Renewing NNADAP

Common Themes from the Regional Needs Assessment Reports and the January 2010 NNADAP Renewal National Forum

Discussion paper prepared for NNADAP Regional Partners and members of the First Nations Advisory Panel

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Executive Summary

The National Native Alcohol and Drug Abuse Prevention (NNADAP) program is undertaking a renewal process intended to develop a vision for the program's direction over the next five to ten years. The renewal process will rely on needs assessments prepared in each region; on the results of a national Renewal Forum held in January 2010; on a series of research papers commissioned by the First Nations Addictions Advisory Panel; and on feedback solicited on a variety of reports through e-mail, fax and via the NNADAP Renewal Website (www.nnadaprenewal.ca). The current paper synthesizes the recommendations that emerged from the first two of these sources—the regional needs assessments and the Renewal Forum—so that they can facilitate dialogue on renewal opportunities with regional stakeholders and more easily be used by members of the project's Advisory Panel, who are tasked with developing a Renewed Program Framework for NNADAP by Fall of 2010.

The regional needs assessments employed a variety of methods, ranging from interviews and focus groups/talking circles to surveys of various types. Assessment teams typically consulted with NNADAP workers at various levels, and with staff in related occupations such as social services; some also held consultations with community members. Out of this emerged a series of recommendations that can be grouped under three main headings: elements that form (or should ideally form) the foundation of NNADAP's approach to addictions (inclusion of culture, a focus on families and youth, adequate training and wages for workers, and accreditation for treatment centres); specific components of the continuum of care; and structural aspects of the program's policies, funding, governance, and coordination.

Foundational elements

There are some differences between the recommendations contained in the regional needs assessment reports, those that regional representatives presented at the Renewal Forum, and the broader recommendations that Forum participants developed during the course of the meeting. Nonetheless, it seems fair to say that the areas of greatest consensus included, first, the need to integrate culture and tradition into addiction programs, and second, the need to provide adequate training and wages for NNADAP staff. Both of these were among the top recommendations in at least five regions. Inclusion of culture is perhaps the one theme on which there was complete consensus, with every regional report mentioning the need to include culture in addictions practice. Participants said that culture, tradition, and spirituality should be the foundation of NNADAP, and integrated throughout its activities.

There was also broad agreement that NNADAP workers need both more training and wage parity with their provincial counterparts. Participants agreed that workers need more opportunities for advancement, with a laddering, career-based approach leading to a degree or post-secondary-level certification, and ideally supported by a mentoring system. Wage parity with provincial addiction

workers was seen as essential: until this happens, participants said, NNADAP will not be able to attract and retain people with higher skill levels. They advocated national or regional salary scales with provision for training and worker certification. They also suggested action to ensure that increases in the NNADAP budget actually get passed along to workers.

Several regions put forward recommendations designed to allow families to take a more active part in treatment. One mentioned the need to support families and communities in addressing mental health and addiction problems. Others recommended that NIHB cover travel costs for families to visit members—especially youth— who are in treatment. Most regions also acknowledged a need for more and better services for youth. Many of the recommendations on this topic called in general terms for more programs and a full continuum of care for youth; a few dealt with specific aspects of youth treatment; and some dealt with greater inclusion of youth in community life and programs.

Most regions seem to support processes of treatment centre accreditation — in fact, several cited accreditation among their "promising practices," and others recommended extending accreditation processes to community level. However, there are concerns that current accreditation standards do not accommodate or encourage cultural practices in treatment. Accordingly, some participants recommended that accreditation standards cover both cultural competence and other aspects. One suggestion was that a First Nations institute develop a training curriculum that could then be built into the accreditation process.

Specific components of the continuum of care

Prevention

There was agreement that prevention activities are particularly needed in three areas: addressing the needs of youth, preventing FASD, and limiting abuse of prescription drugs.

Pre-care and detoxification

Access to detoxification was mentioned as a problem in most parts of the country, with some regions recommending Aboriginal-specific detox, and others advocating better partnerships with provincial services

Assessment and referral

Current processes for assessment and referral to treatment are seen as time-consuming and flawed. Participants advocated solutions such as community-based case management and more-standardized assessment tools and processes, possibly backed by an electronic system.

Treatment

Some regions advocate community-based treatment, so that residential treatment is not the first or only option for care; however, few regions put forward specific recommendations on this topic. Residential treatment continues to be a central component of the NNADAP program, but participants suggested

some changes to meet more specialized needs that are emerging. Several regions advocated re-profiling treatment centres so that some are specialized in specific disorders such as mental health problems or prescription drug abuse. There was also a perceived need to strengthen the links between treatment centres and communities.

In recent years, there has been some discussion of whether NNADAP should be adopting harm-reduction approaches to addictions treatment. Feelings on this topic are at best mixed, with many NNADAP staff suggesting that it would be unwise to move away from the "abstinence" model on which the program is currently based. On the other hand, there are fears that a move to harm-reduction would dilute the current program, and there are concerns about the growing use of methadone in some regions.

Aftercare

Aftercare was typically identified as the biggest gap in existing programs: there was general agreement that it is either very limited or completely absent. Participants said that an ideal aftercare program would include community support, transitional housing, life skills, mentoring, help in getting education or work, and a range of spiritual/emotional support programs.

Structural issues

Scope of the program

There were suggestions for expanding NNADAP's scope in various ways, such as extending it to cover all forms of addiction and a full continuum of care. Forum participants also devoted special attention to the need to address the mental health problems that are often present along with addictions. There are mixed views on the desirability of actually merging mental health and addictions treatment, but general agreement on the need to enhance mental health services and to increase collaboration between the mental health and addiction sectors.

Funding

Regions report needing more funding both to maintain existing NNADAP activities, and to introduce the new ones being envisioned as part of the renewal process.

Policies

By far the most common recommendations respecting policy development dealt with the need to revise NIHB transportation policies. Participants said that NIHB needs to be more flexible in covering travel to and from residential treatment, and to cover costs for family members to visit clients (especially young clients) in treatment. Besides these changes to NIHB, policies that establish "stovepipes" in funding may also need further attention, since this theme recurred in the discussions and has major implications for the structure of the NNADAP program.

Governance and coordination
Participants saw as NNADAP's greatest strength that it is community-driven and community-based, and strongly recommended that this continue to be the case. Nonetheless, many of the recommendations for improving NNADAP imply some amount of regional or national coordination. For instance, the Renewal Forum heard calls for national standards in areas like training and accreditation, and for re-profiling treatment centres to offer specialized services to a whole region. This dual need for community control and broader coordination may explain why some of the existing regional coordination boards and forums were cited as being among NNADAP's best practices. There were also calls for more interdisciplinary teams at the community level, and for more partnerships between NNADAP and other sectors at all levels.

Data-collection and research
There were calls for research demonstrate the effectiveness of culture-based models, and a few suggestions for better data systems to track need, access to services, and outcomes.

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Introduction and background

Purpose

The National Native Alcohol and Drug Abuse Prevention (NNADAP) program is undertaking a renewal process intended to develop a vision for the program's structure over the next five to ten years. This renewal process will rely on three main components:

1. Needs Assessment reports prepared in each region (excluding the Territories) by the regional office of Health Canada's First Nations and Inuit Health Branch (FNIH) and First Nation organizations.
2. Discussions at the *National Forum on NNADAP Renewal* held in Ottawa, January 12–13, 2010. The Forum brought together participants from all regions and from the project's Advisory Panel.
3. A set of research papers, to include: a "systems" paper that will set out a conceptual model; and papers focusing on prevention, the role of culture in addiction services, how to improve the mental health components of the NNADAP program, and a historical timeline of key milestones in NNADAP's history.

These materials will then be considered by a First Nations Addictions Advisory Panel made up of of community, regional and national mental health and addiction representatives tasked with developing a National Program Framework for NNADAP in 2010. The current paper is one part of this larger review process. Its objective is to synthesize the information that emerged from the regional needs assessment reports and the National Forum on NNADAP Renewal, so that it can more easily be used by members of the Advisory Panel and regional stakeholders.

About the regional needs assessments

The regional Needs Assessments were designed to access the knowledge, wisdom and experience of a wide arrange of individuals (community members, service providers, health directors, etc) in identifying gaps, overlaps, and strengths within regional addictions care. Regions were asked to identify promising practices, and to give particular attention to gender-based analysis and to the needs of certain groups: youth, pregnant women, and clients with concurrent mental health disorders. The actual assessments were carried out by consulting companies, under the direction of regional First Nation organizations or of Advisory Committees with substantial First Nation representation (Table 1).

Table 1: Direction and oversight of the Regional Needs Assessments

Region	Oversight Group
Atlantic	Assessment Group of five community representatives and two FNIH employees.
Quebec	Report prepared for the *First Nations of Quebec and Labrador Health and Social Services Commission*
Ontario	Advisory Committee of representatives from First Nations, the Ontario Regional Addictions Partnership Committee, and FNIH Ontario Region.
Manitoba	Manitoba First Nations Addictions Committee made up of Tribal Council coordinators, treatment centre directors, representatives of independent First Nations, and the FNIH NNADAP coordinator for Manitoba region.
Saskatchewan	12-member Oversight Committee including an Elder, one representative each from FNIH, Federation of Saskatchewan Indian Nations, and the province of Saskatchewan, and eight persons employed at a variety of levels in addictions, mental health, and healing.
Alberta	Process steered by Alberta's existing FNIH-Chiefs co-management committee
B.C.	Needs assessment undertaken for the First Nations Health Council, and steered by a B.C. Addictions Advisory Team of persons representing "a broad spectrum of addictions services in B.C."

All regions used a combination of methods for their Needs Assessment, usually including interviews, focus groups or talking circles, and surveys. Every region but one held discussion groups or interviews with NNADAP workers and people in affiliated fields (health directors, youth workers, social services), and many made a point of including staff in all the treatment centres. Most regions also held some form of community meetings; in two cases, current and former clients were explicitly included in these forums. Finally, many carried out surveys of staff working in NNADAP and affiliated occupations, with varying degrees of success (response rates are typically low in such surveys). It is clear that the consultations were wide-ranging, and that while they included community members, they also placed a heavy emphasis on employees of NNADAP programs or facilities.

Most regions concluded that alcohol abuse is still the largest problem, although Atlantic flagged major concerns with prescription drug abuse in some areas, and several regions suggested that poly-drug use is widespread. Often, problems with drugs other than alcohol seemed to be concentrated in certain groups. For instance, use of marijuana and crack seemed to be of greatest concern in youth and younger adults, while abuse of prescription drugs was more of a concern among seniors. This being said, at least one region mentioned problems of seniors having their prescriptions stolen or taken from them, or selling their prescriptions to younger people.

About the Renewal Forum

The national Renewal Forum sought to create a venue in which NNADAP partners from across Canada could discuss and reach consensus on key national priorities and strategies for actions to renew, enhance and validate NNADAP's services. At the Forum, representatives from each region presented the information from their regional Needs Assessments. Other presenters provided information on topics such as traditional and mainstream evidence about what works in addictions treatment; the history of the NNADAP program; the needs of youth, women, and persons with mental health problems; and existing national strategies for addictions and mental health.

At the conclusion of the regional presentations, Forum participants split into groups to identify common themes that should serve as national priorities. The result was a list of 13 priority areas for NNADAP renewal:

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

Participants then engaged in a "World Café" — a sort of brainstorming session in which people formed small groups and then circulated to provide suggestions on each of the 13 themes in turn. The result was an extensive list of possible actions. It is these actions, together with recommendations from the regional needs assessments, that are summarized in the text that follows.

Common themes in the recommendations

Between them, the regional Needs Assessment reports and the presentations by regions contain literally hundreds of recommendations about the NNADAP program (one regional report lists over 45 pages of recommendations). These range from the very specific ("change NIHB transportation policies to allow people to leave treatment in the first two weeks") to the very broad ("institute a full continuum of care.") A complicating factor is that the recommendations included in the Needs Assessment reports do not always coincide exactly with what regions presented at the Renewal Forum.[*] Similarly, the themes

[*] This is probably because the recommendations at the Forum reflected not just what the original reports said, but also what regional Advisory Boards had concluded when they looked at the findings from these reports.

that people identified as national priorities in the "World Café" segment of the Forum are not identical to the themes that emerge as common ground in the regional recommendations. Accordingly, the discussion that follows is a composite. It is mainly based on the recommendations from regions as outlined at the Renewal Forum, with supplemental information added from the regional reports and from the "World Café" material wherever relevant. Readers should note that this is a synthesis intended to guide renewal at the national level, not a summary of the findings in each particular region. Accordingly, the text emphasizes only the recurring themes and areas of commonality. Recommendations that were put forward by only one region, and those calling specifically for community-level actions, can be found in the original needs assessment reports for each region.

The intent at this stage is not to identify the top priorities; rather, it is to identify the recurring themes, and describe what participants said about these themes and what actions or solutions they suggested. Nonetheless, when we compare what seem to be the top 5-10 recommendations in each region, we can see that some themes occur more often than others. Subject to all the caveats noted above, the most common recommendations seem to deal, first, with the inclusion of culture in addiction programs; and second, with training and wages for workers. Both of these were among the top recommendations in at least five regions. Recommendations dealing with youth programs, with the need to have treatment centres specialize in certain conditions, and with the inclusion of mental health were next, followed by a series of other themes. The discussion that follows outlines what was said about each theme, and is divided into three main sections:

1. Elements that should ideally form the foundation of NNADAP's approach to addictions care: inclusion of culture, of families, and of programs for youth, along with adequate training and wages for workers, and accreditation for treatment centres.
2. Elements relating to specific components of the continuum of addictions care: prevention, pre-treatment end detoxification, assessment, , treatment (community-based, residential, specialized, use of harm-reduction models), and aftercare.
3. Elements that relate to NNADAP's overall policies and structures, and that would therefore involve a major overhaul of the existing system. This includes integrating mental health services and addictions care; issues of funding and policy; governance and coordination issues; and data-collection and research.

For each topic, the text summarizes what was said at the Renewal Forum, what was recommended in the regional Needs Assessment reports, and any best practices that were specifically mentioned by participants at the Renewal Forum.

Table 2: Needs Assessment methodology in each region

Region	Methods
Atlantic	• Circles, focus groups, meetings in communities • Questionnaire survey of participants in the process, and of others by web opt-in
Quebec	• Questionnaire-guided telephone interviews with 48 key informants • 4 discussion groups with staff working in NNADAP and related fields (e.g. social workers, health staff) • Report also drew extensively on a survey of addictions carried out by the CSSPNQL in 2008 to profile users and patterns of use
Ontario	• Interviews with key informants • Focus groups with 83 participants at a NNADAP conference • Surveys of NNADAP workers and treatment directors (response rate 31%) • "Case studies" – site visits to 12 communities, for discussions with workers, current and former clients, police, counsellors, youth, others.
Manitoba	• Survey of all NNADAP workers (response rate 40%) • Focus groups • Interviews with NNADAP workers and associated occupations (e.g., Home Care workers, Brighter Futures workers)
Saskatchewan	• Key-informant interviews • Talking circles with former clients and their family/friends • Survey of Treatment Centres (response rate 90%: 9 of 10 centres) • Survey of directors of First Nation Health Centre (response rate 37%) • Survey of projects funded by the Aboriginal Healing Foundation in Saskatchewan • Mail survey of front-line workers—NNADAP and affiliated occupations (response rate 55%)
Alberta	• Survey of addiction workers (convenience/snowball method sample, starting at meetings and conferences) • Interviews with stakeholders: funders, managers, NNADAP administrators, consultants in the field • Large-group discussions with NNADAP workers during three regional training events Jan-Feb 2009. (69 of Alberta's 103 NNADAP workers—67%—participated.) • 37 focus groups, held in 14 different communities and in each of Alberta's six treatment centres.
British Columbia	• 12 key-informant interviews with community health directors, plus an unspecified number with NNADAP workers, Youth Workers, addiction specialists, and community members • Interviews with two people apiece in six of B.C.'s 11 treatment centres • Meeting between B.C. Advisory Team and treatment directors in December 2008 to discuss the study. • Online survey of NNADAP workers (51 responses, response rate unstated) • Online survey of youth workers, opportunistic method (62 responses, response rate unknown) • Online survey of community members (opportunistic/haphazard methods)

The Foundation

Including culture and traditional practices in healing

This is perhaps the one theme on which there was complete consensus, with every regional report mentioning the need to include culture in addictions practice. Participants said that culture, tradition, and spirituality should be the foundation of NNADAP, and integrated throughout its activities. The argument, first, is that this is what clients want. For instance, B.C.'s report noted that when informants were asked what kind of help they would like to see, Elders, traditional and spiritual healers topped the list, while psychologists and psychiatrists were close to the bottom. In a similar vein, Alberta's report says that we must recognize the "thirst for cultural knowledge and identity."

Beyond being what people want, are cultural models also the most effective ones? Some regions said yes, drawing on materials prepared by the Aboriginal Healing Foundation that suggest that these approaches give the best results for Aboriginal clients. Others regions pointed to a lack of studies on the topic, and said that the desire for cultural approaches conflicts with Health Canada's stance that treatments should be based on models proven to be effective. Accordingly, there were calls for research to examine and document the effectiveness of approaches based on traditional values and teachings.

Despite the lack of research, it is clear that many front-line workers find that approaches based on culture and tradition are the most effective. Accordingly, the needs assessments in various regions said that traditional healing approaches need to be recognized, and policy barriers to their inclusion removed. Participants said funding should be adapted to include cultural activities, and funds should be allocated for Elders and for land programs run by Elders. In discussion, participants also mentioned the need for a way to identify and recognize Elders—that is, a process that would fill the same function for Elders as certification does for workers. There were also a few calls for service providers—both First Nation and non-First Nation—to be trained in "cultural safety."

The specific recommendations from the regional reports on this topic were as follows:

Regional recommendations about the inclusion of culture	Region
Recommendations about the need to include culture	
Resources to support cultural healing practices are required, including appropriate honorariums for Elders and cultural knowledge holders who share their time, teachings and talents. Elders who are engaged in their healing journey, who are on the red road, and can offer traditional teachings to communities can be honoured as Role Models and the information can be shared between communities to encourage capacity building across the Atlantic.	Atlantic

There is a growing recognition for the need to continue to move towards self government, enhanced cultural revitalization, and to have culturally appropriate programming integrated into the provision of addiction services and other health care services for all First Nations and Inuit.	Atlantic
Increase access to funds for contributing to the development of traditional activities as necessary "diversion" for successful prevention and aftercare programming.	Atlantic
As substance abuse has been used as a coping mechanism for the growing loss of identity and culture, programs that revitalize and reinforce culture be appreciated as a culturally appropriate form of harm reduction. Workers be hired to facilitate cultural awareness and activities appropriate to each territory and community.	Atlantic
Following *The Aboriginal Mental Wellness Strategic Action Plan* (AFN 2006) goals and objectives, the development of a coordinated continuum of addictions and wellness services for and by First Nations and Inuit must include acknowledgement, recognition and funding for traditional and cultural approaches.	Atlantic
Integrate land based activities and First Nations culture as vehicles for communication and education around substance abuse	Ont
As a matter of best practice, service provision should strive to integrate cultural or traditional approaches with Western, clinical approaches to mental health and addictions services. The specific cultural approaches used, as well as the appropriate balance between Western and cultural approaches, should be a matter for individual communities to determine.	Sask
Recognize Traditional Healers and healing approaches that are different from the western philosophies.	B.C.
Resources to support cultural healing practices are required, including appropriate honorariums for Elders and cultural knowledge holders who share their time, teachings and talents. Elders who are engaged in their healing journey, who are on the red road, and can offer traditional teachings to communities can be honoured as Role Models and the information can be shared between communities to encourage capacity building across the Atlantic.	Atlantic
Explore options where First Nations traditional and spiritual healers can be utilized by community members and be paid at the same rates as their mainstream colleagues. Consider adding some Elders to [NIHB] list of service providers.	B.C.
Recommendations about the need for cultural safety	
Given the number of First Nations people accessing provincial mental health and addictions services, efforts should be made to improve their experience of these services. These efforts could include: encouraging collaboration and cooperation between First Nations and provincial service providers; and developing supports for First Nations people who access provincial services.	Sask
Knowledge of respectful cultural approaches to health and wellness is required for cultural	Atlantic

safety on the part of all service providers. Cultural safety will mean training, mentoring, and supervision of Aboriginal and non-Aboriginal workers, as well as a functional system to adjudicate complaints of unsafe care.	
Recommendations for research to document the effectiveness of tradition-based approaches	
Knowledge about promising traditional and cultural approaches to addictions and wellness needs to be gathered and shared as part of capacity building in training, certification of workers and accreditation of First Nation and Inuit facilities. This would include an inventory of community members and role models as guides and Elders as a resource.	Atlantic
To conduct appropriate evidence based research to demonstrate effectiveness of treatment modalities -- particularly initiate research around First Nation culture as a treatment modality.	Ont
To improve the evidence base, FNIH should undertake more evaluation of culturally based approaches, as well as research to determine what practices and treatment approaches are effective for Aboriginal populations.	Sask
Studies are done into the cultural therapeutic models employed at most First Nations treatment centres.	B.C.

Besides this, participants at the Renewal Forum identified a series of actions that could promote appropriate inclusion of culture:

- Showcase centres that do a good job of incorporating culture (e.g., Sagkeeng), and learn from them.
- Establish a forum for translating cultural knowledge and traditional ways of doing things into ways that are usable in today's world.
- Develop a generic cultural curriculum that can be adapted by each community—and provide funding for this process of adaptation.
- Create a forum to determine what a whole and healthy First Nation person looks like – e.g., someone able to speak his/her Aboriginal language, with connection to family and community. This will help frame needs.
- Include Elders as participating members of all FNIH programs, and possibly use the same model for providing access to Elders as was used by the Residential Schools support program.
- Include Elders on NIHB's list of recognized service providers, provide professional fees for Elders, and cover travel costs to bring Elders into the community.

Promising practices for inclusion of culture[*]

Alberta's Niwichihaw Aboriginal Addiction Counselling Service provides prevention, assessment, referral, and counselling based on the medicine wheel. Drawing on traditional healing practices and Elders, it promotes healing from addictions and from intergenerational trauma such as sexual abuse.

[*] See also some of the promising practices listed under the "prevention" and "treatment" headings.

Involving families in treatment

Several regions put forward recommendations designed to allow families to take a more active part in treatment. One mentioned the need to support families and communities in addressing mental health and addiction problems. Others recommended that NIHB cover travel costs for families to visit members—especially youth— who are in treatment. In the interim, it seems that some centres have already found ways to involve families. Ontario's Muskrat Dam centre has apparently developed a program for the entire family, while one centre in Alberta offers a family program complete with daycare, and another offers a family program once a year. B.C. too has treatment centres that offer family-based programs.

Regional recommendations about involving families	Region
As addictions are understood to affect all members of the family, including children and youth, and women's access to treatment is at times affected by being primary parent, a family wellness center, with a dual focus on addictions and violence be established in Atlantic Canada.	Atlantic
Expansion of family treatment beds and more on-the-land programs for families.	B.C.
Recognizing that mental health and addictions problems affect individuals within a family context, greater use of family supports and family-based interventions is warranted as a matter of best practice. For example: positive parenting programs and other similar supports for families, as a prevention and early intervention strategy; family-based residential treatment, or alternatively, and perhaps preferably, outpatient treatment that includes all family members; strong aftercare programs to support entire families once treatment is completed to maintain successes achieved in treatment.	Sask
NIHB transportation policies should facilitate family participation in residential treatment, and allow for return travel where inappropriate referrals have been made	Man

Promising practices and models for involving families

Ontario, Alberta, and B.C. all have at least one treatment centre that provides services for families. In one case, the centre also provides daycare.

Programs for youth

Most regions acknowledged a lack of programs for youth, and the need for more and better services for youth. Quebec advocated having a community worker dedicated solely to prevention activities, with emphasis on youth. However, it seems that the picture is complicated by the fact that youth do not necessarily *want* services, although they may have multiple problems. In Ontario, "young people indicated that even if programming was available, they would not attend," while in Saskatchewan, youth apparently feel that consulting the existing services simply ends in Child and Family Services being called in. In short, the regional reports note that programs for youth will need a "hook" to encourage participation. Nonetheless, the regional reports provided a series of recommendations about expanding services for youth. Many of these dealt broadly with the need to have funding for youth programs, and to institute a full continuum of services for youth. A few dealt with specific aspects of treatment, such as a need for youth treatment centres, or a need to determine the optimal length of stay in residential treatment. Many of the recommendations, although not explicitly directed at communities, in fact deal with greater inclusion of youth in community life and programs. The various recommendations are reproduced below.

Regional recommendations about youth programs	Region
Funding and developing a strategy to establish a continuum of care for youth	
Increased funding for youth programs (for staff and social activities)	Alberta
Enhance financial and human resource allocations to facilitate implementation of targeted programs for youth and individuals with concurrent disorders	Man
FNIH should take measures to increase the number of qualified First Nations practitioners, in particular, mental health therapists and mental health and addictions workers with specialized training to work with youth.	Sask
Enhance financial and human resource allocations to facilitate implementation of targeted programs for youth and individuals with concurrent disorders	Man
FNIH should develop a comprehensive strategy to address the mental health and addictions needs of First Nations youth. Among other things, such a strategy could involve: developing specialized mental health and addictions services for youth; developing innovative strategies to reach youth; possibilities might be youth outreach programs, peer support programs, and school-based programs; providing more prosocial recreational activities for youth; increasing the number of NNADAP and mental health workers specially trained to work with youth; developing a "youth and elders" program to reconnect First Nations youth with their cultural heritage, expose them to cultural teachings and traditional ways of life, provide them with positive role models in their communities, and engage them in healthy pastimes.	Sask
Develop both an interim and long term plan to address the absence of youth treatment	Atlantic

programs and services in the Atlantic Region. This would include: prevention programs (i.e. providing programs to train and support youth role models and youth workers); identify youth needs, peer issues, relationship issues, concerns, and values; identify youth participation in community process and initiatives and their participation/connection to mainstream society; provide accessible healing centers, youth-specific detoxification programs, and more youth-centered community-based programs and activities; provide youth with a youth-centered continuum of care that includes detoxification, rehabilitation, and aftercare; and, find create ways to encourage parental involvement.	
Support communities to include a youth specialist's worker as part of the wellness team	Alberta
Expand youth treatment continuum to include a community support system and recovery management strategies (i.e. recreational and cultural activities)	Alberta
Treatment Centres to work closely with the referral agent to prepared an aftercare plan that supports the new skills and attitudes learned	Alberta
To provide targeted crisis intervention and direct treatment service strategy towards youth.	Ont
Residential treatment for youth	
Increase the number of youth treatment centres	Alberta
Create gender specific youth treatment centres	Alberta
Determine the recommended length of the treatment cycle for youth	Alberta
Involving youth in community life	
Invite the youth to participate in the organizing and hosting community forums to discuss social issues	Alberta
Include youth in identifying the community issues (personal, social, substance abuse) that need to be addressed.	Alberta
Develop youth leadership councils	Alberta
Provide youth with the leadership training opportunities	Alberta
Provide youth with training in group facilitation and problem solving	Alberta
Strengthen traditional cultural practices and language skills	Alberta
Engage community support systems to assist the youth to develop a strategic plan to address alcohol and drug misuse.	Alberta
Facilitate relationships between Elders and youth, to share knowledge and history and culture.	Alberta
Community support for youth groups (leadership, financial and mentorship)	Alberta
Increase employment opportunities for youth	Alberta

Promising practices in youth programs

Ontario's Nimkee NupiGawagan Healing Centre recently partnered with the Canadian Centre on Substance Abuse and Carleton University on a project to determine the optimal length of stay for youth who abuse solvents—leading to a much longer stay (4 months) that is believed to be a strength of the program.

Training, support, and wage parity for NNADAP workers

There was broad agreement that NNADAP workers need both more training and wage parity with their provincial counterparts. All agreed that workers need more opportunities for advancement, with a laddering, career-based approach leading to a degree or post-secondary-level certification, and ideally supported by a mentoring system. The recommendations with respect to training range from broad recommendations underlining the need for a coherent training program, through to detailed suggestions about particular areas in which training is needed. Some regions also suggest more clinical supervision, a "help line" that community workers can use to obtain guidance from a clinician, and other forms of support to workers, such as clarifying roles and expectations. How should a coherent training plan be developed? Almost all of the recommendations in this area seem to be premised on the assumption of a regional, rather than national, training strategy. Usually, participants advocate a partnership between FNIH and either a regional First Nation organization, or a First Nations educational institution.

Regional recommendations about training and support for workers	Region
Recommendations dealing with the need for training	
Ensure ongoing and up-to-date training and professional development to meet the changing needs of clients and thus staff to confidently address these needs.	Atlantic
More staff are required to operate the current programs. Accessible and culturally relevant training opportunities are urgently needed to increase the number of qualified First Nations and Inuit addictions counsellors. Recruitment policies are needed for Northern remote communities.	Atlantic
Provide resources to establish standardized accredited training for all Band health staff such as NNADAP workers and MH workers for the purpose of protecting and sanctioning Aboriginal world views and blending western philosophy in their services, offered more than one time per year.	B.C.
To develop appropriate training materials and resources for employees to be better equipped to meet the changing substances being abused by FN people -- trained workforce.	Ont
To support any process deemed appropriate aiming the reconfiguration of the network's service offer, including the implementation of training or specialized services.	Que
Foundational Training should be provided to NNADAP workers working in rural, urban and treatment centre environments.	Alberta
A method of obtaining current information and education about the addictive substances available in communities.	Atlantic

Recruiting initiative to bring awareness of opportunities in the addiction field, bursary sponsorships and for recruiting materials and participation in career fairs.	B.C.
It is recommended to develop a database tool that includes a regular update of clinical information on addictions accessible to the whole network.	Que
Develop an emergency response program and training program in coordination with NNAPF that is sensitive to geographic and cultural landscape of the Atlantic Region. This could also include a 24 hour crisis line for the Atlantic Region.	Atlantic
Recommendations about requiring training	
Ensure NNADAP Workers are hired with education, essential skills and psychological aptitudes to work in complex community environments with clients who have multiple substance abuse and mental health disorders. Bridging programs and certificates in community addiction training is desirable as a minimum standard of employment.	Alberta
Before being permitted to practice, NNADAP counsellors should be required to undergo an examination by an independent board of addictions specialists of actual competencies in core areas and in areas of specialty.	Alberta
Require NNADAP Workers to have continued education credits as part of ongoing training and professional certification.	Alberta
Recommendations about the content of training programs	
Advanced Training should continue to be provided in clinical skills, knowledge of the substances, how to deal with mental health issues, case management and record keeping and technology use and community development skills.	Alberta
HC and INAC provide funding at the community level that includes vocational counselling; literacy training; physical health training and social skills involved in aftercare delivery.	B.C.
To maintain the funding required to pursue the youth intervention training delivered by the *Université du Québec à Chicoutimi* and to make this training available for all addiction workers in the communities.	Que
FNIH should support the ongoing professional development and training of mental health and addictions workers. Areas that merit particular attention include basic counselling skills and mental health training for addictions workers, cultural training, computer training, and training in ethics.	Sask
For services to be effective, seniors benefit the most from age-specific interventions, and by service providers trained in both gerontology, family, and substance use issues	Alberta
Transition House workers receive training in addictions and cultural safety, and addictions workers receive training in violence and in particular sexual assault prevalence and intervention to provide a more seamless service for women.	Atlantic
NNADAP Workers to receive gender specific training on addictions	Alberta
NNADAP Workers to receive training on how to work with different demographic groups	Alberta

Begin training HC employees in community-based living and mental health, training be accredited, offered more than one time per year and utilize cross cultural pedagogy.	B.C.
Information regarding the link between opiates, HIV infections, and Hepatitis C.	Atlantic
Information and training for workers, Detox staff, community members, and youth, on the effects and potential behaviours from the effects of mixing alcohol and various other prescription and illegal drugs.	Atlantic
Training for workers on: knowledge of Residential School Trauma (RST) impacts; awareness of specific services for RST clients; awareness educational programming regarding RST for clients; and increase all workers knowledge about Aboriginal culture and Aboriginal safety.	Atlantic
Strategies for developing a training plan	
Hire a consultant to work with RAPC, to move forward with the plan to establish a First Nations and Inuit-specific Addictions research and training institute for the Atlantic Region. This would include an exploration of all options of potential links with existing post-secondary institutes, especially tribally controlled institutions, including the UNBI in Fredericton. Given the range and number of previous training initiatives undertaken, implementation of a PLAR (Prior Learning Assessment and Recognition) process in assessing and assigning post-secondary credit would be beneficial to workers in the Atlantic Region.	Atlantic
Enhancement Funding for training and the Canadian Drug Strategy dollars for research and networking flow through the ABCFNTP.	B.C.
It is recommended to Heath Canada, in collaboration with the FNQLHSSC, to develop a 5-year training plan that includes training on the following subjects among others: work planning/efficient time management, group facilitation, continued training on addictions (new drugs), new prevention and intervention approaches, individual and group counselling, mental health, accompaniment and post-treatment follow-up.	Que
FNIH should work with First Nations post-secondary educational institutions to develop and implement a certificate or degree program in mental health. Consideration should also be given to developing specialized programs to train mental health and addictions workers to work with youth.	Sask
A survey of NNADAP workers to see what their specific training needs are.	B.C.
Treatment Centres who have long term success provide their knowledge to the world and to have research capacity.	B.C.
Mentorship opportunities are made available.	B.C.
Recommendations for supervision and other forms of support to workers	
To make funds available to implement professional coaching and clinical supervision services for addiction workers.	Que

Provide NNADAP Workers with administrative supervision in the areas of case records, referral procedures, continuity of care, and accountability. This could be done through the workplace supervisor or from services provided by NNADAP consultants.	Alberta
NNADAP workers receive mandatory clinical supervision by a person trained in clinical supervision for a minimum of 2-3 hours per week for one year to discuss casework and other professional issues in a structured way and to identify ongoing training needs.	Alberta
FNIH should consider enlisting mental health therapists to provide clinical supervision and training to community-based workers. Such a strategy could include deploying in-person support on a rotating basis to First Nations communities, and developing a 24-hour telephone line workers can access for clinical supervision, advice, and guidance.	Sask
It is common practice for mental health professionals to have their own counsellor/therapist to assist in maintaining personal wellness. It is recommended that NNADAP workers follow these same practices and have access to counselling support from an outside professional.	Alberta
Care for Caregiver programs be developed and made available on a regular basis, individually on a bi-weekly and staffing groups on a monthly basis, funded for all addictions and wellness workers to have the support they need to care for themselves.	Atlantic
The Nunatsiavut plan could be explored as a template for the Atlantic Region. Healing/Treatment Centre mandates could also include providing clinical consultation and support in the areas of trauma, loss and violence to First Nations and Inuit communities and workers.	Atlantic
Facilitate employee retention by facilitating work-life balance through the establishment of workload indicators and reasonable work expectations.	Man
With the FNQLHSSC's support, to raise awareness among the communities' political and administrative authorities regarding the role that NNADAP agents should be playing in order to avoid that the latter be assigned tasks that largely exceed their mandate, their capacity and their expertise, as it is currently the case.	Que
Facilitate employee retention by funding the number of positions required to meet stated work expectations	Man
To make funds available to allow addiction workers to have access to resourcing retreats on an annual basis.	Que

Wage parity with provincial addiction workers was also seen as essential: until this happens, participants said, NNADAP will not be able to attract and retain people with higher skill levels. The drive to increase the number of certified workers is apparently aggravating this situation, as workers get their certification and then leave for better-paying jobs. In response, some people advocate a national salary scale, indexed to inflation, and with provision for training and worker accreditation. Others believe such scales should be developed at the regional level. Alberta's partnership committee apparently developed a guide in 2004 for communities to use in developing their own job descriptions and wage scales. The suggested model has several levels, with each level requiring skills, training, and certification. Despite

this, Alberta still apparently sees considerable variation in worker salaries from community to community.

Part of the difficulty, it seems, is that individual communities are not necessarily passing funding increases along to their workers; they may be using those funds for other priorities. Consequently, some method is needed to encourage Chiefs and Councils to adopt a standardized salary scale, pension plan, and base job description. In discussion, suggestions for doing this ranged from building stipulations into the Contribution Agreement to having national First Nation organizations prepare a letter on the topic to Chief and Council, with a copy to the worker.

Regional recommendations dealing with wage parity	Region
Offer equitable salaries for NNADAP workers comparable to the provincial wage scale.	Alberta
Achieve wage parity with the public sector to ensure the retention of staff and the delivery of effective programs and services.	Atlantic
For NNADAP workers and treatment centres that matches their academic and traditional education to levels on par with their provincial counterparts.	B.C.
Facilitate the retention of competent, experienced community addiction specialists by providing salary scales comparable to other federal and provincial employees in comparable positions	Man
Implement comparable salary scales as per certification levels	Man
From a staff-retention perspective, to prioritize the addiction workers' salary upgrade in order to make the pay competitive compared to similar level positions.	Que
In the medium term, in collaboration with First Nations, FNIH should develop a process to adjust the salaries of workers who complete advanced training as an incentive for retention and advancement. This would require developing job classifications and corresponding salary levels for community-based workers.	Sask

Promising practices in worker training

- Quebec cites as a strength that training for workers is available at three universities in the area (Chicoutimi, Sherbrooke, and Moncton).
- Saskatchewan mentions as a strength that its First Nations Training Institute provides training in addictions.
- Ontario's northern areas have experimented with Telehealth and other distance technologies as a way of providing psychological counselling; this experience might be useful in assessing whether addictions training could also be provided using these technologies.

Accreditation and certification

Most regions seem to support processes of worker certification and treatment centre accreditation — in fact, several cited accreditation among their "promising practices," and others recommended extending accreditation processes to community level. A few regions, however, raise concerns that accreditation standards do not take sufficient account of cultural practices in treatment, so that requiring accreditation amounts to a "backdoor" way of minimizing the role of cultural approaches. Participants said that accreditation standards need to cover both cultural competence and other aspects. One suggestion was that a First Nations institute develop a training curriculum that could then be built into the accreditation process.

Regional recommendations about accreditation	Region
Explore accreditation opportunities for community-based health services and facilities	Man
To financially support ongoing accreditation at the individual, service and network level	Ont
Certification requirements require review as there is a lack of inclusion of Aboriginal culturally specific counselling courses or materials in the programs. That a Certification body for Aboriginal counsellors independent of existing bodies be actively pursued.	Atlantic
That a training institute built on the knowledge and practice of key members of the Atlantic additions networks be developed and used as a springboard for certification and accreditation based on criteria relevant to practice within First Nations and Inuit communities in the Atlantic Region.	Atlantic
Support the First Nations Wellness Addictions Counsellor Certification Board in their efforts to develop certification standards for Elders and traditional/spiritual healers.	B.C.
Require organizational practices with Accreditation Canada be rewritten to eliminate exclusively Western medical approach to health, and include materials, practices and categories specific to Aboriginal philosophies and practices. All pressures towards accreditation by Health Canada should cease until this is completed.	Atlantic

Promising practices in accreditation and certification

- Both Quebec and Ontario mentioned accreditation of treatment centres as a strength of their programs. Ontario suggested that accreditation is improving safety, staffing, and self-care by workers.
- B.C.'s Association of B.C. First Nations Treatment Programs (ABCFNTP) believes that First Nations themselves should set the standards for wellness and addiction workers in their communities; to this end, it has obtained funding to set up an independent First Nations Wellness/Addictions Counsellor Certification Board. The Board's role will be to set standards that will ensure good care, recognize traditional practices, and be generally recognized in the

field. This may include joining existing national and international arrangements under which different organizations recognize one another's credentials.

Specific Components of the Continuum of Care

Prevention

Although everyone agreed on the need for prevention and regions made a variety of recommendations on the topic, few of the "top" recommendations dealt with this aspect; most of the attention focused on treatment. However, the topic was discussed at the Renewal Forum, where participants said that prevention needs to move to a population-health approach. This implies more flexibility in funding and reporting arrangements, to allow a population-health response and development of unique activities. Forum participants said that a good prevention strategy would also have these other characteristics:

- It would be community-driven. Community development would be central, and communities would define for themselves what a "healthy community" looks like. Indigenous knowledge and ceremonies would be an integral part of the strategy.
- It would be an explicit strategy, with an agenda and plans to meet the needs of a variety of age groups.
- It would enlist other jurisdictions and partners (e.g. provinces) in prevention efforts.
- It would address the determinants of health. This means making the case that addressing mental health and addictions requires addressing poverty. It also means considering the health impacts of education, housing, and other determinants, and consequently involving many different sectors—schools, employers, parents, health professionals—in the response. Finally, it means a greater investment in healthy alternatives in the communities.
- It would have a dedicated worker who focuses solely on prevention.

Regional recommendations about prevention programs	Region
Recommendations dealing with the need to develop prevention strategies	
Development of gender specific community prevention strategies	Alberta
Increase awareness of the effects of alcohol and drugs on pregnancy	Alberta
Development of youth gender specific community prevention strategies	Alberta
Create awareness of the risk and determinants of suicide in adults	Alberta
To provide education and prevention activities for targeted age groups including foetal development, pre-contemplative, new users (youth) and established addicts	Ont
Support and resources are needed to deliver messages to communities in a holistic manner, emphasizing the maintenance of overall good health.	Atlantic

Recommendations for specific approaches to prevention	
Make the required financial resources available to communities in order for them to hire an additional resource whose mandate will essentially be to do prevention in the community.	Que
Encourage culturally based parenting and child care initiatives such as the Lytton First Nation and the Coast Salish Employment and Training language CD.	B.C.
To develop toolkits that contain appropriate approaches to more effectively reach the population (i.e. less focus on community workshops and increased focus on contained audiences i.e. schools, staff meetings, AHSOR, church services, interagency wellness fairs, etc.	Ont
One to one support and mentorship for pregnant women based on using motivational interview strategies	Alberta
Increase community awareness and education on the affects of drugs, alcohol and services available through community awareness events	Alberta
Increase school programs that teach the effects of alcohol and drugs	Alberta
Apply strategies from the a social influence model that engages the students to better understand actual alcohol and drug use	Alberta
Develop a yearly schedule for workshops on addictions	Alberta
Establish regular AA/NA/ Alanon meetings	Alberta
Educate the community on the prevention and treatment services available and how to access the services	Alberta
Regular community activities such as craft nights, cultural activities and social gatherings	Alberta
Workshops on anger management and other life skills	Alberta
Develop resources, public education and information specific to seniors	Alberta
Develop a community strategic health promotion program for seniors	Alberta
Prohibition efforts need to be incorporated into broader community prevention strategies.	Atlantic
Prevention material regarding the link between substance use, binge drinking, historical factors and the role of culture as a recovery tool be explored.	Atlantic

There was agreement that prevention activities are particularly needed in three areas: addressing the needs of youth, * preventing FASD, and limiting abuse of prescription drugs. Suggested actions to help

* Further recommendations dealing with the needs of youth are included in the “Youth” section of this paper.

youth included introducing healthy-living programs very early in schools and Head Start programs; offering school programs in First Nations languages and culture; and employing new methods such as Facebook to reach youth with prevention messages. Above all, youth were said to need sports and recreational activities to keep them occupied. As well, communities need support programs to help single parents with their children.

Interventions aimed at preventing FASD are also required. This could include programs to support single parents; education and various forms of support (e.g., videoconferencing) for mothers; and interventions that reach women at risk via correctional centres and daycares. B.C.'s report identifies some specific programs that appear to be successful in preventing FASD, which could perhaps be used as models.

Regional recommendations about preventing FASD	Region
Support the continued funding of programs for high risk pregnant mothers such as the Circle of Life Program in Terrace, and Sheway in Vancouver.	B.C.
Increased awareness among referral workers that NNADAP policies and practices place pregnant women as priorities for admission to treatment centres.	Alberta
Support long term supportive housing with specific regard to FASD.	B.C.
Enhanced community services for FASD remain a necessity, including services for FASD young adults who are now of drinking/child bearing age.	Atlantic

In contrast to the recommendations for other types of prevention, suggestions for reducing prescription drug abuse revolved around raising community awareness of the problem and changing prescriber behaviour rather than client behaviour. Participants at the Renewal Forum said that there is a lack of awareness about the nature and extent of prescription drug abuse, and that prevention programs will need the support of Chief and Council. One helpful strategy may be to use the quarterly reports on prescription drug use that are available for each community from the NIHB program. These provide a profile of prescription-drug use in the community, although they do not include over-the-counter medications or drugs dispensed at nursing stations. Beyond this, there is a need to raise awareness of Aboriginal health issues within the regulatory bodies such as the College of Physicians and Surgeons, the College of Family Physicians, the Canadian Medical Association, and medical schools. Reducing prescription drug abuse will require collaboration between NNADAP staff, prescribers, pharmacies, and police (RCMP/provincial forces). Other recommendations on this topic at the Forum included:

- Reviewing the NIHB formulary to ensure it is current and applicable.
- Reviewing the impact of alternatives to "fee-for-service" remuneration for physicians, especially in rural areas.
- Encouraging patient – doctor prescription monitoring (some provinces have triplicate prescription programs).
- Creating greater opportunities for Aboriginal health professionals (MD's, nurses, etc.)

- Implementing recommendations from the evaluation of the Drug Utilization Prevention and Promotion (DUPP) pilot projects.

Regional recommendations for limiting prescription drug abuse likewise emphasized the need to raise awareness and to work collaboratively with prescribers and law-enforcement agencies. They also describe a need for training in this area—both training for workers, and cross-cultural training for outside prescribers. Many of these recommendations originated with Atlantic region, which appears to be particularly concerned about the abuse of prescription drugs.

Regional recommendations about addressing prescription drug abuse	Region
The prescription drug issue becomes especially complex with those dealing with mental health issues, and requires an immediate strategy for both prevention and treatment.	Atlantic
Research and education for and with addiction, health and mental health workers on the specific affects and interactions of prescription drugs for First Nations and Inuit is desperately needed. Inappropriate prescribing patterns and the need for stronger monitoring of doctors as well as blocking other access routes (known dealers/internet) for these substances, and widespread prevention programming about the risks of these drugs is called for.	Atlantic
Culturally safe methods of engagement with Older First Nations and Inuit be taught to doctors and pharmacists, and advocates/translators provided, to ensure clarity and safety of prescription drug use, along with a re-examination of policies and practices regarding refilling lost or stolen prescriptions.	Atlantic
Information and training for workers, Detox staff, community members, and youth, on the effects and potential behaviours from the effects of mixing alcohol and various other prescription and illegal drugs.	Atlantic
Information on the work of DUPPWG in Elsipogtog, and program developed by Rising Sun/Eagle's Nest be shared with other First Nations and Inuit as examples of innovative strategies to work on prescription drug abuse.	Atlantic
A collaborative infrastructure between FNIH, doctors, pharmacists, RCMP and Band Councils to lessen double doctoring, combined with public information on the dangers and warning signs of frequently misused drugs, as well as innovative healing strategies will be necessary to address this issue.	Atlantic
Raise awareness of substance problems, negative affects of gambling addiction and prescription drug abuse, especially among seniors	Alberta

Promising practices in prevention

In Alberta, the *Grandmother's Guide* affirms the importance of grandmothers' wisdom, knowledge, and prayers in addressing substance abuse in their communities. The program has been holding retreat-style workshops for grandmothers in all three treaty areas.

The *Circle of Life* program (run out of one Friendship Centre in BC) is based on the *Birth to Three* model developed at Washington University, and is funded by FNIH. The program is directed at women at risk of having an FASD child, and provides three years of mentoring to teach basic life and social skills and help with recovery and abstinence. The program is housed in the same building as a series of related programs like community kitchens, and these lend additional support to the initiative.

Pre-care/pre-treatment/detoxification

Pre-care (aside from detoxification) was infrequently mentioned in the regional reports, but received attention at the Renewal Forum, where participants outlined a series of prerequisites for introducing a pre-care program. These prerequisites include adequate funding; training for staff (particularly in the area of detox assessment); better communication with other professionals; and community-based planning committees to develop policies and procedures. Participants also developed the following suggestions for providing pre-care:

- Interdisciplinary team to look at each case – case management
- Use traditional method as an entry for assessment of client "needs"
- Develop promotion/prevention/intervention tools
- Create an Information Management System to track beds, trends
- Transportation should include pre-care, pre-treatment strategy for bringing in Elders/Healers

Access to detoxification was mentioned as a problem in most parts of the country, with some regions recommending Aboriginal-specific detox, and others advocating better partnerships with provincial services. At the Renewal Forum, participants recommended more partnerships with provincial services; developing an information system to track available beds and trends in detox; and training workers in detox assessment. There was also some discussion of developing intervention tools, and of looking at the use of traditional practices in detox. Regional recommendations on the subject followed basically the same lines, with the addition of some suggestions about cultural safety in detox.

Regional recommendations about detoxification	Region
Recommendations about the need for detox	
To fund the implementation of detoxification services within the context of a continuum of care. Excluding this stage in the service reconfiguration would jeopardize subsequent interventions and would maintain the status quo of services as they are currently delivered.	Que
Given the need for other women specific services, a gender based analysis should be considered when exploring the need for First Nations and Inuit Detoxification Programming.	Atlantic
Recommendations for training in detoxification	
Accurate and current materials on detoxification from various drugs and combinations of drugs be gathered and training provided to Detox staff as well as NNADAP/NADACA workers.	Atlantic
There is a lack of knowledge about detoxification and prescription medication, including methadone. This needs to be addressed as a research and training issue.	Atlantic

Recommendations about use of provincial detox systems	
There needs to be dedicated First Nations and Inuit beds and cultural safety training and supervision for provincial detox staff.	Atlantic
An employment equity policy needs to be put into place and monitored to ensure that Aboriginal people are hired, mentored and supported to work in the provincial Detox systems.	Atlantic
That cultural safety training be mandatory for all service providers, and in particular provincial Detox and addictions programs.	Atlantic
Recommendations for Aboriginal-specific detox programs	
An Aboriginal youth Detox program be developed, and in the interim, adequate training and resources be provided to Charles J. to deal with the Detox issues that arise with youth admitted to the program.	Atlantic
Establish First Nations and Inuit driven and medical and non-medical detoxification programs that are culturally relevant for both adults and youth.	Atlantic
At least one First Nations and Inuit specific Detox Center in the Atlantic Region, or alternatively some detox beds assigned to each Treatment Center, with resources to staff them.	Atlantic
Northern Health region look at implementation of "Wet-beds" where clients experience controlled drinking.	B.C.
To provide targeted withdrawal services appropriate for the type of addiction and within a First Nations-based or culturally safe model.	Ont

Assessment and referral processes

Assessment and referral processes generated some frustration, with some regional reports saying that each treatment centre has its own process, while others complained that although standardized assessment tools such as the Substance Abuse Subtle Screening Inventory (SASSI) exist, communities either cannot afford them or are not trained to use them. More generally, community workers reported devoting inordinate amounts of time to the referral process, while treatment centre staff reported frustration at being sent "inappropriate" clients. Despite this, only Manitoba set out recommendations specifically dealing with assessment and referral processes, choosing "community-based case management" as its first Strategic Priority. However, the topic was thoroughly discussed at the NNADAP Renewal Forum, where participants recommended

- Developing an assessment tool that is standardized, comprehensive, and culturally competent—but that also has some flexibility so that it can be tailored to meet the needs of different regions and special groups.
- Standardizing the process by which people are referred to treatment, and using the same process/package when people are sent back from treatment to the community. (Some regions advocate developing an online booking system so that community workers can quickly ascertain which centres have places available.)
- Creating a new Case Manager position within each community, with a clear role and responsibilities. This person should follow the client throughout the process, from pre-treatment through to aftercare, and an electronic system should be developed to facilitate this.
- Training community workers in related occupations to routinely screen, refer and briefly intervene (where appropriate) with clients with addictions, using a standardized tool such as the "SBIRT" (Screening, Brief Intervention, and Referral to Treatment)
- Providing cross-cultural training to staff of agencies that refer clients to NNADAP. This training should be provided by a First Nations institute.

Promising practices in assessment and referral

Atlantic Region has a standardized pre-treatment assessment process that it feels is working well.

Treatment

Community-based treatment

Participants at the Renewal Forum suggested that residential treatment should be seen as a “step” in the continuum of care, and not the first step. Instead, it would be helpful to offer day-treatment programs for addiction in the community, and/or to increase the number of residential treatment beds available in the community. They offered the following recommendations for community-based treatment:

- Involve families: craft an approach to treatment that allows families to receive services even when an individual within the family is not yet ready; educate families about addictions, the healing process, and how they can support a family member with co-dependencies.
- Offer training in how to work with youth.
- Involve communities—there needs to be community reinforcement for treatment.
- Provide funds to incorporate culture throughout, and consider the impact of addictions treatment on community development/healing.

With the exception of Quebec’s far-reaching proposals, the regional reports offered fewer specifics on community-based treatment. Alberta’s report recommends community-based treatment programs for seniors, provided in the context of support for health and activities of daily living. Saskatchewan’s recommends that FNIH experiment with innovative ways of delivering services to communities, including broadcasting Public Service Announcements via the Aboriginal Peoples’ Television Network (APTN); making greater use of telehealth; and creating interdisciplinary teams of staff to visit communities and provide specialized services on a regular basis. Other reports barely mention the topic of community-based services; Manitoba’s report notes that although many informants recommended community-based treatment, only one community in the region is actually putting an alternative to residential treatment in place. Nonetheless, Manitoba saw community-based outpatient treatment as desirable, making it part of its larger recommendations for establishing a full continuum of care. Other regions may similarly have felt that community-based treatments were included in their recommendations for a continuum of care, and therefore omitted to develop specific recommendations on the topic.

Both Forum participants and some regional reports mentioned concerns about confidentiality—an issue that would apply to any type of community addiction service, from prevention through to aftercare. Saskatchewan’s report offers some specific suggestions for addressing these concerns:

> “While the issue is unlikely to disappear in the short-term, the barriers to access stemming from concerns about confidentiality could be mitigated through a multi-pronged approach. Among other things, elements of this approach could include: ensuring that community-based addictions and mental health workers have private office space to meet with their clients (ideally, these offices should be situated within

general-use facilities such as local health clinics or wellness centres); continuing with current efforts to increase the overall professionalism of the mental health and addictions workforce; developing ethics training for community-based workers and requiring all community-based workers to take this training; providing education and awareness programs at the community level on "lateral violence" and its potential harms; employing more group approaches to mental health and addictions services, rather than individual ones; experimenting with or piloting alternative approaches to service delivery, such as worker exchanges, that would enable workers to serve communities other than their own."

Residential treatment

Residential treatment centres are a large part of NNADAP's current structure, but there are some concerns about the centres' ability to meet changing needs, and about links between the centres, communities, and outside agencies. Participants at the Renewal Forum made the following broad recommendations about improving residential treatment programs:

- Need space within buildings that allows for cultural practices, e.g. ventilated rooms
- Need a capital plan for maintaining treatment centre buildings.
- When planning changes, be aware of how change in one part affects the rest of the system (e.g., changing from residential to outpatient treatment decreases number of residential treatment beds in the region).
- Need better connection between the treatment centre and community: use tools like videoconferencing, telehealth, text messaging.
- Negotiate with province and offer choice in treatment approaches. Not everyone wants to use culture, especially if it is not their own culture, and "pan-Indian" approaches are not the answer.
- Care model needs better pre/post measurement and a database, so we can plan properly and see what difference we are making.
- Addiction workers need help translating theory into practice with respect to cultural values.
- Need to stagger intake.
- Need to offer day care for children whose parents are in treatment.
- Need to involve families in treatment—there should be funds for at least the nuclear family to travel to the treatment centre.

Providing specialized treatment services

In recent years, treatment centres have struggled with the need to handle emerging issues such as prescription drug abuse, mental health problems, and other concurrent disorders. Several of the regional reports point out that the existing treatment centres were set up to deal with alcohol problems alone, and their sites were chosen on the basis of geography and community representation, rather than with a view to providing a range of different services. As such, the centres are "generalists," and are ill-prepared to confront new problems such as prescription drug abuse.

Faced with this situation, some regions advocate having treatment centres specialize. Quebec advocates a complete overhaul of the NNADAP structure, with treatment centres specializing in such a way that a range of care is available across the province. Alberta lists among its top regional priorities to re-orient one treatment centre to specialize in concurrent disorders. (More broadly, the region sees a need to adapt treatments to meet the needs of specific groups, such as men/women, seniors, or youth.) Ontario's report suggests both specialized treatment centres and better coordination between related programs. The report points out that while each health and social service sector knows its own responsibilities, there is no formal model to ensure that sectors will communicate or act in an interdisciplinary fashion. While it would be hard to develop one model to fit all of Ontario, the report says, "there is an opportunity to cluster services more effectively within regions to better meet those specialized needs."

Regional recommendations about creating specialized treatment centres	Region
Treatment Centre Reprofiling: (recommended 3 areas be prioritized for reprofiling): One treatment centre be funded and trained to receive pregnant women; pilot four-week treatment programs, comparing outcomes of patients in 4 and 6-week models; one centre receive additional training in cocaine and cannabis use.	B.C.
Provide targeted intervention and direct treatment services for alcoholics (alcohol is primary substance they are addicted to)	Ont
Develop and provide targeted direct treatment services for poly-substance abusers	Ont
Develop and provide targeted direct treatment services to address concurrent disorders - substance abuse and DSM4 mental health disorders as well as anxiety, depression and PTSD. Note: a priority will be to re-profile some of the existing NNADAP treatment centres to deal with changing needs, for example: family-centred treatment centre; youth treatment centre, but for poly substances not just inhalants; alcohol treatment centre for 45+; continuum of care centre (for withdrawal management, pre-treatment, treatment, aftercare and transition).	Ont
Re-profile one NNADAP treatment centre specifically for women	Alberta

Adopting harm-reduction approaches to treatment

Judging by the regional reports, harm-reduction remains controversial, or more simply "nowhere on the radar." Alberta's report notes that not a single informant mentioned harm reduction; Saskatchewan's says the idea is worth considering, but is only beginning to be talked about in Saskatchewan; B.C.'s report concludes that "more discussion is needed." Harm-reduction approaches, the reports say, conflict with the abstinence model around which so many of the existing programs have been built. Further, as one participant in Atlantic explained, "the fear is a diluted program and nothing working well."

As for methadone programs, these seem to raise substantial opposition. Like other harm-reduction approaches, use of methadone conflicts with the abstinence model. In addition, there are fears about the potential effects of methadone on the fetus. Finally, treatment centres are unsure how to deal with clients on methadone—although it is clear that some centres, including five in B.C., do in fact accept such clients.

Regional recommendations about harm reduction	Region
Consider harm reduction strategy rather than total reliance on the abstinence strategy	Alberta
Culturally based forms of harm reduction need more exploration along with collaboration between health and addictions programs to create infrastructure to provide supports to methadone clients without diluting abstinence based healing programs.	Atlantic
Greater information, training, services and supports regarding reduction of dependence on Methadone for those currently receiving Methadone treatment.	Atlantic
There is a lack of knowledge about detoxification and prescription medication, including methadone. This needs to be addressed as a research and training issue.	Atlantic
Research on methadone, short and long term impacts and reactions, including effects on fetus.	Atlantic
Culturally based forms of harm reduction need more exploration along with collaboration between health and addictions programs to create infrastructure to provide supports to methadone clients without diluting abstinence based healing programs.	Atlantic
To research and develop toolkits offering more consistent treatment modalities which are proven effective to respond to multiple substance abuses. (Emphasis on "First Nation Culture as Healing" as a treatment modality; at least in one example. Move away from exclusively abstinence-based treatment options.	Ont

Promising practices in treatment

- In Alberta, the Chief Mountain Residential Healing Impact program addresses the needs of people affected by physical and sexual abuse in residential schools.
- The *Tribal Journeys* initiative has been in place for the past 20 years, and although it is not a NNADAP program, many NNADAP workers have found it helpful for their clients. The program involves a two-week alcohol-free canoe journey along B.C.'s coast, finishing at a host community. Its strengths are a “strong dose of culture” and the fact that it involves entire families and people of all ages.
- Treatment centres in B.C. and Alberta have for the past several years been re-profiling to provide more specialized services. For instance, B.C. has linked the Chehalis Wellness Centre to the family services and FASD treatment offered by Vancouver's Hey Way Noqu. Youth treatment has been added to the family program at Kackaamin Family Development Centre; and at Interior

Native Alcohol and Drug Abuse Society (Round Lake centre), treatment is being expanded to accommodate couples.

Aftercare

Aftercare was typically identified as the biggest gap in existing programs: there was general agreement that aftercare is either very limited or completely absent. However, there are also some concerns that aftercare is little used, even when present. In Manitoba, treatment centre staff and clients apparently assured the research team that aftercare was unavailable, even as workers at the community level bemoaned the lack of participation in aftercare support groups. A similar point was made in Alberta's report, which noted that although some communities have re-allocated resources to create aftercare programs, at most 40% of clients participate in them. This suggests that some thought needs to be devoted to the kinds of aftercare that are developed.

Development of aftercare will be able to build on a strong basis, in that some regions have already begun to consider and test different models. Alberta has a pilot project underway to assess the use of telehealth for aftercare, while Quebec has developed a job description for an aftercare worker. Atlantic recommends looking at the model used by the Eel River Treatment Centre. B.C.'s report sets out the elements of an "ideal" aftercare program, saying that it would have community support, transitional housing, life skills, mentoring, help in getting education or work, and a range of spiritual/emotional support programs. Part of this ideal is that treatment centres would send staff out to the communities to work with the client and the referral worker. Apparently many Friendship Centres in B.C. have programs that approach this ideal, which suggests that partnerships between communities and Friendship Centres would be useful.

Discussions at the Renewal Forum in large part corroborated B.C.'s ideal, saying that aftercare should be a formal process initiated by the case manager even before the client leaves treatment; that it should centre on the family, not the individual; that it should use community peers as helpers; and that it should include life skills and job training, so that people can feel the sense of purpose and pride that goes with making a contribution.

There also seemed to be general agreement across regions that aftercare will require transitional housing for those who do not have healthy homes to return to. In Ontario, informants said that every community needs a transition home. As one client explained,

> "You are on such a high when you leave here, thinking 'Life is great,' feeling empowered, but when you go home you realize you have changed but the community has not. As fast as it was there, it is gone."

Regional recommendations about aftercare	Region
Coordinated after care support, workshops, life skills, sharing circles	Alberta

Develop a community aftercare program that provides support for all clients and those who are returning from Treatment Centres	Alberta
Provide aftercare support to women in the areas of childcare, counselling, financial management support, life skills development, job readiness, housing and protection against family violence.	Alberta
After care programs for women that focus on women's issues and needs	Alberta
Further exploration of Eel River Bar aftercare as an innovative practice is recommended.	Atlantic
The feasibility of a culturally-appropriate Atlantic-wide crisis line be explored.	Atlantic

Promising practices in aftercare

- Atlantic Region cites its good models of aftercare as a strength.
- Manitoba sees promise in processes that allow clients to have some continuing contact with the treatment centre after completion of treatment.

Structural changes to the NNADAP program

Beyond all the recommendations on specific topics, participants in the regional needs assessments and the national Renewal Forum also considered broader issues of how the overall NNADAP program is structured. Their recommendations fall into six main groups:

1. General comments on the context in which addiction services are offered;
2. Recommendations about the scope and approach of the NNADAP program, and in particular about the inclusion of mental health services;
3. Issues of funding;
4. Required policy changes to support the program;
5. Data-collection and research to support program activities; and
6. Issues of governance, coordination, and relationships with outside agencies.

The context

Participants recognized the reality that addictions are strongly related to larger social issues (in particular socio-economic conditions), and that addiction services for First Nations people operate within a context of overlapping and unclear jurisdictional boundaries. Accordingly, there were calls to address the underlying social determinants, and to establish clarity around the respective roles of federal, provincial, and First Nation addiction agencies.

Regional recommendations about the context in which addictions services are offered	Region
As the current health and addictions patterns of First Nations and Inuit are impacted by poverty, housing, employment, and educational attainment these conditions must change in order for levels of addictions to change.	Atlantic
Much more work will be necessary, both to identify the extent to which lack of basic needs may impact on First Nation health, addictions, suicidal behaviours, and to commit resources to dealing with these issues.	Atlantic
To address factors contributing to addictions through First Nations and Regional advocacy regarding the identified underlying factors and social determinants of health	Ont
A process to resolve issues of jurisdictional responsibilities at the provincial, First Nations and federal levels.	Atlantic
Clarify the delineation of provincial government services vs NNADAP services	Alberta

Expanding the scope of the NNADAP program to include new areas such as mental health

There were suggestions for expanding the scope of the existing NNADAP program in various ways—to encompass all addictions, to cover the full continuum of care, or to develop programs adapted to the needs of specific groups, such as women, youth, or two-spirited people. In particular, regions and Forum participants devoted special attention to the need to expand NNADAP to address the mental health problems that are present along with addictions. This issue received so much attention that it is treated separately from the more general regional recommendations reproduced below.

Regional recommendations on the scope of the NNADAP program	Region
All addictions are interrelated and should be treated together. This concept has implications for research, training, treatment, and policy changes.	Atlantic
Show some flexibility in the adaptation of its programs to new realities experienced in First Nations communities. These realities leave us no other choice than to recommend to Health Canada to expand its understanding of addiction problems beyond those already agreed upon, particularly regarding alcohol and drugs, in order to include other forms of addiction that are as destructive as those previously identified.	Que
To develop a change management strategy to support a multidisciplinary pre-treatment and aftercare model at the community level	Ont
Review funding structures and decision-making process in terms of defining and delivering programs for youth, women, two-spirited people, residential school survivors and people with mental health issues.	Atlantic
Development of gender specific treatment programs	Alberta
There is a critical need to take gender into account when analyzing historical and current struggles with addictions and in developing solutions.	Atlantic

The need to address concurrent mental health problems was frequently mentioned in the regional needs assessments, although some of the recommendations lacked specifics ("address mental health"). It seems fair to say that there are mixed views on the desirability of merging addiction and mental health treatment, and that some of those who favour the idea in principle nevertheless think it would be difficult to achieve. As some of the regional reports pointed out, addiction and mental health services are administered by different organizations, funded from different envelopes, and have historically used different methods. Further, people are concerned that there are fewer services for mental health than for addictions, and that because the mental health funding is in "silos," there is no coherent mental health program. As a result, many of the recommendations for integrating mental health into addictions treatment essentially say "First, we need to develop a mental health program."

This being said, there is certainly support for more collaboration between addiction and mental health services, and some of the regional reports present ideas on how to foster this. Ontario positions the

issue in the context of the need to create multidisciplinary teams, saying that there are resources (albeit limited) at community level, and multidisciplinary approaches would allow a full continuum of care to be provided. Saskatchewan's report offers some specific suggestions on how FNIH could bring addiction and mental health services closer together:

- Encourage mental health and addiction workers to take cross-disciplinary training;
- Invite mental health workers to the annual NNADAP conferences;
- Have managers from communities where mental health and addiction services are already integrated present to communities where they are still separate.

What would be required to fully integrate the mental health and addiction programs, as recommended by some regions? Alberta's report suggests that communities could use existing models, such as *Communities that Care* and *Wellbriety*. Saskatchewan advocates removing the silos in mental health funding, and agreeing on the components of a basic mental health package that would be available in every community, with more specialized services available at other levels. Discussions at the Renewal Forum centered on the need for more collaboration between mental health and addiction services at all levels, from community to national. Forum participants outlined a set of actions and resources that would be needed to integrate mental health and addiction services:

Collaboration

- Concerted action is needed to produce federal-provincial collaboration. Need a federal/provincial/territorial forum.
- Collaboration/communication with regional health authorities, and other provincial bodies, needs to be improved (e.g., need protocols for discharge reports)
- Mobile team in provinces to do screening/referral/aftercare for addictions not just mental health.
- Case conferences with all agencies should be routine
- Leadership needs to be educated and brought on board

Training and clinical supervision for workers

- Need to define the basic skill set needed for mental health services.
- Capacity building should be done in clusters, not silos—especially at the community level.
- Treatment Centres employees will need training in mental health, and addictions workers will need clinical supervision in order to become certified.
- Tele-health will be needed for training, assessment, clinical supervision, and consultation. (In fact, Tele-psychiatry would be useful.) Treatment Centres need to be wired for e-Health
- Need to recruit more Aboriginal students into mental health.
- Mental health professionals will need cultural training to work in the communities.

Community education and actions to reduce the stigma associated with mental illness

- Need a social-marketing campaign or culturally relevant education in the community regarding mental illness. A clinical nurse specialist could provide this via Tele-health.
- Education needs to cover the impacts of residential schools and colonization
- Elders need education too regarding mental illness.

Development of assessment tools

- Accurate screening and diagnosis of mental health and addiction problems is needed.
- Mental Health and Addictions should use common screening tools .
- Culturally relevant assessment tools need to be developed.

Regional recommendations for integrating mental health into addiction services	Region
Recommendations for developing a mental health program	
FNIH, in consultation with other stakeholders in the region, should determine what mental health and addictions services should comprise a "basic package" available in all communities. Tentatively, these services could include prevention, crisis response and intervention, referrals, basic addictions and mental health counselling, cultural support, and aftercare.	Sask
FNIH should develop a more coordinated approach to mental health services for First Nations. One possibility might be to rationalize the current approach to funding by eliminating the multiple sources of funding for mental health services, and restructuring them into a single mental health or wellness program for First Nations. Ideally, the new program would include elements spanning the continuum of care, including promotion, prevention, crisis response and intervention, early intervention, treatment, aftercare, and long-term rehabilitation and healing.	Sask
Development of a core National and Provincial Aboriginal Mental Health program that identified key goals, philosophy, and components of the program.	Alberta
Specific policies, procedures and staff development with respect to clients with mental health issues be reviewed across the Atlantic Region to provide more integrated services to people showing more visible signs of trauma.	Atlantic
Given the small amount of money spent on mental health counselling under NIHB, FNIH should consider phasing out funding for mental health counselling as part of that program and focus on developing mental health counselling as an element of a new mental health program.	Sask
Recommendations for training and support	
Service providers to be trained in Cultural Safety and to be aware of their own social location and the impact they have on program development and delivery.	Alberta

Better understanding among service providers of the distinction between urban and rural First Nation and the impact on mental health issues and to access to services.	Alberta
Increased training for community workers and professionals and mentorship opportunities to support professional development in the area of mental health and to become aware of mental issues and the cultural context.	Alberta
Clinical supervision and support by licensed professional to front line community workers to support the development and implementation of a client wellness plan	Alberta
Recommendations for improving coordination between addiction and mental health services	
Better case coordination including protocols for information sharing across agencies.	Alberta
Better coordination of mental health services available for children's mental health needs.	Alberta
In addition to the other recommendations of this report, FNIH could undertake other measures to promote integration of mental health and addictions services, including: Encouraging mental health and addictions workers to take cross-disciplinary training; Inviting mental health workers to the annual NNADAP conferences for professional development and networking purposes; Inviting program managers from communities where integration has occurred to present their models to other interested communities.	Sask
Specific suggestions	
Travel funds for those requiring specialized mental health treatment services outside of the local area.	Alberta
Increase in the number of Youth and Elders community living homes available that meet the different levels of need for supervised living	Alberta

Funding

The issue of funding was repeatedly mentioned both in the regional reports and at the national Renewal Forum. Participants at the Forum said that NNADAP needs to be adequately resourced, and to be supported by a national partnership network. (The National Native Addictions Partnership Foundation was suggested for this role.) They said that mechanisms need to be developed to ensure that resources meet community needs, and that they continue to do so as these needs evolve. They also called for a review process to ensure that program funds are used accountably. Finally, Forum participants shared the same concerns as regional informants about the need for NNADAP workers to have wage parity with their provincial counterparts, and they called for sufficient resources to permit this.

Many of the recommendations around funding in the regional reports are succinctly summarized in Atlantic's call for "more money and more long-term money." Regions report needing more funding both for existing NNADAP activities, and to introduce the new ones being envisioned as part of the renewal process. Besides this, one or two regions called for revisiting the processes by which funding levels are established and by which funds are allocated between different regions or sub-regions. Saskatchewan's report noted with consternation that NNADAP lacks data to measure the extent of need for addiction services, what services already exist, or administrative parameters like the length of waiting lists. Without such data, the report said, it becomes very difficult to assess in what ways programs should be changed.

Regional recommendations about funding	Region
Collect data on scope of need, such as prevalence rates, rates of service utilization, and wait times for services; as well as comprehensive information about the mental health and addictions services available at the community level, including budgets, staffing levels, staff qualifications, service availability and utilization, and outcomes.	Sask
A review of the funding formula based on the geographical logistics and cultural landscape of four provinces within the Atlantic Region is essential.	Atlantic
Enhance budget allocations to facilitate implementation of identified best practice, traditional, cultural, and spiritual approaches	Man
Support the full continuum of care through potential enhancements in human, fiscal, capital, and material resources	Man
Facilitate effective program delivery by ensuring adequate levels of human, fiscal, capital, and material resources	Man
Ensure budget allocations facilitate the implementation of evidence-based, best practice program approaches	Man

Ensure budget allocations support the delivery of addiction services and support across the full continuum of care including withdrawal management services	Man
Facilitate implementation of transitional programming with enhanced human, fiscal, and material resource allocations where necessary	Man
Increase funding levels for program delivery, resources, training and wage parity	Ont
From a continuum of care perspective, support, through additional human and financial resources, if required, the necessity to carry out a reconfiguration of the service offer delivered by treatment centres in order to ensure it corresponds to the current reality and meets the needs that result from it.	Que
More money and more long-term money.	Atlantic
Improve physical infrastructure through enhanced capital funding.	Ont
Stable funding and resources should be in place to support the important role that NADACA workers are playing to address addictions/substance abuse issues in First Nation communities in Nova Scotia and extended to NNADAP in the Atlantic Region.	Atlantic

Policy

By far the most common recommendations respecting policy development dealt with the need to revise NIHB transportation policies. Regional representatives repeatedly expressed frustration with the existing policies, saying that they confront clients with unrealistic travel itineraries, and prevent treatment centres from being able to return clients safely home if they have been inappropriately referred or if they drop out of treatment. Further, many participants said that funding needed to be available to allow family members to visit clients—especially youth—at treatment centres.

Regional recommendations for changes to NIHB transportation policies	Region
Changes in the guidelines for the provision of transportation though Medical Services are necessary to acknowledge geographic disparities, to fund transportation to preventive and aftercare services, to encourage access to treatment in a timely manner and to give more flexibility in treatment options. Recovery is a long-term process and may take many attempts before being successful. Transportation policies need to account for this.	Atlantic
Transportation of clients to residential treatment facilities should be compensated at rates comparable to government travel rates.	Man
NIHB transportation policies should facilitate family participation in residential treatment, and allow for return travel where inappropriate referrals have been made.	Man
Transportation policies must make provision for client safety and facility liability in situations where individuals are asked to leave residential treatment, especially during inclement weather.	Man
Review and discuss travel policy; delivery and administration of the policy is consistent; return travel arrangements be allowed at the beginning of treatment, especially for detox and treatment centres along Highway 16; appeal process is timely for patients.	B.C.

Beyond changes to NIHB policies, there were some broader recommendations about the policy-development process, and a few suggestions about creating policies to address gender issues (contained in Atlantic's needs assessment report):

- Need to be able to adapt policies to meet the needs of service providers as they evolve.
- Need better ways for staff to communicate information to higher levels. Establish a mechanism for community workers to raise issues at regional and national levels; consult with staff in the governance and administration of programs, to ensure activities are sound, meet a need, and provide workers with comprehensive support.
- Establish a comprehensive and inclusive approach to community development – identify promising practice models.
- Explore best practice and policy options for NADACA/NNADAP based on traditional philosophies of self determination.

- That a position and a process be established to provide a gender based analysis (GBA) of policies and practices affecting women workers and clients in addictions services in the Atlantic Region, with special attention to hearing and mediating claims of sexual harassment/abuse.
- Personnel policies developed for consistency across the Atlantic Region, and to help new staff. Policies should be reviewed for a gender-based analysis and to be in keeping with aboriginal views of egalitarian decision making and self-determination.

Policies that establish "stovepipes" in funding may also need further attention, since this theme recurred in the discussions and has major implications for the structure of the NNADAP program. Stovepipes are seen as an impediment to community development, an obstacle to multidisciplinary teams, and hence a barrier to population-based prevention strategies. They are widely reviled, yet some participants advocated retaining or introducing them to prevent NNADAP funds from being re-allocated to other purposes—and in particular, to ensure that increases in the NNADAP budget actually translate into salary increases for addictions workers.

Governance and coordination

Governance

Issues of governance and coordination—both within community programs, and at regional and national levels—received a good deal of attention. Participants at the Renewal Forum made the following recommendations about NNADAP's governance structure:

- There is a clear difference between governance and system coordination.
- Must maintain community governance and control in management of programs and services.
- Re-establish and fund regional Working Groups to represent the interests of, and be accountable to, community/NNADAP programs
- Need formalized reporting relationships between Regional Working Groups and political leadership.
- Need to link the front-line with political leadership.
- Make better use of NNAPF as a resource; fund NNAPF to help develop capacity in governance and administration
- Engage an Elders' Advisory Committee
- Boards of Treatment Centres must have the capacity to ensure accountable and transparent programs and management of resources.
- Need education and awareness on key components of the renewed NNADAP framework and the links to community-level governance and administration. This requires a clear communication strategy to regions, using tools such as PowerPoint presentations.
- Regional and community political bodies should be engaged in the validation process.

Region-level coordination

Issues of regional and national coordination may require particular attention. There is inevitably some ongoing tension between the community-driven model and a desire for national standards and coordination. People see as NNADAP's greatest strength that it is community-driven and community-based, with services provided by people who are familiar with local customs and traditions. Yet despite its undoubted strengths, this model has some drawbacks. First, according to some of the regional reports, concerns around confidentiality are so great that clients refrain from using community services in many cases. Second, despite the desire to let communities determine what is best for their own people, the Renewal Forum heard calls for national standards in many areas—especially training and accreditation. Finally, some of the reports noted that a community-driven model makes it more difficult to develop a continuum of services in which certain treatment centres offer specialized services to the whole region.

Perhaps this ongoing need to balance community control with regional or national needs explains why, along with praising the community-driven model, so many of the presentations also cited regional coordination boards and forums as one of NNADAP's best practices. Currently, every region but

Saskatchewan has at least one forum that allows for region-level coordination, and these were often mentioned as a strength of the program. In fact, Atlantic's report explicitly advocates continuing and expanding such arrangements, saying that a model such as Nova Scotia's NADACA (which supports, advocates, and trains First Nation workers and helps make best use of available funds) should be explored for the Atlantic Region as a whole, and that the Regional Advisory Panel should continue to play a coordinating role in the NNADAP renewal process. The table below summarizes the existing coordination arrangements across the regions.

Regional coordination structures in place across southern Canada	
Atlantic	Native Alcohol and Drug Counselling Association of Nova Scotia (NADACA), made up of chiefs from 11 of the 13 communities. According to Atlantic's report, NADACA creates policy, allocates funds to two treatment centres, hosts training, and organizes the RAPC (Regional Addictions Partnership Committee), a working group of Treatment Centre directors and prevention representatives from the four provinces.
Quebec	Full-time NNADAP coordinator at the CSSSPNQL (First Nations Health and Social Services Commission). Effective joint working group with Health Canada.
Ontario	Network of treatment centre directors. Ontario Regional Addictions Partnership Committee.
Manitoba	Manitoba First Nations Addictions Committee – made up of coordinators from the Tribal Councils, directors of treatment centres, representatives of independent First Nations, and FNIH's NNADAP coordinator (ex-officio). Non-decisional.
Saskatchewan	Had a Regional Advisory Board until 2008; representatives say something similar is needed again to coordinate, plan, and set regional standards.
Alberta	Co-management of all health programs by Chiefs and Health Canada, with a subcommittee specifically devoted to mental health and addictions. One Wellness Consultant per treaty area to orient new workers, provide support, help at treatment centres, and backfill for workers on training.
B.C.	Association of B.C First Nation Treatment Programs (ABCFNTP) is an umbrella group made up of directors from 10 of the 11 treatment centres, plus community workers. The group advises FNIH and the First Nations Health Council.

Community-level coordination

Coordination is apparently also an issue at community level, with various regions calling for more coordination between health and social programs, and multidisciplinary teams. A few suggest that interdisciplinary collaboration would be promoted by better information systems, clear definitions of the roles of the various intervenors, and explicit mechanisms to share information between programs.

Regional recommendations for improving coordination at the community level	Region
Better coordination among service providers to develop and implement a client based	Alberta

treatment plan that addresses co-occurring and mental health substance abuse issues	
Facilitate effective case management amongst health and social service providers through the establishment of information management systems, information sharing mechanisms, and electronic health records.	Man
Establish case management processes that clearly identify the roles and responsibilities of all stakeholders, including which agency takes the lead.	Man
Institute community-based case management	Man
Alcohol and drug counselling be cross-jurisdictional.	B.C.
Each of these four locations (Conne River, MCPEI, Elsipogtog Health Center, and Natuashish Healing Lodge) could be further explored as models of innovation regarding positive collaboration.	Atlantic

Coordination with outside organizations

One topic is notable for its relative absence in the needs assessment reports and recommendations: the issue of establishing closer coordination between NNADAP and provincial services, which was specifically included in the recommendations from only one region. This may be in part a result of the way the needs assessments were conducted, since it seems that few of the assessment teams interviewed or surveyed people working in provincial health departments. However, it does stand out as an area that may be worth further attention in future. In the interim, there were recommendations for closer collaboration with specific sectors, such as justice and education.

Participants at the Renewal Forum examined the issue of partnerships with outside agencies, and came up with the following list of suggestions:

- Networks should encompass a wide cross-section of partners from both mental health and addiction fields: researchers, policy developers, workers involved with culture, and Elders.
- Link with Aboriginal off-reserve counterparts to meet the needs of transient clients.
- Networks must be cross-jurisdictional (i.e. federal, provincial and FN). Federal and/or external partners need to have cultural competency.
- Establish formal connections to child welfare, justice system, and others, at both system-wide and service-delivery levels.
- Working relationship between National bodies.
- Monitor policy changes that impact the addictions field (e.g. taxation and HST, regulation of illegal drugs, privacy legislation).

Regional recommendations about partnerships with other sectors	Region
Given the link between addictions, corrections, and colonization, a greater collaboration between addictions and justice workers to develop a more seamless healing program based on an understanding of historical and structural impacts, and the Aboriginal	Atlantic

principles of restorative justice be initiated. This could include cross-training opportunities to network and build stronger interrelationships.	
Embrace partnerships where possible – between education programs and health.	B.C.
Partnerships with academic programs, specifically looking at Indigenous research by Indigenous researchers on Indigenous people.	B.C.
Develop partnerships with the Quebec heath and social services network in order to foster First Nations' access to the existing services in the Quebec addiction network.	Que
Establish knowledge transfer agreements with the Quebec network and notably with the Addiction Prevention Centre and other related organizations.	Que

Promising practices in governance and coordination

Promising practices in region-level coordination

- Atlantic: NADACA is felt to be useful.
- Quebec: The presence of a full-time NNADAP coordinator at Quebec's First Nations Health and Social Services Commission is a strength, as is an effective Joint Working Group with Health Canada.
- Ontario: Regional Action Plan is useful. Ontario's Chiefs recently passed a resolution on prescription drug abuse, saying that First Nations would work with Health Canada to develop a strategy to address this problem. This is a particularly welcome development.
- Alberta: co-management of the entire First Nations Health envelope by Chiefs and Health Canada is a useful model. There is also a promising amount of cooperation with provincial health services to improve the care offered to First Nations clients.
- Association of B.C. First Nations Treatment Programs (ABCFNTP) is in itself a good practice, and is spearheading some promising initiatives. The organization allows it members to discuss the best ways to organize services, and provides economies of scale for training programs (such as a core skills program, training on FASD, and training on suicide prevention). And as mentioned in the "Accreditation" section, ABCFNTP is spearheading development of First Nation-specific standards for wellness and addiction workers.

Promising practices in governance

- Saskatchewan cites as a particular strength of NNADAP that it is community-driven. Strong political support and good management at the community level are believed to contribute to the program's effectiveness.

Promising practices in funding

- Ontario mentions the recent move to "cluster funding" (which allows communities to combine funds for related programs) as a promising initiative.

Data collection/management/research

Data-collection and research are essential tools for managing a program and developing new and effective models of intervention. As noted in the preceding sections, participants called for research in a variety of areas, particularly to demonstrate the effectiveness of culture-based models in addictions treatment. More broadly, participants at the Renewal Forum set out a series of recommendations about data-collection, managing data systems, and research:

Demonstrating the value of research

- Need to demystify research, demonstrate its value, and overcome barriers such as the perception of being "researched to death."
- Knowledge Translation may help—make sure people see the results of research and how these can be clinically useful.
- Culturally-competent research is needed, with Aboriginal-specific measures.
- Research might be better used if it we employ common data systems, or data systems that "talk" to each other.
- Research may also be useful for evaluation, needs assessment, investigating causes of problems, and identifying emerging trends.
- Some research issues are related to quality control, credibility, and accreditation
- Need ongoing funds for research
- Need a clearinghouse to conduct research, connect to researchers, and disseminate information across the country. NNAPF or ACADRE centres may be good choices.

The research process

- Community-based participatory research may be useful, as will research projects initiated from the bottom that respect principles of Ownership, Control, Access and Possession
- Accept all forms of knowledge, including oral stories, lived experience.
- Elders guide what traditional knowledge can be shared and documented.
- Partners can include justice system, health system, university, Elders, organizations such as NNAPF and CCSA.

Possible areas for research

- Stigma
- North
- Youth programming
- Emerging issues (e.g. hand sanitizer)
- Detox models
- Ways to integrate practices: mental health and addictions; cultural and western approaches to healing; continuum of care.

- Research on effectiveness of various prevention programs
- Research on effectiveness of alternative approaches (equine therapy, land-based therapies)
- Research on criteria for treatment “success” (alternatives to simply insisting on the 80% bed-use measure)
- Create an evidence-base for culturally competent assessment tools.