect with diverse groups (e.g. youth, other Nations, urban centres, incarcerated people, isolated communities, people in shelters).

Virtual care reduces barriers to accessing care and provides the ability to build trust for those who may come into treatment. It can also open the door to culture and could be the start of a spiritual journey for clients. In addition, it provides opportunities to connect with other Nations and treatment centres to share teachings and best practices, and to find commonalities.

Virtual care may not be appropriate for everyone; some people do better with in-person care. Another drawback is the lack of access to medicines with virtual care, although kits could be sent to homes. There is also no connection to the land, which makes it hard to feel energies.

Ensuring the safety of clients is paramount. For example, when the Truth and Reconciliation Commission was conducting hearings, there were Indigenous Knowledge Keepers present so that people would have someone to talk to if trauma came up. Something like this is needed for virtual care.

Client confidentiality must be protected, therefore ensuring network/platform security and data security is critical. Cultural teachings need to be protected to ensure that they are not appropriated or misused. Protocols should be developed for working with Elders and Knowledge Keepers in this context. Elders and Knowledge Keepers must give their consent to share teachings and be given credit for their teachings. They may also require support to feel comfortable in virtual care environments, and they should be recognized with honoraria and/or gifts for sharing their medicines and teachings.

Barriers to the use of technology must be addressed, (e.g., lack of internet access, lack of access to computers/smartphones) especially in remote and rural locations.

It could be helpful to develop national standards/guidelines, so all providers are *on the same page*. Those centres already doing virtual care could share their lessons learned with other centres. At the same time, different Nations have different cultural teachings and protocols, so this should be recognized, and people must be met with respect wherever they are and whatever their cultural and religious backgrounds may be. Some suggestions for avoiding a Pan-Indigenous approach include:

- Work with humility.
- Learn from places that have been doing virtual care and develop standards and guidelines, including standards of cultural competencies.
- Learn about cultural differences, and accept other Nations' ways of being, doing, thinking, etc.
- Acknowledge where stories, teachings, and other offerings come from – look for similarities and share differences.
- Encourage participants to share what they know and/or assist them to find out how and who to connect with in their area.
- Provide introductions and acknowledge self, community, and Nation – give people the opportunity to share their uniqueness.
- Interpret the language to ensure understanding.
- Establish a cultural database, specific to each community that includes cultural protocols, and an updated resource list to find more teaching locally.
- Set up an Elder Advisory Table.

Accreditation

INTRODUCTION/OVERVIEW

Across the country, there are more accredited Indigenous treatment services than mainstream publicly funded addiction programs. That is a testament to the strength, resilience, determination, and commitment to the quality of Indigenous treatment programs. On the other hand, accreditation is costly, and it is often tied to contribution agreements. However, accreditation and demonstrating excellent service quality has not yielded more funding to pay adequate wages, take care of buildings, or to buy needed equipment. And yet, many centres have maintained their commitment to accreditation.

Accreditation Canada and the Canadian Accreditation Council both provided presentations to the Gathering and indicated that they are interested in working as allies. Accreditation Canada and the Health Standards Organization (HSO), which focuses on developing standards, assessment programs and other tools for health and social services care providers, both share the goal of strengthening the health of Indigenous communities and, to that end, a Qmentum Global Project focused on Indigenous Health and Wellness has been established.

Accreditation Canada supports an Indigenous-led process. However, as that is not yet in place, they are reviewing how to improve current standards. Culture as foundation has emerged as a critical priority in moving away from a colonial process towards something that is relevant and responsive to the needs of Indigenous communities. The outcome will be a new assessment manual, program description, updated instruments, and surveyor resources released this year, based on which organizations will be assessed starting in 2025.

The Canadian Accreditation Council (CAC) has First Nations representation on the Board of Directors and on its committees. It has an Indigenous Advisory Committee, Elders and Knowledge Keepers to guide processes, and the Director of Accreditation Services is First Nations. The CAC is also looking to bring on an Indigenous Advisor/Cultural Lead. Regarding reviewers, 30% are First Nations or Métis. The CAC values relationships and really wants Indigenous organizations to succeed, so they provide a great deal of support to ensure that by the time reviewers arrive, it is just about "ticking the boxes." The CAC Manager of Support Services offer unlimited phone calls, texts, emails, and virtual meetings, as well as in person visits, monthly check-ins, and post-accreditation support. The accreditation process is designed to be a good experience and to help people showcase their work. Further to that, the CAC is open to feedback and to change if something is not working.

Key Findings

There was a large group discussion about accreditation, from which the following key themes emerged.

Culture must be seen as foundational in accreditation processes. Accreditation standards should be reformulated around culture and include language. Indigenous representation is vital, so Indigenous voices must be included. Elders and Knowledge Keepers must also be part of the process; they are the cultural leaders. There must be a recognition of the centrality of oral teachings as well, and culturally based practices such as the use of traditional medicines and land-based programming must be recognized and included in assessment processes.

To support culture as foundation, there must also be improvements to how and what data is collected (e.g., centres need better ways to log non-western methods). Currently, there are no standards for recognising and using traditional medicines, and this should be addressed. Standards should also reflect small First Nations community-based services.

Lack of adequate resources and support for accreditation emerged as a dominant theme in the discussions. Centres need to have sufficient resources to support the accreditation process, which involves a significant amount of work. Current staffing levels are insufficient to implement the annual updates and changes, and to develop new policies and train staff on them. Adequate funding and resources are needed to develop required staff skill sets, or for designated persons to support accreditation. More support and training are needed for staff – training, manuals, and information sessions for prep. Accreditation bodies should provide presentations and information sessions on the expectations, rather than just expecting staff to know what they want. In addition, it can be a barrier when standards criteria require that staff have certification or titles they do not have.

Ideally, accreditation will be Indigenous led and overseen by an Indigenous organization. At the least, Indigenous advisors must be involved to provide guidance. Reviewers should be Indigenous, or if they are not, they must, at a minimum, have lived experience with Indigenous people and with treatment centres and understand Indigenous cultures, traditional teachings, and ways of knowing.

Accreditation must be approached with an attitude of respect for diversity – every First Nation is unique, and it is important to consider unique community cultures, and how to measure their successes in the context of diversity.

Accreditation needs to be approached in a warm and respectful manner, using accessible language. Using plain language to communicate with staff creates transparency. In person visits should be part of the process – it should not be virtual only. Basic procedures should be established for visits, including welcomes and introductions. Providing ongoing support and encouraging people to ask questions should be part of the process as it will help to relieve staff anxiety.

Processes should involve a constructive and productive approach. Reviewers should consult with treatment centres before they visit: there should be a conversation in advance about protocols, and any changes to standards and practices should be communicated to centres prior to the initiation of the process. This will help staff to prepare for the assessment. Currently, lines of communication only provide the date – centres would like time to prepare and to understand exactly what is required from them, in advance. In addition, accreditation should be more than a checklist – reviewers should be open to listening to explanations related to requirements.

The accreditation process should be strengths-based, including all feedback provided. Reviewers often just point out what is wrong. They need to be more positive and focus on what is working well and use strengths-based language. Often the process makes people feel like they are being tested and graded. It would be preferable to use more of a teambuilding approach such as collaborative communication and working together to achieve success.

Day 1

Welcome and Opening Remarks

Carol Hopkins, CEO of Thunderbird Partnership Foundation, greeted and welcomed everyone in attendance at the Gathering, and thanked them for the important work they are doing. The goal of the Gathering was to have conversations to understand the greatness, learning and expertise of those present, to move forward as a national network of treatment and healing, both in treatment centres and in community. She noted that Elders Wes Whetung and Leona Stevens would be leading the opening and acknowledged the presence of Elder Oscar Kistabish who sits on the Thunderbird Board of Directors.

Following the opening ceremony, Carol thanked Elders Wes and Leona, and noted that "...for every generation of people that has walked this earth, the Great Spirit has always been there for us, looking after us, and helping us find the answers to how to live life, and what to do about life. Everyone at the Gathering works daily with First Nations across this country, trying to help them find their identity and find their connection to creation and to the Great Spirit, and to help them to live a good life." She thanked everyone for that.

Gratitude was also expressed to Vincent (Vee) Whitehorse from Leading Thunderbird Lodge in Saskatchewan for helping with the Gathering, and JayR (Delbert) Jonathan from Native Horizons Treatment Centre in Hagersville, Ontario, located on the Mississaugas of the Credit First Nation, who are the original people of this land. She also acknowledged all the ancestors that have put their tracks on the earth leading to this place.

Next to be introduced was Jennifer Novak, the new Director-General of the First Nations Inuit Health Branch of Indigenous Services Canada (which has now put into place a Director-General role specific to mental wellness).

Jennifer Novak thanked the Elders for setting the tone for the Gathering, thanked Carol for bringing everyone together, and acknowledged the ancestral land upon which the meeting is being held. She noted that the last few years have been challenging with the pandemic and the various crises people are struggling with across the country, including harm and deaths due to substance use/misuse. She acknowledged the hard work that everyone in the room is doing to mitigate that harm. She also talked about the great innovative work that people are doing including virtual work, and the resilience and flexibility that everyone has shown in service of their people.

Introduced next was Pamela Charlong, the Executive Director of Walgwan, a youth treatment centre in Québec, and the new Vice President of the National Native Addictions Partnership Foundation (NNAPF), the incorporated body that facilitates Thunderbird's financial and legal matters, with Thunderbird Partnership Foundation being the public facing name.

Pamela Charlong opened in her traditional language and gave thanks to the Creator for allowing her to be present at the Gathering. She also acknowledged her grandparents and thanked her colleagues for sharing the car ride with her. On behalf of the Board of Directors, Pamela thanked everyone for attending the Gathering. She noted that "... everyone in attendance represents a rich tapestry of the cultures, traditions and experiences that make up our First Nations. The Gathering reflects our unity, our shared commitment to healing, our unwavering dedication to improving our communities' health outcomes. Our ancestors have passed down a profound legacy to each one of us, one that teaches us the importance of unity, resilience, and the connection between the land, our people, and the spirit. We gather here to honor that wisdom, and to take a step forward in building a brighter and better future for the future generations."

The purpose of the Gathering was to highlight strengths, resilience, and all our initiatives around wellness and mental health within our communities and organizations, while also recognizing the need for culturally sensitive and community-based solutions to empower peoples' healing journeys. The Gathering would provide everyone with many opportunities for sharing as well as valuable tools and knowledge to take home. Pamela closed by thanking everyone who helped to organize the Gathering and asked everyone to spend the next few days with an

open mind and an open heart, and to follow the guiding principles of compassion and solidarity. She also expressed the hope that the Gathering would renew our sense of Hope, Belonging, Meaning, and Purpose as a network.

Following Pamela's comments, gratitude was expressed to NNAPF Board Members: Angela Miljour, Executive Director at the Wanaki Center, Jeannie-Marie Jewel who traveled from the Northwest Territories to be at the Gathering, and Duanna Johnston-Virgo with the First Nations Health Authority in British Columbia. Also thanked for her attendance was Tanya Churchill, an ex-officio member of the NNAPF Board of Directors from Indigenous Services Canada. Also attending was Keith Leclaire, a special advisor with the Board of Directors, who worked as a Health Director prior to his retirement, along with Thunderbird's National Elder Oscar Kistabish, and Wanda Smith, from Native Horizons Treatment Centre representing the Ontario Region. Then introduced was Dr. Bill Mussell, who represented First Peoples Wellness Circle on the NNAPF Board of Directors and who was the outgoing Vice President. Also acknowledged was Dawna Prosper from the Atlantic Region, who brought all staff from NADACA in Nova Scotia, braving the heavy snow fall and travel delays.

Carol closed her remarks by thanking all the Thunderbird staff and acknowledging their hard work in putting the event together and said that Wednesday afternoon would be dedicated to recognizing the good work that is being done by attendees, followed by a Round Dance. The Round Dance would be accompanied by teachings and was intended as a collective way to honor the Spirit of people who have passed on, including all our relatives across the land who have lost their lives to the poisonous drug crisis. The Round Dance would be followed by a giveaway to honour the Spirit that gives healing.

Elder Opening

The Gathering was opened by a smudge from Elder Wes Whetung, with Elder Leona Stevens providing opening reflections. Elder Stevens noted that the main purpose of the Gathering was to share ideas and hold discussions with the objective of bringing the knowledge back to communities, children and families. She emphasized the importance of identity: knowing who we are, where we come from, and the history and knowledge of generations past which must be passed on to those to come. She also emphasized the importance of determination, which could be seen in the arrival of those who travelled to the Gathering through difficult weather, not letting anything stop them from attending. Related to that theme, she shared a story of a mother and young son who patiently waited outside, during winter, to offer their tobacco and prayer; the son reflected that it was hard being Anishinaabe but did not budge or complain about the cold. She also spoke of Josephine Mandamin, who took up walking around the great lakes to raise awareness of the sacredness of water for everyone and for future generations; to nourish bodies and spirits. This work sparked the same determination in other women throughout the world.

Elder Stevens invited everyone to give thanks to the Creator and Spirit for guiding them through the next couple of days and to also give thanks to the to Shkawbeywis, helpers, who brought the smudge so that participants may carry that with them through the day and wash away thoughts they do not need. She mentioned the upcoming Round Dance, noting that people will be dancing for their relatives and for life itself.

She encouraged everyone to move forward and share the collective knowledge in a good way, and talked about the importance of reclaiming culture, language, and land crucial to First Nations communities: young people want to know who they are and where they come from, and providing services based in Indigenous way of knowing and doing is what makes the impact. She reminded participants that they are the steppingstones to the future generations, and it is their turn to make those steps, with the supports of teachers. Elder Stevens also talked about the importance of working from kindness and love, especially when the work gets difficult, and she reminded people that it is important to know that there are strong supports for the future and for children, including good aunties and uncles.

She then re-emphasized the importance of Aayangwaamazin: to be determined. She encouraged everyone to enjoy conversations and laugh as laughter is medicine. Elder Stevens closed in the language, acknowledging everyone as relatives and giving thanks for their listening and attention.

National Mental Wellness Workforce Association

OVERVIEW

The first day of the Gathering focused on identifying core competencies of a First Nations Mental Wellness Workforce Association and on the development of a Standardized National Curriculum. There was a facilitated World Café discussion on the core competencies required for a First Nations Mental Wellness Workforce Association, followed by a presentation and a large group discussion on a National Standardized Trauma Informed Curriculum for Addiction Services.

Activity – Core Competencies

Introduction

In 2022, Thunderbird and the First Peoples Wellness Circle co-chaired a Northern Round Table with First Nations, Inuit and Métis populations from northern parts of Canada. As part of the discussions, participants were asked to identify their priorities and one of the recommendations was to develop a National Mental Wellness Workforce Association. This recommendation emerged again from the first Indigenous Mental Wellness Summit held in 2022, and it was supported at the time by the federal Minister of Mental Health and Addictions (Minister Bennett) and the Minister for Indigenous Services (Minister Hajdu), who were both in attendance.

A Workforce Association has as its foundation defined core competencies for the workforce that forms it membership. The core competencies are structured with the knowledge, skills and behaviour required to do a particular job. These are meant to change over time in response to the environment. For example, there is a growing need to identify specific knowledge and skills required to effectively support people who have challenges with opioids and methamphetamines.

The mental wellness workforce has been working with core competencies for many years now and indeed, that is what certification is about. Many staff have been certified, hopefully by the Indigenous Certification Board of Canada but perhaps through the Canadian Council for Professional Certification or another body. The key point is that these bodies assess worker competence in terms of education, experience, knowledge, and skills to certify. This is an assessment of competency or in other words, "you have what it takes to do this work". However, there are also other workforces in the Indigenous mental wellness community who do not have any certification processes in place, and may not be certified, or their core competencies do not reflect all of what the First Nations Mental Wellness Continuum (FNMWC) framework says about the work.

One of the ongoing challenges is aftercare, which should really be called continuing care because treatment is a journey. Care should be coordinated, and oftentimes responsibilities overlap.

To summarize, core competencies are about understanding the quality that we all want to see in mental wellness services. As wellness workers, those in attendance have a foundation of knowledge, skills, and behaviors, and are therefore well positioned to identify core competencies for a First Nations Mental Wellness Workforce Association.

The following themes for the 39 competencies are drawn from the First Nations Mental Wellness Continuum (FNMWC) framework:

- Substance Use/Mental Health
- Harm Reduction
- Trauma
- Culture
- Service Components
- Population Specific.

The objective of the discussion groups at the Gathering was for participants to identify and shape core competencies based on their own work experience, their knowledge and skills, what they see in their communities and what people are asking questions about.

World Café – Core Competencies

List of Core Competencies

There are 39 core competencies, under six key themes, as shown below.

A. Culture

Consider what is unique to your Nation of people that is critical for the workforce to know, have skills to support or to act on. Also identify where the workforce would not have a role.

1. **Culture is the Foundation** – refers to the importance of Elders, cultural practitioners and kinship relationships, language, culture-based practices, ceremonies, knowledge, and land and values.
2. **Indigenous Knowledge** – is about the translation of teachings held in sacred societies, through family bundles, community knowledge passed through generations based on understanding the spirit, or Indigenous world view.
3. **Culture-Based Practitioners** – are individuals who have been sanctioned in their knowledge, culture-based skills and scope of practice. They are often known as helpers to Elders who then are trained to lead culture / ceremony.
4. **Land-Based Healing** – involves practices that take place with and on the land such as, harvesting medicines, sweat lodge ceremony, teachings, hunting, berry picking, and knowledge of history of the land/rivers/lakes/mountains, etcetera.
5. **Traditional Healing / Culture Interventions** – recognize that there are many culture-based healing practices and they are specific to the Nation of people. Teachings specific to the practice are grounded in a long history of the healing practice and rely on the original Indigenous language.
6. **Cultural Competency** – relies on cultural humility, awareness of culture-based practices, authority for scope of practice, and rights and protocols for accessing culture.
7. **Cultural Safety** – means facilitating an environment that is respectful of culture-based practices and practitioners. Policies support and champions culture-based evidence.
8. **Strength-Based Approaches** – celebrate and honour the strengths of the whole person rather than approaching Indigenous People for the challenges they face. Understanding that every person has inherent strengths gifted by the Great Spirit that is their Indigenous identity, that exist continuously.

B. Trauma Category

What is unique to your community, specific population, or of Indigenous people that the workforce should know about, understand the skills necessary to support, and to act on.

9. **Intergenerational Trauma** – recognizes that trauma is common to the whole of Indigenous people due to colonization, racism, and other systemic policies and practices. This trauma is internalized and then transferred to the next generation, often without resolution.
10. **Trauma Informed Care** – is the awareness of population level trauma experiences and intentionally attending to the experience of trauma as it continues to appear, normalized, without blaming / shaming the individual.
11. **Complex Trauma** – is understood as exposure to multiple traumatic events with wide ranging and multiple impacts, often with a strong sense of helplessness to change or get relief.
12. **Colonization and Decolonization** – The actions of colonization take place at a systems level, are pervasive to the population and transcend generations. Likewise, decolonization must intentionally distinguish colonial practices and impacts to effectively address them. This is instead of blaming/shaming or stereotyping the population for the internalization of colonial ways of being.

C. Harm Reduction

In the competencies below, identify what this looks like in your work experience, community, and what knowledge, skills and behavior would have been helpful for you to have in a coordinated and consistent response.

13. **Contaminated Drugs / Drug Poisoning / Overdose** – Drug poisoning is the experience of unknowingly consuming contaminated drugs which can lead to near death / death. Overdose implies that someone purposely consumed too many drugs and those drugs cause their breath or heart to stop, have a stroke or other impact.
14. **Safer Supply** – refers to providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose.
15. **Harm Reduction** – is a set of practical strategies aimed at reducing negative consequences associated with drug use.
16. **Human Trafficking and Drug Mules** – The trafficking of drugs and particularly the use of human carriers (often called *drug mules*) can include children, youth and adults as drug couriers who are paid, coerced, or tricked into transporting drugs and who have no further commercial interest in the drugs.
17. **Naloxone and Aftercare** – Naloxone (also called Narcan) is a life-saving medication that can be used to reverse the effects of opioids during an opioid overdose. People who survive an overdose can be traumatized by the experience and benefit from a quick connection to mental health or culture-based supports and services in their community. With a warm handoff, a first responder can engage with a person who uses drugs to build trust. This relationship is used to connect that person to other services so they can develop a survival plan & continue receiving care.

D. Substance Use and Mental Health

Even though your community, treatment center, or service provider may not have provided the following services, think about the unique needs of people who use drugs and alcohol or appear to have a mental health condition. What knowledge, skill, and actions / behaviors would have been helpful to Indigenous people along the continuum of care?

18. **Substance Use Medicine** – Opioid Agonist Treatment (OAT) is medication-assisted treatment that prescribes methadone, buprenorphine/naloxone and alternatives including Slow-Release Oral Morphine (SROM) and Injectable Opioid Agonist Treatment (IOAT) where appropriate.
19. **Outreach** – is the activity of providing services to any population that might not otherwise have access to those services.
20. **Wraparound Services** – focus on a team-based planning process intended to provide individualized, coordinated, family-driven or community-based care that will meet the complex needs of people who use drugs and would not otherwise be able to access services for health and social.
21. **Withdrawal Management** – may be residential or day program services aimed at medically based interventions which are specific to the drugs used and can be supported alongside culture-based strategies on the land, or in ceremony.
22. **Early Psychosis** – is aimed at helping people spot the signs of psychosis (hearing & seeing things that others do not) early so that the person can be supported and treated as soon as possible.
23. **Drug Induced Psychosis** – Psychosis is a mental health problem which temporarily causes someone to interpret the world differently from those around them. Drug-induced psychosis happens when you experience episodes of psychosis, such as delusions or hallucinations, as a direct result of substance misuse.
24. **Trauma Induced Psychosis** – Trauma experiences may cause psychotic symptoms such as hallucinations and/or delusions. There is evidence from population-based studies that controlled for a variety of environmental and biological factors, indicate childhood sexual abuse is strongly linked to psychosis among youth and adults. Psychosis examples include schizophrenia, emotional dysregulation, mood and anxiety disorders, eating disorders, personality disorders, dissociative disorders, and substance dependence.

E. Service Components

The service components listed below are unique to Indigenous Peoples' experience and impact their mental wellness. Consider what unique knowledge, skills, and behaviors are essential for acting in your role to prevent, respond to someone's needs, plan to address, or to coordinate allies.

25. **Indigenous Determinants of Health** – includes environmental stewardship; social services; justice, education and lifelong learning; language, heritage and culture; urban and rural; land and resources; economic development; employment; health care; digital capacity; and housing.
26. **Anti-Oppression** – is the method and process in which we understand how systems of oppression such as colonialism, racism, sexism, homophobia, transphobia, classism and ableism can result in individual discriminatory actions and structural/systemic inequalities for certain groups in society.
27. **Anti-Indigenous Racism** – refers to the practice of intentionally acting to address and prevent racism specifically experienced at the systems level by Indigenous People. Often the Indigenous experience is rooted in colonization.
28. **Stigma** – is a set of negative and unfair beliefs that are focused on people who use drugs and alcohol that often act as a barrier to supports and services.
29. **Peer Support** – honours life experiences and views it as a foundation of qualifications to provide emotional and practical support, often between two people who share a common experience, such as a mental health challenge or illness, and / or substance use challenges.
30. **Partnerships** – are understood to be the relationship between people in the community and a professional (or other) workforce coming into the community for service delivery.

F. Populations

The mental wellness needs of the population groups listed below are unique and specific to their identity. Consider what is most essential for the workforce to have to be able to support the mental wellness needs of these populations, be it specific knowledge, skills or actions / behaviors.

31. **Children** – Services are planned to facilitate the mental wellness of children by recognizing the developmental stages of life / milestones from a culture-based lens and from a psychological evidence base.
32. **Youth** – Services are planned to facilitate the mental wellness of the specific needs of youth by recognizing the developmental stages of life / milestones from a culture-based lens and from a psychological evidence base.
33. **Chronic Health Conditions** – There are many medical complications that arise from alcohol and drug use and affect multiple body systems. The impacts depend on many different things such as patterns of consumption (e.g., frequency, how much alcohol/type of drug and controlled substance), presence of chronic health conditions in the family, environment, access to health care / treatment and many other things.
34. **Murdered & Missing Indigenous Women and Girls** – Evidence indicates that substance misuse can lead to a number of public health and safety issues including dependence, overdose, violence and crime, which contributes to both the vulnerability and violence suffered by Indigenous women and girls.
35. **Qualified by Experience (Lived and Living Experience)** – is represented through on-the-job training and supports and recognizes the valuable expertise that comes from living experience and/or past life experience specific to drug and alcohol use, trauma, culture, overall mental wellness, etcetera.
36. **LGBTQ2S+** – is understood to be a gender diverse or fluid population often excluded or unable to access the right service at the right time for mental wellness support. Barriers to available and accessible health and social services to support mental wellness must be addressed to attend to the specific experiences of the LGBTQ2S+ population.
37. **Persons with Disabilities** – refers to people with medical conditions such as physical impairments, brain injuries, neurodivergence, hearing impairment, Fetal Alcohol Spectrum Disorder (FASK), and Attention Deficit Hyperactivity Disorder (ADHD).
38. **Aging Out of Care** – Given that Indigenous children and youth are over-represented in child welfare, there is a great need to ensure that common outcomes are planned for specifically including youth aging out of care. Without planning and support, typical outcomes for youth who age out of care include low academic achievement, unemployment or underemployment, homelessness and housing insecurity, criminal justice system involvement, early parenthood, poor physical and mental health, and loneliness.
39. **Post-Traumatic Stress Disorder (PTSD)** – can be caused by environmental and social emergencies, war, and climate change events. For example, military veterans are sometimes known to suffer the effects of PTSD.

Activity Instructions

Attendees received an instruction sheet when registering on Day 1. Thunderbird printed five sets of instruction sheets, each having a different sequence of numbers in the boxes following the first paragraph. These numbers corresponded to numbers on each table which, in turn, connected to the competency themes. One goal of this numbering was to encourage attendees, who may have travelled together, to make new connections and share discussion about the competencies. On the reverse side of the instruction sheet was a map, which showed the layout of the numbered tables. The activity took place across three rooms. Tables were grouped according to competency category or theme. The six themes or categories were noted on each table with a tent card.

For each competency, participants were asked to consider the following questions:

What do you think are the critical knowledge, skills, and behaviours that competency should ensure? What is your perspective on what a frontline worker should have or develop and what a supervisor or manager should support?

Knowledge – What do you need to know to serve First Nations? For example, what education, educational experience, teacher, or course component provides a necessary foundation of knowledge?

Skills – Is there a unique way of doing or applying this knowledge in working with Indigenous Peoples? What skills are essential for demonstrating competency?

Behaviours – What actions are essential to acting on knowledge and skills? You can have the education so that you know how to do something, and have the skills to apply the knowledge, but then what helps to build confidence to act when needed and in a way that attends to the needs of Indigenous people.

Frontline – What would you say is essential for a front-line worker of the knowledge, skills, and behaviors you have described?

Supervisor – For a supervisor / manager to effectively represent the workforce, coordinate tasks, & coach and support workforce, what is essential that a supervisor or manager demonstrate regarding knowledge, skills, behavior, or some combination?

Competency Themes

The primary, overarching themes for each competency with participants responses are listed below.

Culture

Culture is foundational to healing and wellness. It involves Elders, Cultural Practitioners, kinship relationships, language, culture-based practices, ceremonies, knowledge, land, and values. Indigenous Knowledge is the translation of teachings held in sacred societies, through family bundles and through community knowledge passed through generations based on understanding the spirit, or the Indigenous world view.

Culture-based practitioners are individuals who have been sanctioned in their knowledge, culture-based skills, and scope of practice. They are often known as helpers to Elders who then are trained to lead culture / ceremony.

Land-based healing practices take place with and on the land such as, harvesting medicines, sweat lodge ceremony, teachings, hunting, berry picking, knowledge of history of the land/rivers/lakes/mountains, etc.

Culture based healing practices are many and are specific to the Nation of people. Teachings specific to the practice are grounded in a long history of the healing practice and rely on the original Indigenous language. Cultural competency relies on cultural humility, awareness of culture-based practices, authority for scope of practice, and rights and protocols for accessing culture. Cultural safety facilitates an environment that is respectful of culture-based practices and practitioners, and policies support and champion culture-based evidence.

Strength-based approaches celebrate and honor the strengths of the whole person, understanding that every person has inherent strengths gifted by the Great Spirit that is their Indigenous identity.

The discussions on these aspects of culture gave rise to several key themes in relation to core competencies.

Knowledge

Participants listed many types of knowledge that are required to serve First Nations in terms of culture which includes

- an awareness that Elders and Knowledge Keepers are the best listeners, teachers, and speakers, and
- an ability to develop relationships with and seek information and lived experience knowledge from Elders, Knowledge Keepers and community.

This type of knowledge is complemented by general land-based knowledge – land-based medicines, harvesting medicines, gun safety, hunting, trapping, fishing, first aid, survival skills, etcetera.

Also important is an understanding of the difference between a senior and an Elder, knowledge of how to participate alongside cultural practitioners, and knowledge of the local community, including its cultural heritage, traditional teachings, and cultural practices (this includes all staff, not just frontline workers).

Additional understanding required includes

- knowledge of seminal documents and recommendations related to Indigenous Peoples (e.g., the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), different cultures),
- Indigenous origins, teachings and protocols,
- respect for cultural differences,
- the value of holistic approaches to health and healing,
- the importance of language and having knowledge of the local language, or committing to learning the language,
- understanding how connecting with cultural practices builds Indigenous identity and supports healing, and trauma-informed and strength-based treatment, and
- knowledge about creating supportive environments and promoting client empowerment.

Skills

Participants outlined many culture-related skills such as training in the history and culture of the local community, including cultural traditions, teachings and protocols, and training in other Indigenous cultures and teachings.

Additional skills identified were

- Indigenous community experience,
- trauma-informed and strengths-based therapy,
- communication/listening,
- teaching and language,
- following sacred knowledge and teachings,
- serving as a role model,
- putting knowledge into action,
- land-based therapy,
- craft-making skills (e.g., ribbon skirts, moccasins), and
- emotional CPR (eCPR) training.

For cultural practitioners, participants noted the importance of skills and experience with medicines, protocols, ceremony, language and land-based healing practices.

Behaviours

In terms of behaviours in the context of culture participants noted curiosity and openness to learning, being inclusive, non-judgemental, flexible and adaptable, having humility as well as being diplomatic, kind and understanding. Also noted as important were having patience, a sense of humour, and the being a good listener and practicing sobriety, and living by one's words and actions.

Other behaviours identified were

- providing opportunities for staff to heal from trauma histories,
- embracing cultural teachings and having access to items required for ceremony such as tobacco, skirts, etcetera,
- participating in cultural ceremonies, Indigenous events or days, and other relevant activities,
- being prepared and willing to share knowledge of culture, and
- supporting staff who were not raised in culture guidance.

Of equal importance, is asking for guidance about using established protocols. If hesitant, especially as a non-Indigenous person, it is important to be able to seek clarification.

Frontline

Frontline workers must be respectful, open-minded, flexible, and willing to learn. They should also share their own knowledge, look for ways to connect to the land and encourage clients to participate.

It is essential that frontline workers to be approachable and welcoming, and listen and respect culture-based practitioners. Also important is having a sense of humour, engaging in cultural activities such as hunting, trapping, and fishing, medicine picking, crafting (e.g., making ribbon skirts, moccasins), and ceremonies.

At a personal level, frontline workers must have self-awareness and know where they are in their healing journey, be open to learning about their own culture (if different), live a healthy lifestyle, be a role model and build knowledge by seeking out wellness, Elders, teachings, etcetera.

Supervisor

Supervisors must be team players who are supportive, open-minded, determined, flexible, and good listeners who have knowledge of culture. They should also encourage the teaching of culture and its practice, and model this type of behavior for the organization.

Supervisors should share with and debrief staff when needed; build on team members' knowledge, confidence, and gifts of culture; complete annual performance assessments that address personal wellness; and be a helper who learns and encourages learning.

Participants also noted that supervisors must show support to frontline workers; provide individual support to staff based on their unique learning styles; create a safe environment which includes having policies against lateral violence/bullying/gossip; understand the strengths of staff and clients; value contributions; and ensure cultural representation and cultural awareness within the organization.

Supervisors should also acknowledge Elders and helpers who are accepted by the community, ensure Cultural Practitioners have supplies for activities and ceremonies and provide program equipment. Additional expectations of supervisors included supporting land-based activities and advocating for the Indigenous workforce.

Data Visualization – **Culture**

Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the culture visualization, the three longest radial bars are connected to knowledge and skills in cultural competency and to behaviour in land-based healing practices.

Trauma

Intergenerational trauma is common to the whole of Indigenous people due to colonization, racism, and other systemic policies and practices that are internalized and then transferred to the next generation, often without resolution. Trauma-informed care is the awareness of population level trauma experiences and intentionally attending to the experience of trauma as it continues to appear, normalized, without blaming / shaming the individual.

Actions of colonization take place at a systems level, are pervasive to the population and transcend generations. Likewise, decolonization must intentionally distinguish colonial practices and impacts to effectively address them. This is instead of blaming/shaming or stereotyping the population for the internalization of colonial ways of being.

Discussions on all these aspects of trauma gave rise to several key themes in relation to core competencies.

Knowledge

From the perspective of knowledge of trauma competencies, participants noted the importance of knowledge about intergenerational trauma, including the history and effects of colonization; systemic racism; residential schools; the 60's scoop and other First Nations trauma experiences; the harms of white saviour mentality; and community resources, including people who have the skills, knowledge, and life experience to help.

Competency, in terms of trauma, requires understanding models for decolonization and how to implement decolonization through policy. This competency also requires the ability to understand the effects of grief, different types and levels of trauma, the different ways that trauma can present, and vicarious trauma and the effects on staff.

Also important is Indigenous knowledge and healing practices (including different cultural traditions); knowing the protocols for engaging with Elders and language speakers (and how to seek them out); local community knowledge (including the community's history, cultural traditions, and strengths); knowing ceremonies for grief and loss; land-based programming knowledge; and Indigenous language for clients who are First language speakers.

Other types of required knowledge include lived experience – and understanding that formal education is not the only way, education in the field of mental health and substance use, wrap-around services, the relationship between trauma and lateral violence in the workplace, and understanding the importance of client privacy.

Skills

Participants identified a number of skills required for the trauma competencies including the ability to watch and learn from others; the capacity to participate in structured debriefs to support learning and accuracy; regulate emotions; build trust and relationships; access wrap-around services; serve as a role model and support team morale; plus be trauma-informed, land-based, and have art therapy skills.

Also important are the ability to use two-eyed seeing and to live the culture, speak original languages, smudge and to participate in ceremonies.

Behaviour

The behaviours required for this competency include compassion, empathy, and kindness, patience, openness and receptivity, flexibility, humility, and accountability. Also important is being a role model and leading by example, facilitating the sharing of culture and a vision of healing as well as doing daily debriefs, along with utilizing circle and smudge.

Administrative behaviours encompass keeping accurate and up-to-date logbooks; providing orientation to staff for clients; working with other agencies and learning from each other; having a personal wellness plan; listening to and learning from Elders; and supporting language strategies in community and engaging with language keepers.

Frontline

Frontline workers must have the ability to identify needs, and the appropriate approach, have adequate training, an awareness of healing strategies, and awareness of their own personal history, story and trauma, plus be educated on colonization and how it affects substance use and mental health.

Also important is having skills in emotional regulation and effective listening, being compassionate, empathic, and trauma informed as well as having cultural knowledge, and knowledge of grief counselling, harm reduction, and lived experience.

Supervisor

It was determined as essential that supervisors and managers ensure that resources are available in place for staff healing work. Supervisors should also understand that culture is foundation and have the skills to put culture into practice. They also should understand employees' histories and be able to identify intergenerational trauma and how it affects others (and their performance), and have knowledge of community, and support culture enhancing practices and traditional knowledge.

Supervisors should also be trauma informed, have a strengths-based outlook and be ethical. In addition, they should

- have the capacity to supervise and support staff in the context of vicarious trauma,
- discuss and facilitate growth and accountability,
- be explicit about changes and steps involved in growth and change,
- participate in staff training, debriefings, and safety planning,
- provide ongoing education and training for staff, develop and implement required policies,
- recruit local staff with language skills,
- provide daily updates to staff,
- demonstrate positive leadership and management skills,
- show appreciation and acknowledge the work of staff, and
- practice open communication.

Data Visualization – **Trauma**

Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the trauma visualization, the three longest radial bars are connected to knowledge and skills in intergenerational trauma and colonization/decolonization.

Harm Reduction

Drug poisoning is the experience of unknowingly consuming contaminated drugs which can lead to near death / death. Overdose implies that someone purposely consumed too many drugs, and those drugs caused their breath/heart to stop, have a stroke, or other impact. The trafficking of drugs, and particularly the use of human carriers (often called *drug mules*), can include children, youth and adults who are paid, coerced, or tricked into transporting drugs (as couriers) and who have no further commercial interest in the drugs.

Harm reduction is a set of practical strategies aimed at reducing negative consequences associated with drug use. Safer supply is a harm reduction intervention providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose. Naloxone (also called Narcan) is a life-saving medication that can be used to reverse the effects of opioids during an opioid overdose. People who survive an overdose can be traumatized by the experience and benefit from a quick connection to mental health or culture-based support and services in their community. With a warm handoff, a first responder can engage with a person who uses drugs to build trust. This relationship is used to connect that person to other services so they can develop a survival plan and continue receiving care.

Key themes regarding core competencies that emerged from discussions about these aspects of harm reduction may be seen below.

Knowledge

The knowledge needed for this competency includes a solid understanding of First Nations history and the reasons for, and origins of, toxic drug use in First Nations populations. Also required is knowledge of substance names on the street; drug culture, and demographics; human trafficking and drug mules, what causes people to participate in it, and the prevalence of it; safe drug use/safer supply; medical oversight requirements; patient navigators; cultural programming for harm reduction; and safety tips.

Other types of knowledge that are important include

- an understanding of what is happening in communities regarding toxic drug poisoning,
- knowledge of the various toxic drugs in use, including alcohol, opioids, stimulants, etcetera,
- drug mule demographics including ports/cities,
- issues of safety and stigma,
- what harm reduction is, how it works, and the language and terms associated with it,
- the signs and symptoms of toxic drug overdose,
- Opioid Agonist Treatment/Therapy (OAT) including training to support, administration of, overdose training, and first aid training,
- which agencies support harm reduction in the local area, and
- spiritual laws, teachings, sweats, smudging, ceremonies, and natural medicines.

Skills

Being competent in the practice of harm reduction requires many skills such as first aid response; training on administering medications, and on how safer supply works, and harm reduction; administration of medications; hands on training; education for Elders; naloxone training and its use (and after-effects); multiple dosing; and drug testing education including what to look for, active use, and overdose.

Other important training includes drug use trends, police interaction, how to access resources, after care response, and computer skills. Also important are fluidity in approach, advocacy and relationship building skills, and training in working with individuals who are treatment resistant/refuse medical attention.

Behaviour

From the behaviour perspective, competency in harm reduction requires empathy and compassion, patience and understanding, a calm demeanor, self-confidence, *street smarts*, self-reflection abilities regarding knowledge and skills, and taking a trauma-informed approach.

Participation in community surveillance involves being aware of what is going on, working with Elders, being a good listener and valuing people for who they are, understanding individuals' lived experience and their point of voice.

Also important is informing and educating communities about toxic drug use, drug mules and human trafficking; providing referrals to people who know about safe supply; record keeping as needed; ensuring safe storage; demonstrating good time management; as well as an ability to network, advocate and promote the new "don't use alone" campaign.

Frontline

For these competencies, frontline workers need training in aftercare response practice, and use proper language - be patient, flexible, open minded, confident, and able to facilitate subject matter sessions.

It is also important that frontline workers have education and knowledge about safer supply; understand traditional and cultural practices; have the ability to network, advocate, and provide referrals; understand the history; know about safe consumption; and be aware of pharmaceutical companies and processes.

Frontline workers should take a Reconciliation approach (under safety, fear and stigma), and understand drug mules and human trafficking.

Supervisor

To be fully competent in harm reduction knowledge and practices, supervisors should be flexible, patient, and open minded, have a thorough understanding of harm reduction, and the various services and supports available. They should also maintain awareness of research findings, facilitate education and training for staff on relevant subject matter, develop policies on harm reduction, network with police forces, and ensure staff and client safety.

Also important for these competencies is the ability to re-introduce culture to community and staff, understand social media, be willing to support land-based therapies and training for safe spaces in community. Supervisors should also participate in networking and be able to complete funding reports.

Data Visualization – **Harm Reduction**

Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the harm reduction visualization, the three longest radial bars are connected to frontline workers in terms of their knowledge, skills, and behaviour in human trafficking and drug mules as well as to skills and knowledge in safer supply.

Substance Use and Mental Health

Addiction medicine includes prescribing Opioid Agonist Treatment (OAT) such as methadone, buprenorphine / naloxone and alternatives including Slow-Release Oral Morphine (SROM) and Injectable Opioid Agonist Treatment (IOAT) where appropriate.

Outreach is the activity of providing services to any population that might not otherwise have access to those services.

Wraparound services focus on a team-based planning process intended to provide individualized, coordinated, family-driven or community-based care that will meet the complex needs of people who use drugs and would not otherwise be able to access health and social services. Withdrawal management may be residential, or day program services aimed at medically-based interventions which are specific to the drugs used and can be supported alongside culture-based strategies on the land, or in ceremony.

Psychosis is a mental health state which temporarily causes someone to interpret the world differently from those around them. Early psychosis intervention is aimed at helping people spot the signs of psychosis (hearing and seeing things that others do not) early so that the person can be supported and treated as soon as possible. Drug-induced psychosis happens when people experience episodes of psychosis, such as delusions or hallucinations, as a direct result of substance misuse.

Trauma experiences may cause psychotic symptoms such as hallucinations and/or delusions. Population-based studies, that controlled for a variety of environmental and biological factors, indicate childhood sexual abuse is strongly linked to psychosis among youth and adults. Emotional dysregulation, mood, and anxiety disorders, eating disorders, personality disorders, dissociative disorders, and substance dependence are also linked to traumatic experiences.

Key themes regarding core competencies that emerged from discussions on substance use and mental health may be seen below.

Knowledge

To be competent in terms of substance use and mental health, participants noted the importance of basic knowledge of pharmacology and drug interactions, education on types of drugs, effects of drugs and drug therapies, as well as having academic credentials in the study of substance use/misuse, and a thorough understanding of the history and root causes of mental health and substance use issues (e.g., the legacy of colonization).

Also important is knowledge about

- the different kinds of trauma (such as mental, sexual, emotional, physical, and spiritual) and how the brain and body process trauma,
- sexual abuse symptoms,
- the Diagnostic and Statistical Manual (DSM),
- active drugs being used in the community,
- the interactions between drugs and mental health conditions,
- the importance of cultural interventions,
- land-based care and ceremonies,
- relevant health professionals and other resources available outside communities,
- referral protocols, and
- outreach as prevention.

Knowledge of outreach programs and understanding that outreach needs to address the social determinants of health is also important, as is knowledge of the importance of pre-care in getting people into the treatment they need, plus detox and withdrawal management care. It is also important to know about trauma-informed practice, wraparound care and family-centred care, and the range of treatment options.

Other knowledge needed includes wellness promotion, peer support initiatives, early psychosis, drug-related psychosis and trauma-based psychosis, hereditary effects/family history in relation to psychosis, early signs/symptoms of psychosis, spiritual gifts versus psychosis, and understanding the difference between psychosis, early psychosis, and drug-induced psychosis - know the symptoms.

Knowledge of the natural caregivers of the community and how to provide them with training and recognition, as well as understanding how to educate families (to help their family members) was also noted by participants.

Skills

Participants noted the following skills as important regarding substance use and mental health:

- evaluation and assessment,
- treatment-matching skills,
- medical administration training,
- Mental Health First Aid,
- Native Wellness Assessment NWA™ training,
- Licensed Practical Nurse (LPN) training,
- advocacy skills,
- trauma-informed therapy skills,
- case management and case conferencing,
- facilitation abilities, and
- the ability to provide training and education for the general population (e.g., basic understanding of signs and symptoms of drug use).

Also important is the ability to create ceremonies in the community, along with having good communication and listening skills, and the capacity to read non-verbal cues. Add to that crisis management skills, personal safety skills (e.g., when to call for help), the ability to complete proper paperwork and documentation, liaising and working with other organizations, and the use of traditional medicines and land-based activities to support withdrawal management.

Behaviour

Competency in this area requires openness, diplomacy, flexibility, empathy and compassion, humility, patience, assertiveness and the ability to act in a non-judgemental way.

Other important behaviours include acting as a role model, recovery coach and mentor; understanding and using resources such as cultural care kits; thinking outside the box; creating a safe environment and build trust; recognizing people's strengths; explaining things in a good way; and being aware of withdrawal symptoms and signs that people are using, or may use, again.

This competency also requires an ability to help people to connect with culture, including medicines, ceremony and identifying *spirit name*. In addition, it is important to be able to work effectively in a team, include Elders and Knowledge Keepers as part of the team, work collaboratively with other organizations, follow policies and procedures of workplace, trust the knowledge and expertise of clinical supervisors, manage your time effectively, keep accurate records, carry naloxone or have access to it, and debrief and get support for oneself after difficult/challenging interactions with clients if needed.

Frontline

Frontline workers in substance and mental health professions should prioritize

- safety,
- carrying naloxone or having access to it,
- clinical supervision,
- effective communication,
- awareness of appropriate treatment for clients and how to access it,
- being supportive and understanding,
- building relationships,
- being okay to talk about what they are experiencing,
- case management and case conferencing,
- the circle of care, and
- collaboration.

Also important is community engagement, along with

- having compassion and a lot of understanding,
- cultural strength,
- understanding data analysis,
- having facilitation skills,
- engaging with families,
- being flexible,
- following the policies and procedures of a workplace,
- getting support after a difficult call,
- ensuring detox beds in local hospital or in community,
- having incentive,
- being intuit,
- knowing their resources, and
- building rapport/trust recognizing a person's strengths not just short comings.

Frontline workers must be non-judgemental, able to do recording keeping, respect of their culture, value teamwork, and know if someone is volatile or angry. It's also important that they understand time management case load ratio, be kind and patient (as it takes time for people to open up about their substance use and mental health), build that trust, and have open communication with co-workers, clients, helpers, and others. Frontline workers should also have someone to debrief with afterwards, be able to walk in both worlds (Western and Indigenous), respect Indigenous ways, be trauma informed, and trust they have the knowledge to guide you. Also important is understanding complications, being willing to work outside of the workplace, and knowing that withdrawal management should be in a hospital setting or a clinic setting not in a treatment centre.

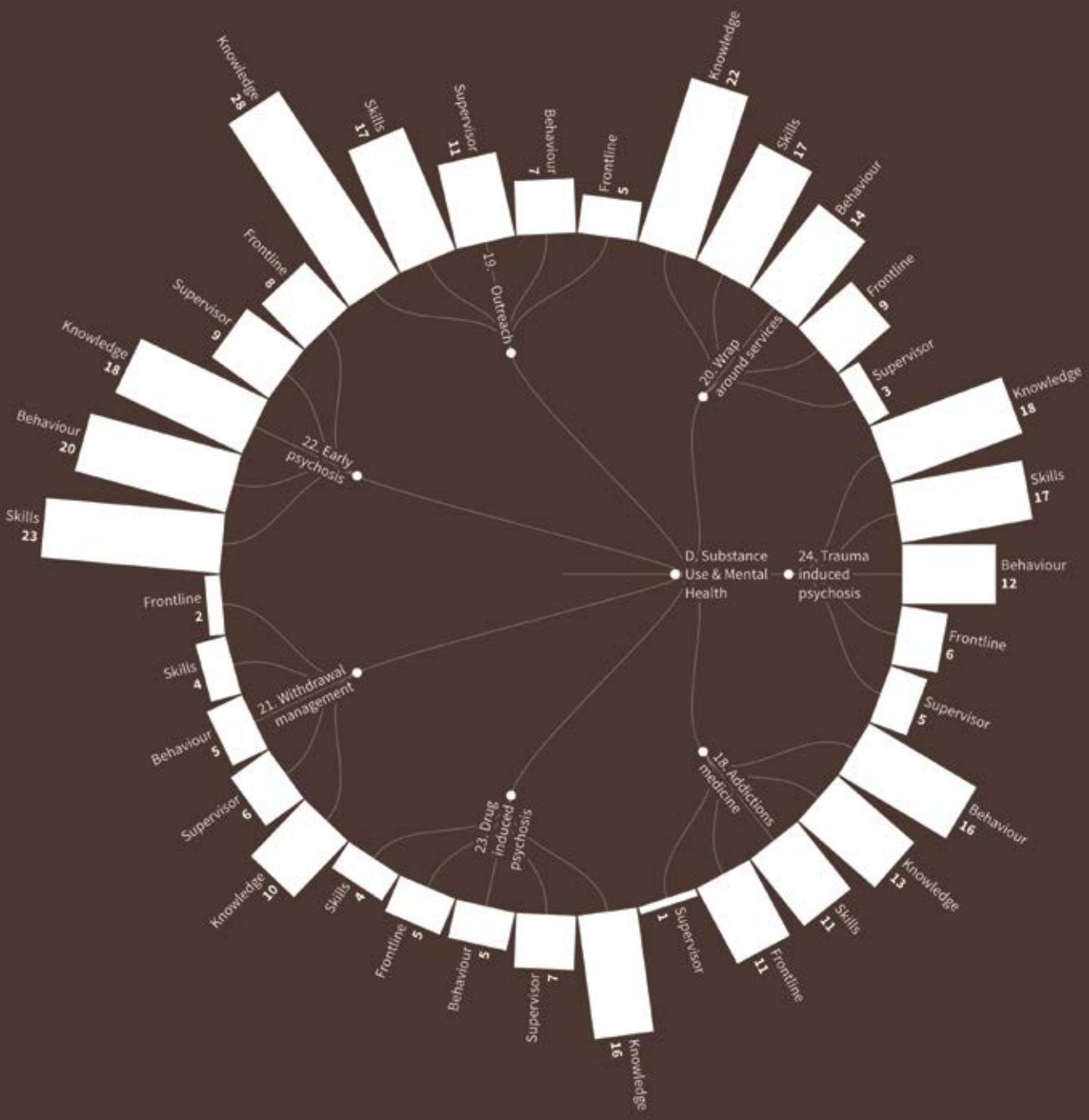
Supervisors

Supervisors should have flexible policies, be a role model and mentor for staff, and participate in community development with the understanding that it's a community issue and all must be involved. They should also implement case management – involve all supports required for healing, provide effective clinical supervision, use best practises and standards, and support Indigenous gifts and skills.

The ability to ensure safety mechanisms are in place is also important, along with having a process for dealing with trauma triggers, and providing enhanced training such as strategies, identification and implementation of train the trainer programs.

It was determined that supervisors should also be expected to develop support systems, help to facilitate referrals, seek out more funding (e.g., for additional therapy, O.T.), plus identify and share different resources with staff, (e.g., Hearing Voices workshop). Supervisors should also have training in psychosis, encourage land-based knowledge and grounding experiences, and support continuation of care plans.

Data Visualization – **Substance Use and Mental Health**



Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the substance us and mental health visualization, the three longest radial bars are connected to knowledge of outreach and wrap around services and to skills in early psychosis.

Service Components

Indigenous determinants of health include environmental stewardship; social services; justice, education, and lifelong learning; language, heritage and culture; urban and rural; land and resources; economic development; employment; health care; digital capacity; and housing.

Anti-oppression work involves the method and process in which we understand how systems of oppression (e.g. colonialism, racism, sexism, homophobia, transphobia, classism and ableism) can result in individual discriminatory actions and structural/systemic inequalities for certain groups in society. Anti-indigenous racism is intentionally acting to address and prevent racism specifically experienced at the systems level by Indigenous People. Often the Indigenous experience is rooted in colonization.

Stigma is a set of negative and unfair beliefs that are focused on people who use drugs and alcohol and that often act as a barrier to supports and services.

Peer support honors life experiences and see this as a foundation of qualifications to provide emotional and practical support, often between two people who share a common experience, such as a mental health challenge or illness, and / or substance use challenges.

Partnerships are the relationships with people in the community and with professionals or other workforces coming into the community for service delivery.

Discussions on service components identified several key themes regarding core competencies, as seen below.

Knowledge

In terms of service components, required knowledge for this competency includes

- Indigenous history and the effects of colonization and racism including intergenerational trauma,
- an understanding of how systems of oppression impact the lives of Indigenous People,
- knowledge of Indigenous culture(s), including Indigenous worldviews, teachings, ceremonies, and protocols,
- an understanding of best practices for First Nations by First Nations, and
- cultural competency along with how to assess it.

Also important is knowledge of lived experience, the seminal documents (e.g., Truth and Reconciliation Commission recommendations) of Indigenous social determinants of health, service systems and how funding is distributed. Service component knowledge of how to do community asset mapping is also important, as is knowing the local community's strengths, cultural traditions, resources, programs and workshops, etcetera. Add to that the continuum of care, racial bias (including unconscious bias), microaggressions, the causes and effects of lateral violence (and how to mitigate it), knowledge of co-occurring disorders, knowing who are reliable allies (and how to connect with them), and understanding the service components of relationship building and partnerships.

Skills

Participants noted many skills for this competency including mental health education, substance use/misuse and other types of counselling, cultural sensitivity, communication and listening, motivational interviewing, conflict resolution, collaboration and partnership building skills.

Also important for these competencies is the ability to

- notice defense mechanisms in peers that block them from reaching out,
- provide trauma-informed care,
- carry out Mental Health First Aid from an Indigenous perspective,
- manage needs-based planning,
- administer person-centered and strengths-based care,
- provide family treatment,
- teach parenting skills,
- implement wholistic approaches to support individuals and communities, and
- facilitate appropriate referrals.

Behaviour

Required behaviour for this competency includes empathy and kindness, being non-judgmental, accepting and open-minded, inclusive and respectful. Being competent in the various service components requires humility, authenticity, confidence, courage, and a collaborative spirit.

In terms of specific behaviours, participants noted the importance of working with different service sectors; participating in annual program evaluations; surveying clients; having parenting skills; working with parents and children to teach Indigenous history; having cultural awareness; sharing cultural strengths with others; and participating in ongoing training.

Also important is respecting a client's individual journey and supporting clients to make their own decisions, ensuring client confidentiality is maintained, practicing self-awareness, and focusing on maintaining personal wellness.

Additional behaviours also noted include

- helping to create a positive work environment and supporting other staff,
- knowing you do not have all the answers and being willing to seek out information,
- using privilege to speak up for what is right and to support others,
- checking in with allies on how to report racism,
- reporting racism to management in hospitals, to dentists, or to other medical services (as it is crucial to be a voice),
- teaching others ways to address racism, and
- monitoring body language and facial expressions.

Frontline

For these competencies, frontline workers must be compassionate and openminded, have good communication skills and be empathetic listeners. They need to understand stigma and have a strong understanding of colonialism and its effects. Frontline workers must also be able to encourage and motivate, and have education in substance use/misuse and substance use/misuse counselling, as well as mental health and wellness. Also important are humility, kindness, trust, and advocacy skills.

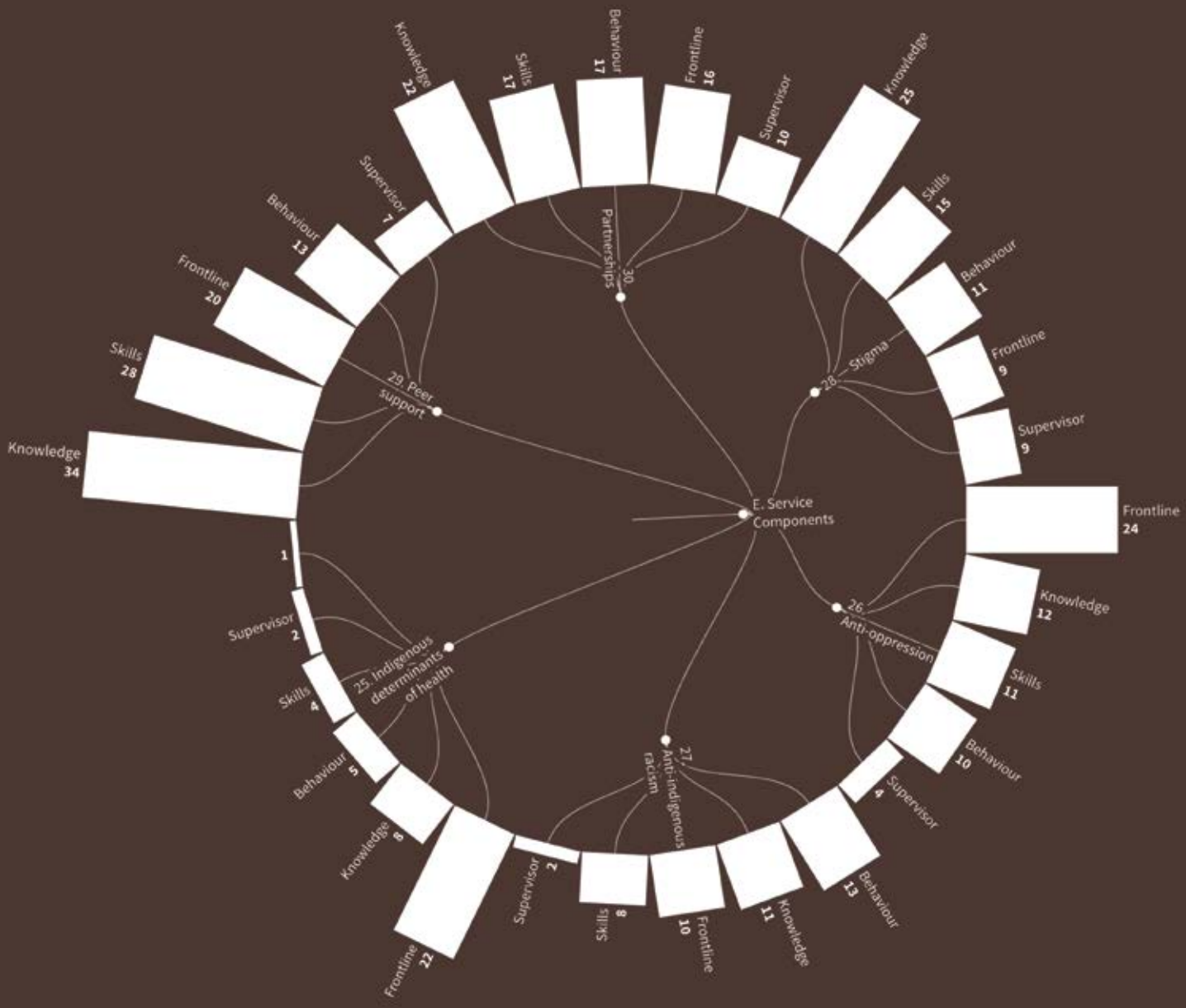
Supervisors

For supervisors to be competent in-service components, they must have a clear understanding of the vision, mission and strategic goals of the organization and local community, and be able to access invitations to tables that make decisions about funding. They should also know how to network with other services, discuss and support social determinants of health, lead by example, treat all as equal (i.e., no one is above anyone), reach out to other resources to share their knowledge, and incorporate peers into teams.

Also important is the ability to

- promote and support workforce diversity,
- provide equity and inclusion training,
- be aware of stigma in all areas (policies and procedures),
- train staff in non-stigma assessments,
- advocate for training for staff on discrimination and other matters,
- promote and support self-care for frontline workers,
- demonstrate trust and confidence in staff (do not micromanage),
- get involved in the community, and
- invite community members to share their lived experiences with youth to help them make better choices – to not follow the same path and heal the cycle.

Data Visualization – **Service Components**



Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the service components visualization, the three longest radial bars are connected to knowledge and skills for peer support and knowledge of stigma.

Populations

Discussions on populations identified several key themes regarding core competencies, as seen below.

Children

With the recognition of the developmental stages of life / milestones from a culture-based lens and from a psychological evidence base, services are planned to facilitate the mental wellness of children.

Youth

With the recognition of the developmental stages of life / milestones from a culture-based lens and from a psychological evidence base, services are planned to facilitate the mental wellness of youth specific needs.

Chronic Health Conditions

People may experience many medical complications that arise from alcohol and drug use and affect multiple body systems. These are chronic health conditions. The impacts are dependent on many different things such as patterns of consumption (frequency, how much alcohol/type of drug and controlled substance) presence of chronic health conditions in the family, environment, access to health care / treatment and many other things.

Missing and Murdered Indigenous Women & Girls

Evidence indicates that substance misuse can lead to many public health and safety issues including dependence, overdose, violence, and crime, which contributes to both the vulnerability and violence suffered by Indigenous women and girls.

Lived/Living Experience

Lived and living experience is represented through on-the-job training and supports, and recognizes the valuable expertise that comes from living experience and / or past life experience specific to drug and alcohol use, trauma, culture, overall mental wellness, etc.

LGBTQ2S+

LGBTQ2S+ is a gender-diverse or fluid population that is often excluded or who may not often be able to access the right service at the right time for their mental wellness. Barriers to availability and accessibility of health and social services to support mental wellness must be addressed to attend to the specific experiences of the LGBTQ2S+ population.

Persons with Disabilities

Persons with disabilities may have physical challenges or brain injuries. They include those who are neurologically diverse, hearing impaired, have Fetal Alcohol Spectrum Disorder (FASD) or Attention Deficit Hyperactivity Disorder (ADHD).

Aging Out of Care

Typical outcomes for youth who age out of care include low academic achievement; unemployment or underemployment; homelessness and housing insecurity; criminal justice system involvement; early parenthood; poor physical and mental health; and loneliness. Because Indigenous children and youth are over-represented in child welfare, there is a great need to ensure that the common outcomes are planned for, specifically including youth aging out of care.

Post Traumatic Stress Disorder (PTSD)

PTSD can be caused by many stressful life experiences including but not limited to, environmental and social emergencies, war, and climate change.

Knowledge

Participants noted many types of knowledge for this competency such as Bill C-92 and changes at the provincial level, the current trends around substance use, brain development, and physical and mental disabilities.

Also important was knowledge about

- the causes of PTSD, FASD,
- child development and the effects of adverse events and childhood trauma,
- attachment theory,
- cultural milestones,
- grief and loss,
- holistic medicine knowledge (traditional medicine),
- how healthy relationships function,
- ways to connect with children and youth,
- diversity of youth and their identities (e.g., two-spirit),
- harm reduction approaches,
- health effects that communities face (e.g., diabetes, food insecurity), and
- how to engage with Elders and Knowledge Keepers.

Understanding Indigenous culture(s) was also considered to be important along with Indigenous worldviews, teachings, ceremonies, land-based cultural activities, protocols, and Indigenous history including the effects of colonization and racism.

Other knowledge areas include

- intergenerational trauma,
- child welfare system and youth justice system,
- cultural / ceremonial / food harvesting related effects of climate change,
- the range of available resources and supports for different populations,
- the signs of physical / psychological / sexual abuse,
- traditional parenting,
- personal self-care and assertive boundaries,
- the complexities/challenges that youth face today (e.g., social media, sexuality)
- the perspective and background / history of LGBTQ2+S people,
- the roles and responsibilities of different services and service providers,
- the stages of life,
- trauma and trauma triggers,
- how systems of oppression impact the lives of Indigenous people,
- the local community's history and culture, and
- vulnerability risk factors for Missing and Murdered Indigenous Women and Girls (MMIWG).

Skills

These competencies require the ability to connect people to peer support, coordinate and integrate care, create a cultural / spiritual wellness plan, conduct strengths-based assessments and treatment plans, plan aftercare / continuing care, and share traditional practices.

Other important skill competencies include

- crisis intervention training,
- cultural training including traditional teachings and developmental ceremonies (e.g., fasting, naming ceremonies),
- traditional foods and land-based healing,
- family therapy training,
- gender identity and diversity training,
- good listening and communication skills,
- harm reduction training,
- motivational interviewing skills,
- play / game-based therapy training, and
- the ability to engage in self-reflection.

Skills also considered to be a requirement include trauma-informed and strengths-based practice as well as training on abuse (abusers and victims), available services and supports (and how to access them), barriers to accessing required care, plus child development and parenting. Add to that, skills related to diagnoses, disabilities, ways to access services for First Nations veterans – specific programming to meet unique needs, risk factors for MMIWG, service systems applicable to various populations, the causes and effects of trauma, and the signs of physical/psychological/sexual abuse.

Behaviour

Required behaviours for the *population's* competencies are empathy and kindness, humility, and acceptance. Also important is acting in inclusive and non-judgemental ways, being resourceful and an advocate, and being a good storyteller and role model.

Respecting and maintaining client confidentiality, engaging with families and children in a fun and safe way, validating clients' needs, and giving clients a voice and choice were also viewed as important behaviours for *populations* competencies. Also important were behaviours that gave access to peer support, traditional teachings, medicines, and activities which looked for support from Elders and Knowledge Keepers, as well as resource networks for learning and debriefing.

Emphasis was also placed on behaviours related to youth, which included providing mentorship; helping youth develop life skills; supporting youth to connect to cultural identity and sense of belonging to maintain and connect to *healthy* family and community; plus being in schools and community events to build relationships.

From the individual or personal perspective, it is important to check oneself for judgement, beliefs, limitations, use appropriate pronouns when communicating, debrief after stressful / challenging circumstances, learn about burnout and vicarious trauma (and how to manage it), and support personal wellness and self-care.

Frontline

Frontline workers need to check themselves for judgement, beliefs, and limitations. They should also be adaptable, approachable, and kind, trauma informed, and approach their work with humility and understanding. Also important is having knowledge of stigma and stereotypes, as well as cultural and culturally-based interventions training. Frontline workers should also have the ability to involve Elders in their work, and access support networks for resources, learning and debriefing.

They should have some capacity to support staff with lived experience who still have healing to do, understanding that individual paths to healing will be different (everyone is on their own journey). Helping clients to recognize and stay away from unsafe situations is also viewed as important.

Frontline workers should be good listeners, passionate about their work, empathetic, and able to put their own feelings and biases aside. Also, they should have their own wellness plan, know boundaries, have at least basic counselling skills, be able to maintain confidentiality, and use their own experiences to relate it to staff and clients.

Supervisor

For supervisors, participants noted that important competencies included being flexible and supportive, serving as a mentor / role model to staff, providing shadowing opportunities for learning, having management skills, being an effective communicator, and debriefing staff and supporting triggered staff.

To be competent, supervisors should also

- recruit and retain good staff,
- ensure staff can access the education and training they need,
- offer Employee Assistance Programs,
- offer healing ceremonies to staff,
- support diversity, equity, and inclusion in the workforce,
- allow for use of technology supports,
- provide training on chronic health conditions, and
- implement motions to stall, as part of the accreditation norms.

Also important is ensuring there are protocols and plans related to MMIWG, developing strong connections to local resources and a good rapport with the community, performing policy reviews and updates, participating in events for specific populations, supporting circles of care for those using multiple services, advocating for additional required funding, and networking and developing partnerships.

Data Visualization – **Populations**

Each of these data visualizations is a summary of the responses received from all participants in the world cafe activity. These show the number of responses received for each competency in terms of knowledge, skills, and behavior. Longer radial bars with higher numbers denote more responses and could suggest participants placed greater emphasis or more significance on this/these aspect(s) of a given competency.

For the populations visualization, the three longest radial bars are connected to knowledge, skills and behaviour regarding children (followed closely by the youth population).

National Standardized Treatment Curriculum

INTRODUCTION

Carol Hopkins began by introducing Gilbert Whiteduck, who is the Programs and Services Team Lead at Wanaki Centre in Kitigan Zibi, Quebec. Gilbert was instrumental in developing the virtual treatment program there, and Carol asked him to talk about that work.

Gilbert spoke about the importance of healing and how it takes medicine. He noted that all the people in the room represent that medicine to the people they work with. Despite the trauma that everyone present carries and lives with, as Indigenous people, they are still working hard to be balanced and to make a difference in the lives of people who are suffering. He applauded everyone for their work and emphasized the importance of culture as the foundation of healing. Gilbert also talked about the importance of love and how to express it through the work. He shared some thoughts about his journey through life and how he has evolved as a person, particularly regarding understanding the lived experience of Indigenous women, and appreciating the gifts he has received from women and girls over the years.

In Gilbert's community, when COVID began, they decided very quickly to put a virtual program into place, which was launched in June 2020. It was designed to be flexible to meet a variety of client needs. Evaluations have shown that this met a need that otherwise would not have been met; however, there is now an issue of funding to continue the program. In his view, such programs should be funded – and expanded – to men and women in detention centres as one example.

With respect to a trauma-informed standardized curriculum, Gilbert liked the idea and suggested that it should be developed as a framework, adaptable to different contexts and needs. He used the analogy of building a house, where the basic structure is there but people have the option of deciding where to put the windows and doors. He also talked about the need for more training, including online training, training for the younger people moving into the field, and ongoing training. Gilbert closed by saying that the ancestors are watching with smiles on their faces, recognizing that the people in the room are doing the best they can, fighting, demanding changes, and not giving up.

Carol then introduced Dr. Elaine Toombs, a Clinical Psychologist with Dilico Anishinabek Family Care in the Robinson Superior Treaty Area and Fort William First Nation on the shores of Lake Superior in Thunder Bay. Her work involves assessment, diagnostic, treatment, and consultation services to 13 remote and rural Indigenous communities. She is also a researcher at Lakehead University, focusing on adverse childhood experiences in relation to substance use services.

Dr. Toombs told the group that they would be discussing a trauma-informed national standardized curriculum. She noted that sometimes people have different reactions to, or concerns about, such a curriculum. Further to that, Gilbert's comments about the need for flexibility are important. The curriculum needs to be regionally specific with consideration of culturally relevant foundations.

The primary goal of the discussion was to identify the content that participants would like to see in the curriculum, based on their work experience and what they think would be most relevant, building on conversations that already happened that day (background information and core competencies), and leaning on the collective expertise in the room.

Dr. Toombs said that the building blocks of wellness, in terms of the First Nations Mental Wellness Continuum (FNMWC) framework, are Hope, Belonging, Meaning and Purpose and these are already being facilitated at treatment centres. She acknowledged that the people in the room are the experts in this work and are already working with individuals with high and complex needs, often in many contexts and with the least resources. So, the success of this work is admirable.

Some of the questions that need to be answered in relation to the development of a national curriculum are:

- What are people doing currently?
- What type of wraparound services are needed?
- Who has more specialized needs and how can those needs be met in a context of nationally based standards of care?
- What learning experiences, knowledge and skills can be shared, for instance, on the topic of substance misuse and mental health?
- How do you want this curriculum to be delivered?
- How can it be integrated with and support the services you are already providing?

Dr. Toombs then asked if anyone had any comments they would like to make.

One participant from northern Manitoba said they are paying a lot of money to learn more about trauma-informed care. This training was lacking in the past and it is very important to teach clients about trauma to support them in their healing journey. People are so busy talking about educating clients about alcohol, all the substance use and how bad they are, that they forget to teach about trauma. In fact, there is very little alcohol use now, it is more an extremely high rate of pills and other substances. Another issue is that there is no specific term in the Cree language for trauma – the closest translation would be a broken heart. There are a lot of trauma-related terms that need to be interpreted back into the Cree language for the Elders.

Dr. Toombs agreed that it is important to recognize that many people who go into treatment have concurrent needs in lots of ways. Working with them calls for cultural safety, building trust and transparency, collaboration and mutuality, mutual respect, empowerment, and peer support. These are all aspects of trauma-informed care. She then asked "When you hear about a national curriculum, what do you think? How could it be a potential benefit to the work that you already do?"

A participant from Ngwaagan Gamig Recovery Centre on Wikwemikong First Nation mentioned that they, like Gilbert's centre, had developed a virtual treatment program during COVID. It has since been discontinued but it did help a specific population that needed it, due to long wait lists for in-person care. It could also be useful for continuing care as well as for youth aged 16 or 17, because the Recovery Centre is for adults 18 plus. She also said that a national curriculum could provide general wellness supports – both virtually and in-person – helping people to be well, not just treating substance use. This would include teachings about culture and traditions.

Dr. Toombs then asked if anyone present was doing their own aftercare or continuity of care programs.

The Director of Rising Sun Treatment Centre in New Brunswick was providing aftercare which, thanks to discussions at the Gathering, will be renamed continuing care. It was provided through a specific block of funding through Regional Mental Wellness, and it involved engaging with people through their pre-treatment journey, identifying and supporting people who may be interested in treatment and developing relationships. They also have an aftercare continuum care process, which identifies community-based resources and services for clients. Some graduates have started their own recovery groups in their communities. They maintain contact with graduates and if someone is struggling, they can keep that person within the circle of care. They are also talking about having meetings with past graduates to keep the circle strong, as well as having conversations about going back to some virtual care options.

Dr. Toombs acknowledged the importance of continuing care and spoke about how a warm handoff can be incredibly helpful if people are being referred to or moving to a different program of some kind. Building that relationship means that they will continue to feel Hope, Belonging, Meaning and Purpose as they move from active-based to maintenance-based treatment.

A participant spoke about the need for a national trauma-informed curriculum, based on the story of a client who had gone through treatment 10 times and relapsed after each round. He tried but he kept going back to drinking, and what was probably missing in the treatment was addressing his trauma.

Another participant said that talk therapy is often overrated and sometimes staff also get stuck in telling their stories about what worked for them. It is important to get clients involved in something that will help them to process their emotions. Treatment needs to be client-centred, and this must be part of national standards of care ethics and guidelines. It is also important to focus on strengths-based assessments, rather than deficits-based (e.g., What is wrong with you?).

One participant working as a Community Services Manager talked about their centre's aftercare/continuing care program. It is client-centred and client-focused, and they check in with clients to see what supports they need, whether it's a once-a-week check-in or every few months. They are also looking at introducing a recognition system to acknowledge key milestones, such as after the first three months. The outreach counselor and the aftercare counselor work very closely together to ensure that people remain within the circle of care posttreatment. This includes outreach activities, virtual services and access to workshops and other resources.

Dr. Toombs noted that substance use work is very challenging, and it takes a lot of time and resources. It can also be overwhelming. One benefit of a national curriculum would be to take some of that load off, by offering a potential community of practice where there would be access to specialized resources and knowledge sharing to help with specific aspects of the work. In terms of wraparound services, she noted that continued care had been discussed, but wondered if there are aspects of pretreatment or brief treatment prior that people think would be relevant for consideration at a national level.

One participant from Nunavut talked about pretreatment and how often the simple things are overlooked. For example, because their clients must fly south to access treatment, letting them know what the process is going to look like can be very helpful – what time they will need to be up, what the schedule is like, etcetera. This helps to prepare them to know what to expect.

Another participant from Nunavut asked how the Inuit voice and Inuit Qaujimajatuqangit principles and laws would be incorporated into a national curriculum. Dr. Toombs acknowledged that this is a good point which relates to the importance of consultation and a flexible framework that will allow people to adapt it to meet their own needs.

A participant said that they do not necessarily have a pre-treatment program, but they do have a two-week type of prep program because they have youth that travel from all over to attend treatment, so they take some time to get them grounded, and familiar with the property and each other, and help them with self-care, etc. There's also a virtual meet and greet with staff before the program starts.

Another participant – an outreach counselor – said that she reaches out to all applicants to have a conversation with them about where they come from, their family and living situation and anything else they would like to share prior to treatment. There is also a pretreatment Zoom meeting with the outreach counselor, the counselor that is assigned to them, the cook, one night staff, the custodian, the aftercare worker, and traditional healers, so that clients get to know the staff in advance. Staff also meet them at the airport. The first week of treatment is dedicated to settling people in to learn about the facilities, learn how things work and meet their roommates.

Dr. Toombs noted that pretreatment can also address some of the concerns about reintegrating back into community, by identifying barriers upfront and integrating those into the treatment plan.

Presentation – **National Standardized Treatment Curriculum**

Dr. Elaine Toombs shared a presentation on Developing a National Standardized Trauma Informed Curriculum for Addiction Services. She acknowledged the expertise and collective knowledge of the participants as the experts in the room and noted that their work contributes to the development of four key outcomes for First Nations peoples – Hope, Belonging, Meaning and Purpose.

The presentation built on the six areas relating to core competencies identified in the previous session:

- Substance Use/Mental Health
- Harm Reduction
- Trauma
- Culture
- Service Components
- Population Specific

A key question is how to develop a national curriculum in the context of these core competencies, about which Dr. Toombs presented the following steps:

1. Develop core competencies
2. Establish process
3. Develop topics
4. Create learning experiences
5. Implementation - big and small
6. Evaluation of effectiveness

Another question participants might ask is how a national curriculum could support our current work? This gives rise to the following issues for consideration:

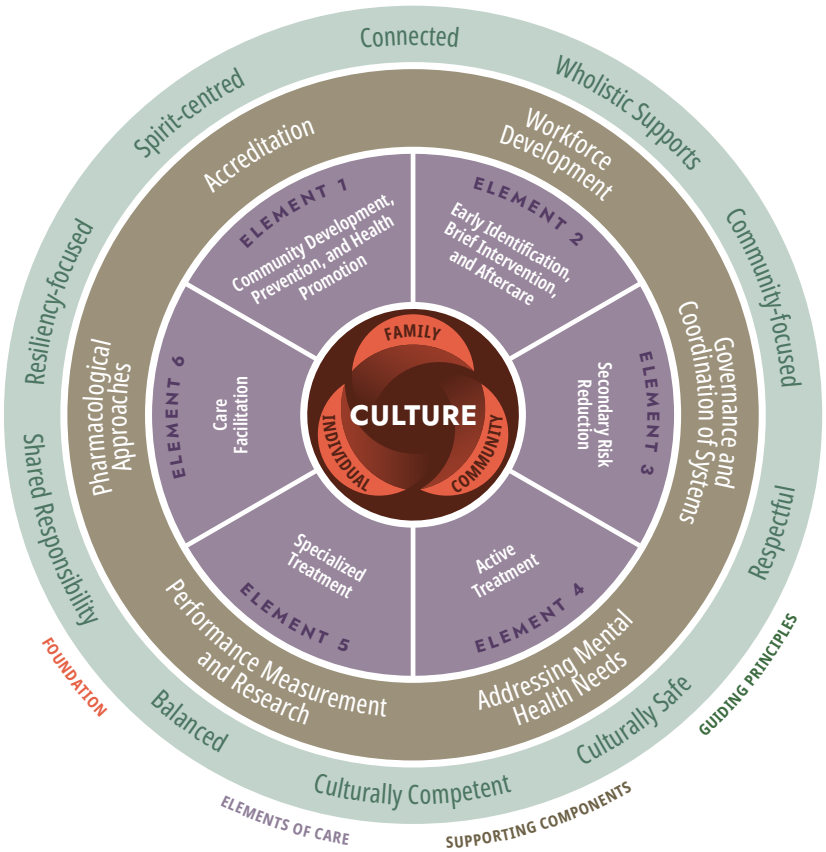
- What do you do currently?
- What type of wrap around curriculum do you need for your clients?
- How do you want this curriculum delivered? How can clients access it?

Focus of a National Curriculum

A national curriculum would be focused on several elements of care, namely:

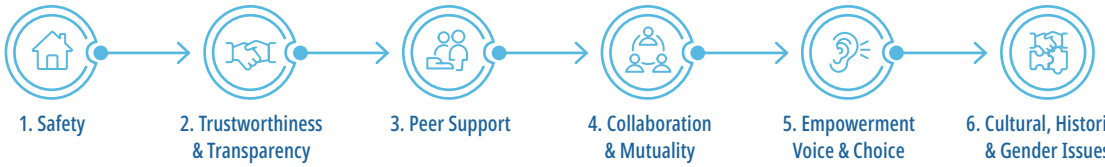
- Community Health/Promotion/Prevention
- Early Identification/Brief Tx/Continuing Care
- Harm Reduction
- Active Treatment
- Specialized Treatment
- Care Facilitation

The graphic below depicts how these elements of care fit into a model for a national curriculum, with culture as foundation, and including supporting components and guiding principles.



Integrating Trauma-Informed Treatment

Trauma-informed and trauma-based treatment will require implementation/ consideration of all of the following items, as shown in the graphic below.



Dr. Toombs shared an extensive list of research topics and published articles that she and her colleagues have reviewed, which covers all sorts of trauma and trauma informed interventions in various contexts. She also shared links to two papers that provide an overview of these topics:

Toombs, E., Lund, J., Kushnier, L., Stopa, A., Wendt, D. C., & Mushquash, C. J. (2023). Addressing experiences of trauma within Indigenous-focused substance use residential treatment: a systematic review and environmental scan. *Journal of Ethnicity in Substance Abuse*, 1-53.

Pride, T., Lam, A., Swansburg, J., Seno, M., Lowe, M. B., Bomfim, E., Toombs, E., & Wendt, D. C. (2021). Trauma-informed approaches to substance use interventions with indigenous peoples: A scoping review. *Journal of Psychoactive Drugs*, *53*(5), 460-473.

With respect to trauma-based interventions in substance use treatment, some of the key findings from the research are:

- It differs across sites.
- Treatment providers identified needs for
  - intergenerational trauma-focused treatment,
  - more training,
  - more resources,
  - networking with other centers, and
  - referral pathways after treatment.

Key Questions Related to Identified Core Competencies

To develop a national curriculum, there are specific questions that need to be answered regarding each of the areas requiring core competencies. For substance use/mental health, harm reduction, trauma, and culture, the questions would be:

1. What topics should be covered in a national curriculum relating to this theme?
2. What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences)
3. What do you need moving forward? What are other considerations?

With respect to populations, the questions would be:

1. Who are the people who may need more specialized services or content delivery?
2. What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences)
3. What do you need moving forward? What are other considerations?

Dr. Toombs then shared a QR code with the group for a Mentimeter online poll about a national curriculum, to be used during the group discussion.

Next Steps

Moving ahead with a national curriculum will involve the following steps:

1. *Tailoring to regionally relevant needs*
2. *Evaluation and assessment metrics*
3. *Incorporation with individual treatment centres*

Large Group Discussion

Core Competencies

There was a large group discussion following the presentation where participants reviewed the core competencies and talked about issues relevant to the development of a national trauma-informed curriculum. They would like more information about the specific contents of each of the core competencies, related learning experiences, and information about any organizations that have been doing teaching around these issues.

Existing Expertise of Treatment Centres and Workers

Participants talked about the excellent work that treatment centres were currently doing to keep communities well. They noted that treatment centres are experts in this area. They are working with the highest needs clients, with the least resources, training, and capacity, and yet they are building blocks of wellness to facilitate Hope, Belonging, Meaning and Purpose. The determination and toughness of the workers are key to this success, and it was agreed a national curriculum should be developed based on their expertise.

How Can the National Curriculum Support Current Work?

The discussion then turned to how a national curriculum could support the current work that treatment centres are doing.

Two ongoing challenges were identified, that being (1) long wait lists for specific populations to access care, and (2) large numbers of youth who need support.

Several themes related to the development of a national curriculum also emerged during this discussion.

- Flexible foundations are important. A national curriculum must include both national standards and be adaptable for diverse populations. As an example, the Inuit voice and the principles and laws they follow must be incorporated into a national curriculum.
- There is a need for worker training on trauma-informed care.
- There is a need to teach clients about trauma.
  Communities are paying a lot of money for trauma informed care, to learn about it. And one of the things that I noticed with my work with treatment was we never had this kind of training. And I think that was the most important piece that was missing, to teach the clients what is trauma? And let them go with that, to continue with their own healing journey. We're so busy talking about educating clients about alcohol, all the addiction, everything, and how bad it is, one of the things that we forgot and neglected to teach is trauma. – comment from a treatment centre worker
- There is a need for counselors to do outreach activities to connect with clients, and to engage with, and support people who may be interested in treatment (there is a pretreatment journey to start a conversation of loving relationships).
- There is a need for pre-treatment programs, for example clients have a two-week program, get familiar with the property, and have a virtual meet and greet before they go to treatment centres. This will reduce anxiety.
- It is important to focus on treatment modalities other than just talk therapy, which will support clients in processing their emotions, and incorporating these into national standards of care.
- Defining wellness and focusing on facilitating wellness is also important.
- There is a need for both personal and virtual support.
- Engaging peers is an important part of the treatment journey.
- Heart-centred approaches to care are important.
- There is a need for continuing care/aftercare, ensuring that it is client based and client focused, and supporting what is needed (i.e., clients being in control of their own after care) as well as identifying and addressing barriers to reintegration.

Small Group Discussions

In small group discussions, tables of participants were asked to fill in six boxes on flip chart paper, and to consider the questions in Table 1 below, within the context of the following topics:

- Substance Use/Mental Health
- Harm Reduction
- Trauma
- Culture
- Service Delivery
- Populations

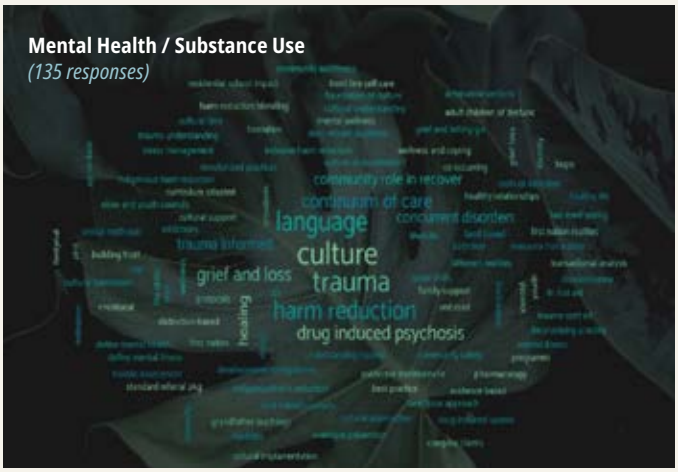
Participants were also asked to consider, within those contexts, (1) what topics should be included in the national curriculum, (2) how to share this topic knowledge with clients, (3) what they need moving forward, and for populations, (4) who are the people who may need more specialized services or content delivery? More specifically, the boxes were arranged as shown below.

Table 1

Who is at your table? ***Where do you work?*** ***What roles do you play in your organization and community?***	**Substance Use and Mental Health** What topics should be covered in a national curriculum relating to this theme? What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences) What do you need moving forward? What are other considerations?	**Harm Reduction** What topics should be covered in a national curriculum relating to this theme? What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences) What do you need moving forward? What are other considerations?
Trauma What topics should be covered in a national curriculum relating to this theme? What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences) What do you need moving forward? What are other considerations?	**Culture** What topics should be covered in a national curriculum relating to this theme? What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences) What do you need moving forward? What are other considerations?	**Populations** Who are the people who may need more specialized services or content delivery? What are ways to share this topic knowledge with clients? (creating meaningful client learning experiences) What do you need moving forward? What are other considerations?

Following the small group discussions, Mentimeter was used to aggregate 1-2 key words that represent each of the topic areas listed above, as well as those related to service delivery. Each generated a word cloud with the most common themes appearing as the largest words most relevant to the topic, as shown in the graphics below.

Mental Health / Substance Use
(135 responses)



Harm Reduction
(132 responses)

Trauma
(139 responses)

Culture
(136 responses)

Service Delivery
(120 responses)

Populations
(171 responses)

Day 2

Data, Quality, Indicators, Reporting and Policy

OVERVIEW

The second day of the gathering focused on data collection, data quality, indicators, reporting and data policy.

Introduction

Day two began with participants gathering in a circle for smudging. Carol Hopkins, CEO of Thunderbird Partnership Foundation, then introduced the topic of data and indicators. She noted that Indigenous people have a natural way of thinking about the results that their work will achieve. As an example, Anishinaabe people were given the natural ability to think ahead, which comes from stories of creation and the patterns that people witness in creation. This generates an ability to think about how to get where to go, and what to do when adjustments are needed: it is both a way of doing and a way of being. Some of the questions participants needed to ask themselves to define indicators of success and collect data were:

1. What is it that we naturally do?
2. How does that which we do naturally fit into our work?
3. How do we represent our values, fulfill our purpose, and reflect our natural ability, gifts and responsibility in our work?

We all have the responsibility for creating healing and wellness for First Nations and Inuit populations, so how do we know we are making a difference and what tells us that?

Nimkee NupiGawagan Healing Centre Story

Carol then shared a story reflecting how data made a significant difference for the youth in the program and services offered at Nimkee NupiGawagan Healing Centre. Nimkee had great staff; they also had high rates of serious occurrences, fighting and other challenging normal teenaged behaviors. Some youth had graduated and gone home, and during a staff debrief one half of the staff were reflecting on the male cohort that just left and reflecting on self care. The other half reflected on the challenges of the female cohorts and their emotions.

The staff focus was turned to the reports and the indicators within. Carol shared a small piece of the creation story; sharing that it is our world view, and all creation stories are true. The creation story tells us that the Great Spirit gave us the gift of kindness. This needs to take root and be enacted along our path of life. If we only see or recognize deficits then we do not see wellness, and change is an important element of healing and wellness.

One staff spoke up and said that he had never thought of the youth as being kind, another shared that they didn't think of the youth as truth tellers. They continued to share their thoughts. Carol asked what could be done differently to create an environment of kindness, strength, and honesty. Staff said they could start by removing the forms that only identify the things that have negatively impacted their life. They were encouraged to try this for three weeks, and after that, if it was not working, they could go back to collecting deficit-based data.

The baseline data was 30 serious occurrences, which meant one per day based on the past five years. The stories were accurate and matched with control, restrictions, and policies. After trying the new approach, there were zero serious occurrences over the next three months. Also, staff sick time decreased – they liked coming to work and encouraging kindness and caring. Staff turnover rate decreased as well.

This was a culture-based program – the foundation of kindness and caring. With more invested in strength-based stories, outcome rates improved, and more young people stayed and finished the program. They almost had a 100% completion rate. In the 13 years Carol was there, there were only two girls who left the program, but when they went home, they called every day and asked questions about culture that they did not understand. One year later they came back. One had become a young woman during her program, and she chose to do her berry fast, a great spiritual work. She came back a year later to finish her ceremony.

Summary

To summarize, Carol told the gathering "If you want to inspire change and encourage people, you need to know what's going on with people."

She further noted that Thunderbird gathers data, but more data is needed. They gather data on mandated subject matter and would like to have more information on the population of front-line workers. They also gather data internally for the organization, for example an organizational vital signs survey is conducted annually to understand the staff, celebrate successes, and understand what needs to change.

Presentation 1 – **Quality, Data and Data Quality**

Carol Hopkins, CEO of Thunderbird Partnership Foundation, and Dr. Deb Dell, Director of Youth Solvent Addiction Committee (YSAC), shared a PowerPoint slide presentation with the participants on Quality, Data, and Data Quality.

To start, they told the group they had mined several prominent reports including those from Accreditation Canada, the Recovery Research Institute, the Canadian Accreditation Council, Canadian Centre on Substance Abuse and Addiction (CCSA), and Institute of Medicine (IOM) Standards of Care (Health Quality Care) on defining quality. This generated more than 42 different quality and accountability indicators across several areas including governance, direct client care, outcome monitoring and human resources. They noted that across all programs, there are mechanisms to monitor and measure all the indicators.

When they began this process, their work was guided by a set of assumptions about quality and accountability, which include:

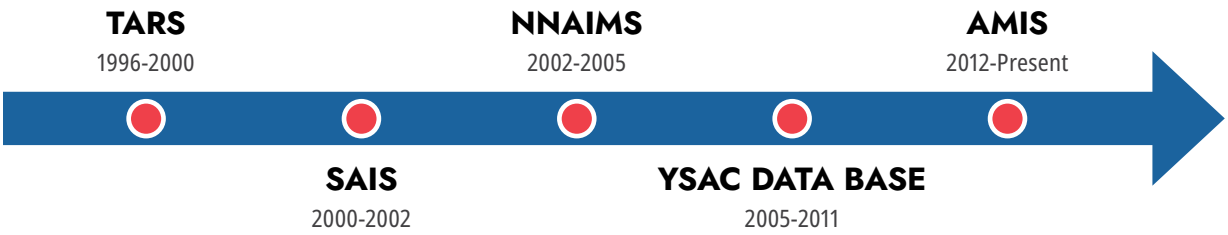
- Quality **human resources** lead to quality care (ethics, qualification, knowledge skill, attitude, work satisfaction).
- This creates a healing experience (e.g., safety, quality **environment**, comfort).
- Quality human resources combined with quality environment are achieved through policy and practical implementation.

Practical implementation can be monitored and indicated by data, including satisfaction, certification rates, completion rates, occupancy rates, and treatment outcomes data (Dusi-R/NWA).

They also discussed why they started the AMIS (Addictions Management Information System) project. Treatment centre reporting systems started with TARS (Treatment Activity Reporting System). This was a Health Canada driven and accountability focused system in which a 1998 NNADAP review found no confidence in the system: it was fax based, seen as punitive, had irrelevant questions, and lacked flexibility. This was noted in the review - *"TARS needs to have additional capabilities such as client monitoring systems for program information and accountability; tracking client outcome, and measuring quality assurance programs for the treatment centers"* (NNADAP General Review, 1998).

TARS was followed by SAIS (Substance Abuse Information System), which had several issues: inaccuracy, crashing, fax driven, no real time data out, national data only. After that came the NNAIM (National Native Addictions Information Management System), which was community driven and meant to incorporate treatment centre level reporting but lacked national support. The YSAC data base was a YSAC only cloud sharing data base site built on the YSAC indicators of quality and trauma-needs history (e.g., family substance use, suicidality, abuse).

Carol noted that there was a growing recognition of the uniqueness of our data and the wholistic way we were framing quality and success, which led to a home-grown development of intake data like Adverse Childhood Experiences (ACEs), and to the understanding of the need for a more comprehensive system including trauma informed assessment tools/quality indicators. This in turn led to the introduction of AMIS. The graphic below shows the implementation of these information systems over time.



Towards a Quality Framework

It should be noted that quality treatment may be defined differently based on the lens and the angle of the perceiver, whether that be a funder, a treatment centre, a client, families or communities. This calls for a comprehensive quality framework, with a complicated and collective web of indicators to be considered, as shown below.

Using this type of framework allows for the collection of quality indicators in systematic ways. Indicators span across a variety of treatment areas, and they involve processes, perceptions and measurable outcomes using standardized tools.

What Is Quality Treatment?

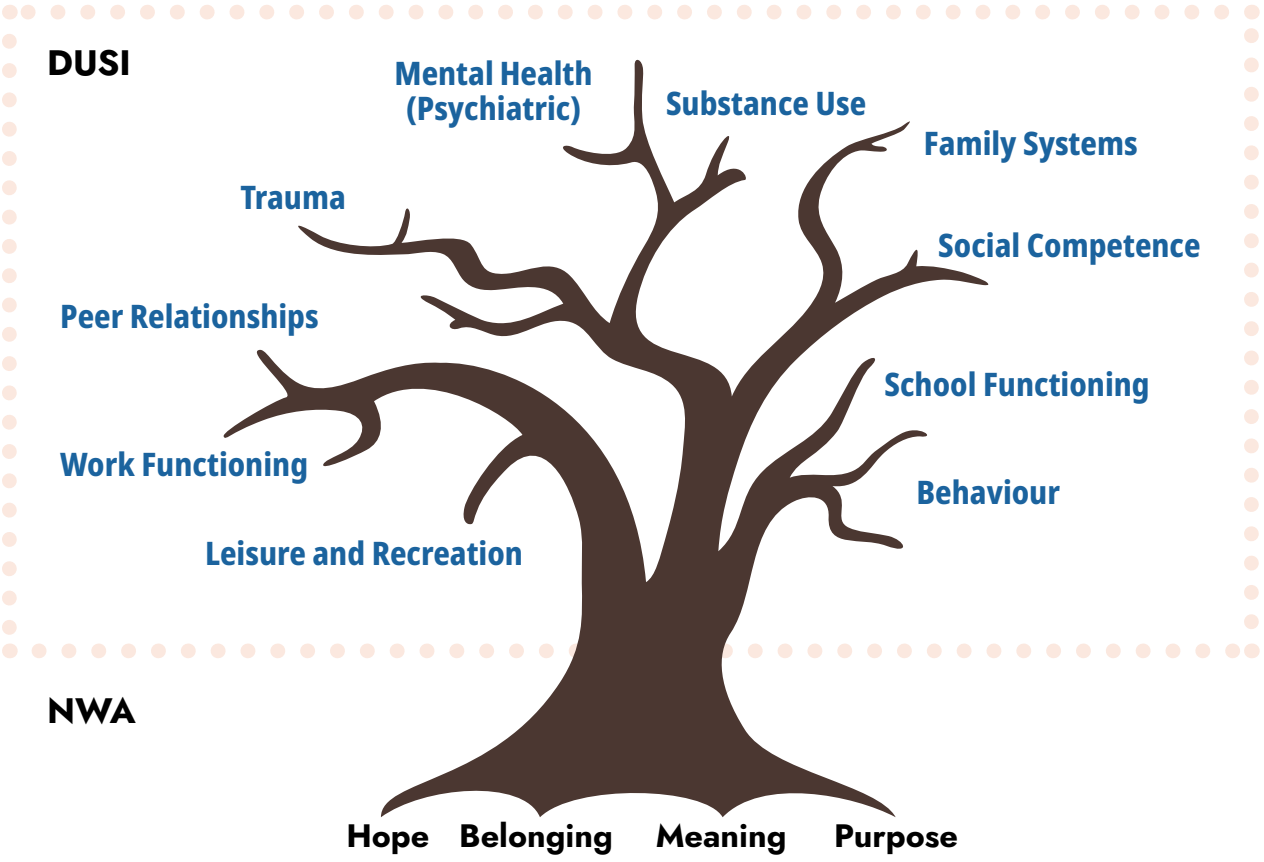
Based on the work done to date, indicators of quality treatment are:

- It is safe.
- It is evidence-based.
- It is culturally congruent.
- It matches needs – it is appropriate.
- It is qualified.
- It is effective.

Assessment Tools

The DUSI (Drug Use Screening Inventory) and the NWA™ (Native Wellness Assessment) are both important tools. The NWA™ domains and the cultural interventions that support it are the roots of change, and the DUSI represents the fruits of change. The graphic below shows how the roots and fruits function as a metaphor for culture as the foundation of Indigenous treatment centre programming.

The Roots of Meaningful Change



Presentation 2 – **Introduction to AMIS**

Thunderbird staff members, Christy Bird and Yvonne Olivier, shared a slide presentation about AMIS from an AMIS Expansion Pilot Webinar. AMIS is a national system for NNADAP and Youth Substance Awareness Program (YSAP) and it includes the DUSI and NWA™ data.

Reporting is important because it provides evidence that what we are doing is working in our communities. However, using AMIS is entirely optional and centres can decide whether they want to work with AMIS.

AMIS includes competencies and client records. There is a referral, information sharing, and transfer process embedded, which helps to improve client care coordination. AMIS helps with screening and can assist clients to go to the centre that would suit them best. For treatment planning, it includes goal setting and can monitor program effectiveness. For client follow-up, AMIS includes monitoring, case notes, treatment plan adaptations and aftercare.

AMIS includes several reports, such as annual, quarterly, and other options. One purpose of using AMIS is to increase organizational efficiency – it allows treatment centre staff to follow clients especially if they move between centres. This provides a continuity of care that is helpful and can be very important for support once back in community. AMIS also has a client view so a client can follow along on their progress/see their wellness plan. The data collected through AMIS can support research initiatives and accreditation.

AMIS system navigation is flexible, and AMIS has online support, various tools, tabs, and filters. It includes competency linkages to support organizational strategic planning, accreditation needs (Canadian Accreditation Council, Accreditation Canada, Commission on Accreditation of Rehabilitation Facilitation, and Canadian Centre for Accreditation), individual certification competencies (ICBOC/CCPC /Other), Certified Indigenous Addictions Specialists, plus the Honouring our Strengths Framework and Indigenous Wellness Framework.

The screening tool DUSI (Drug Use Screening Inventory) is comprehensive, efficient, and pragmatic. It ranks severity and helps to support decision making and management. It also looks at outcomes, engagement, and evaluation. There are different versions available depending on needs. The NWA™ (Native Wellness Assessment) is an instrument developed by First Nations people using Indigenous-based knowledge to measure the impact of culture on wellness over time among youth and adult populations. The assessment measures wellness across four areas: spiritual, emotional, mental, and physical well-being. It is based on Indigenous knowledge, is strengths-based and measures Hope, Belonging, Meaning and Purpose. The NWA™ can be used in treatment centres or community programs that implement Indigenous culture-based programs to

- set goals for treatment or plans of care,
- monitor change over time,
- establish targets and benchmarks,
- understand the relationship between changes in wellness and cultural interventions, and
- evaluate programming with culture interventions.

The NWA is useful because cultural interventions improve wellness and the overall treatment journey for youth and adults. It can help to understand areas of strength and areas that need improvement over time, which can be meaningful and to help set the path toward a client's individual wellness journey. The assessment can also use aggregate results to evaluate cultural programs to improve programming.

To find out if AMIS is a good fit for an organization, there is a complete readiness assessment that Thunderbird sends out for organizations to complete. Thunderbird also has a data sharing agreement: Thunderbird is the data steward, so it does collect the data and store it. Thunderbird provides a national report based on all information collected; this is used for work that includes research and education advocacy for how to better provide support to community organizations.

AMIS is completely web-based and can be accessed via laptop or computer. Training to use AMIS is free to First Nations organizations. In addition to free training, Thunderbird offers webinars, user group meetings, an annual report workshop, ongoing support, and AMIS support tickets.

AMIS is currently undergoing expansion at Thunderbird to include national case management and more culture-based support. The AMIS expansion pilot project looks at access, the continuum of care, the streamlining of workloads, and outcomes. Use of the program requires high speed internet.

Q & A

Q: Is it possible to keep our notes confidential in the system?

A: Confidentiality is very important. However, it is critical that notes can be shared to ensure continuity of care, risk (e.g., if there was an issue during the day shift, it is vital to have that noted for the evening shift to mitigate risk)

Q: AMIS seems very clinical – where is the Indigenous side of things?

A: It's built on the Native Wellness Assessment and so the "Indigenous side of things" is integrated into the system.

Presentation 3 – Changes to Indigenous Services Canada (ISC) Outcome Reporting Processes

Tanya Churchill is the Acting National Manager of the Substance Use Program with Indigenous Services Canada (ISC), and she lives and works on Treaty 6 territory in Edmonton. She provided the Gathering with an overview of changes to ISC reporting processes and identified several issues that need to be addressed.

Tanya started working at the frontline, completing forms and collecting data, then began working in the Regional Office with First Nations and Inuit Health Branch (FNIHB) in Alberta. In that capacity, she reviewed reporting and data to understand how to best distribute funding based on data. Nationally, she can see the *big picture* data and recognizes how critical data is. As most of the participants are probably aware, treatment centre reporting is mandatory. However, everyone has different ways of collecting and reporting data. It is important to note that the data currently being collected is not helping us to tell the story we need to be telling. It is important to help tell the story to access federal funding.

The data collected currently is primarily about outputs (How many days were you open? How many people did you serve?). It does not focus on outcomes. Tanya emphasized the importance of using both quantitative and qualitative data in reporting. To date, decision makers have been more focused on numbers. Moreover, while numbers are needed, centres also need to be reporting more consistently, and different numbers are needed as well.

She said that the hope for today is to initiate a conversation on what is working, what is not working, how service providers use information to tell their story and progress, and to determine if information displaying program results is shared with clients. Tanya would also like to hear examples of anything new and innovative happening in treatment centres.

Tanya closed by saying she is hoping to continue the conversation going forward with Thunderbird's supported treatment centre calls. By September 2024, Tanya expects to know what will be proposed in terms of updates to data collection and reporting process for 2025 – 2026, recognizing that this will be the beginning of a longer-term process.

Small Group Discussions

Discussion Group 1 – AMIS

This discussion was about AMIS and two questions were posed to attendees.

1. What works for those using AMIS and if not using AMIS what would you expect to work for your organization if using AMIS?

Discussion results about what works:

- Data rolls up automatically.
- AMIS generates reports.
- It is customizable.
- Event reports can be added for accreditation tracking.
- It offers web-based client information management.
- Client files are paperless.
- It captures good demographics when data is entered consistently.
- It provides a good client snapshot, but it is missing part of the story.

2. What doesn't work for those using AMIS?

Discussion results about what does not work:

- How to analyze data.
- The NWA™ was not well received by some staff. They felt they didn't want to observe/judge people practicing cultural activities or not (e.g., religious beliefs).
- It does not accommodate individuals who are illiterate.
- It is time-consuming for staff.
- There is a lack of data if DUSI is not used (i.e. only use intake form to open a file).
- DUSI has not been well received by some participants (it is perceived as not culturally safe).
- It cannot accommodate multiple cycles (residential and virtual).
- Participants need more training to use the tools.
- DUSI questions are too personal. For example, questions include: Were you promiscuous and skipped school or classes? (and other personal info) Why? What is the significance of these sorts of questions?

Discussion Group 2 – Changes to Indigenous Services Canada (ISC) Outcomes Reporting

This discussion involved changes to ISC outcomes reporting and it revolved around benefits and challenges/concerns related to AMIS, as well as some other topics. Many discussion participants were using AMIS and were generally positive in their views about it, but many also felt it did not fully capture everything they needed it to capture.

Benefits

Some centres reported ease of use with AMIS and they liked being able to quickly generate reports at end of year with a single button press.

One person liked the changes to AMIS to include Diagnostic and Statistical Manual (DSM) tags, and to better see data trends.

One speaker noted that they use AMIS to generate quarterly reports for their board on things like number of beds occupied, outreach, etcetera.

Some of the Québec treatment centres have customized AMIS to include custom forms like incident reports. They have AMIS user groups that people attend to advocate for changes with AMIS.

One speaker praised the extra tracking and reporting done by some centres to help justify extra funding.

Challenges/Concerns

Cultural components are not being captured in AMIS (number of Elders utilized, language instruction, ceremonies, and land-based treatments).

Many people shared concerns that the data captured was too quantitative and missing the story (qualitative) piece. These missing components might also affect other funding bodies and require using other reporting systems for their needs (e.g., data usage needed by funding groups to justify investments such as waitlist lengths). Tanya assured participants that FNIB is looking at qualitative and quantitative reporting, but other areas in the federal government might be focused more on just quantitative reporting.

There is no clear consensus on simple quantifiable outcomes to measure success.

Some struggle with generating reports, as this requires continual, correct, and valid data entry for the reports to be properly done.

Some concerns were raised about staffing with regard to using AMIS. It creates an added burden on existing staff and not all staff are trained adequately in filling it out. There are also issues with wage parity in terms of getting more specialized staff to work on AMIS.

There were concerns expressed that reporting could look negative if every single bed is not full.

There is also a lack of resources for and investigation into follow-up data collection and reporting after people leave the program.

AMIS does not fully capture all the actual services offered, such as community-based services (although Tanya clarified that Thunderbird is piloting this) as well as outreach services. It was also noted that AMIS reporting is not capturing methamphetamines, only opioids. Tanya mentioned that they do not have full access to all the information from reporting, but that Thunderbird does.

For some, AMIS does not meet their funding requirements for reporting. Contribution agreements, for example, require certain data, but they do not specify how it must be reported. It could be on paper or using a different data system. AMIS should be able to meet these requirements, but it does require specific data collection all year long.

There is a need for better cooperation between referrers and treatment centre staff. It would be helpful to better capture that data between referral agents and treatment centres.

There was some mention of detox data not being captured. However, Tanya clarified that detox is not funded through them (although she would like it to be).

There needs to be a way to capture quality of life of program participants in a longer-term follow-up.

Other Discussion Topics

Funding and wage parity emerged as significant issues. Many centres felt that the NNADAP funding levels were not where they needed to be and the inflationary increases since the 1970's were not adequate to cover increased population and needs. This has resulted in significant wage disparities (i.e., people can make 95k tax-free as frontline workers as opposed to $16/hr at healing lodges) which has created difficulties in attracting talented workers. One speaker identified a need for more specific roles in human resources, data collection, quality assurance, etcetera, as well as more administrative supports. Another pointed out that they also face a lack of human resources to supply the data and added that perhaps Thunderbird could provide this training. Tanya noted that NNADAP funding has not kept up over time since it was created in the 1970's. A similar program implemented now would start at a much higher budget. It was also mentioned that salaries from ISC are too low; some are having to pay workers more and to fill in the difference with funding from other sources and grants. The lack of funding available for virtual care was also mentioned.

ISC contributions come in the form of extension agreements that keep funding at the same levels. There are too many extensions and some feel that they are forced to sign unfair agreements as the alternative is zero funding.

Tanya asked the group about follow-up reporting and which centres are contacting clients one plus month after leaving. A few people said they did up to two years after. Some start contact as early as two weeks after, then continually throughout two years. This data can be used to determine if someone might need to come back for a shorter term as opposed to a full treatment.

Treatment incentives were mentioned. For example, one centre gives clients an eagle feather when they graduate. Another is taking lessons from Narcotics Anonymous and Alcoholics Anonymous by using tokens and such, and talked about how much pride people take in those. They are creating their own based on the seven grandfather teachings to give to people at the 30/60/90-day marks.

There was some discussion on difficulties NNADAP workers might face getting people into programs. A specific example was provided from Ottawa, with Inuit unhoused clients who do not own phones being unable to complete intake, as a phone number is necessary. So, the centre is unable to get them into beds.

Discussion Group 3 – Data Policy & Advocacy

Carol Hopkins, CEO of Thunderbird, and Dr. Debra Dell, Director of YSAC, asked participants about the indicators that they are currently using to collect data. They noted that Thunderbird did not have access to certain datasets, for example the number of people certified by the Indigenous Certification Board of Canada (ICBOC), or Canadian Council of Professional Certification (CCPC), or the number of treatment centres that are accredited. Attendees were asked to think about the kinds of data they were currently collecting that could help them to tell a story about how their treatment centre runs and what kind(s) of data they could or should be collecting to help them build, change, or grow, and support policy change and advocacy. Participants identified the following as data that would help to support those objectives:

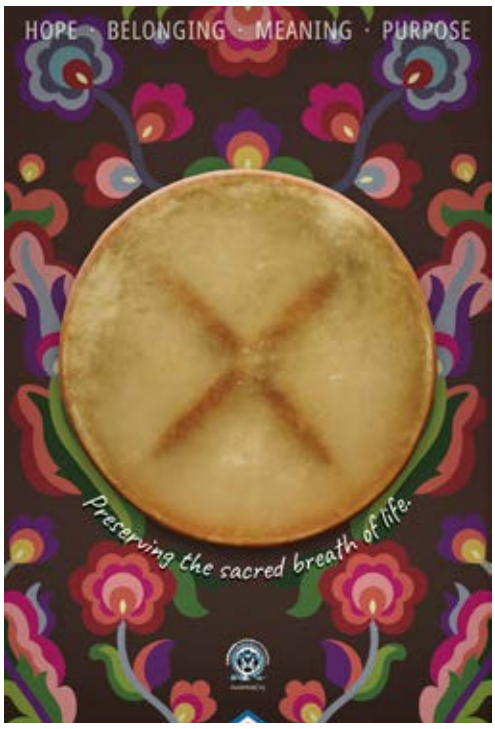
- Satisfaction levels of clients and staff
- Information about staff – age, gender education, First Nations status, length of employment, training, core competencies, personality traits, certification rates, staff self-care, turnover rates and data from exit interviews
- Evaluation findings from board and program evaluations, and quality assurance data using standards, governance, management, and resources, and regular SWOT analyses, e.g. every three years
- Critical incident reporting and risk mitigation data
- Enhanced Indigenous assignation standards
- Data around strength-based programs
- Information about how to build culturally based services with a strong team, using natural healing approaches
- Indicators for virtual programming
- Data about partnerships and potential partners
- Development of policy committees for staff and boards
- Data on wage parity for traditional healers and traditional wellness
- Information on complexity of clients who need higher levels of care
- Information on funding, for example the type of information needed for applications to granting bodies and funders
- Data on outreach, prevention and stabilization services provided to advocate for additional funding

Recognition Ceremony

The afternoon activity was a ceremony to acknowledge the hard work and accomplishments of a number of individuals and centres, nominated by their peers for recognition. Forty individuals and ten treatment centres were recognized and received gifts.

Individual Recognitions (present)		
Leah Louis	BC	Round Lake Treatment Centre
Willie Alphonse	BC	Nenqayni Wellness Centre
Sharon Duffy	BC	Nenqayni Wellness Centre
Valerie McLeod	SK	Woodland Wellness Centre of La Ronge
Jaqueline Anaquod	SK	Treaty 4 Territory
Tammy Lemaigre	SK	Armand Bekkattla Treatment Centre
Neanna Catt	ON	Nimkee NupiGawagan Healing Centre
Dave Trudel	ON	Nimkee NupiGawagan Healing Centre
JayR Jonathan	ON	Native Horizons Treatment Centre
Claudette (Claidi) Mitten	ON	Native Horizons Treatment Centre
Pamela Charlong	QC	Walgwan Centre
Gilbert Whiteduck	QC	Wanaki Centre
Angela Miljour	QC	Wanaki Centre
Chad Thusky	QC	Wanaki Centre
Ryan Ward	NB	Rising Sun Treatment Centre
Michelle Anderson	NB	Rising Sun Treatment Centre
Dawna Prosper	NS	NADACA - Native Alcohol & Drug Abuse Counselling Association of Nova Scotia
Wekatesk Augustine	NS	NADACA
Robert Casey	NS	NADACA
Marcia Johnson	NS	NADACA
William Morrison	NS	NADACA
Jolita Stevens	NS	Mi'kmaw Lodge (NADACA)
Mary Freda Simon	NS	Eagles Nest Recovery House (NADACA)
Bernadette Syliboy	NS	Eagles Nest Recovery House (NADACA)
Anita Taylor	NS	Eagles Nest Recovery House (NADACA)
Deb Dell	National	Youth Solvent Addiction Committee (YSAC)

Individual Recognitions (not present)		
Fran Quewezance	SK	Leading Thunderbird Lodge
Bailley Taylor	ON	Curve Lake First Nation
Barbara Ballantyne	SK	Prince Albert Grand Council
Melvin Taypotat	SK	Leading Thunderbird Lodge
Leroy Cornell	ON	Nimkee NupiGawagan Healing Centre
Daniel Doxtator	ON	Nimkee NupiGawagan Healing Centre
Jonathan Summers	ON	Nimkee NupiGawagan Healing Centre
Kristen McKenna	ON	Nimkee NupiGawagan Healing Centre
Marlene Carle	QC	Wanaki Centre
Jamie Carle	QC	Wanaki Centre
Maude Paul	QC	Wanaki Centre
Jenny McConni	QC	Wanaki Centre
Evelyn Winters	NFL	Charles J Andrew Youth and Family Centre (CJAY)
Tammy Michelin	NFL	CJAY



Descriptions

Leah Louis
(Associate Director, Round Lake Treatment Centre)

Leah Louis has worked in the field for over 30 years and plays a critical role in the ongoing leadership, policy/program development and guidance at Round Lake Centre, to our external partners and to industry stakeholders. Her ongoing commitment to the individuals we serve has been key to the success and high standard of care that Round Lake is known for, and her diligence and hard work are greatly appreciated.

Willie Alphonse
(Executive Director, Nenqayni Wellness Centre)

Recognizing Willie for 15 years as the Executive Director of Nenqayni Wellness Centre.

Sharon Duffy
(HR manager, Nenqayni Wellness Centre)

Recognizing Sharon Duffy for 27 years at Nenqayni. She has worked pretty much every position – a very hard-working individual.

Valerie McLeod
(Director, Woodland Wellness Centre)

Recognizing Valerie for her strong dedication to introducing Traditional Teachings with the WWC Elders and staff.

Jaqueline Anaquod
(Muskwopetung NNADAP Worker)

Jaqueline has over 10 years of experience working in the Treaty 4 Territory and in Regina. She started an opiates support circle and has done countless good deeds.

Tammy Lemaigre
(Armand Bekkattla Centre)

Ms. Tammy Lemaigre has been providing dedicated organizational and visionary support to the Armand Bekkattla Centre in Clearwater River Dene Nation in Saskatchewan for 24 years. Tammy has supported staff development, organizing inspirational workshops that offer professional development, self-care, and team building. In the various roles she has held over the years, she holds a vision and passion for healing and transformation, not only for participants in the centre, but for centre staff and for her community as well.

Neanna Catt
(Nimkee NupiGawagan Healing Centre)

Neanna has been working very hard to complete Expressive Arts training to become a REASE Registered Expressive art facilitator. Her goal is to write an expressive arts program with an Indigenous foundation, and she is working to finish her Clinical supervisor program. With the expressive arts program she is so far the only one in Ontario that is actively practicing this style of therapy.

Dave Trudel
(Executive Director, Nimkee NupiGawagan Healing Centre)

Dave has worked at Nimkee NupiGawagan Healing Centre for 16 years from opening to 2012, returned in November 2021 and rebuilt a brand new Nimkee, re-wrote all policies and procedures (with ED at the time), completed Accreditation in 17 months with Canadian Accreditation Council and obtained 4 years accreditation with 0 infractions with policies and onsite visits. Dave has promoted community development and prevention with the reduction of substance misuse. He has promoted healthy living and coping with mental health within communities. Dave provided ongoing support for those individuals seeking treatment, outside of the workplace. Has attended the AFN on December 6th, 2023 to speak to the Chiefs of Ontario about reinvesting money to the already existing treatment centres in Ontario.

JayR (Delbert) Jonathan
(Program/Cultural Team Lead, Native Horizons Centre)

Native Horizons would like to acknowledge JayR (Delbert) Jonathan, our Program/Cultural Team Lead. JayR has been with us for 14 years being promoted to his current position from an attendant position. JayR leads the program team with openness, fairness and integrity. He has modeled the importance of staff wellness by continually addressing his own triggers, traumas and issues. He willingly shares his healing and vulnerability. Many organizations have tried to lure JayR from us - we know what a gem we have with him and would not let him go gently into the night.

Claudette (Claidi) Mitten
(Native Horizons Centre)

Claudette Mitten has been employed with Native Horizons Centre for 30 years and will be retiring in March of 2024. “Claidi” has been the Program Supervisor for many years, mentoring the program staff through program development, delivery, staff administration with supervision, scheduling, personal and professional development. She has been my supporter in implementing the practice and commitment to staff healing and wellness. Native Horizons will certainly miss Claidi but hopes to keep her engaged with staff and our community members.

Pamela Charlong
(Executive Director, Walgwan Centre)

Pam has worked in NYSAP for more than 25 years. She has moved through a variety of roles in her tenure, from direct counselling youth care positions through supervision to her current role as Executive Director. Her staff comments from a recent staff satisfaction were full of comments about her humility, dedication, ethics, and work ethic. She takes on new research projects and board roles in her spare time! All of this together with continued involvement in her own lifelong learning, education, and certification. Recognizing Pamela for her leadership, her dedication to the vision and mission of the center, but even more for always wanting to make a difference in the lives of everyone who crosses her path.

Gilbert Whiteduck
(Program and Services Team Lead/ Counsellor, Wanaki Centre)

Recognizing Gilbert for work done to promote harm reduction and in particular the availability with individuals and communities. Also, for implementation of a 4-week Virtual Program since June 2020, a short 2 months after COVID started. A quick mitigating transition to meet the needs of participants. An option for a continuum of care that is now part of the options available.

Angela Miljour
(Executive Director, Wanaki Centre)

Recognizing Angela for implementation of a 4-week Virtual Program since June 2020, a short 2 months after COVID started. A quick mitigating transition to meet the needs of participants. An option for a continuum of care that is now part of the options available.

Chad Thusky
(Wanaki Centre)

Recognizing Chad for his input and leadership related to cultural programs and in particular of the teaching of Anishinabemowin.

Ryan Ward
(Rising Sun Treatment Centre)

Ryan is a Mi'kmaq warrior who has stepped up in the process of the Rising of the Rising Sun. His gifts of gentle strength, loving kindness, cultural crafting and adaptability are a tremendous gift to all our clients who walk through our doors for healing.

Michelle Anderson
(Executive Director, Rising Sun Treatment Centre)

I believe my Director Michelle Anderson is a perfect fit for this nomination. She came into the centre's life during a period of change and growing pains. And has been our incredibly dedicated and loyal leader for nearly 2 years now, with results that have made waves, and introducing new and wonderful ideas into the rural area of NB we live in such as harm reduction strategies and policies. And on a larger scale NB as a whole. She is a fighter and the truest ally we could have at the helm, holding and sharing the torch that is Rising Sun Centre.

Dawna Prosper
(Executive Director, Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Dawna has spent the last 26 years building and developing programming for aftercare, prevention and now treatment. Within our Community of Eskasoni but as well, the Atlantic region through the treatment programming. She sees this as all heart work and is very appreciative of the staff I work with. What a team. After taking on this roll Dawna fought hard to enhance accreditation... enhanced care and mental wellness - this was a lot of work having to increase her own level of certification and supporting staff their own journey with accreditation.

Wekatesk Augustine
(Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Recognizing Wekatesk for support in creating NADACA's online wellness program. Created out of the pandemic back in June 2020, this program provides a 4 week Wellness program helping those to maintain sobriety, offer support or lead them along their healing journey, and now an accredited program providing services across the nation.

Robert Casey
(Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Recognizing Robert for continued support in delivery of NADACA's online wellness program. Created out of the pandemic back in June 2020 this program provides a 4-week wellness program helping those to maintain sobriety, offer support or lead them along their healing journey, and now an accredited program providing services across the nation.

Marcia Johnson
(Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Recognizing Marcia for their dedication and hard work with NADACA over the past 2 years.

William Morrison
(Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Recognizing William for their dedication and hard work with NADACA.

Jolita Stevens
(Native Alcohol & Drug Abuse Counselling Association of Nova Scotia, NADACA)

Recognizing Jolita for their dedication and hard work with NADACA over the past 8 years.

Mary Freda Simon
(Eagles Nest Recovery House, NADACA)

Recognizing Freda for her leadership and work during the pandemic and beyond to ensure community was supported.

Bernadette Syliboy
(Eagles Nest Recovery House, NADACA)

Recognizing Bernadette for her work during the pandemic and beyond to ensure community was supported.

Anita Taylor
(Eagles Nest Recovery House, NADACA)

Recognizing Anita for her work during the pandemic and beyond to ensure community was supported.

Debra Dell
(Executive Director, Youth Solvent Addiction Committee, YSAC)

Although Deb is not affiliated with any specific YSAC Centre, Debra has worked with and for the YSAC network for 28 years. In her early years, Deb started out as Executive Director of White Buffalo Treatment Centre and moved to the position of YSAC Executive Director, a position she has held for 26 years. Deb has tirelessly advocated for YSAC's growth and development both as an organization as well as each individual treatment centre. Deb has helped each treatment centre in their developmental years and continues to help each centre in all areas of operation, governance, human resources, accreditation, and training and development. Deb is a very humble person, who does not like to be in the spotlight, nor does she like to be photographed, however, her contributions to the YSAC network are to be commended as she has put many years into a network that has gained a positive reputation and in building quality treatment centres that focus on cultural and clinical best practices. Deb is not afraid to think outside the box and challenge the status quo. She is a person of integrity, honesty, empathy, and great generosity. I believe she deserves to be recognized.

Fran Quewezance
(Leading Thunderbird Lodge)

Fran has committed all his career as a youth care worker. Over 30 years of working with youth as an intervention to high-risk youth. Fran has been with Leading Thunderbird Lodge for over 10 years as youth counsellor. He has been a youth care/counsellor for over 30 years. His ambition is to help Indigenous youth become healthy through holistic programs and counselling. Fran has always worked extra-long hours to provide a safe environment for youth at risk. Those environments he provided were grounded in cultural base programming and counselling.

Bailley Taylor
(Curve Lake First Nation)

Bailley has 15 years in the field and accomplished her NNADAP certification, is a key support to the mental health and wellness team, supports justice programs, and contributes to programs that make a huge difference in our community. Bailley always goes above and beyond. She developed an Indigenous Harm Reduction Circle that focuses on Anishinaabeg recovery and mental wellness healing supports; coordinated a local Indigenous women's support group; ensured safe return of trafficked women; and supported equitable access to a rehabilitation centre for community members. She is dedicated to ongoing training and education to further support her community. A single mother, intergenerational survivor, dedicated to her work, and a force for the community.

Barbara Ballantyne
(Prince Albert Grand Council Holistic Wellness Centre)

Barbara has dedicated over 10 years of service towards mental health and addictions and has developed programs from the ground up including the Montreal Lake Treatment Centre, Camp Hope, and the newly developed Yuasni Family Treatment Centre for PAGC. As a leader, Barbara is the embodiment of empathy and intelligence, we believe that she should be recognized for her caring heart, her ability to walk in another's shoes, her creativity, her dedication to the development of culturally appropriate programming and overall; her ability to effectively manage a unit of peoples. There are not many leaders who are willing to walk a mile in the shoes of another, but with Barb, she always aims to understand another's perspective—she is always willing to lend a listening ear. As the famous Aristotle proclaimed, "we are what we repeatedly do. Excellence then, is not an act, but a habit". Thank you Barbara! -*PAGC Holistic Staff*

Melvin Taypotat
(Outreach/Intake Worker, Leading Thunderbird Lodge)

I would like to nominate Melvin Taypotat for his work in Suicide Prevention/Life Promotion between the years 2015-2024. During these nine years, Mel has either facilitated alone or co-facilitated, YSAC's two-day Life is Sacred Suicide Prevention/Life Promotion to over 523 First Nation Community Members treatment centre staff, not just within Saskatchewan but also out-of-province. Like many of us, Mel has been personally affected by suicide and has become a strong advocate for dispelling myths and facts and stigma around suicide; the role colonization and media play in suicide; what warning signs to look for; and how to incorporate protective factors and self-care in one's life. Mel continues to play a role in supporting and promoting YSAC's Life is Sacred training program both within his workplace and communities within the Province of Saskatchewan - and more recently, in assisting with YSAC's Train the Trainer program.

Leroy Cornell
(Intake Worker, Nimkee NupiGawagan Healing Centre)

Leroy is the intake worker and sees that Nimkee has youth here to get the healing they need. He plays a role in every step of providing youth with care. Leroy is everyone's first point of contact as well as their last point of contact as he heads our admissions and intake department as well as our aftercare department. Leroy also plays a large role in treatment when youth are here. Additionally, Leroy goes above and beyond for our organization in obtaining outside resources as well as doing outreach in other communities that he visits.

Daniel Doxtator
(Nimkee NupiGawagan Healing Centre)

Daniel helps youth work towards their healing and recovery. He takes time to deliver programs centered around harm reduction, positive psychology, emotional intelligence and building strengths. He has worked so hard on continuing his education and reaching to higher levels of knowledge.

Johnathan Summers
(Nimkee NupiGawagan Healing Centre)

John provides traditional healing care for Indigenous youth at our organization. He focuses on providing traditional care through ceremonies and various traditional healing modalities. John makes time for the youth and prioritizes ethical practices and quality time with those that need it.

Kristen McKenna
(Nimkee NupiGawagan Healing Centre)

I believe Kristen McKenna is truly deserving of this nomination, as she has a direct impact in keeping our treatment centers doors open. Kristen McKenna is an extremely selfless individual who is always putting the needs of both youth and staff before her own, while simultaneously staying on top of any and all tasks put before her that allow for us to remain operational from a logistical standpoint.

Marlene Carle
(Wanaki Centre)

Recognizing Marlene for her work in mastering the AMIS program and ensuring that the participant process of application is supported and as seamless as possible.

Jamie Carle
(Wanaki Centre)

Recognizing Jaime for work done to promote harm reduction and particularly availability with individuals and communities.

Maude Paul
(Wanaki Centre)

Recognizing Maude for her on-line communication work on all platforms to promote various program activities. This was stepped up at the beginning of COVID.

Jenny McConni
(Wanaki Centre)

Recognizing Jenny for her administrative work and technical expertise that has allowed the Wanaki Centre to solidify its administrative requirements to ensure transparency and accountability.

Eveyln Winters
(Charles J Andrew Youth and Family Centre)

Recognizing Evelyn for her leadership at CJAY.

Tammy Michelin
(Charles J Andrew Youth and Family Centre)

Recognizing Tammy for her leadership at CJAY.

Treatment Centre-specific Recognition

Rising Sun Treatment Centre (NB)

The staff at the rising sun is one of our keys to succeeding. Dedicated, intelligent, passionate, and kind. Time and time again I hear from former clients how they wish they could stay - because we are a family. Treating everyone who walks through our door as a relation, with the utmost respect and dignity. Because the staff at Rising Sun Centre believes "your" ceremony starts, when you walk through that door.

Mi'kmaw Lodge & Eagles Nest Recovery House - Native Alcohol & Drug Abuse Counselling Association of Nova Scotia

NADACA staff for being strong and providing services during the pandemic.

Nimkee NupiGawagan Healing Centre (ON)

They constantly raise the bar for thinking of new innovative ways to come up with treatment and aftercare. They look at health from multiple aspects.

Walgwan Center (QC)

Today, more than ever, the centre's vision and mission are a symbol of resilience and strength for First Nation youth.

Mawiomi Centre (QC)

Mawiomi Treatment Centre has evolved to offer a more thorough continuum of care through enhancing pre-treatment support with circle of care meetings and medical evaluations with the CHUM Hospital. We have also made modifications to our intake calendar by offering specific pre-treatment weeks to prepare the client for treatment and withdrawal management weeks to ensure they are receiving the best possible step forward to a successful healing program. Withdrawal management weeks include meeting with our physician at the CHUM, in-house psychologist, nutritionist, and our future full time nurse.

Mawiomi Treatment Services was recently Accredited with Exemplary Standing under the Qmentum Global accreditation program.

Pekiwewin House (Leading Thunderbird Lodge), SK

I would like to nominate our Centre as providing aftercare support with our Transitional Home "Pekiwewin". It has been successfully running for the past 5 years, and also our Land Base Camp which has been in operation since October 2021.

Pekiwewin House started in 2018 as an offshoot of their residential treatment centre in providing a peer supported living environment for youth aged 16 and over who graduated from LTL's residential treatment program and want to continue their sobriety, continue their education and gain work experience and further life skills while living in a peer supported environment.

Gya'Wa'Tlaab (BC)

As the opioid crisis and toxic drug poisonings continuing to rise, Gya'Wa'Tlaab offers early recovery to First Nations people in BC. Located in the oceanside community of Haisla, BC, this centre offers a seven to eight week program with the purpose of stabilization. The motto of the centre is "Client first, last and always". They provide supports to men 19 and over, including those with legal orders. Gya also brings in a variety of resource specialists when needed in areas of gambling awareness, life skills and relationship building.

Round Lake Alcohol and Drug Treatment Society (BC)

Round Lake Alcohol and Drug Treatment Society have truly overcome and moved forward since the Public Health Emergency with strong and consistent care for community members. Through strong leadership and guidance, this centre continues to support the culture-based care necessary to provide a solid foundation on the healing journey. They remain a strong and reliable force amongst all First Nations centres and communities exploring the growth of First Nations treatment in BC. They are also providing second stage treatment through their recovery home in the Painted Turtle Lodge.

Tsow-Tun Le Lum Society (BC)

Tsow-Tun Le Lum Society means "Helping House" and that is at their core. Tsow-Tun Le Lum has undertaken a huge move to a new facility this year and have overcome monumental adversity to settle in and provide programming to even more First Nations people. Under the leadership of Nola Jeffrey, this centre has flourished and provides multiple programs and services in and out of community. We honour them for their commitment to trauma-informed care, ceremony practices and care for those most vulnerable.

Kackaamin Family Development Centre (BC)

Kackaamin Family Development Centre has been working with families for 45 years. This centre is vibrant with care that supports families to learn, heal and build into strong parents raising strong children. Over the previous few years Kackaamin has started some unique healing work that has been long needed. Rebuilding the Circle utilizes both Western and Nuu-Chah-nulth practices to address the impacts of sexual abuse for both those that have been harmed and those who have been harmed.

Day 3

OVERVIEW

The third day of the Gathering focused on discussions about virtual care, culture in virtual care environments, and accreditation.

Introduction

Carol Hopkins introduced day three by talking about the Round Dance the previous evening and how wonderful it was. Many of the participants said that it was a beautiful experience and that it was very helpful. It was an opportunity to remember, and honour lost clients or family members, and also to remember that we still have life, and we need to continue to celebrate life. Following this welcome, everyone gathered in a circle for an opening prayer and medicine, led by Elders.

Presentations and discussions for Day 3 were about culture in virtual care environments and accreditation. Regarding the former, it is important to consider protocols across the Nations when using culture in virtual environments – what is appropriate in the context of that diversity? Conversations are also needed on protecting the integrity of Indigenous ways of knowing. There has been misappropriation by many people claiming to be Indigenous, so it is important to be careful about sharing culture in virtual environments in case someone might record that information and become an *instant teacher*. There was also going to be a conversation about accreditation and participants were asked to think about an Indigenous accreditation program organization.

Culture in Virtual Care Environments

Presentation – Culture in Virtual Care Environments: Considerations for Wise Practices in a Digital Age

Mary Deleary (Thunderbird Partnership Foundation) and Dr. Elaine Toombs (Lakehead University) shared a presentation on culture in virtual care environments. The presentation began with the acknowledgement that culture is grounded in the Creation Story of each Indigenous language family across Turtle Island and maintained through their sacred knowledge structures. Culture is the foundation of Indigenous identity and includes the land and the languages. The pandemic required a shift to virtual services, and there is a need to identify best and wise practices for culture in virtual environments.

Indigenous Wellness Framework

The Indigenous Wellness Framework, shown below, was developed by First Nations. The four essential components of Wellness are Hope, Belonging, Meaning and Purpose.

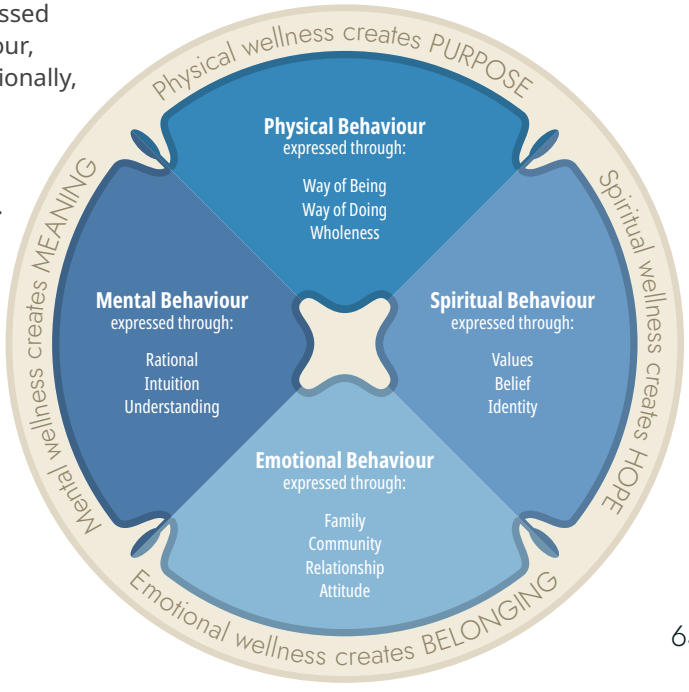
Spiritual Wellness creates **Hope**.

Emotional Wellness creates **Belonging**.

Mental Wellness creates **Meaning**.

Physical Wellness creates **Purpose**.

There are also 13 wellness indicators expressed through behaviour, spiritually, emotionally, mentally, and physically, that contribute to these outcomes.



Managing Change for Effective Virtual Services

Virtual services must be developed in the context of this framework and to support the Indigenous Wellness Framework outcomes of Hope, Belonging, Meaning and Purpose. There must be

- ethical guidelines for mental wellness virtual service delivery.
- parameters for engaging Indigenous Knowledge in a virtual environment.
- identification of best practices and engagement strategies for solutions for use of equipment and platforms.
- literature review of effective practices for virtual service delivery model.
- materials to support external stakeholders delivering messages in virtual environment.
- staff competencies with clear roles and responsibilities across all positions.
- expanded and developed Community of Practice, including youth-specific content/functionality and French translation & interpretation capabilities.
- key components for continued advocacy.

Working Group

A working group identified some additional priorities for virtual services:

- A key area is cultural inclusivity.
- Cultural safety must be a safe environment for all participants.
- Cultural safety training is needed for health care providers utilizing virtual services.
- Understanding the needs of mental wellness teams across the country. What type of technology? What type of access?
- Know how to effectively share Indigenous Knowledge (e.g., how to respectfully honour an Elder).
- There is potential for the development of a toolkit /guide resource grounded in Indigenous knowledge in providing virtual services.
- Sustainable funding considerations include how a connection can be made in terms of how virtual programs are filling the gap with persons in remote locations or those who may be incarcerated.
- The identified priority considerations highlight the need to coordinate dialogues with additional Indigenous Elders and Knowledge Keepers for further direction in the development of protocols and guidelines and training.

BIRCH

BIRCH – *Bundle of Interventions, Resources and Cultural Hub* – will be designed collaboratively and will involve research sharing platform for service providers that is evidence based and culturally relevant. There will be a prototype by fall 2024.

A series of key milestones have been mapped out in relation to Hub development, as shown below.

Key Milestones

Research to Date	Hub Development	Evaluation
• Strengths and barriers for eHealth services to date • Updated literature review of eHealth services for Indigenous youth (Hicks et al., submitted manuscript)	• Curating and creating resources to be used for treatment centres • Branding • Develop recommendations	Usability of hub: • Descriptive use statistics • Qualitative user evaluation
2021 & 2022	**2023 & 2024**	**2025**

Strengths, Barriers, and Required Resources

Participants identified outcomes, barriers and supports that are needed. A strength is that people can access treatment from their own homes. Barriers include internet and equipment usage, and lack of resources. Treatment centres need additional resources and supports to provide virtual treatment.

Virtual Access to Culture as Treatment

Virtual services should be thought of in terms of culture as treatment rather than culture in treatment. This is a priority, and it was noted that modifications to teachings can be made and still lead to good outcomes. As this area is still relatively new, consultations are needed on wise practices and sharing strategies.

Proposed Wise Practices

- Respect local cultural norms.
- Create options for engagement.
- Provide individual options – understand where a community is at in their cultural knowledge and healing.
- Obtain consent and credit.
- Develop shared standards – share things in multiple ways so everyone can access, including laterally and not just passed down.
- Connect with experts in person.
- Mutually share information.

Hicks*, L., J., Toombs, E., Lund, J., Kowatch, K., Hopkins, C., Thunderbird Partnership Foundation, & Mushquash, C.J. (submitted). Expanding our understanding of digital mental health interventions for Indigenous youth: An updated systematic review.

Toombs, E., Radford*, A., Mann*, V., Turner, K., Augustine, W., Moore, S., Hopkins, C., & Mushquash, C.J. (submitted). Strengths and Barriers Implementing Virtual First Nation-Led Treatments for Substance Use.

Small Group Discussions

Discussion Group 1 – Protecting Cultural Knowledge

What needs to be considered in ensuring the protection of Indigenous Cultural Knowledge in virtual care programming?

Participant responses were as follows:

- Ensure protocol diversity acknowledgement.
- Access guidance from Elders.
- Develop a framework for each centre to share.
- Protect client confidentiality.
- Protect teachings.
- Understand barriers to the use of technology.
- Ensure network/platform security.
- Manage challenges with loss of connection during client sessions.
- Mitigate fear of all treatment eventually becoming virtual.
- Understand that virtual care is not a replacement for people.
- Define who is the holder of the knowledge shared by an Elder.
- Include regional/community perspectives.
- Make sure that participants understand how medicines are used.
- Have a 24/7 counselor available in case there are triggers after virtual sessions.
- Remove any judgements due to diversity.
- Ensure common objectives of inclusivity as would occur in person.
- Virtual care allows people to give real life feedback of culture use outside of residential services.

When one receives or seeks Cultural Knowledge from a Knowledge Keeper, there is an inherent sense of the need to express gratitude. What are some ways to embed opportunities for reciprocity in a virtual care environment?

Participants shared the following comments:

- One challenge is that medicines are real and tangible (not virtual). Another challenge is that in-person contact is missing in virtual contexts: no personal contact.
- To embed opportunities to express gratitude, honoraria can be provided. It is also important to offer a prayer, and everyone can lift their spirit plate together. Virtual emojis can show appreciation. Active engagement while online can demonstrate that people are listening and participating. Prepaid envelopes can be prepared for participants to send cards, homemade gifts, etcetera. As one participant noted, the Knowledge Keepers may prefer to have these gifted to someone else; this occurred when a Medicine Man asked a participant in a teleconference to give the gift to someone else – paying it forward.
- Additionally, it may be useful to share with Elders how individuals practice culture at home. It could also be helpful to encourage participants to find Elders and Knowledge Keepers in their own communities.

What do you want to see (as far as guidance materials/ protocols)?

Participants recommended the following:

- Share lessons learned from those doing it – stories of the lessons learned.
- Develop national standards/guidelines so we are all on the same page.
- Implement quality assurance processes.
- Ensure data security and integrity – where is it kept?
- Address the issue of network quality in northern and remote communities.
- Ensure continuing care.
- Develop Thunderbird videos that can teach – for example *sacred fire how to* – from different Nations perspectives.
- Set up a database of Nations specific protocols and practices.
- Share each centre's resources at gatherings.

Discussion Group 2 – Creating Culturally Safe Virtual Care Environments

What do you want to know about culture in virtual care environments? (What are your questions?)

Questions from participants included the following:

- What are the protocols for Zoom and virtual care environments? How can we standardize virtual care throughout the Nations, which can be broken down based on communities and treatment centres?
- How do we build trust? How do we ensure that when we talk about things that there is not going to be some compromise?
- How do we build trust with Elders and Knowledge Keepers? How do we make them more comfortable with virtual tools?
- How do we engage them in supporting clients when trauma comes up?
- How do we ensure that knowledge is attributed to the person who shares it?
- How do we create spirituality? Culture is spirituality.
- What tools do we have to ensure that cultural safety comes through, to ensure that people are thinking from the heart first?
- What can we do to protect our teachings without causing harm, for example a watered-down version of our teachings?

What are your treatment centre's/treatment program's best or wise practices and protocols for sharing Cultural Knowledge in virtual care programming?

Comments from participants included the following:

- Virtual care is going to evolve in many ways that we cannot even imagine. We have transformed our approach. It will be interesting to see how it will look in 10 years, for example, with Artificial Intelligence (AI) and its potential impact. That presence that we feel we are far away from, might become something different.
- We need to remember that virtual programming is not for everyone. It could be that when centres have a gap then it is an option.
- Perhaps videos could be standardized across the Nations and then *broken down* as required for specific communities and treatment centres. It is important, if recording presenters and/or using their teachings in programming, to gain their consent in advance. Treatment centre workers could be used as a conduit to transfer Indigenous Knowledge, knowing that they do not conduct ceremonies. However, there are things that they can incorporate into virtual sessions. When using recordings from Knowledge Keepers, staff must know the teachings themselves to be able to answer questions.
- Protocols need to be put in place to protect information (for example, password protection). However, it is impossible to stop someone from recording the screen.
- People come from different backgrounds (e.g. cultural, religious backgrounds), and they need to be met with respect wherever they are.
- Ensuring the safety of clients is paramount. For example, when the Truth and Reconciliation Commission was conducting hearings, there were Indigenous Knowledge Keepers present so that people would have someone to talk to if trauma came up. Something like this is needed for virtual care.
- Recognize that virtual care may take longer than in-person care.
- An example of best practices was shared of an accredited program at Mi'kmaw Lodge (the first of its kind), which was launched at the start of the pandemic.
- It is a four-week program in Google classroom and can be accessed 24 hours a day. It is a team effort as all staff works together. At the end of each week, all participants in the virtual program are called to see how they are doing.
- People tell their stories and share in the videos, and it gives people hope.
- There is a cultural therapist at each centre. They make sure that clients can get access to services and make referrals to a clinical therapist.
- There was a lot of interest from persons in corrections, and the Lodge started working with corrections (Correctional Service Canada) to ensure that the program became available to them.
- They got tablets from Thunderbird to help support the program.
- The program is grounded and wholistic, however, staff must be careful about what they share as they are not the Knowledge Keepers.
- The program is helping people who may be undecided if they want to go into residential treatment or not.
- People who have done the online program tend to do well in treatment as they know what to expect.

Several people spoke about the importance of traditional language and how language and culture are inextricably linked. Indigenous languages are powerful and there is spirit in the words. Teachings based on the language are very powerful and they support people. Unfortunately, concepts often must be translated into English, which is not a good fit and is essentially, a foreign tongue. The English language is not spirit-based nor verb-based like Indigenous languages, and many terms do not translate well into English.

What are your best practices for engaging with Knowledge Keepers and Elders in relation to virtual care programming?

Best practices would involve helping Elders and Knowledge Keepers to become more comfortable with virtual tools. Building trust with them is critical for this. Protocols should be developed for working with Elders and Knowledge Keepers in this context. Giving Elders and Knowledge Keepers credit for their knowledge and teachings is essential. In terms of accessing Elders and Knowledge Keepers, perhaps they could be *borrowed* from communities who have them, and their stories and teachings could then be used in virtual treatment.

Discussion Group 3 – Parameters for Sharing Indigenous Knowledge in a Virtual Environment

This discussion addressed the questions of potential risks and barriers to sharing cultural practices in virtual spaces, and how to best avoid a pan-Indigenous approach and respect community/nation norms, customs, and cultural practices in Virtual Care programming.

Potential Risks

- Cultural appropriation, for example the potential of *non-Indigenous people falsely claiming Indigenous ancestry* causing harm, someone becoming an *expert* without proper knowledge/training or people profiting from using work they did not create
- Ethical questions – who is qualified to be a Knowledge Keeper and who validates teachings?
- Need to compensate Knowledge Keepers and Elders for their time and teachings
- Potential for misinterpretation of teachings
- Risk of people providing services for profit motives
- Multiple demographics (i.e., loss of language usage when different people participate); need to organize by community to incorporate local cultural protocols, and recognition that different communities have different beliefs (e.g. Christianity)
- Lack of awareness of virtual services – need for education
- Lost of *hands-on* practice and *heartfelt* connection with clients
- Technological challenges, for example a lack of bandwidth, clients not having access to internet, computers, smartphones, etcetera
- Interruptions, distractions (e.g., people turning cameras off, and background noise)
- Privacy considerations, for example recording people without permission, the need for data control/protection, and oversight
- Need to ensure platform security
- Need to protect the intellectual property of Knowledge Keepers and Elders
- Lack of access to medicines, for example clients may not have access to the medicines for smudging (although kits could be sent to homes)
- Lack of safety plans for virtual care – risk mitigation for managing traumas and triggers which could involve access to emergency contacts if required and a 24/7 on call counselor
- Knowledge Keepers may not be comfortable with virtual services
- Loss of the connection to land, which makes it hard to feel energies, and loss of spirit/intent, (e.g., the smells of smudge and sweetgrass)
- Virtual is time-limited and cultural learning takes time

Potential Benefits

- Opportunities to reach out to and connect with diverse groups, for example youth, other Nations, urban centres, isolated communities, incarcerated people, people in shelters, etcetera
- Reduction of barriers to accessing care – people can access virtual care from any location without any travel costs
- Virtual programs could provide continuing care, pre and post treatment
- Ability to build trust online for those that may come into treatment
- Opens the door to culture which could be the start of a spiritual journey – virtual care could support the revitalization of language and culture and promote ceremonies
- Opportunities to connect with other Nations and treatment centres to share teachings and best practices and to find commonalities
- Access to Knowledge Keepers that people would not have otherwise
- Reduced stress on Elders and Knowledge Keepers
- Service providers can work from home
- Opportunities to share teachings more widely

How to Avoid a Pan-Indigenous Approach

- Work with humility.
- Learn from places that have been doing virtual care and develop standards and guidelines, including standards of cultural competencies.
- Learn about cultural differences and accept other Nations' ways of being, doing, thinking, etcetera.
- Acknowledge where stories, teaching, etcetera come from – look for similarities and share differences.
- Encourage participants to share what they know and/or or assist them to find out how/who to connect with in their area.
- Ensure openings and closings are relevant.
- Provide introductions and acknowledge self, community, and Nation – give people the opportunity to share their uniqueness.
- Interpret the language to ensure understanding.
- Keep videos on for two-way communication.
- Establish a cultural database, specific to each community that includes cultural protocols, and an updated resource list to find more teaching locally (Thunderbird to develop list).
- Provide supports to stockpile medicines in local areas.
- Validate information sources, knowledge and skills – have a clear definition of what a Knowledge Keeper is.
- Nurture Elders and Knowledge Keepers.
- Reach out to Elders and Knowledge Keepers about how and what they would feel safe sharing with others.
- Set up an Elder advisory table.
- Help Elders and Knowledge Keepers to learn about the technology.
- Be upfront and clear about where teachings are coming from.

Accreditation

INTRODUCTION

Carol Hopkins talked about accreditation, noting that, as most people are aware, accreditation has been around for a long time. For example, when the National Youth Solvent Abuse Program started in 1995, the First Nations Inuit Health Branch (FNIHB) at Health Canada, asked the National Network of the five youth treatment centres to select someone to sit on a committee to review standards for accreditation. The five leaders said *no, it is all of us or none of us*, so they all got to participate in the conversation. Since that time, it has been a long journey and treatment centres have chosen different accreditation bodies to work with.

She noted that the Canadian Executive Council on Addictions, which is hosted by the Canadian Centre on Substance Use and Addiction (CCSA), did a study on accreditation and found that, across the county, there are more accredited Indigenous treatment services than mainstream publicly funded substance use programs. That is a testament to the strength, resilience, determination, and commitment to quality of Indigenous treatment programs. And the only thing unique to Indigenous organizations is the section specific to substance use; otherwise, they are using the same governance, information management, infection control and human resources standards as large corporate entities, so that is something to be proud of. On the other hand, accreditation is costly, and it is often tied to contribution agreements. However, accreditation and demonstrating excellent service quality has not yielded more funding to pay adequate wages, take care of buildings, or to buy needed equipment, such as a new computer for the staff who are entering the data into the Addiction Management Information System (AMIS). And yet, centres have maintained their commitment to accreditation.

Treatment centres have told Thunderbird that something needs to be done about accreditation. It must provide a return on investment and match the realities of Indigenous service providers. Currently, surveyors who know nothing about First Nations go on site and try to apply standards outside the context of culture.

Carol noted that Accreditation Canada and the Canadian Accreditation Council are in attendance, and they are interested in working as allies – indeed Accreditation Canada has said that they would support the development of an Indigenous accreditation body. Both are doing a presentation and are committed as allies to work with treatment centres and programs in terms of what they can do differently and/or better moving forward. She then introduced Carla Palmer from Accreditation Canada, along with Chris Mahoney and Nadine Lafferty from the Canadian Accreditation Council.

Presentation 1 – **Accreditation Canada**

Carla Palmer, Director of Community Services with Accreditation Canada, brought greetings from Serghei Reabov the new Client Engagement Team Lead who was unfortunately not able to attend the gathering. Carla told the participants that Accreditation Canada is using the Truth and Reconciliation Commission recommendations to support their work. She said that inspiring positive change is Accreditation Canada's goal, but that this is a goal that can only be accomplished through co-design in collaboration with partners, and through implementing processes to support strengths-based improvement. She also mentioned Health Standards Organization (HSO) formed in February 2017, which focuses on developing standards, assessment programs and other tools for health and social services care providers. Accreditation Canada and HSO share the goal of strengthening the health of Indigenous communities. To that end, a Qmentum Global Project focused on Indigenous health and wellness has been established.

One area of focus is developing a cultural safety and humility standard, which was codesigned with the First Nations Healthy Authority (FNHA) in British Columbia (BC). The project involves preparing and testing a cultural safety and humility standard for use by health and social services organizations across BC and then engaging with Indigenous governing bodies, communities, and peoples from across Canada to identify the needs and to design a national standard.

The second thing they have been looking at is how to improve their approach to accreditation and, as Carol said, Accreditation Canada does support an Indigenous-led process. However, as that is not yet in place, they are reviewing how to improve current standards based on a report on accreditation by the First Nations Inuit Health Branch and the First Nations Health Authority, which highlighted what is working well and what is lacking. *Culture as foundation* emerged as a critical priority in moving away from a colonial process towards something that is relevant and responsive to the needs of Indigenous communities. There was a co-designed engagement process related to this, which involved Elders as well as many other partners.

The outcome will be a new assessment manual, program description, updated instruments, and surveyor resources released this year, based on which organizations will be assessed starting in 2025. Organizations will have at least 12 months in advance to prepare and it will be easier than previous processes. She acknowledged the importance of responsive and culture-based processes and surveyors, so that organizations will feel understood and supported throughout the accreditation process.

Presentation 2 – **Canadian Accreditation Council: Changes to the Indigenous Accreditation Programs**

Chris Mahoney, the CEO of the Canadian Accreditation Council (CAC), gave a presentation to the Gathering. She told the participants that the CAC is extremely committed to their work, and to working with them in a way that makes sense and provides meaning for them and their communities.

The CAC is a Canadian based not-for-profit accrediting body, which is itself accredited. It has been in existence for over 50 years. The CAC believes that communities are the experts on what is happening in their programs and to the people they serve. About 48% of their programs have enhanced Indigenous designation (i.e., a group of standards specific to Indigenous programs focused on language, culture, and connection to community).

The CAC Board President and Vice President are both First Nations, and there is a new Board member coming in, Dr. Reed, who completed a doctorate on reconciliation and work with children and youth. There are also many strong allies on the Board, and all of the CAC committees have Indigenous representation. In addition, there is an Indigenous Advisory Committee which reviews standards and processes, an Elder and two Knowledge Keepers who help to guide processes, and the Director of Accreditation Services is First Nations. The CAC is also looking to bring on an Indigenous Advisor/Cultural Lead. Regarding reviewers, 30% are First Nations or Métis, and 60% of those who attended a training for reviewers last week were First Nations.

The CAC values relationships and really wants Indigenous organizations to succeed. So, they provide a great deal of support to ensure that by the time reviewers arrive, it is just about *ticking the boxes*. Chris Mahoney then introduced Nadine Lafferty, the CAC Manager of Support Services.

Nadine told the Gathering that with CAC, support starts with the accreditation application. Following the application, she will contact the centre and offer unlimited phone calls, texts, emails, and virtual meetings. She will also visit centres in person, provide monthly check-ins and offer information sessions. Once accreditation is achieved, she is still accessible and will check in every six months or so. There are also other team members who provide ongoing support.

Chris Mahoney added that the CAC also has examples and samples of forms and how to write policies, and those are available to all applicants. She emphasized that the accreditation process is designed to be a good experience and to help people showcase their work. Further to that, the CAC is open to feedback and to change if something is not working. She thanked everyone present for the quality of their work and invited participants to share any thoughts they may have about how accreditation processes could be improved during the upcoming discussions.

Carol Hopkins then took the stage and told the group that setting standards for mental health and substance use services in Canada is a federal responsibility, and that the federal government has organized a national collaborative to talk about these standards. Reports will be created from the national collaborative which will go to national accrediting bodies and standards development organizations like HSO to inform them about what needs to be place and what is missing. This will be a roadmap of sorts for accrediting bodies. There have been conversations specific to Indigenous People as part of that process, and there is still time to provide input.

It is important that standards reflect the realities of Indigenous communities – the continuum of care that is culturally relevant, for example. In addition, available services may not be Indigenous governed or Indigenous specific. Indigenous organizations – including those who are not yet accredited – all support quality improvement, and none are against the idea of accreditation. The issue is more about developing standards that work for Indigenous organizations.

Racism has been identified as an issue, and anti-racism needs to be built into the standards in a systemic way. Standards also have to support equity: Indigenous centres get 50% less funding on average than provincially funded substance use services and may not have the resources to achieve accreditation, and yet their funding is tied to accreditation. That is not equity, nor is measuring Indigenous treatment centres using the same standards applied to major health corporations across the country.

Carol then asked the group to consider what quality looks like, what it would look like if it was working and centres did not have to struggle to fit the existing standards, and to provide some overall direction to Thunderbird on the topic of accreditation.

Discussion

After the presentations, there was a group activity with all attendees seated at tables in the Mountbatten Salon to discuss the three questions below:

1. ***How do we enhance cultural sensitivity/appropriateness of accreditation processes?***
2. ***What are some of the current challenges folks are having with accreditation, and how can it be enhanced to better meet the treatment centre needs?***
3. ***How do we ensure that accreditation continues to meet the intended needs and track/measure our success in this (i.e. continuous improvement of services in long-term)?***

How do we enhance cultural sensitivity/appropriateness in accreditation process?

The following emerged as key themes related to enhancing culture sensitivity/appropriateness in the accreditation process.

Culture as Foundation

Culture must be seen as foundational in accreditation processes. Accreditation standards should be reformulated around culture and include language.

Indigenous representation is vital, so Indigenous voices must be included. Elders and Knowledge Keepers must also be part of the process; they are the cultural leaders. There has to be a recognition of the centrality of oral teachings as well, and culturally-based practices such as the use of traditional medicines. Land-based programming also must be recognized and included in assessment processes.

Ideally, accreditation will be Indigenous-centred and overseen by an Indigenous organization. At the least, Indigenous advisors must be involved to provide guidance.

Smudging should be part of the process, to be culturally sensitive.

To support culture as foundation, there must also be improvements to how and what data is collected (e.g., centres need better ways to log non-Western methods). Currently, complying with processes to use traditional medicine is difficult.

Characteristics of Reviewers

Reviewers should be Indigenous, or if they are not, they must at a minimum, have life experience with Indigenous people and have received training on First Nations realities.

They need to understand Indigenous cultures, traditional teachings, and ways of knowing. They must understand exceptions related to cultural protocols, for example, the use of tobacco. Land-based centres are another example of this – the work is less clinical and activities such as berry picking (as one example), need to be acknowledged as cultural interventions. Anybody assessing should take the time to understand these important issues. Reviewers need to use a cultural lens in their work. They also must be accountable to what they are asking. They must be sensitive to language barriers, and to those with whom they are working, respecting the way that programs are delivered. Every reviewer should consult with treatment centres before a visit, and there should be a conversation in advance about protocols.

Respect for Diversity

Accreditation needs to be approached with an attitude of respect for diversity – every First Nation is unique, from coast to coast to coast. It is important to consider unique community cultures, and how to measure their successes in the context of diversity. Communities use different languages that affect the way that things are understood and interpreted, and these should be captured in accreditation standards.

There should also be collaboration with national Indigenous groups to develop a distinctions-based approach.

Respectful and Accessible Approaches to Accreditation

Accreditation needs to be approached in a warm and respectful manner, using accessible language. Using plain language to communicate with staff creates transparency. In-person visits should be part of the process – it should not be virtual only. Basic procedures should be established for visits, including welcomes and introductions. Providing ongoing support and encouraging people to ask questions should be part of the process; this will help to relieve staff anxiety.

Processes should involve a constructive and productive approach. Reviewers should consult with treatment centres before they visit: there should be a conversation in advance about protocols, and any changes to standards and practices should be communicated to centres prior to the initiation of the process. This will help staff to prepare for the assessment. Currently, lines of communication only provide the date – centres would like time to prepare and to understand exactly what is required from them, in advance.

In addition, accreditation should be more than a checklist (i.e., reviewers should be open to listening to explanations related to requirements).

Timely Feedback

Feedback on the accreditation results should be timely – it is unfair to leave centres in the dark for three months to receive feedback.

Capacity Issues

There is a lack of capacity in terms of staff to meet accreditation standards, and insufficient resources and funding to hire more staff. It would be helpful for Thunderbird to assist with resources and support persons (e.g., information technology and bookkeeping).

Strengths-Based

The accreditation process should be strengths-based, including all feedback provided. Reviewers often just point out what is wrong. They need to be more positive and focus on what is working well and use strengths-based language. Often the process makes people feel like they are being tested and graded. It would be preferable to use more of a teambuilding approach (e.g., collaborative communication and working together to achieve success).

Provide Information and Materials in Both Official Languages

What are some of the current challenges folks are having with an accreditation and how can it be enhanced to better meet treatment centre needs?

Lack of Adequate Resources and Support

Lack of adequate resources and support for accreditation emerged as a dominant theme in the discussions. Centres need to have sufficient resources to support the accreditation process, which involves a significant quantity of work. Support is required for financial needs including money for certification of workers (e.g., Indigenous Certification Board of Canada) funding to support certifications, and for policy makers and writers.

High staff turnover rates impact the whole process and the funds available. Current staffing levels are insufficient to implement the annual updates and changes, and to develop new policies and train staff on them. As one participant noted, 30 to 40 staff have procedures and policies to be updated: for example, reworking client files, health, and safety standards.

Adequate funding and resources are needed to develop required staff skill sets, or for designated persons to support accreditation. The demands associated with accreditation can lead to staff burnout and turnover. Salaried positions would be better than contracted positions.

The current funding tied to accreditation is sometimes not enough for staff to complete required documentation. A budget is needed to support the process, and it should be tied to inflation. In addition, accreditation incentives should be more than a mitigation of the costs of accreditation.

In addition, the Commission on Accreditation of Rehabilitation Facilities (CARF) regulations conflict with funding – there is not enough time to do the training to be compliant to one accreditation organization and to also meet the funding requirements of the funders. More immediate support and a faster response time are also needed from the Indigenous accreditation body.

Education and Training for Staff

Education and training for staff to support accreditation is also lacking. Some staff do not understand the value of charting, so more education on accreditation would help with this. Staff need to be *on the same page,* so training should be standardized. As part of this, all staff need orientation training on the accreditation process.

There is also a need for more instructional templates, training on how to access the portal(s), and a database for personnel to track required training.

Simplify the Process

The accreditation process should be simplified. Sometimes it can be difficult to understand the questions. The amount of paperwork should be reduced. Constant supervising related to accreditation can be an overload.

More Transparency and Better Communications

More communication is needed to ensure transparency, and there should be better communication around new standards.

Need for Indigenization of Standards and Process

At the least, one surveyor on site should be First Nations. Currently, there are no standards for recognising and using traditional medicines, and this should be addressed.

Accreditation should dedicate a position to transcribe oral knowledge of standards currently being met by treatment centres. Standards should also reflect small First Nations community-based services. There should be a *human aspect* to analyzing documents, and respect for anecdotal information in forms and documents. Reviewers should also implement a peer review capacity for centres.

Need for Consistency of Standards

Standards and expectations need to be consistent across all treatment centres.

Need for Oversight of Accreditation Bodies

Accreditation bodies should be able to demonstrate adherence to their own standards.

Lack of a Strengths-Based Approach

Accreditation should focus on strengths and move away from a deficit model. Shift away from a pass/fail approach to emphasize strengths and opportunities for improvement. Accreditation bodies should be allies in ensuring the quality and safety of the services offered.

Lack of Equity

There is a lack of equity in comparison to mainstream services. Current accreditation processes were developed based on large healthcare facilities and may not be appropriate for Indigenous services.

Accreditation Process Should Be Iterative and Ongoing

The focus of accreditation should be on what has happened and what has changed since the last accreditation, rather than starting anew. There should be more communications between accreditation bodies and centres (e.g., getting together more often to know each other better, not just meeting every four years).

How do we ensure that accreditation continues to meet the intended needs and track/measure our success (i.e., continuous improvement of services in the long-term) in this?

Ensure Adequate Resources Are Available

The accreditation bodies need to work with our funders to get them to understand the need for wage parity and adequate funding compared to other non-Indigenous organizations. Currently, there are limited resources to support accreditation. Supports are the key to starting, and centres need an increased budget for the first year to address the needs, training, etcetera. Centres also need to define their own accreditation credits (e.g., pay scale, operational, budget, and salaries).

There must be an understanding between funders and accreditation bodies in terms of what it means to maintain accreditation – the cost and time of accreditation for example, the cost of books (every year finding changes in the books and implementing them). There is also a survey at the three-year mark. This must be covered in terms of cost and will go up exponentially during the survey year. Remote and rural centres may also have to deal with power outages, limited or loss of internet connections, etcetera. These realities must be recognized and addressed.

Indigenous-Specific Accreditation Processes

Accreditation needs to be Indigenous-specific and include cultural components of care. Standards for Indigenous and non-Indigenous should not be the same. Accreditation must have Elders involved, be culturally integrated and trauma informed, and include sacred medicine and sharing circles. Relationship building with centres is needed for accreditation bodies to understand Hope, Belonging, Meaning, and Purpose (e.g., understand the needs of centres and their clients).

Ideally, there would be an Indigenous accreditation body. Otherwise, non-Indigenous accreditation bodies should have Indigenous Board members, and there should be a department dedicated to Indigenous organizations. Reviewers should be Indigenous or, at the least, be culturally safe and have experience working with Indigenous people.

More Training and Support for Staff

More support and training are needed for staff – training, manuals, and information sessions for preparation. Accreditation bodies should provide presentations and information sessions on the expectations, rather than just expect staff to know what they want. In addition, it can be a barrier when standards criteria require that staff have certification or titles they do not have.

Improved Indicators

Indicators should be reviewed and modified as required – they should not be binary, and the matrix should be outcome driven, based on desired health outcomes. They should also include qualitative data.

Create Better Documentation Options

Accreditation bodies should implement better documentation options. For example, a drop-down menu of choices is not good enough; there needs to be space to go outside the box and to follow up after the accreditation visit.

Improve Relationships and Communication with Centres

Accreditation bodies should build trusting relationships with treatment centres and work with them to implement required improvements. They need to also communicate to treatment centres how standards come to be, and who creates them. There should be continuous communication with both sides open to feedback.

Client-Centred Approaches

Accreditation should be focused on the client experience (i.e., *What's in it for them?*). Use this question to help shape the accreditation process. How is it facilitating a stronger healing process for those being served and quality care? There should also be a client led grievance process; for example, a complaint circle where the client chooses who attends and which feels like a safe space for them to share their issues.

Strengths-Based Approaches

Accreditation should focus on shift away from a pass/fail approach to emphasize strengths and opportunities for improvement.

Develop Opportunities for Centres to Work Together and Share Information

Indigenous organizations should work together to ensure needs align with current standards. A hub should be established to share best practices, resources and tools.

Update Standards to Include Virtual Care

Incorporate data collection, tools, evidence, template, risk management, and standards around virtual practice.

Other

Consider increasing the time limit for visits from four to five years – there are too many new standards/procedures to apply and a lack of time to adapt.

Focus on areas that are not automatically covered by other organizations (e.g., employment, standards, and employment safety).

Ensure that communities are aware of the findings and outcomes of the process.

The Commission on Accreditation of Rehabilitation Facilities (CARF) seems to be *ahead of the game* in terms of meeting new standards and benchmarks.

Final Reflections

Carol Hopkins asked the group if they had any final reflections that they would like to share. Those who did selected a spokesperson for their table. Responses included:

Deep appreciation to Carol and the Thunderbird team for organizing and hosting the gathering.

Highlighting the issue of wage parity: many contribution agreements were written decades ago and there have been no increases since then except for those linked to inflation. Despite this, treatment centres have gone above and beyond in meeting standards. It is time for accreditation bodies to take a stand and advocate for increased funding/parity for Indigenous treatment centres.

Regarding accreditation processes, it is important to ensure that the culture of individual Nations is honoured, to support cultural leadership that reflects the culture of each Nation and ensure the voices of Indigenous People are heard (including Elders, youth and other groups), to have Indigenous people do the evaluations, and to educate communities about accreditation and inform them of the findings and outcomes of the process.

Carol pointed out that there is still an environment of colonization and oppression, and as a result, sometimes treatment centres are judged, and communities can have unrealistic expectations (e.g., you haven't solved the opioid crisis yet, *what's wrong with you?*). So, it is important to educate communities about the continuum of care, and to get them to appreciate that treatment centres are invested in quality and that focusing on improvement is a good thing – it is not a pass or fail. This is part of decolonization. Communities need to be engaged in these conversations.

One group identified the need for an Indigenous evaluation model to which Carol highlighted the Native Wellness Assessment (NWA™). This tool asks what wellness is from an Indigenous perspective, what quality means from the Indigenous worldview, and what words exist in our original languages that tell us about quality.

Another group talked about honouring the Truth and Reconciliation Commission recommendations and ensuring that culture and language are not *add-ons* to accreditation standards. Also, cultural lived experience is knowledge that is valuable and meaningful in communities, and this applies to human resources – language and culture should be considered core competencies. Regarding accreditation processes, there is often a lot of anxiety among staff related to the accreditation coming in-house. It would be helpful to include staff face-to-face or at least virtually at the beginning of the process, so that they feel supported and have a voice. This would humanize the process.

Further to that, Carol noted that there are times when there is a community in crisis, and treatment centre staff, being helpers, are going to respond to the crisis. If the centre has some obligations around accreditation and tells the accreditation body that they must pause for a bit to address the crisis, the accreditation body needs to recognize that and respond with empathy and support.

One group said that they would like to see Thunderbird establish its own accreditation body. This would solve the problem of people with no understanding of Indigenous culture deciding whether centres are good at what they do (which they are).

Carol noted that one of the huge issues with accreditation is the poverty of Indigenous treatment centres, and how wage disparities can cause low workforce self-esteem. Since there is no rational explanation for the wage discrepancies, staff may conclude that it is because they are not good enough. So, accreditation is a way to say "yes, we are good enough". However, there also needs to be a way to ensure that the voice of treatment centres is heard and respected in the accreditation process – accreditation bodies should listen to centres when centres tell them reports do not reflect an understanding of the work. There must be more investment to support treatment centres as well, and accreditation bodies must understand that centres are trying their best to do good work, but they are operating in impoverished environments.

Another group reiterated the need for an Indigenous accreditation body, and also talked about data collection, (e.g., setting up a platform or templates to store and analyze information to address the standards). Accountability should also be a two-way process – accreditation bodies should be clear about what they are collecting, what they are seeing, how they are using the information, and find a way to feed all of that back to centres so expectations and understanding are clear on both sides.

One group said that accreditation requirements and standards were not developed with Indigenous centres in mind. For example, there may be a requirement for six hours of cultural training for staff to receive a certificate. Firstly, six hours is insufficient for non-Indigenous organizations and secondly, Indigenous organizations are already culture. It is also important that reviewers have lived experience. There should be some sort of peer-to-peer capacity in place from reviewers. This group was also in support of an Indigenous-led accreditation body.

Gilbert Whiteduck spoke to the need for an Indigenous accreditation body, and said that until one is established, centres will have to work with the existing bodies and to help them improve, but this should be viewed as a transition, not a goal.

Carol said that the NNAPF/Thunderbird Board of Directors supports the idea of an Indigenous accreditation body and it is in their business plan, but the challenge is accessing the required funding, so there is no confirmation on that as yet. She said that change always begins with a vision and having the courage to explore new possibilities. She thanked everyone for having conversations about ensuring that First Nations people have the best environments to support their wellness, and that staff have the best environments to honour their knowledge, skills, and experience.

Closing Remarks

Carol Hopkins invited some guests to provide closing remarks, mentioning that she, as CEO of Thunderbird, Dr. Brenda Restoule, CEO of First Peoples Wellness Circle, and Marion Crowe, CEO of the First Nations Health Managers Association, consider themselves to be three sisters representing three sister organizations.

Dr. Restoule said that she had heard some great conversations about the continued growth and development in treatment centres. The shift to virtual work during the pandemic, which opened up access to services, is very exciting. She applauded the investment of centres in providing quality services and ensuring that people have a place where they feel they belong, which gives them a sense of Hope. In her clinical practice, she has seen people come back from treatment centres having made connections to their language and their culture, and feeling excitement about the potential for their future. She thanked the participants for their amazing work and thanked them for their thoughts and comments relating to cultural safety and virtual care, core competencies and accreditation standards.

Marion Crowe brought appreciation, gratitude, and love from the First Nations Health Managers Association Board of Directors to the participants for giving people Hope, Belonging, Meaning and Purpose. She is looking forward to working more closely with Brenda and Carol as the three organizations have now implemented a formal reciprocal relationship agreement to recognize and lift each other up. She shared a token of gratitude from her board with Brenda and Carol.

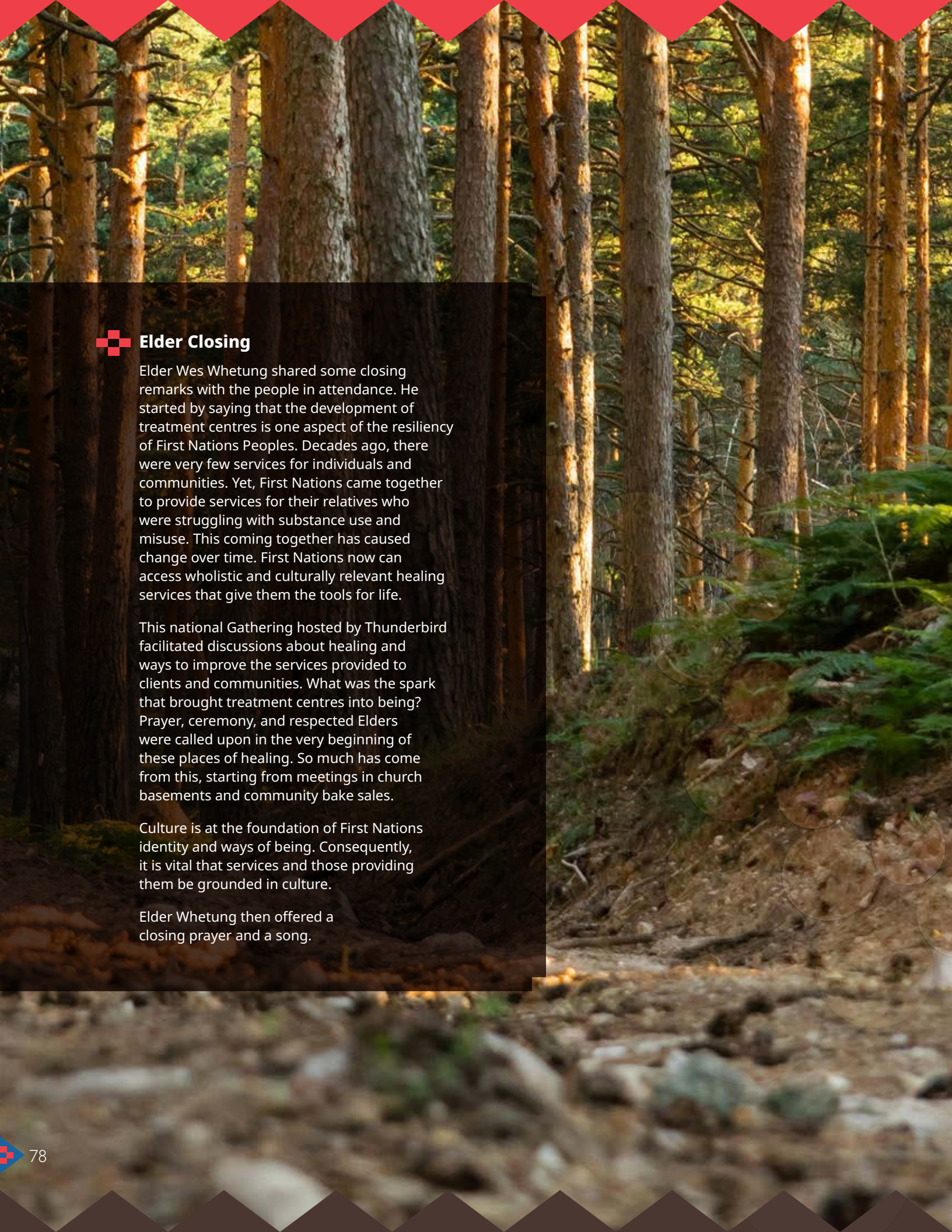
Jennifer Novak, Director-General of the First Nations Inuit Health Branch of Indigenous Services Canada, spoke next and thanked Carol and the Thunderbird staff for the Gathering. She noted that the opposite of addiction is connection, and connection is what has been happening for the last few days as people shared their stories, their struggles, and their shared opportunities. She also talked about how people said they want tools, not rules and this is something that she and Carol will be discussing. She heard the conversations about systemic discrimination in the funding models and said that this is at the top of the list of things she wants to address. She acknowledged that people have heard empty promises for a long time, but she is committed to investing in Indigenous treatment centres and in looking at ways to move forward together. She acknowledged her privilege and told the Gathering that she wants to use it to be in service to everyone present. That is her commitment – to be in service to treatment centres, the communities they serve, and to help improve outcomes for everyone. She encouraged people to get in touch with her by email anytime if they have any thoughts or suggestions they would like to share.

Carol then introduced Dr. Bill Mussel, who is a thought leader and Board of Director representative for First Peoples Wellness Circle. Bill thanked Carol for all her hard work. He said that he has had the pleasure of working with the Board since 2015 and left the Vice-President position about a year ago. He spoke about his lengthy history with First Peoples Wellness Circle (formerly the Native Mental Health Association of Canada) dating back to the 1990s, and where he served as President for 15 years.

The work they did during that period focused on bringing leaders with special knowledge and skills together from tribal groups in the First Nations, to participate in annual competency building sessions. Funding was cut for that in 2011, as was funding for the Aboriginal Healing Foundation as well as many Friendship Centres and other organizations. There was a great deal of lobbying to try to persuade the government to continue the funding and one of the results of that was more people stepping forward with the kind of courage that is necessary to create change.

Bill said that he was really pleased that Thunderbird organized this Gathering, and he would like to see more of such gatherings, particularly in Western, Northern or Eastern Canada. Gatherings are needed nationally, regionally and locally. He very much enjoyed the discussions and commended the participants for their creative and courageous thinking. He is hopeful for a brighter future where more and more Indigenous people understand the teachings of their ancestors and of their relative cultural Nations. He thanked everyone for attending and sharing their knowledge.

Carol agreed that it would be a good idea to have gatherings, including round dances, on a regular basis, and they do not have to be in Toronto every time. She closed by thanking everyone for listening and sharing their perspectives, which developed into many rich conversations. She also expressed appreciation for the partners and board members who attended and thanked the Thunderbird staff for all their hard work.



Elder Closing

Elder Wes Whetung shared some closing remarks with the people in attendance. He started by saying that the development of treatment centres is one aspect of the resiliency of First Nations Peoples. Decades ago, there were very few services for individuals and communities. Yet, First Nations came together to provide services for their relatives who were struggling with substance use and misuse. This coming together has caused change over time. First Nations now can access wholistic and culturally relevant healing services that give them the tools for life.

This national Gathering hosted by Thunderbird facilitated discussions about healing and ways to improve the services provided to clients and communities. What was the spark that brought treatment centres into being? Prayer, ceremony, and respected Elders were called upon in the very beginning of these places of healing. So much has come from this, starting from meetings in church basements and community bake sales.

Culture is at the foundation of First Nations identity and ways of being. Consequently, it is vital that services and those providing them be grounded in culture.

Elder Whetung then offered a closing prayer and a song.


THUNDERBIRD PARTNERSHIP FOUNDATION
thunderbirdpf.org