Care Pathways for Healing Journeys: A Systems Model to Support NNADAP Renewal

Discussion Paper

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First Nations Addictions Advisory Panel

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(in alphabetical order)

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A. Introduction

1. Context of the NNADAP Renewal

The NNADP Renewal is a First Nations Addictions evidence-based process that includes a comprehensive, culturally-relevant review of NNADAP. It involves regional needs assessments, a series of research papers, and input from a national advisory panel. The renewal process seeks to systematically enhance, renew and validate on-reserve prevention and treatment services by engaging First Nations communities, service providers, representative organizations and other stakeholders. Ultimately, the renewal process will lead to development of a strategic vision to guide program planning and service delivery for the next 5-10 years. Critical to that strategic vision will be the development of a culturally-relevant conceptual model of a continuum of care for a system of NNADAP prevention and treatment services.

This paper takes some first steps toward mapping out such a model. In doing so, consideration has been given to other documents produced as part of the renewal process, including the reports on prevention, integration and cultural practices. Particular attention was paid to the synthesis of recent completed NNADAP regional needs assessments. The regional reports placed an emphasis on the inclusion of culture in substance-related services and supports, addressing the needs of families and youth, the provision of adequate training and wages for workers, and accreditation for treatment centres. Also emphasized was the need to strengthen specific components of the continuum of care as well as the need to address structural aspects of NNADAP program policies, funding, governance and coordination

2. Purpose of this discussion paper

The purpose of this discussion paper is to present and outline a conceptual model that reflects and is informed by the realities of First Nations communities, and at same time explores potential bridges with Canada's National Treatment Strategy. The National Treatment Strategy provides a general set of system-level principles and key concepts for building a comprehensive continuum of care focused on addressing broadly defined risks and harms related to substance use. The challenges in relating the National Treatment Strategy to the context of First Nations communities in Canada are significant. However, this paper attempts to address them as much as feasible within a conceptual, system-level document. This is facilitated by the recent Regional

Needs Assessments that were conducted across Canada, which provide a guiding context that shapes this document.

The challenges can be expressed in three questions: First, are the principles and concepts appropriate for NNADAP renewal, given the historical, geographic, cultural, and jurisdictional factors that need to be taken into account? Second, do the means of describing or visually representing the National Treatment Strategy, including its tiered framework, resonate well with First Nations ways of understanding the world? Finally, since the National Treatment Strategy is still a work in progress, what lessons can it learn from the NNADAP renewal process on how to create more harmonious, interconnected systems working to prevent and treat addictions problems?

3. Overview of the paper

The paper is organized as follows. Section (B) describes the assumptions and concepts that inform thinking about service and support systems within the context of First Nations. This will include assumptions about the centrality of culture and community, recommendations and findings from the Regional Needs Assessment documents and summaries produced for NNADAP, key concepts and principles from the National Treatment Strategy, and themes derived from the literature review conducted as a precursor to this paper. Section (C) attempts to build on and extend the central elements in the National Treatment Strategy in ways that are more clearly community-centered and focused on the perspectives of people journeying through services and supports comprising the broad continuum of care. What emerges is a model that is consonant with the NTS but that has a shape and direction of its own. Section (D) discusses implementation issues by identifying potential choices and challenges for further consideration. Finally, Section (E) gives a summary of the overall discussion and makes some suggestions for the way forward.

B. Foundations

1. Some assumptions

In this paper some assumptions are made about the main intended outcomes of a substance use-focused continuum of care, as well as of the services and supports that comprise it. Broadly

speaking, it is assumed that the goal is to improve the health and wellness of First Nations people, families and communities through the intentional use of health promotion, prevention and intervention policies and practices.

More specifically, it is assumed that systems and programs are considered effective insofar as they show themselves to facilitate the reduction of risks and harms, with an emphasis on the reduction of mortality and morbidity as primary or secondary consequences of substance use. From a holistic perspective this would include addressing spiritual, emotional, physical, psychological and social issues as they relate to substance use and substance use problems.

In addition, it can be taken as a given that traditional cultural approaches to addiction prevention and treatment are highly valued by First Nations people, whether these emerge from traditions specific to particular First Nations communities or from shared indigenous values that might be pan-Canadian, pan-American or even global in scope. The Regional Needs Assessments articulate important details and give thematic shape to what is needed. This paper thus tries to offer a vision of a system model in which culture and traditional healing practices have central places in the overall continuum of care, and are anchored in the feedback of the extensive needs assessment process undertaken by NNADAP and FNIHB as part of the renewal process. Also in keeping with the First Nations' cultural emphasis on community, the paper has assumed that it is the place of each community to negotiate and define culture in ways that are its own, including the ways that different kinds of cultures or cultural practices might be brought together or kept separate from each other. This is reinforced by the strong consensual finding of the needs assessment process that culture, tradition and spirituality are integral to NNADAP renewal.

The diversity among First Nations communities requires the greatest respect, so the mix of healing approaches becomes the task of communities and regions. This includes not just existing approaches and methods, but the development of innovative approaches, still in the spirit of First Nations culture and values, that offer new creative solutions to problems related to addiction. Opportunities are then created in for evaluation and research that bring together Aboriginal knowledge and formal scientific methods, building an emerging evidence-base that is comprehensive and inclusive. This allows for the construction of a national strategy that can determine:

- what should count as desired health promotion, prevention and treatment outcomes for their own communities;
- which intervention programs and strategies should be used to attain those outcomes; and
- which means should be used to validate those intervention choices.

At the same time, it sets the stage for each First Nations community to implement the specific ensemble of services and supports that are most relevant to their local context.

There is much potential in the deliberate and thoughtful bringing together of diverse approaches to helping and healing in intentional ways that can be carefully developed, implemented and studied. Such an approach can lead to new knowledge and skills to enhance the ways that the prevention and treatment of substance use problems are addressed in First Nations communities and beyond. It is that spirit that guides the drive to NNADAP renewal, and it is that desire that resonates through the recommendations of the Regional Needs Assessments.

Finally, while it is common in non-Aboriginal jurisdictions to place the main emphasis on the individual person within a client-centred approach, it is important in the context of First Nations to reflect the priority accorded to community. That is the same emphasis so evident in the background documents developed in support of renewal process, acknowledging the call for renewed centrality of culture and tradition in recovery and healing. Whereas western client-centred approaches may sometimes (and there are significant exceptions) imagine individual well-being regardless of the community context, a community-centred approach recognizes the community and family context as the necessary nexus within which healthy human development and functioning occurs. This more ecological approach sees the community and the family as the client in equal balance with the individual who is at risk to or is being harmed by problems related to substance use.

For these reasons, the language chosen in this paper reflects and emphasizes an approach that is fundamentally community-centred.

2. System challenges and regional needs

A prior literature review was conducted as a separate project to anticipate the concerns of this discussion paper. Given the necessary concentration on system questions, the literature review

did not address in detail the types of prevention or intervention programs, but rather addressed issues surrounding how programs might be chosen and integrated. In that way, it sought to identify thematic issues and key system challenges cutting across selected research and policy documents. As a result, a set of four central system-level challenges were identified that appeared to underlie the thematic issues emerging from the literature.

These challenges suggest that when developing, adapting or renewing a substance use-related system of services and supports, stakeholders need to:

- take into account historical factors and existing system arrangements, as well as acknowledging differences among and within First Nations communities;
- find ways to support First Nations in their efforts to bring together traditional and other health promotion, prevention and treatment approaches in a manner consistent with community identification of desired health outcomes and indigenous worldviews;
- find ways to support First Nations in their efforts to build on their strengths for community engagement, knowledge development and exchange, and effectiveness in addressing substance use, mental health and related issues they have identified in their midst; and
- bring service and support pathways and doorways together in such a way that First Nations communities, families and individuals experience care journeys that are accessible, respectful and effective in meeting their desired health outcomes across the full continuum of care.

While these challenges cannot be addressed fully in this paper by any means, it does explore how the National Treatment Strategy might provide a useful system-level framework to approach them. However, this also requires us to lay out some considerations about how to reframe the National Treatment Strategy in order for it to make more sense within the context of First Nations.

Parallel to the process of reviewing the literature, a comprehensive set of Regional Needs Assessments was being conducted across the country. As reports of these assessments were prepared and submitted, thirteen themes were identified. Addressing these effectively will create direction for renewal.

Priority areas identified in the Regional Needs Assessments include:

1. Culture and traditional practices
2. Community development

3. Prevention and health promotion
4. Assessment, referral, and community intervention
5. Pre-care/pre-treatment
6. Intervention/treatment services
7. Aftercare
8. Mental health services and supports
9. Workforce development
10. Governance and coordination of systems
11. Pharmacological approaches and prescription drug abuse
12. Data collection and research
13. Wage parity

Most of these priority areas are concerned with specific elements in the continuum of care (4, 5, 6, 7, 8, 11), while others address the need for a renewed workforce (9, 13). Perhaps most significant from a system perspective are those priorities relating to a more comprehensive framework for NNADAP renewal that includes culture and tradition (1), extends the scope of the system to community development, prevention and health promotion (2, 3), while including the need to be able to monitor and improve the system (12) and have effective systems governance and coordination (10). Taken all together, the priority areas provide anchor points around which NNADAP renewal can emerge and coalesce.

3. National Treatment Strategy

The National Treatment Strategy (NTS) is a set of concepts and principles for guiding the development of a broad continuum of care, rather than a concrete prescription for implementing substance use-related services and supports (NTSWG, 2008). The NTS central guiding concepts (Table 1) and associated 'tiered framework' reflect a growing view that addiction services and supports need to move to a more comprehensive design which responds to the needs of all people adversely affected by substance use, rather than only the most severe cases of chemical dependence. In this view, the specialized addiction treatment is located within the larger frame of services within which it needs to support and interact effectively.

Aboriginal participants leveraged their knowledge, skills and traditions to develop the NTS process and were central in the development of its vision, guiding concepts, values and recommendations. The literature review and the Regional Needs Assessment reveal perspectives

and points-of-view that were—while not identical with the NTS—very similar in spirit in the language used, in core issues identified and in proposals advanced.

Table 1: National Treatment Strategy Guiding Concepts

No wrong door A person may access the continuum of services and supports by way of any of the five tiers and, upon entry, should be linked to other needed services and supports, either in the same tier or in a different tier.
Coordination of program linkages Coordination of this linkage is the responsibility of the system, not the individual. To ensure that this principle can be applied in practice, all sectors should routinely screen people for substance use problems and provide ready access to comprehensive assessment services if needed.
Availability and accessibility Services and supports in all tiers should be both available and accessible within a reasonable distance and travel time of each person's home community, or should be facilitated by different means (e.g., telehealth, online or mobile services).
Matching A person should be matched to services and supports whose intensity is appropriate to his or her needs and strengths. Matching implies a need not only for standardized screening and assessment tools, but also for processes that respect each person's informed choice of what type of care may work best for him or her (based on cultural relevance, language group or other considerations).
Choice and eligibility If more than one service or support meets a person's needs, the person should be able to choose among those services and supports for which he or she is eligible. A person should be able to access services and supports within a given tier and across different tiers, as needed over time, though the focus might be in a particular tier at a given time.
Flexibility

A person should be referred from a lower tier to a higher tier (stepped up) or from a higher tier to a lower tier (stepped down) as appropriate to his or her needs.

Responsiveness

People—and their needs—change over time and with changing circumstances. As a person travels along pathways and through the lifespan, he or she should be given the help needed (e.g., information, referral, assessment, treatment) to ultimately shift the focus to services and supports in lower tiers as appropriate

Collaboration

A person's journey through the pathways should be facilitated by collaboration between providers of distinct kinds of services and supports. Collaboration should occur both at the clinical level (e.g., through shared service protocols between different providers) and at the administrative and organizational levels (e.g., through partnerships and inter-agency agreements), and should always include the person seeking help.

Coordination of system information

To facilitate service delivery as well as system planning, monitoring and evaluation, health information systems should allow easy sharing of information between systems.

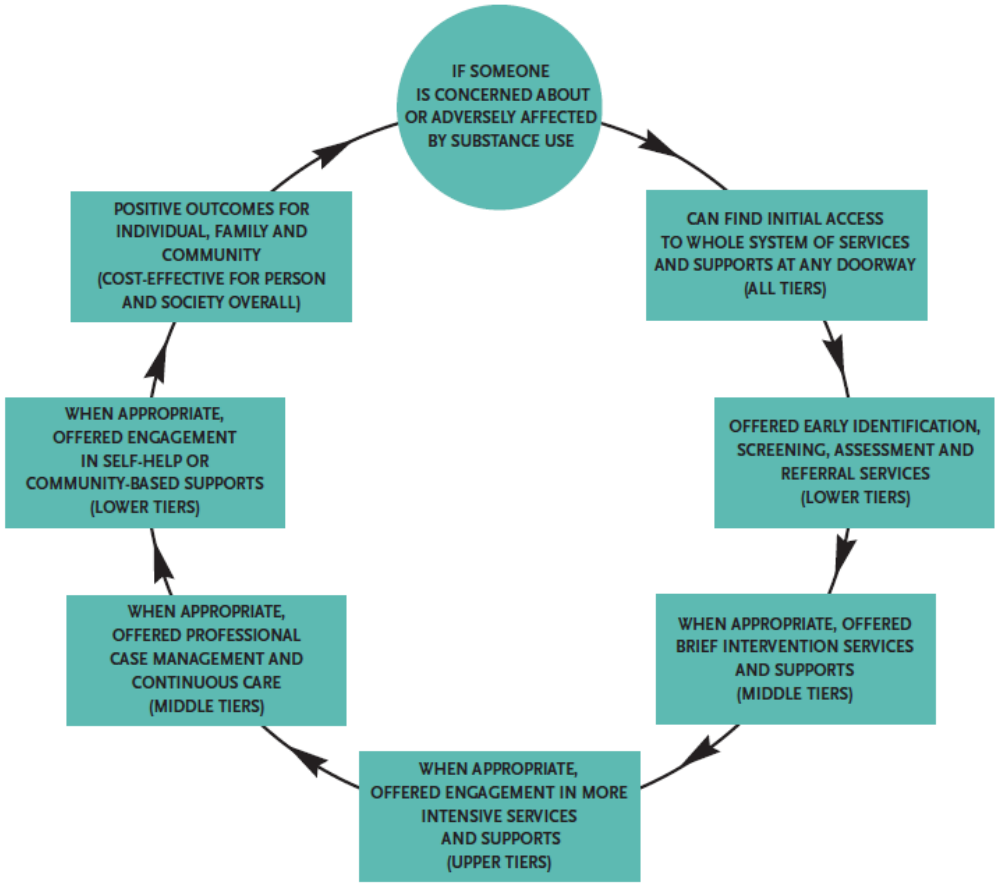
The essence of these principles resonates with the emerging perspective that is shaping NNADAP renewal. The comprehensive approach in the NTS explicitly includes a central emphasis on community-based prevention and treatment initiatives, including engagement of families. It also reflects a shift in thinking toward a greater role for other kinds of service and support providers, and away from a reliance on highly specialized treatment services which may often only be appropriate for individuals with particularly complex and severe problems.

Important in the NTS framework, and echoed elsewhere in the literature, is the emphasis placed on access, flexibility and matching of all individuals adversely affected by substance use to the kind of services and supports they most need at a given point in their care journeys. *Figure 1* below illustrates how the NTS has conceptualized care journeys (NTSWG, 2008) based on these principles.

The NTS also builds on the view that prevention or treatment interventions occurring prior to or early in an individual's history of substance use are more likely to be cost-effective and successful than those implemented after problems become more severe. As well, the NTS reflects the movement toward greater integration of services and supports across the broad continuum of care. Finally, the NTS underscores the need to build networks that can be conduits for knowledge exchange, as well as the need for infrastructure that can support program and system monitoring and evaluation.

One of the ways that the National Treatment Strategy expresses these concepts and principles is through a tiered framework, adapted from the UK and the WHO. Each of the five NTS tiers can be thought of as elements with particular service and support components for responding to the needs of people with different kinds of substance use problems or at different stages in addressing those problems. It is important to underscore that the five NTS tiers are differentiated from each other primarily by the range of people requiring their services and supports. For example, Tier 5 includes services and supports that are only needed by people with very severe and complex substance problems. Other tiers in the model have services and supports with the

Figure 1: NTS Care Journey Diagram



potential to meet the needs of larger groups of people who have more moderate levels of risk or more moderate severity problems. However, individuals are always anchored in Tier 1 with its family- and community-based sources of prevention and support, even when their care journeys take them temporarily to one or more of the other care elements.

While the NTS offers a general overview and a broad set of recommendations, NNADAP renewal allows for – and requires – more specificity in what needs to be done and how. The remaining sections of the paper strive to reframe the NTS concepts and imagery in a ways that may help First Nations communities to think through how to apply aspects of the model in ways that are that are appropriate for them in particular. The framework outlined here goes beyond NTS, while remaining consistent with its spirit and recommendations. Thanks to regionally-

based commentaries and recommendations, and a specific literature addressing First Nations and Indigenous issues, the opportunity arises to have a more articulated set of strategies and action steps coming from the NNADAP renewal process.

The next section describes how the information shaping this process allowed for thinking and planning that is derived from and responsive to the strengths and weaknesses, opportunities and challenges that are particular to the First Nations context in Canada. This begins to propose a shape within which system priorities identified in the Regional Needs Assessment can be placed, bringing prevention and early intervention into the picture, and allowing after care to be understood within a framework of continuing care to bridge the formal treatment system and the communities they serve. This model requires that family and community be seen as integral to the process of renewal and that culture be recognized as foundational. It also calls for a broader approach that is not just professionally based, holistic in its viewpoint and in its direction.

C. Visualizing care journeys and pathways

While both continuity of care journeys and the constant presence of community are very much part of the NTS intended vision, the implicit vertical language of the *tiered framework* may be problematic. Specifically, it does not capture well the continuing and open-ended nature of healing journeys. Nor does it make clear the principle that family and community remain essential parts of people's lives even as they engage in other healing activities, including those beyond the geographic base of the community. The language of 'tiers' reinforces the vertical imagery, so a useful starting point may be to think of tiers as *elements* with service and support *components* for responding to the needs of people with particular kinds of substance use risks or problems or at particular stages in addressing those risks or problems.

Two notions are central to the model outlined here. First, *the model is for a continuum of care that responds to the needs to of all individuals put at risk or adversely affected by substance use at a given point in their lives or care journeys*—rather than only those struggling with severe chemical dependence. Second, *the five elements in the model are differentiated from each other primarily by the range of people requiring their services and supports*. In other words, the elements are defined by the different populations and their different needs. The relative number

of people needing different services and the costs of offering those services can thus be taken into account during program planning and resource allocation.

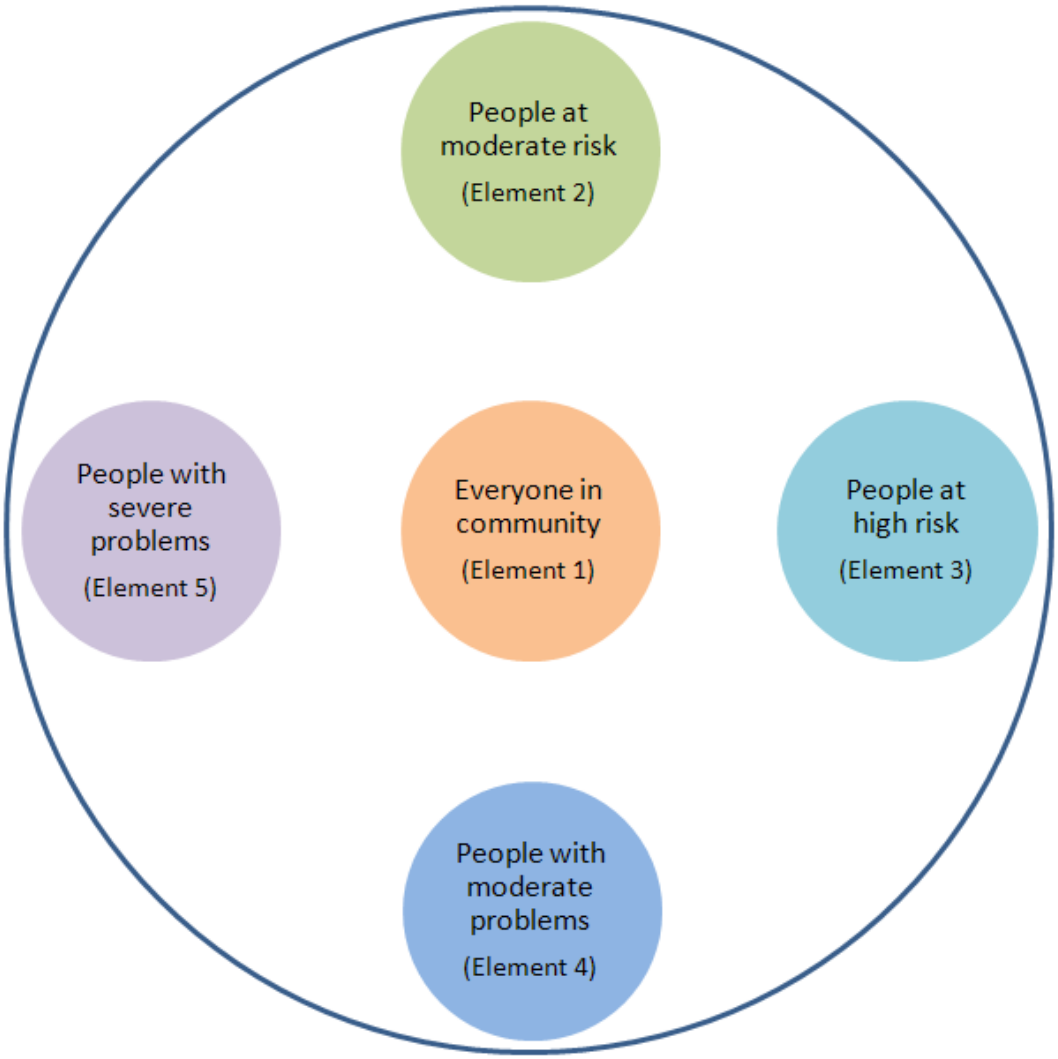
The circular representation in *Figure 2* maps out the segments of community requiring distinct responses to their substance use risks and harms. In *Figure 3*, this mapping of the continuum is taken a step further to suggest the general kinds of services and supports required for each population-defined element. These concepts are described with greater detail in *Table 2*. When interpreting the diagrams, table and text that follow, note that these populations are not mutually exclusive, but rather nested within one another.

From this perspective, everyone in the community benefits from being engaged in Element 1 services and supports. Those alcohol or other drug users who are minimally at moderate risk for harms will benefit from Element 2 services and supports. Those users who are at high risk, but not yet in treatment, will benefit in particular from Element 3 components. Substance users with at least moderately or highly severe (or complex) problems will benefit from Elements 4 or 5 services and supports respectively.

People may need help in getting to the right elements, or in moving from one element to another. This highlights the importance of having the means for care facilitation (CF) in place. Whether through formal case management or other forms of community-based or professional support, a critical part of care facilitation is "active and intentional efforts to keep connected with clients, especially when—as is commonly the case—various service components are not well integrated" (Heire & Skinner, 2010).

To better reflect its importance, universal prevention and social support have been placed within the context of family and community at the centre as part of Element 1, within a wider circle of care elements characterized in general by community-based early identification and intervention (Element 2), secondary risk reduction (Element 3), and the provision for active treatment where serious harm related to addiction is occurring (Elements 4 and 5). The circle of elements is completed by seeing people return to community-based services and supports (Elements 1 and 2) for effective re-integration and functioning in the communities to which they belong. The five elements can be described in more detail as follows.

Figure 2: Population segments requiring distinct service and support elements, and the corresponding elements



Note that these populations are not mutally exclusive, but rather are nested within each other. For example, everyone that could benefit from Elements 2-5 are in the first place always members of the overall commmunity. Similarly, populations experiencing moderate or severe substance use problems are by definition subsets of the populations at moderate or high risk. They are separated here in order to make it easier for the reader to relate them to particular service and support elements (see Figure 3).

Figure 3: System model based on population-defined care elements

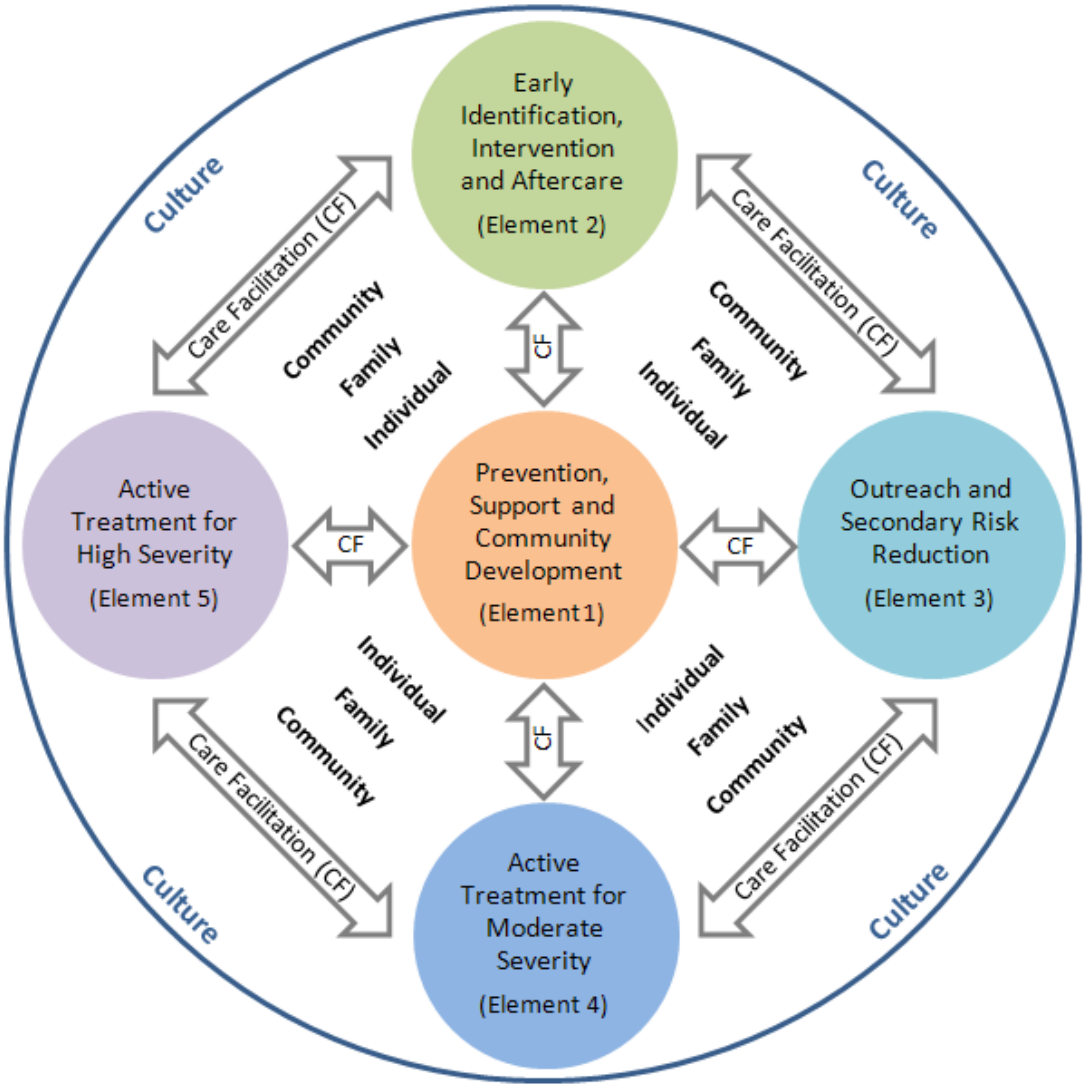


Table 2: Continuum of Care - Overview and System Planning Questions

Major Care Elements	1	2	3	4	5
Defining Population Segment[1]	**everyone**	**people at moderate risk**	**people at high risk**	**people with moderate problems**	**people with severe problems**
Characteristic Service and Support Components	Universal Prevention Self-Care Social Support Community Development	Early Identification Brief Intervention Risk assessment and Pre-treatment Support Relapse Prevention and Continuing Care Referral to more specialized or appropriate services and supports	Addressing Secondary Risks Community Outreach	Engagement, Stabilization and Withdrawal Management Assessment, Goal Setting and Care Planning Active Treatment and Discharge Planning Relapse Prevention and Continuing Care	Treatment Centre
Questions					
People	Which individuals, families and communities require each component?				
Providers	For each component, what kind of people can provide needed help?				
Settings	In what kind of settings can each component be provided?				
Approaches	For each component, what mix of approaches is appropriate?				
Linkages	How can each component be linked to the others within and across elements?				
Resources	What resources are needed to sustain these linkages effectively?				

[1] Note that these populations are not mutally exclusive, but rather are nested within each other. For example, everyone that could benefit from Elements 2-5 are in the first place always members of the overall commmunity. Similarly, the populations experiencing moderate or severe substance use problems are by definition subsets of the populations at moderate or high risk.

Element 1

The provision of Element 1 services and supports—including prevention and support by family and community—is foundational to the model. Element 1 service and support components are "broad efforts that draw on natural systems and networks of support for individuals, families and communities. They provide a foundation for a healthy population, and have broad eligibility criteria, allowing anyone access to them" (NTSWG, 2008). Community networks of support might include peers, neighbours, work colleagues, playmates, and of course families, in neighbourhoods, workplaces, recreation spaces, faith communities and homes.

The providers of prevention and social support are family and other community members or community workers. Native people experience family and communities as a set of nurturing relationships that can in turn serve as a fundamental source of universal prevention. These relationships may also provide a first context through which people begin to realize their own substance use problems as well as the first encouragement to undertake healing journeys through various services and supports. Even when those journeys take people out of the physical community, they may still experience family and community as their most important source of continuing support.

It needs to recognized that social support in the form of interpersonal care is vital throughout care journeys and therefore throughout the elements of this model. Interpersonal care is an important catalyst for on-going renewal (through teaching, learning and healing) as well as for healthy living.

Element 1 is also is the focal point for community development. A key role of community development is fostering a shared understanding of how stigma can be a major barrier to communities engaging in effective prevention and intervention strategies. A more extensive discussion of community development is presented later in the paper.

Element 2

The service and support components in Element 2 are in intended as responses to the needs of people with at least moderate levels of risk from their alcohol or other drug use. In some cases, people are not only at risk, but also have already started to experience moderate or severe levels of harm, including possibly chemical dependence. Where moderate or severe harms have emerged, the service and support components associated with active treatment will also be applicable (see *Elements 4* and *5* below). The characteristic *Element 2* service and support components needed by the moderately at-risk population are (a) early identification, (b) brief intervention, (c) risk assessment and pre-treatment support, (d) relapse prevention and continuing care, and (e) referral to more specialized or appropriate services and supports.

Early identification is concerned with identifying the possibility that a person has a substance use problem, preferably - before serious adverse consequences emerge, in preparation for being explored further. This may involve the use of formal screening tools that have been validated for use with specific populations such as women, youth, or cultural groups such as First Nations people. However, early identification can also sometimes be accomplished through less formal means, such engaging in supportive conversations through which the individual comes to identify their own risks or problems. Either approach requires care and appropriate training.

Brief intervention is a time-limited set of supportive discussions between a substance user and someone they trust and respect, with the aim of helping the individual to set goals for substance use behaviour changes and developing motivation to pursue those goals. A style borrowed from the motivational interviewing approach is often followed, and this requires some minimal training on the part of the provider. Brief interventions are usually conducted by health or social service providers already known to individual, but they could also be delivered by others on an opportunist basis, such as by emergency department staff or others working in the local community. Interactions of this kind often involve only one to three sessions of less than an hour each.

Early identification and brief intervention are critical links in the continuum of care, as they engage and begin to help people with potential substance use problems who have not (yet) become engaged with services that specialize in providing addiction treatment. This can be accomplished by connecting with people when they routinely access local services such as

community and emergency health care, housing services, social services or community-based NNADAP workers. In this way, early identification and intervention may reduce the number of people ultimately needing specialized treatment by addressing substance problems earlier in the history of the addiction. Brief intervention and early identification also may help many people with less severe substance issues who would not necessarily benefit from more intensive treatment (for example, people engaged in risky but non-dependent drinking patterns).

Evidence suggests that individuals who still need assistance in managing their substance use after a few brief intervention sessions might be best referred to more specialized counseling and support, such as self-help groups or more formal addiction counseling. As a starting point, brief intervention can benefit people with chemical dependence; however, more intensive care will likely be called for before long (see Elements 4 and 5). Thus providers of brief interventions need to be engaged in ongoing risk assessment with their clients and know where to refer when it appears that risks or harms are higher than initially thought. This applies to risks and harms associated with spiritual, mental and physical health problems as much as it does to those directly resulting from alcohol or other drug use. Pre-treatment support may be necessary for people in the moderate to high risk groups, if they are being referred to active treatment (see Elements 4 and 5). The aim of risk assessment and pre-treatment support is not only to prepare and motivate the client for a successful treatment experience, but also to help reduce the risk of complications resulting from further substance abuse and even greater consequences in the interim.

In addition to sources of community and family support, there are points in their care journeys that people—still at moderate to high risk—may benefit from community-based relapse prevention and continuing care (see Elements 4 and 5 for a more extensive discussion) after having been involved in more intensive or specialized kinds of active treatment. This may take place through services and supports provided by a variety health and allied professionals (including NNADAP workers, mental health, housing and social service providers) working in the community. These may well be the same providers who deliver early identification and brief intervention services. The purpose is to facilitate the longer term journey of individuals and families toward healing and integration back into a positive community life.

Element 3

It is important to recognize the need for communities and systems to respond to the needs of individuals who may be at high risk for substance-related harms, even if they are not yet ready to engage in active forms of treatment. These would include individuals at high risk for adverse consequences for which substance use increases the risks or level of physical harms from factors not themselves directly caused by the substance use. The logic here is that by addressing these secondary risks and harms through outreach and other means, there is a greater chance that individuals will regain sufficient health to eventually be able and ready to seek treatment for their substance use. Moreover, addressing secondary risks and harms is a critical public health strategy, since it reduces risk to the general population (e.g., by limiting the spread of infectious disease). Element 3 services and supports are thus "intended to engage people experiencing substance use problems who are at risk of secondary harms (e.g., HIV, victimization). They include active outreach, risk management, and basic assessment and referral services" (NTSWG, 2008).

Elements 4 and 5

The two remaining elements provide services and supports that respond to the needs of people experiencing at least moderate levels of substance use harms. The difference between these two elements is based on the level of treatment intensity and specialization required by clients to address different levels of severity and complexity evident in their care journeys.

Element 4 components involve services that are more intensive than those found in Element 3 and may involve specialized addiction treatment providers. Element 4 provides service components that can be more involved, but they do not necessarily require residential care and support or attendance on a full day basis. These can be community-based or provided as outpatient extensions of programs that have a residential capacity. Another important function provided by Element 4 services is a step-down resource for people who are completing more intensive residential treatment programs (Element 5). Having an aftercare stage or a second phase of care that provides active support and structure facilitates a more gradual transition to community reintegration that permits extended recovery work.

In contrast to Element 4 services components, Element 5 provides active treatment for people whose substance use problems are of higher complexity or severity. These cases would typically involve strong chemical dependence, high acuity (immanent serious harms), high chronicity (enduring risks and harms) and particularly challenging life circumstances that could not be adequately addressed through other elements. The kinds of services components provided in Element 5 are the same as those mentioned above for Element 4, but usually with significantly greater levels of intensity and professional specialization.

Element 4 contains the residential-based services that most people think of as being the very essence of addiction treatment. Many people can bear witness to the life-saving benefits they received through access to a residential treatment program provided by NNADAP. These resources represent important hubs that provide treatment services for First Nations people. However, in the absence of resources for doing prevention, early intervention or continuing care, residential treatment has for too long had to assume the solitary burden of helping individuals effect a major turn-around in their lives, often far away from family and community supports.

The service components found in both Element 4 and 5 include (a) engagement, stabilization and withdrawal management; (b) assessment, goal setting and care planning; (c), active treatment and discharge planning; and (d) relapse prevention and continuing care.

Engagement, Stabilization and Withdrawal Management

As much as engagement is a task in all facets of a renewed system of care, it has particular challenges for Elements 4 and 5. The ability to effectively and caringly connect with and engage clients is a crucial task that each program and service needs to be able to accomplish skillfully. Once engaged, the immediate tasks are to stabilize the individual. In many cases that will involve active withdrawal management, which may involve medical treatments and social support systems used to help people withdraw safely from the use of alcohol or other drugs.

Assessment, Goal Setting and Care Planning

Assessment starts at the front end of service delivery and sets the stage for further participation and treatment completion. Through ongoing assessment, “the client and clinician establish the

nature and severity of the problem(s), the client's strengths and social supports, and the client's readiness to change." (CAMH). Assessment is distinct from and typically occurs subsequent to screening (see above). As the needs and goals of the client are identified, it becomes possible to do more person-centred care planning, such as incorporating provisions early on to address the expected needs of the person upon completion of active treatment. For example, there may be aftercare planning concerning ongoing support networks such as peer groups (e.g., attending 12-step meetings).

Active Treatment and Discharge Planning

A comprehensive set of specialized active treatment services for First Nations people will have a range of options. This will centre on those that are based on indigenous culture and traditions, but the entire range must have an open attitude to identifying and accessing other services outside of that context that may be appropriate for the person, if the person is interested in seeking them. This includes choosing between residential and non-residential settings. The main function of active treatment is to help people who complete these programs move on with their lives without the disabling level of suffering and dysfunction that necessitated their entry into care. To that end, planning for what is to happen when the treatment period is over is a fundamental task of the work. It becomes both more necessary and more possible the closer the client is to the discharge date, since the process itself facilitates the person in becoming actively involved in thinking about and setting goals for their own healing journey and recovery.

Relapse Prevention and Continuing Care

The primary goal of relapse prevention is to complete active treatment so that the person has a reduced risk of relapsing into the problem behaviours that led to their admission. When problems are particularly severe or complex, it is important to provide pathways of continuing care. This involves the client preparing to self-manage and cope with social pressure to engage in addiction-related behaviour. Central to this process of self-management is the mobilization of social support at the family and community levels. This needs to include follow up by treatment providers, supportive families, peer networks, mutual aid, and access to community resources

such as housing, education and employment intended to offer the person a life in community in which they are productive, cared for, and valued.

In both Elements 4 and 5, an effective understanding of the whole person becomes increasingly important, over and above just the addictive behaviour. The complexity of issues in each person's life needs to be understood and included in the planning and delivery of care if efforts at treatment and healing are to be effective. The provision of Element 4 and 5 components therefore requires clinical staff trained to identify and work with diverse problems, and the programs in which they work need to have effective partnerships with that providers of other health and social services.

D. Implementation considerations

1. Continuum of care decisions

The reality of diversity among First Nations implies that a *cookbook approach* is not appropriate; that is, communities cannot just be given a standard recipe for making these critical choices. Instead, this paper has taken a *workbook approach*, in which a sequence of questions has been identified for each community to answer for itself in the course of making decisions concerning their own continuum of care. These guiding questions are outlined in *Table 2* above. It is will important for communities to answer each question for each distinct function, since how a community determines the appropriate handling of one function may be quite different and independent from how it addresses another function.

For example, within First Nations communities the *providers* of universal prevention and continuing support can include elders, members of immediate and extended family, neighbors, peers and/or community-based social and health workers. This is particularly complex since—in the context of First Nations—community and family may extend beyond the immediate community-of-residence. For some people, important parts of family and community may be based within the broader region or in large urban areas, and this affects which choices might be made regarding where prevention and support are covered and by whom.

Moreover, choices could be made concerning different approaches or combinations of approaches that might be taken to accomplishing prevention, as well as ongoing support. Some communities may wish to give traditional practices the primary role, or they may balance such practices with approaches that more mainstream. Similarly, communities need to make their own decisions about how prevention and continuing support are linked or integrated with other functions in the continuum of care and how best to ensure that factors are in place to support those linkages.

A comparable but independent set of choices might well be made by each community for each of the other major functions. Thus, in addition to decisions about universal prevention and continuing support, the questions described above and presented in Table 2 will need to be answered by each community concerning early identification, brief intervention, secondary risk reduction, active treatment (for care journeys of high complexity as well as those of moderate complexity), and post-treatment or aftercare. In mainstream contexts, as well as in numerous First Nations communities, some of these functions are delivered by providers from health or allied professions based in non-community settings. But it may be that many aspects of even formal treatment functions could be covered within the community by addiction workers and other community members or visiting health care providers, if sufficient funding for current and additional positions were available.

Similarly, different approaches or combinations of approaches might be used in the community, including cultural approaches, western faith-based approaches, western clinical approaches or even alternative eastern approaches. Each community has (or ought to have) a rich range of options from which to configure their own continuum of care. Taken together, the questions in Table 2 provide a preliminary road map for the questions that communities may want to ask themselves. However, it is not possible to anticipate the answers that would be most appropriate for individual communities.

2. Supporting the linkages

An important part of any continuum of care is the building and sustaining of linkages between the elements discussed above. As already noted, given the diversity among First Nations and the inherent value of community self-determination, it is not possible to specify mechanisms for

individual communities to adopt. However, some suggestions can be made concerning structural factors that may affect the strength of linkages. Linkages between components both within and across elements in a continuum of care need to occur at different levels, and they ultimately involve relationships between people participating in different roles.

The structural factors shaping working relationships fall into four general areas: commitment, understanding, accountability and resources. Service and support relationships between providers and their organizations or communities along the continuum are likely to be stronger when a felt sense of mutual commitment has been nurtured. In other words, the relationship is strengthened by an explicit ongoing dialogue about how "we're working toward the same goal together." These relationships are also likely to be more enduring and lead to better health outcomes when the different stakeholders share an understanding of the problems and definition of the solutions in the same or complementary ways. Such an understanding can be facilitated by active ongoing conversations, and perhaps "cross-training," about what service and support partners assume to be the most important healing outcomes and the most appropriate means to achieving these outcomes.

Furthermore, partnerships of this kind along the continuum are likely to be stronger when there is both sense and practice of mutual accountability. That is, there may need to be mechanisms such as letters of understanding or protocols through which distributions of control and responsibility are agreed upon and made explicit. Finally, it is clear that there must be an investment of resources to have partners along the continuum striving to create and sustain positive working relationships. It takes time and infrastructure to set up such a structure and to maintain it.

Most critical in this regard is the need to channel adequate increased funding to support community-based NNADAP workers. These workers are typically isolated, constantly on call, and often struggling to help people with addiction-related problems for which they may lack expertise (e.g., child welfare). They must manage complex working relationships with Chief, Council and family members. Despite the heavy burden they must bear, they may often have limited training and supervision, limited self-care knowledge and many have personal issues that absorb their emotional and mental energies. It is vital to develop a system whereby NNADAP

workers can be cared for and supported themselves through such means as videoconferencing, monthly meetings, monthly supervision, and mental wellness teams.

Similarly, implementation requires a staffing level commensurate with the significance of the work involved in the process. As such, pre-intervention and certified training for NNADAP workers is essential. If NNADAP workers are not adequately supported, the whole system is doomed to fail.

3. Knowledge exchange

Devising evidence-based prevention and intervention planning choices is known throughout the addictions field in Canada to be a daunting process, and for good reason. The call to be evidence-best or to use best practices immediately raises differences in styles of knowledge, criteria for evidence and intended program outcomes. Interpreting and staying abreast of the research literature also can require considerable resources from communities and organizations, not to mention the workforce development costs associated with implementing new approaches.

The provision of services and supports along the continuum of care should be grounded in defensible claims of known effectiveness. However, there are limits to which research findings from the broader population may be generalizable to First Nations peoples. Much is promising in the research literature, but much also remains uncertain pending funding for additional specific studies. For example, primary care-based brief alcohol interventions now appear to have fairly solid support from the research literature in mainstream populations. At the same time, few studies have examined the efficacy of brief intervention with Indigenous populations. Thus brief intervention is for the moment a promising practicing in the context of First Nations, although it as yet remains understudied in this population.

This example illustrates the need for an innovative strategy through which promising practices are adapted to an indigenous cultural context with a view to evaluating them and, if findings are positive, to disseminate them more broadly for adaptation and application to other First Nations communities. For this purpose, the primary knowledge exchange strategy for addressing substance-related risks and harms in First Nations communities may be to foster ongoing

reflective dialogue among community-based practitioners, rather than between communities and researchers.

In this strategy, knowledge exchange becomes an exchange of lessons learned among people engaged in prevention and treatment work in the First Nations communities of a common region, along with the opportunity to ask each other questions about any forms of evidence they consider relevant and necessary. This sharing of experiences would ideally lead to a validation of basic principles and established practices, to knowledge and skill transfer across communities and practitioners, and provide the impetus to explore innovative prevention and treatment strategies for addressing unmet needs. The regional treatment centres, NNADAP regional consultants and, especially, the Regional Addictions Partnership Committees (RAPCs) could play pivotal roles in bringing these conversations together and fostering changes in practice based on the emerging insights, potentially powerfully grounded in Indigenous forms of knowledge.

In addition to facilitating the exchange of insights between communities in a given region, the regional consultant, treatment centres and RAPCs might also provide a two-way link between the local knowledge base and research practitioners. This would necessitate the examination of emerging research on the relative effectiveness of prevention and treatment strategies, and then translation of this information into a form that would be useful for community-based practitioners. It would also involve a complementary role of communicating promising practices from community practitioner experience to the broader addiction field. Moreover, drawing on experience with both formal research and Indigenous knowledge, regional consultants and treatment centres may be able to serve as resources that communities can draw upon in their efforts to gather ongoing feedback on community-based prevention and intervention efforts.

With respect to the workforce development aspects of knowledge exchange, there may be value in enhancing the role of the RAPCs and NNDAP's regional treatment centres to serve as sources for ongoing training support to addiction workers in the region. More than just giving information and manuals to workers and other practitioners, this would require ongoing education and supervised practice, supported by continuing consultation and learning while in the field. Training through the centres could cover such topics as dealing with concurrent disorders, opiate abuse, and methadone. NNADAP addiction workers could thus be certified and

receive boaster sessions throughout their careers. As an added benefit, these new skills may be transferable to other career positions, thereby contributing to a more highly skilled community workforce in general. This strategy would call for new investment explicitly dedicated to the task of building excellence in knowledge and skills in the NNADAP workforce.

Finally, there may be ways of strengthening the concept of each treatment centre serving the communities in their respective regions. This might be accomplished by giving communities within a region an even greater shared role in guiding the treatment approaches used by treatment centres in the same region as opportunities arise. Such explicit collaboration may help to enhance the level of engagement of communities in the whole continuum of care.

4. Community development

Having strong social networks and communities is important not only for prevention and social support, but to also provide a community-based foundation for all aspects of the continuum of care. Community well-being rests upon strong patterns of effective parenting and childrearing, where the community is joined in the task of raising children who are healthy enough in mind and body to preserve traditional ways and to work towards a future in which communities, neighbourhoods, families and individual flourish and thrive. Some families and communities may not be fully realizing their potentials in universal prevention and continuing aftercare support, but they will benefit from different forms of strengthening in order to promote healing journeys for individuals. Indeed, families and communities are on healing journeys themselves.

As has been previously noted, broadly defined community development needs to be seen as a fundamental part of universal prevention. This may range from supporting community efforts to engage in health promotion activities to addressing as far as possible the vestiges of colonialism. Such an approach to health promotion and prevention derives from community development that starts at the ground level, in particular and unique communities, rather than coming from the aggregate top down. Community development in this sense takes in account and organizes local realities, aspirations and goals.

Sharing of lessons learned among First Nations about engaging in applied local community development may lead to the emergence of useful regional knowledge exchange. In turn, it is

through the sharing of experience, needs, and aspirations across regions that a national perspective may be designed and built. The proof of regional and national approaches will be in the ways that they resonate with the distinct and evolving efforts of First Nations, community by community.

Although this requires significant time and investment, it may be the most effective strategy for building processes and institutions to nurture and expand healthy community development. This does not mean abandoning or leaving communities alone to do their work, nor does it mean subjecting them to intrusive strategies that are driven by rules, values and goals external to those particular communities. Rather, important resources can be provided at the national and regional levels in the form of secretariat support to emerging regional and national collaborations.

The NNDAP renewal process might additionally explore examples of resilience in some real-world communities with a strong orientation to passing on traditional culture, and also communities where culture is being shaped and created to adapt to contemporary realities and opportunities while still maintaining resilience. This may lead to even greater insights into how healthy communities are able to experience and transform culture in various mixes and permutations.

Community development is important ultimately because it focuses the approaches taken to be more reflective of the social determinants of health. It underscores the need to develop linkages between the social determinants of health: how they are impacted by and how they influence each other and the problematic substance use. Community development seeks to bring an awareness of the social determinants of health and the need to link services to the community at large, and it builds understanding of how each has a role to play in addressing problematic substance use (including partnerships with services from outside the community). Finally, it acknowledges explicitly that these roles need to be coordinated through a systematic community-defined approach.

5. The Role of NNADAP

Various points in this paper have implications for the important role of NNADAP within and as a facilitator of the broader continuum of care. Some of the directions recommended in the Regional Needs Assessment Reports and the NNADAP Renewal National Forum (January 2010)

could be realized through decentralized administrative models in which critical elements are controlled by each community to reflect its own values and cultural approach. Many aspects of prevention, pre-care, assessment, referral and aftercare might be managed by the community even more directly. Similarly, some communities may want to shift toward a more community-based rather than regional-based residential treatment model (especially given the distance and higher costs to travel to regional centres in some cases and the associated costs).

The role for NNADAP may then become more focused on providing financial resources, expertise, and other supports to tackle issues identified by the specific communities. As noted above, communities can then share acquired experience amongst themselves on a regular basis through knowledge exchange structures facilitated by NNADAP.

Regardless of the particular changes made in processes, NNADAP should certainly continue to support community identification of problems and solutions, both regionally and nationally. It can also provide further funding for training and set up regional standards for training certification. Efforts to support training may include regular updates of the training, establishment of a data base with information on addiction and mental health, and accreditation of individual treatment centres. NNADAP`s role also should include providing advice on policies, research, and models of best practices, as well as making links and liaising with mainstream institutions (i.e., developing agreements and protocols with other partners, including Federal Departments, Health Canada (FNIHB), Corrections Canada, Indian Affairs, and provincial governments) so that communities can access those services as required.

Therefore, as part of a renewal process, it may be useful to develop further the role of NNADAP as a summary resource for training standards, policy papers, research, best practices and liaisons with provincial and federal bodies, including facilitating access to these services and programs for First Nations clients who need services off the reserve. In the latter case, NNADAP might provide leadership and assistance in dealing with issues of payment, case management, accountability and procedures. Finally, it must be emphasized that adequate funding needs to be channeled to communities in order for them to develop and direct their own care systems.

E. Summary

This discussion paper has attempted to adapt the conceptual model from the National Treatment Strategy to the context of First Nations communities. In doing so, it has been guided by an earlier review of the literature, and it has paid particular attention to the system-level challenges that emerged from that review. The paper was also influenced by other reports developed for the NNADAP renewal process, with various threads converging from those documents.

After providing an overview of the National Treatment Strategy, the paper offered two circular visual representations of the continuum of care that may be useful for mapping out subsequent NNADAP renewal discussions. These representations overcome some of the limitations inherent in the vertical imagery from the NTS tiered framework. However, it is still necessary to underscore that communities have decisions to make for each function in the continuum of care, concerning questions about providers, settings, approach and links. Such decisions would have implications for which of level of resources will be required in a given situation, and in turn how to strategically allocate those resources in support of functions all along the continuum of care.

The paper went on to discuss factors that may enhance the strength of working relationships to link different functions across the continuum of care. The theme of relationship was then extended to a vision of knowledge exchange and community development in the context of enhancing substance-related care journeys and pathways. Throughout, the paper has tried to build on community and regional strengths. It has urged a more salient role for community members as well as the regional treatment centres, while moving away from a model that relies on the centres for all forms of active treatment.

Finally, the paper has tried to convey a central and respectful place for Indigenous culture and traditional practices, while still recognizing the diversity among Indigenous communities. In addition, it has emphasized the sovereignty of each First Nation community to make choices about how to configure its own continuum of care. Each configuration will be a unique mix of ways to support care journeys and pathways through particular combinations of providers, settings, approaches and linkages. In the end, discussions such as this can only suggest what substance-related services and supports might be useful at the community level. It is the

individual community's right and responsibility to define what particular services and supports would look like in practice for its own individual circumstance.

While most of this paper has focused on a system of services and supports for people, families, and communities affected by problems related to substance use, it is important to emphasize that these problems do not occur in isolation. Instead they are related to and linked with other health and social problems. The most obvious connection is between addiction and mental health. The roles of intergenerational trauma, of childhood development, of disadvantage and discrimination —all contribute to the likelihood that substance use problems among First Nations people will need to be understood within the context of complexity. That complexity extends beyond mental health to physical health, and then further on to issues around higher rates of legal involvement, incarceration, and recidivism.

The complex problems and challenges that underlie substance use problems for many people mean that a system approach to addictions needs not only to improve specific strategies for preventing, identifying, treating and maintaining care for people with these problems, but also has to extend across the range of services that offer support to people with health, social, economic, legal, leisure, educational, vocational and employment issues. Renewing the addiction treatment system for First Nations requires strategies that go beyond just improving the continuum of care for addictions prevention and treatment, to explore these problems in a broad socio-historical context that requires an understanding of complexity and an active ability to engage and work effectively with multiple diverse systems.