Regional Addictions Needs Assessment Guidelines

For Addictions Programs Serving First Nations Communities in Canada

Section One: Establishing the Context

From its inception, the goal of the National Native Alcohol and Drug Program (NNADAP) has been to provide culturally-based addiction prevention and treatment services to First Nations and Inuit peoples. Since it was established as a pilot project in the 1970s, hundreds of community-based alcohol prevention and community treatment projects have been created across Canada. While it has been acknowledged that First Nations and Inuit people are, in general, satisfied with NNADAP's services, alcohol and other substance use problems persist as a priority concern to the health and well-being of First Nations and Inuit communities.

In the 1998 NNADAP Review, it was acknowledged that a principal challenge for NNADAP remains its ability to coordinate and integrate services. While this challenge is not unique to the NNADAP system, many municipal, provincial, and Aboriginal services have, over time, introduced measures to integrate, renew, and coordinate their addiction treatment and prevention services based upon population needs and best practices. It follows that First Nations communities and FNIH Regions stand to benefit from a comprehensive review of the NNADAP system to ensure the best allocation of existing and potential resources, and the optimal configuration of services at community, regional, and national levels.

Recent Trends in Substance Abuse and Addiction Services

Within the past 25 years, there have been considerable advances in approaches to prevent, treat, and/or minimize the harms associated with problematic substance use. In light of these advances, there has been increased pressure on delivery systems to ensure that the approaches being offered are supported by evidence and are accountable to measurable standards of quality. Within First Nations communities, a similar trend towards evidence-informed approaches is occurring[1]; however, in many of these communities it is recognized that models developed for mainstream populations often need to be coupled with traditional knowledge and adapted to recognize the cultural realities, spiritual beliefs, and holistic views of many First Nations people.

Similarly, there has also been increased recognition interrelationship between substance use and mental health problems, particularly when one considers the prevalence of concurrent disorders. While mental health and addiction services have historically operated in separate spheres, more recently, there have been calls to further integrate and coordinate these services. Within the NNADAP system, service providers have worked to increase their awareness of mental health issues; provide services for concurrent disorders; and collaborate with provincial services to ensure that clients have access to appropriate mental health services.

Along with this trend, there has also been an increased awareness that individuals who experience substance use problems are a heterogeneous population, with individual and cultural differences regarding the context and motivations in which substance use occurs,

[1] It should also be noted that an evaluation of NNADAP service delivery models will be carried out between 2009-2010 and 2010-11.

and the factors that contribute to substance use involvement. Likewise, there has also been recognition that the problematic use of alcohol and other drugs is the result of a complex interplay of physiological, psychological, interpersonal, and other social and situational factors. For service providers, both in addiction prevention and treatment, this has necessitated broadening the scope of approaches offered to individuals, chiefly towards addressing and considering determinants of health, such as employment, housing, and relationships. With these factors in mind, many NNADAP facilities offer, or have been encouraged to offer, approaches that focus on the whole person (e.g., biological, psychological, social, and spiritual realms of the individual) and the person's context within broader systems (e.g., community and family) as a focal point of intervention.

The Addictions Evidence-Base

In light of recent trends occurring both in mainstream and Aboriginal delivery systems, the Addictions Evidence-Base process has been proposed to provide NNADAP with strategic direction, at community, regional, and national levels[2]. This process is guided by the collaborative work of the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The purpose of this partnership is to develop a comprehensive national program framework that will enable Health Canada and its community-partners to enhance the coordination and integration services offered by through NNADAP.

The Addictions Evidence-Base process will involve a two pronged strategy:

First, FNIH Regions will be required to complete Regional Needs Assessments on their substance use and addiction-related services. Employing various research techniques and engaging in appropriate consultations, each Needs Assessment will produce findings that will inform the renewal of addictions systems and services within each FNIH Region.

Second, FNIHB, in collaboration with the AFN and NNAPF, will convene a First Nations Addictions Advisory Panel (FNAAP), consisting of members of the AFN's Public Health Advisory Committee and additional addictions experts. FNAAP will provide guidance on the renewal of addictions services for First Nations communities by: assisting with regional needs assessment workplans; reviewing the available evidence and promising practices; considering current gaps and needs; reviewing regional priorities; and providing a national program framework to guide NNADAP's renewal activities over the coming years (Annex A proposes a timetable for the Evidence-Base process). It is also anticipated that FNAAP will be available as a resource to regions throughout the needs assessment process.

Furthermore, as NNADAP continues to be an initiative that is national in scope, it should be noted that FNAAP will be involved in making recommendations on the best national configuration of addictions services based upon the results of the regional needs assessments, best practices identified by communities, and other evidence-based information.

[2] An Inuit-specific Evidence-base process is currently being developed by FNIHB in partnership with the ITK and the National Inuit Committee on Health.

Section Two: What is a Needs Assessment?

A needs assessment is a systematic exploration of the extent and nature of identifiable needs within a target population relative to the services that may or may not be in place to address those needs. The purpose of this process is to identify gaps, overlaps, strengths, and areas for improvement (via asset mapping and other activities) within current services. In turn, the outputs of this process will be used to identify the best possible blend of services necessary to respond to these needs effectively and efficiently given available resources.

Benefits of an Regional Addictions Needs Assessment

A properly conducted needs assessment can benefit regions by:

- Identifying the optimal configuration of services relative to community/regional needs;
- Identifying and building upon knowledge, strengths, and assets within communities;
- Identifying and promoting best/promising practices already existing at the community level;
- Enhancing collaboration/cooperation between service providers within the region and across jurisdictions;
- Improving regional data quality;
- Identifying the best allocation of current and projected resources within the current system;
- Enhancing professional development activities; &
- Providing a collaborative process that serves as a medium for community members, service providers, and service users to have a voice in regional and national decision-making activities.

Section Three: The Needs Assessment Parameters

The guidelines that have been developed are based upon an examination of several documents including Health Canada's Needs Assessment Guidelines for First Nation and Inuit Health Authorities, the Community Health Needs Assessment Guidelines (Manitoba Health), and workbooks developed by the World Health Organization. A number of successful First Nations needs assessments were also examined, including the 2004 Saskatchewan Needs Assessment and Program Proposal (Saskatchewan Aboriginal Youth Services).

Purpose of the Needs Assessment Guidelines:

The intent of this document is to set forth parameters for the first phase of the Evidence-Based process: the regional needs assessment. Establishing needs assessment guidelines will serve two purposes: 1) it will articulate what a needs assessment is and provide a framework for activities that will be carried out; and 2) it will introduce a proposed set of criteria and assumptions that will help to ensure that consistent and reliable processes occur within and across FNIH Regions.

To ensure a smooth and collaborative needs assessment process, it is recommended that the following criteria and assumptions are adhered to:

Criteria

- First Nations regional partners must be engaged and be supportive of the regional assessment process and its intended goals (see Annex B);
- The needs assessment should consider the needs and resources for the following groups/lenses: gender, youth, pregnant women, and mental health (concurrent disorders). Other lenses may be utilized at the discretion of the Region and their partners, such as considerations for two-spirited individuals, children, and people with disabilities;
- The needs assessment should employ appropriate and proven data collection methodologies to ensure valid results. An objective and experienced researcher is mandatory and partnerships with post-secondary institutions or other researchers are encouraged;
- Problem gambling, tobacco, and enforcement issues are outside of the scope of this exercise, due to NNADAP's limited mandate for drug and alcohol programs; in the event these issues are raised by the needs assessments, the assessment may provide some analysis regarding how these issues may inform other policy or program areas;
- The needs assessment, both its processes and outputs, should consider the mainstream and First Nations-specific addictions evidence-base (a compact disc will accompany these guidelines which includes all of the resources listed in the annexes of this document);
- The needs assessment should seek out and emphasize arrangements or best/promising practices that are already being delivered within the NNADAP system, particularly those that offer culturally-appropriate services to First Nations communities;
- The needs assessment should consider existing services in relation to a continuum of services (e.g., protective factors, prevention, detoxification, assessment, referral, treatment, and aftercare) when identifying gaps and assets. In doing so, current and potential linkages with key provincial services, including specialized addictions and mental health services, should be emphasized.

Assumptions

- The addictions funding envelop will not be negatively impacted by the outcomes of the Evidence-Base exercise. In fact, additional resources, provided through National Anti-Drug Strategy, will be used to support NNADAP's renewal over the coming years;
- The needs assessment will inform recommendations to maximize the impact of current and projected investments into the NNADAP system;
- It is expected that First Nations representative organizations, in partnership with FNIHB, will drive the needs assessment and renewal processes within the region;
- The aim of the regional needs assessment process is to ensure that the region's First Nations communities have access to an effective, sustainable, and culturally-appropriate continuum of addiction prevention and treatment services.

Section Four: Needs Assessment Phases

1) Consultation and securing community support

Regions should engage in their normal consultative processes with First Nations communities and representative organizations, as appropriate consultations are considered essential for both achieving buy-in from communities and ensuring valid

results. To support the development of an effective needs assessment process, regions should also engage with other knowledge partners including, but not limited to: mental health and addictions service providers in First Nations communities; mainstream health providers (health authorities, provincial mental health and addictions agencies, provincial officials, etc.); previous and current service users; academics or researchers; professional regulatory bodies (e.g., college of physicians and surgeons or college of pharmacists); and law enforcement officials (see Annex B for a list of other potential partners).

Community engagement and support from First Nations leadership will provide valuable partnerships that can be utilized to access quality data about the population; minimize the duplication of previously collected baseline data; help establish the incidence (i.e., rate at which new problems occur during a specified time period) and prevalence (i.e., proportion of the population experiencing problems at a given time) of substance use problems; build and strengthen partnerships; and ensure that communities have a voice in the needs assessment process.

2) Review existing health data and service information

Before moving to the data collection phase, efforts should be made to locate and review regional, provincial, and federal reports, briefs and statistical profiles relevant to the physical and mental health of First Nations communities within the region (e.g., the First Nations Regional Longitudinal Health Survey [RHS]). Regional health information is also available through a review of: previous research; previous needs assessments; existing community health planning documents; health-related environmental reports; region-specific data from the RHS; and various health and social service agency reports (see Annex C for a list of population profiling documents). This process will help ensure that there is no duplication of previously-collected information, and will provide the baseline necessary for establishing the extent of need in the community and region.

It is also recommended that consideration be given to outputs produced by treatment program accreditation activities and unpublished community-driven research. It is anticipated that examination of this information will assist with identify potential partners or interviewees for subsequent phases of the needs assessment exercise, and will help to ensure that there is minimal duplication of data.

3) Review evidence-based documents and identify best/promising practices

In addition to collecting health-related data relevant to the region, efforts should also be made to consult the latest research from the addictions field and identify promising and innovative approaches already being offered within the region. A review of the available evidence (see Annex D for a recommended list of evidence-based documents) should provide a framework for an evidence-based continuum of services for various substance use and addiction problems (Annex E provides an example of matching services with various subgroups). Likewise, efforts should be made to identify and elaborate on innovative models, arrangements, and promising practices offered within the region, particularly culturally-appropriate approaches that incorporate traditional healing, culture, and/or spiritual beliefs. In addition, unpublished research should also be consulted to provide additional context, particularly when considering the historical and cultural context that may be unique to specific communities or regions.

4) Design the process

After reviewing the existing health data and best/promising practices, it will be clear where the gaps in the information exist and specific target groups/areas that require attention. Based upon an evaluation of the available data, and referring to previously conducted needs assessments, construct a needs assessment workplan (see Annex F for a list of documents to assist with the needs assessment design). To assist in the needs assessment workplan, Annex G provides research resources, many of which consider aspects such as culture, gender, age, and mental wellness. In addition, emphasis in the design should be placed on mapping assets (see *Strengths First* document in Annex G), innovative models or services, and evidence of resiliency witnessed in the community in their responses to substance use problems. Moreover, attention should also be given to the governance, coordination, and organizational structure of addictions services within the region when considering the optimal configuration of prevention and treatment services. Finally, it should be noted that a similar governance assessment will be carried out at the National level, following discussions with FNAAP.

At a minimum, the needs assessment workplan/design should allow for the following components:

- a regional profile of First Nations communities;
- a detailed profile of existing regional mental health and addictions services accessed by First Nations clients (including municipal, provincial, and those administered by FNIHB; see Annex J for a recommended list of questions to consider when profiling existing services);
- an overview of promising and innovative approaches offered within the region;
- an overview of the prevalence of substance use problems (see Annex H for a list of recommended use categories);
- an overview of the risks and harms associated with substance use within communities and in a region (e.g., suicide, FAS/FASD, DUIs; see Annex I for a list of alcohol and drug-related harms and potential data resources);
- the prevalence of high-risk methods of substance use (e.g., IDU or crack pipe sharing);
- an overview of the provincial services (e.g., mental health, employment, education, etc.) accessed by substance abuse and addiction programs;
- an overview of regional governance structures within the region;
- the views of community members, service users, service providers and experts; &
- an ideal continuum of care for addiction prevention and treatment services in the region that accounts for services offered both in region and accessible through the province.

Throughout this process, First Nations representative organizations should continue to be engaged to ensure that they support and approve the needs assessment design and process. **Moreover, vital to the efficacy and consistency of this process is an examination of the criteria listed in this document when formulating the needs assessment design; these criteria will also be of assistance in establishing the scope and limitations of the regional process**.

After a preliminary design has been completed and approved, Regions will be asked to submit their needs assessment designs/workplans to FNAAP for review; however, it

should be noted that FNAAP will not be responsible for approving each FNIH Region's need assessment. Based upon their review of the needs assessment designs/workplans, the Panel will provide feedback to each Region in order to: 1) validate and contribute to their needs assessment designs/workplans and 2) ensure that consistent processes and comparable data across FNIH Regions. It is anticipated that comparability of information across regions will be an important factor to assist FNAAP with the development of a national program framework for NNADAP.

5) Collect data for the needs assessment
In order to ensure the validity of conclusions and recommendations drawn from the needs assessment, it is suggested that data is collected from a variety of sources, including qualitative, quantitative, and mixed methods approaches (see Annex B for a list of potential participants & see Annex K for a list of data collection methods).

6) Analyze the data
Once the data is collected, synthesize and analyze the data in order to establish key themes; these themes should be reviewed with key knowledge partners and First Nations leadership to establish the significance of the information.

7) Establish priorities for action
After engaging in appropriate consultations, it is expected that FNIH Regions and First Nations representatives will then work to establish priorities for strategic action (e.g., a strategic plan). The priorities identified in this plan should account the following the following factors: feasibility, community support, supporting evidence, impact (current and potential), training needs, policy factors, and available resources, to name a few. It is also expected that the continuum of care developed in *phase 4* will be revisited at this stage to help identify how current and potential services may enhance the range of services available to the community.

With regards to funding, priorities should also account for the following considerations: 1) ways to maximize investments under the existing funding envelope; 2) linkages or partnerships with third parties (e.g., provinces, regional health authorities) that could be leveraged in support of addressing an identified outstanding need that requires additional resources; 3) how new investments that will be provided to NNADAP under the National Anti-Drug Strategy (NADS) can be best directed within the region.

It is also expected that a discussion will be necessary regarding the effectiveness of current systems and governance structures in addressing the gaps identified (e.g., between existing community-based prevention programs, treatment programs, and specialized provincial addictions and mental health services). If these systems and structures are deemed inadequate, consideration should be given to how these can be optimized to ensure the best use of regional resources.

8) Prepare draft
Once data has been collected and interpreted, and priorities for the region have been established, a draft of the Regional Needs Assessment should be produced; it is anticipated that the draft will be reviewed by community leaders, community-based service providers, provincial service providers, and others who have been consulted

during the process for feedback (see Annex L for a checklist of considerations when evaluating the report).

9) Present the findings; propose actions

The next phase of the needs assessment is to present the findings and propose actions in the form of a final report. The report should include, but is not limited to:

- A description of the needs assessment process, identifying the purpose, methods, participation/consultation that took place, the tools used for collecting information, and the limitations in the processes or with the tools;
- A description of the region, including a description of the communities within the region and their specific assets, challenges, and resources;
- A description of promising or innovative approaches, practices, and arrangements within the region;
- Connections to the literature, both with regards to services being offered and those being proposed;
- An analyses of both existing and proposed mental health and addiction services, taking into account strengths/limitations/assets of services;
- Any cost sharing agreements that may or may not be impacted;
- A systemic review of existing substance use and addiction services and their
- regional governance structures;
- A detailed substance abuse and addiction continuum of care for the region;
- An overview of the connections/referrals to other services (e.g., provincial) as they relate to an addictions continuum of care;
- A listing of the priorities that considers the desires of communities;
- Proposing actions and recommendations (e.g., a five-year strategic plan) based upon the available evidence to either modify, maintain, or propose services in the region; recommendations should reflect the views of communities as well as consider current and potential resources within the region;
- Additional resources that maybe required;
- Considerations for further research.

10) Present findings to the First Nations Addictions Advisory Panel

Once the needs assessment has been completed and the final report, including a strategic plan, has been validated, results will be submitted to FNAAP. The findings of the Regional Needs Assessments will then be reviewed by the Panel along with other evidence-based materials. Based on a review of the information collected or submitted, FNAAP will produce a five-year program framework for NNADAP.

In reviewing each Regional Needs Assessment, the members of FNAAP will provide feedback and guidance to each Region regarding their Needs Assessment findings. Regions and their partners will be responsible for considering this feedback in concert with the program framework produced by FNNAP. Based upon the guidance from these processes, a final program framework for NNADAP will be created that is supported by key regional partners, achievable within reasonable time-lines, and cost-effective.

Appendix A

Evidence-Based Process Timeline

- Draft of the guidelines – November 30, 2007
- Guidelines approved by the First Nations Addictions Advisory Panel – March ‘08
- Guidelines sent to region – April ‘08
- First meeting of First Nations Addictions Advisory Panel – May ‘08
- Regions submit methodologies – June – Sept ‘08
- NAs completed up to March ‘09
- Program Framework expected to be produced in Summer ‘09

Appendix B

Potential Needs Assessment Partners/Participants

Potential interview, survey, and focus group participants might be:

- Academics
- Child and family service workers (on-reserve and provincial/municipal)
- Community leaders
- Community members
- Hospitals
- Community-based NNADAP workers
- Community mental health workers
- Current and past NNADAP service users
- Elders
- Other health workers and social service providers
- Health professionals
- Other community-based program staff (e.g., Brighter Futures, AHSOR, CPNP)
- Police
- Probation officers
- Regional Committees
- Religious/spiritual leaders
- Staff of NNADAP facilities
- Teachers and school administrators
- YSAP workers

Appendix C

Population Profiling Documents

- First Nations Regional Longitudinal Health Survey (RHS) 2002/03: The Technical Report. AFN, 2007

- Profile of Substance Abuse Treatment and Rehabilitation in Canada. Minister of Public Works and Government Services Canada, 1999

- Statistical Profile on the Health of First Nations People in Canada for the year 2000, Health Canada, 2000

- Provincial data

Appendix D

Recommended Evidence-Based Documents

Mandatory Document

- Interventions Supported by Scientific Evidence for Substance Abuse Treatment, Harm Reduction and Prevention. First Nations and Inuit Health Branch. Health Canada, 2005

Recommended Documents

- Addictive Behaviours among Aboriginal People in Canada. Aboriginal Healing Foundation, 2007

- Alcohol Problems and Approaches: Theories, Evidence and Northern Practice. Ajunnginiq Centre. National Aboriginal Health Organization (NAHO), 2004

- Best Practices: Concurrent Mental Health and Substance Abuse Disorders. Health Canada, 2002

- Best Practices: Early Interventions, Outreach, and Community Linkages for Women with Substance Abuse Problems. Health Canada, 2006

- Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems. Health Canada, 2001

- Best Practices: Treatment and Rehabilitation for Youth with Substance Use Problems. Health Canada, 2001

- Every Door is the Right Door: A British Columbia Planning Framework to address problematic substance abuse and addiction. BC Ministry of Health Services, 2004

- Evidence-based Treatment: Information for the Service Provider. CCSA, 2006

- Harm Reduction Policies and Programs for persons of Aboriginal descent. CCSA, 2007

- Harm Reduction Policies and Programs for Youth. CCSA, 2006

- Literature Review: Evaluation Strategies in Aboriginal Substance Abuse Programs: A Discussion. First Nations and Inuit Health Branch. Health Canada, 1999

- Mental Health and Addiction Services in Regionalized Health Governance Structures: A Review. The Centre for Addiction and Mental Health, 2005

- Models of Care for the treatment of adult substance misusers: Update 2006. National Treatment Agency for Substance Misuse (UK), 2006.

- Prevention of Substance Use Problems among Young People – A Compendium of Best Practices. Health Canada, 2001

- Responding to the Risks and Harms of Problematic Substance Use: Re-thinking the Continuum of Care– a background paper for the National Treatment Strategy Working Group. CAMH, 2007

- Strengthening Evidence-Based Addictions Programs: A Policy Discussion Paper. Alberta Alcohol and Drug Abuse Commission, CCSA, and the National Policy Working Group, 2003

- Towards a Model System of Services and Supports for Addictions– a background paper for the National Treatment Strategy Working Group. CAMH, 2006

- Substance Abuse in Canada: Current Challenges and Choices. CCSA, 2005

- Substance Abuse in Canada: Youth in Focus. CCSA, 2007

Appendix E

Example of connecting subgroups of drug users with appropriate services

Subgroups of drug abusers: major problems and main services needed

The Office of National Drug Control Policy in the United States has developed a performance management framework based on the following structure:

Subgroups of drug abusers	*Major problems*	*Main services needed*[a]
Non-dependent drug abuser	Negative consequences and risks of becoming dependent	Appropriate early interventions
Injecting drug abuser	Drug abuse, at risk for blood-borne infection and other medical complications	Drug abuse treatment programmes, HIV/AIDS education and counselling, needle and syringe exchange programme and medical care
Dependent drug abuser	Drug abuse disorders, health and other negative consequences	Drug abuse treatment programmes
Acutely intoxicated drug abuser	Acute behavioural disorders and overdose	Short-term medical and psychiatric intensive care
Drug abuser in withdrawal	Withdrawal symptoms	Short-term detoxification programme
Drug abuser in recovery	At risk of relapse to drug use	Rehabilitation and relapse prevention programme

[a]A variety of services are included in drug abuse treatment programmes, for example, intensive community and residential treatment, aftercare support and social and legal assistance.

Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide. United Nations: Office on Drugs and Crime, 2003

Appendix F

Needs Assessment Resources

- Community Health Needs Assessment Guidelines. Manitoba Health, 1997
- Community Health Needs Assessment: A Guide for First Nations and Inuit Authorities. First Nations and Inuit Health Branch. Health Canada, 2000
- Developing and Implementing a Health Plan: A Guide for First Nations and Inuit. First Nations and Inuit Health Branch. Health Canada, 2007
- Guidance for the Measurement of Drug Treatment Demand: Toolkit Module 8. United Nations: Office on Drugs and Crime, 2006
- Workbook #3: Needs Assessment. World Health Organization (WHO), 2000

Appendix G

Recommended Research Documents

- CIHR Guidelines for Health Research Involving Aboriginal People. Canadian Institutes of Health Research, 2007
- Costs of Substance Abuse in Canada in 2002: Highlights. CCSA, 2006
- Developing a Gender-based Framework, AFN, 2007
- Developing and Implementing a Health Plan: A Guide for First Nations and Inuit. First Nations and Inuit Health Branch. Health Canada, 2007
- Draft Framework: Gender Balancing: Restoring Our Sacred Circle, AFN, 2007
- Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide. United Nations: Office on Drugs and Crime, 2003
- First Nations Public Health: A Framework for Improving the Health of Our People and Our Communities. Assembly of First Nations, 2006
- A Guide to Developing a Multi-year Workplan. First Nations and Inuit Health Branch. Health Canada, 2007
- A Holistic Framework for Aboriginal Policy Research. Status of Women Canada, 2004
- NNADAP Renewal Framework for Implementing the Strategic Recommendations of the 1998 General Review of the NNADP. NNAPF, 2000
- OCAP: Ownership, Control, Access, and Possession. NAHO, 2007
- Strategic Action Plan for First Nations and Inuit Mental Wellness. First Nations, & Inuit Mental Wellness Advisory Committee, 2007
- Strengths First: An Asset Mapping Guide for First Nations and Inuit, Health Canada, 2007

Appendix H

Recommended Substance Categories

1. Alcohol

2. Opioids (heroin/methadone/other opioids)

3. Cocaine (cocaine/crack)

4. Stimulants (amphetamines/crystal meth/MDMA and other derivatives/other stimulants)

5. Hypnotics and sedatives (barbiturates/benzodiazepines/others)

6. Hallucinogens (LSD/others)

7. Volatile inhalants

8. Cannabis

9. Other substances

With the exception of alcohol, the above categories come from the European Monitoring Centre for Drugs and Drug Addiction; more information on these can be found at http://www.emcdda.europa.eu. Considering the extent of polydrug use in First Nations Communities, these categories may be grouped together when necessary.

Appendix I

Assessing Alcohol and Drug-Related Harms

Another way of highlighting the extent of drug and alcohol problems within First Nations communities is through an examination of frequency of drug and alcohol-related harms experienced by this population. Broadly defined, these harms can be divided into acute and chronic health consequences (see chart below).

Assessing Alcohol and Drug-related Harms		
Chronic and Acute Harms	**Examples**	**Potential Data Resources**
Acute Consequences	Suicide; self-injury; motor vehicle accidents; alcohol poisoning, sexual assaults; alcohol or drug-attributed violence, overdose, etc.	**Record-based**: Regional hospitalization data*****; police records; previous research/reports; health centre/nursing station data; regional treatment and detoxification centre data
		Self-reported: Previous research; region-specific date from the First Nations Regional Longitudinal Health Survey******
Chronic and other conditions	Liver cirrhosis; HIV & hepatitis-C infections; FASDs; some cancers, etc.	Regional hospitalization data; health centre/nursing stations; regional treatment and detoxification centre data

*****Regional data may be applicable in this process if the data included both First Nations and alcohol or drug identifiers. It is suggested that the Canadian Institute for Health Information be contacted as an initial step in this process.

****** Region-specific data can be requested; however, it should be noted that much of the youth-specific data in the Survey, as it relates to drug and alcohol use, are considered estimates due to the fact that many youth chose not to answer these questions.

It should be noted that this data should be available based upon previously conducted research and therefore ***no primary research*** will be required to do this analysis.

Recommended Resources:

- Costs of Substance Abuse in Canada in 2002: Highlights. CCSA, 2006
- Substance Abuse in Canada: Current Challenges and Choices. CCSA, 2005
- The relative risks and etiologic fractions of different causes of disease and death attributable to alcohol, tobacco and illicit drug use in Canada, Single, E. et al. in CMAJ, 2000
- Statistical Profile on the Health of First Nations People in Canada for the year 2000, Health Canada, 2000

Appendix J:

Possible Questions to Consider when Profiling Existing Services

Regional Programming

- Where are the services located? Are programs located on or off reserve?
- What is the composition of programs in the region (e.g., inpatient, outpatient, day programs, outreach, and prevention)?
- Are there programs available for families, youth, women, pregnant women, and people with concurrent disorders in the region?
- What information or networking and information sharing occurs between regions/provinces/treatment centres/health centres?
- What is the perceived level of need for various harm reduction approaches? To what extent are needs for harm reduction services being met? What are barriers and facilitating factors to providing harm reduction?
- What programs or services exist for heavy episodic drinkers?
- Are current programs devoted to particular types of drug use?
- What programs exist that have a harm reduction focus?
- What other programs in the community exist that address addiction-related needs (e.g., support groups, school programs, 12-step meetings, etc.)?
- To what extent are there cross-sectoral partnerships to address contextual factors (e.g. justice, education, employment, housing)?
- To what extent is there effort to promote resiliency, in addition to reducing risk factors?

Program Specifics

- What are the service's hours of operation? Are there any additional supports available after program hours such as a helpline or answering service?
- What range of clients does the service cater to — in terms of age, gender, drug of abuse, geographical distribution, etc.?
- Do programs for women/families have day-care or schooling for children incorporated?
- To what extent are there linkages among NNADAP services and FN/I Community Health Services and Community Health Planning Processes?
- How accessible is the service? How do existing clients access the service — on foot, by car, by public transportation, NIHB transportation?
- What *specific* needs does the service meet for its clients?
- What specialized programming is offered to clients? Are their accommodations for clients with FASD, learning disabilities, and/or brain injuries? Are clients on probation served? Are clients on methadone accepted?
- How does the service receive referrals, and from whom do its referrals come?
- How many clients visit the service each week, month, quarter, year?
- Are services available that do not require complete abstinence from drugs and alcohol?
- Are services available that provide harm reduction services (e.g., needle exhanges)?
- What services are available that encourage moderated or lower-risk consumption or use of drugs and alcohol?
- On average, how long do clients stay with the service and what are their reasons for leaving (e.g., drop-out, referral)?
- Does the service have a waiting list? If so, how long do drug users have to wait before accessing the service?
- What support, if any, is provided while waiting? What follow-up support is provided?
- What mix of treatment models are presently offered at the service (e.g., Biopsychosocial, Disease-based, Cultural model, etc.)?

- What modalities are utilized within these models (psychosocial counselling, group therapy, etc.)?
- Are the programs for men, women, or co-ed?
- Are the services accredited? If so, who are they accredited by? How long is the accreditation for? If not, are there plans to become accredited?
- For treatment facilities, what is the number of beds available? Or, for other programs, what is the # of clients served during a program cycle?
- What is the length of the program?
- What is the intake frequency?
- Who funds the services (be sure to indicate if funding is allotted to specific programs)?
- What relationships exist with off-reserve programs or other service providers?
- To what extent are there linkages among NNADAP services and provincial/regional addictions and mental health services?
- Does the program offer regular access to professional mental health services (e.g., counsellors, psychologists, psychiatrists, community physicians, nurses)?
- Which concurrent disorders are most prevalent among NNADAP clients (e.g. depression, anxiety, affective schizoid disorder, ADHD, FASD)?
- Does the program have access to pharmacological treatments?
- What are strengths and challenges in how NNADAP currently identifies and treats clients with concurrent disorders?

Worker Specifics

- What is the usual caseload # for various staff members? What is the worker to client ratio? How many full-time staff does the service employ?
- What are the training levels of staff? How many of the staff are certified?
- What training opportunities are employees currently engaged with?
- What is the access to training?
- What are the retention rates of qualified personnel?
- How many Aboriginal staff are employed? How many non-Aboriginal/non-Inuit staff?
- What access is there to addictions/mental health-related training for workers?
- What are the employee retention rates for Aboriginal and non-Aboriginal staff?
- What are the average employee pay rates?

First Nations and Inuit Program Specifics

- What culturally appropriate/specific services are being offered in the various services?
- Is there an integration of First Nations or Inuit spiritual practices?
- Are band/community elders accessed by programs?
- Do programs incorporate specific programming for issues related to residential schools and/or trauma?
- Are traditional ceremonies or practices acknowledged as part of programs (e.g., sweat lodges, smudge ceremonies, etc.)?
- Are traditional medicines and teachings integrated into services?
- Are programs offered by or for a specific band?
- What do stakeholders and community members see as the most immediate needs in their community in regards to substance use/addiction?

Appendix K:

Data Collection Methods

Note: A professional research consultant or organization should be well-versed in the following methodologies:

Document Approaches

Document Review

- A document review collects relevant information about the community, addiction rates, where health services are obtained, other related services, and a preliminary idea of the gaps in services.

Surveys

- When conducting surveys, be sure to include enough people to allow for general statements to be made about substance use and addiction issues within the community. It is important that the samples are representative of the population and randomized in order to ensure valid representation and a reasonable cross-section of views.

Oral Approaches

Note: For interviews, community members/workers may prefer spoken forms of knowledge input as they are consistent with oral traditions. While quantitative approaches are necessary, an emphasis should be placed on qualitative approaches at the community level.

Interviews with Key Informants

- Based upon information obtained from the document review, interviews can then be conducted with key individuals if more information can help to identify the unique characteristics of the community as well as potential health problems.

Focus Groups

- Focus groups can be used along with surveys to provide greater insight into the key issues identified by the document review, interviews, and surveys.

Reaching "hidden" Populations that may not come into contact with Services:

Snowballing

- A technique whereby a user is initially identified and then asked to introduce other acquaintances, who are then each asked to introduce acquaintances of theirs and so on until a sufficient sample size is reached. A "reward" or incentive is sometimes provided to the individual for each new contact.

Outreach

- Employing outreach workers to engage with difficult-to-reach populations such as homeless people, prostitutes, children, or young people.

Appendix L:

Report Evaluation Checklist

Checklist for Evaluating Your Report		
The Needs Assessment Process		
Have appropriate consultations and partnerships been made with First Nations representative organizations and community leadership?	Yes □	No □
Has there been an objective and experienced secured for this process?	Yes □	No □
Is the purpose of the needs assessment clearly identified?	Yes □	No □
Are the methods explained?	Yes □	No □
Are details provided on how the methods were carried out (e.g., how focus groups were organized, how a survey was distributed, etc.)?	Yes □	No □
Are all of the tools (e.g., survey questionnaires, interview protocols, and focus group protocols) included in the appendices?	Yes □	No □
Are the participants in surveys, focus groups, and community meetings described, e.g., numbers, who they are, age range if appropriate?	Yes □	No □
Does the process consider the needs and resources specific to gender, youth, pregnant women, and mental health (concurrent disorders)?	Yes □	No □
Are the limitations in the process, the tools, and available information described?	Yes □	No □
Are considerations for further research provided?	Yes □	No □
Collected Data		
Is the qualitative data grouped into themes?	Yes □	No □
Is the quantitative data reported using charts and graphs?	Yes □	No □
Are answers to multiple choice questions reported in terms of the percentage or number of people who chose each response?	Yes □	No □
Are baseline data or comparison data provided?	Yes □	No □
Existing and Needed Services		
Are the programs and services that are currently available to meet the substance use and addiction priorities described?	Yes □	No □

Is there an overview of promising or innovative approaches, practices, and arrangements within the region?	Yes □	No □
Are needed additional programs and services noted in appropriate detail and consistent with best/promising practices?	Yes □	No □
Are proposed services or modifications to services supported by evidence?	Yes □	No □
Are the existing services and programs considered in relation to an integrated continuum of services (e.g., prevention, assessment, referral, treatment, and aftercare)?	Yes □	No □
Is there a systemic review of existing substance use and addiction services and their overarching regional governance structures?	Yes □	No □
Substance Use and Addiction Priorities		
Are the substance use and addiction priorities described?	Yes □	No □
Is the method for deciding the region's substance use and addiction priorities described?	Yes □	No □
Is the criteria provided for how priorities were selected described?	Yes □	No □
Is the process of community engagement for determining priorities described?	Yes □	No □
Strengths and Assets		
Are the assets in the region made explicit?	Yes □	No □
Have community efforts to prevent or minimize the harms associated with substance use and addiction been acknowledged?	Yes □	No □
Is there a discussion of the evidence of innovation and resiliency in the region/communities?	Yes □	No □
Proposed Actions		
Are actions and recommendations for system renewal proposed?	Yes □	No □
Are the actions and recommendations based upon available evidence?	Yes □	No □
Do proposed actions take into account the existing resources/capacities within the region?	Yes □	No □
Do proposed actions give consideration to ways of more effectively using current resources?	Yes □	No □
Are requests for additional investments clearly articulated and do they give consideration to partnerships with provincial services?	Yes □	No □