National Native Alcohol and Drug Abuse Program

Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program

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Executive Summary

The overall purpose of this research paper was to explore opportunities for improving the integration of mental health and addictions programming within the National Native Alcohol and Drug Abuse Program (NNADAP).

Two data sources were utilized to develop this report. The primary data source was a set of key informant interviews with NNADAP staff to gather their perspectives, expertise and recommendations on how to best approach the integration of mental health services into NNADAP. The second source of data is a set of examples from the literature of approaches, principles and practices to integrating mental health services into addictions programming.

There were several arguments made in the literature for the integration of addiction and mental health services such as: the prevalence of co-occurring disorders, the fact that it is already taking place in most provinces and in some FNIH regions, it provides expansion and increased access to mental health services, it is more cost effective than two separate systems, and consumers are demanding a more effective, holistic, client-centred service.

There were numerous gaps identified that would need to be addressed should FNIHB move to integrate and/or improve mental health services/supports in NNADAP. Some of those gaps are:

- There was a general consensus among witnesses that the current funding levels for mental health services and addiction treatment in First Nations and Inuit communities are inadequate and disproportionate to the burden of illness.

- Mental health and addictions systems are highly fragmented for Aboriginal communities. Services and supports are provided by different levels of government, different departments and there is limited collaboration.

- There is considerable fear among NNADAP workers that they might lose their job or lose job status if they are somehow integrated with mental health workers.

- There is a critical shortage of adequately trained Aboriginal mental health and addictions professionals. Generally, there is also a lack of culturally appropriate services.

- Traditional healers: There is a need to define the roles and to recognize the contributions of traditional healers.

- Clinical consultation and supervision: since services are frequently needed in small, remote communities and provided by paraprofessionals, effective means of providing clinical consultation, advice and supervision needs to be developed.

- Concurrent disorders: NNADAP workers need to develop a better understanding about concurrent disorders.

There is an important need to integrate culturally based approaches, culturally appropriate approaches, indigenous knowledge and traditional healing, as an accessible and critical part of the overall integrated community continuum of care services.

The primary theme in participants' responses was the lack of capacity to provide mental health services and supports. They easily identified examples from their work of the gaps they see in mental health services within their centres. For example, there is a lack of expertise in dealing with complex mental health issues such as grief and loss issues and post traumatic stress disorder.

NNADAP workers either need adequate training to deal with suicidal clients, clients on antipsychotic, anti-anxiety, antidepressant medications, methadone, etc or they need to refer them to other qualified service providers.

NNADAP workers require adequate training and resources to provide some measure of aftercare to their clients.

Further research is needed to determine best practices, models, partnerships, and agreements for the improvement of mental health services within NNADAP.

If NNADAP wishes to integrate addiction and mental health services then they need to decide on an appropriate approach to integration, e.g., integrated treatment, integrated programs, integrated system.

Specialized training for workers will be required — training that would incorporate mental health, addictions and cultural knowledge. Other challenges/opportunities around training involve supporting the trainees.

Problem-solving "Hotlines" and Internet links should be established to ensure that NNADAP workers have ready access, when necessary to 24-hour, professional advice regarding addictions problems/solutions and mental health problems/solutions.

Resources would need to be made available for workers to sustain their new role, e.g., "debrief" (peer consultation), mainstream, cultural and traditional (e.g., EAP supports and clinical supervision). Videoconferencing methods could be utilized for clinical supervision, case consultation and for training of community mental health and addictions workers.

From a mandate perspective, in order to move toward a more integrated continuum of services, facility-based treatment centres would need to broaden their mandate to include the treatment of mental health issues, and increase their capacity accordingly.

Increased funding for NNADAP workers is also critically needed in order to increase opportunities for recruitment and retention. Increased salaries and supports will also be necessary if higher training requirements are put in place. The cost of this integration is a critical issue and solutions may require partnerships between federal and provincial services.

A. Context and purpose of the paper

General Context

The National Native Alcohol and Drug Abuse Program (NNADAP) is one of the programs managed primarily by First Nations through contribution and/or transfer agreements with the First Nations and Inuit Health Branch (FNIHB), Health Canada. *The mandate of the NNADAP program is to support First Nations and Inuit people and communities in establishing and operating programs aimed at arresting and off-setting high levels of alcohol, drug, and solvent abuse among target populations living on-reserve.* The most recent review of NNADAP services[1] found that alcohol and drug abuse continues to be one of the major health concerns among First Nations. Most of the NNADAP activities are included in the following four areas of emphasis: prevention and intervention, treatment, training, research and development. NNADAP supports a national network of 52 residential treatment centres with approximately 700 treatment beds.

In the most recent program review, NNADAP noted the need for a system that allows funds to move to areas of greatest need and to provide incentives for changing programs to respond to changing needs. In recognition of the growing trend within addictions delivery systems to better integrate and provide mental health services, NNADAP developed a vision to integrate and further coordinate services. This initiative will enable addiction treatment and prevention services to benefit from mental health approaches, services and supports.

Substance abuse is a major public health issue in Canada creating significant health care demand, social problems and productivity losses. The Canadian Centre on Substance Abuse (CCSA) estimated the related direct and indirect costs of substance abuse in a 2002 report[2]:

- Alcohol accounted for about $14.6 billion in costs including $7.1 billion for lost productivity due to illness and premature death, $3.3 billion in direct health care costs and $3.1 billion in law enforcement costs.

- Illegal drugs were estimated to be approximately $8.2 billion in costs including $4.7 billion for lost productivity due to illness and premature death, $2.3 billion for law enforcement costs and more than $1.1 billion in direct health care costs.

Considering the impact on all facets of society, it is important to understand the context of addictions in order to provide the best prevention and treatment strategies. Research tells us that mental health issues are one of the key factors to address in substance abuse and treatment. The term *concurrent disorders or co-occurring disorders* is used to refer to individuals who suffer from a mental illness and a substance use disorder at the same point in time[3]. Health Canada defines the co-occurring disorders population as — those

[1] NNADAP Review Steering Committee, n.d.
[2] Rehm et al., 2006.
[3] Centre for Addiction and Mental Health, 2009.

people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug[4]. Studies have found that between 75 percent and 100 percent of those seeking treatment for substance abuse have a concurrent mental health issue[5]. Further, substance abusers with co-occurring mental health conditions have poorer treatment outcomes, higher risk for harm, and the most unmet needs; they are also the least satisfied with services and have higher social/health costs[6]. However, the relationship between substance use and mental health is a complex issue. Report number one from the Standing Senate Committee on Social Affairs, Science and Technology (2004) notes that mental health problems/illnesses may act as risk factors for increased substance use *or* the use of substances may increase mental health problems. Regardless of the direction, researchers agree that this co-morbidity of mental health and addictions should be expected as the norm. As such, there needs to be opportunities to provide mental health supports in addictions prevention and treatment services.

Unfortunately, mental health and addictions have historically been treated as separate conditions, with separate systems of care. In their 10-year strategic plan, the Native Mental Health Association of Canada (NMHAC) noted the continuation of "silos" even though there is evidence that integration of services brings better outcomes over time[7]. Health Canada defines program integration as an opportunity for a systematic approach to treating these issues:

> *Mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers* [8].

This integration would see addictions treatment and prevention services benefit from mental health approaches, services, and supports. The results of the current research will provide counsel to those who administer and deliver addiction prevention and treatment services in First Nations communities. It is also intended to be a resource for the development and implementation of NNADAP policy. The results and guidance from this current project will be presented to a national committee and a copy of the report will be made available to all participants.

Cultural differences in defining mental health

What if any are the differences between Aboriginal mental health and western mental health? To attempt to make such distinctions it will be necessary to commit the crime of generalization. In addition, it is difficult to distinguish between mental health and health in general for Aboriginal people as health is seen as a balance of the mental, physical,

[4] Health Canada, 2002.
[5] Rehm et al., 2006.
[6] Addictions Foundation of Manitoba, 2005.
[7] NMHAC, 2008.
[8] Health Canada, 2002.

emotional, and spiritual. This holistic concept of balance differs from western medicine and psychiatry, which focus on discreet parts of human functioning, separating the physical from the mental, emotional, and spiritual. Similarly, western mental health practices tend to focus on the individual and not on the collective. Western mental health tends to be future oriented, while Aboriginal mental health focuses on the present. There is an emphasis on mastery in western mental health versus an emphasis on harmony in Aboriginal mental health. Western medicine has a focus on the cure, while Aboriginal healing has more of a focus on the journey. Aboriginal people seem to be pulled forward on their journey of healing in an effort to connect with sources of meaning and well-being, such as significant connections/relationships, spirituality, culture, feelings of contribution to ones community, etc. Western health looks at determinants and causes; the individual is pushed versus pulled in a cause and effect relationship. Self actualization is a goal in western mental health, while self transcendence leading to interconnection is a goal of Aboriginal mental health. The doctor and in part the patient are responsible for healing in western medicine, while the creator and the patient are responsible for healing in Aboriginal medicine. Spiritual or metaphysical considerations are as important as or more important than biological and experiential considerations for causes and treatments of illness in Aboriginal mental health, while only the biological and experiential tend to be examined in western mental health. Finally, western medicine places great emphasis on diagnosis and labelling and is limited in terms of treatment. Aboriginal medicine and mental health places less emphasis on diagnosis but has an abundance of options for treatment.

Gender differences

Although it is known that the prevalence rates of drug and alcohol use disorders are consistently higher among men than among women[9] it is less clear as to whether treatment works differently for men and women. There are, however, some gender differences in terms of mental health and addictions. This section will briefly summarize some of the relevant literature regarding gender differences. It should be noted that all but one of these studies involve mainstream participants and do not involve Aboriginal participants.

Gender differences in the patterns of comorbid psychiatric disorders in substance users follow the same patterns seen in the general population, with women more likely to meet criteria for anxiety, depression, eating disorders, and borderline personality disorder and men more likely to meet criteria for antisocial personality disorder[10]. One study exploring gender differences in the onset of a major depression episode (MDE) and alcohol dependence found that women with MDE were more than seven times as likely as women without MDE to have alcohol dependence at a two-year follow-up point. However, men with MDE were not at any enhanced risk for developing alcohol dependence[11].

[9] Kessler et al., 1994; Regier et al., 1990.
[10] Brady et al., 1993; Sinha & Rounsaville, 2002.
[11] Gilman & Abraham, 2001.

Evidence suggests that a relationship between trauma, post-traumatic stress disorder, and substance use disorders may be particularly important for women. Women exposed to violence in adulthood also demonstrate a higher risk for drug and alcohol dependence. Moreover, alcohol and drug abuse place women at risk for repeated victimization, thus perpetuating the cycle of victimization and substance use[12].

In another study, it was found that drug dependent men were more likely to use drugs to socialize, and more likely to externalize problems in childhood than were women. Drug dependent woman were found to be more likely to use drugs to cope with negative mood; more likely to need help for emotional problems at a younger age than men (17 years old versus 20 years old); more likely to have attempted suicide; and more likely to have internalized childhood problems[13].

Gender differences in treatment

A number of studies indicate that women are less likely than men to enter treatment[14]. Reasons for lower rates of treatment entry may include socio-cultural factors (e.g., stigma, lack of partner/family support to enter treatment), socio-economic factors (e.g., child care), pregnancy, fears concerning child custody issues, and complexities associated with increased rates of co-occurring psychiatric disorders and the availability of appropriate dual-diagnosis treatments[15].

There are few, if any, consistent gender differences in treatment outcome, retention rates, or relapse rates across various types of substances, treatment settings, and types of treatment[16].

It is still unclear whether women-focused or gender-specific treatments are more effective than standard substance abuse treatments[17]. Some data suggest that women-focused out-patient or residential treatments produce higher rates of treatment completion than traditional programs[18]. Data also suggest that residential programs that allow women to be accompanied by their children result in higher rates of retention, an important factor in predicting treatment outcome[19].

Only one study [20] was found that looked at gender differences specific to Aboriginal drug and alcohol treatments. This study examined gender differences within a sample of Canadian Aboriginal individuals admitted to an in-patient, hospital-based substance abuse detoxification program. Even though alcohol was the most frequent primary drug of detoxification for both genders, women received proportionately higher rates of cocaine or opiate detoxification diagnoses. In addition to being younger in age, females

[12] Kilpatrick, Resnick, Saunders and Best, 1991.
[13] Haseltine, 2000.
[14] Kessler et al., 1994.
[15] Greenfield et al., 2007; Brady et al. 1993.
[16] Greenfield et al., 2007; Hser et al., 2001; Mangrum, et al., 2006.
[17] Ashley et al., 2003; Niv & Hser, 2006.
[18] Dahlgren & Willander, 1989; Hughes et al., 1995.
[19] Hughes et al., 1995; Szuster et al., 1996.
[20] Callaghan et al., 2006.

reported higher rates of physical and sexual abuse. Women were also administered more antidepressants, antibiotic medication protocols, and more medical evaluation tests.

Purpose of this research paper

The overall purpose of this research paper is to explore opportunities for improving the integration of mental health and addictions programming within the National Native Alcohol and Drug Abuse Program (NNADAP). The project was commissioned by Health Canada's First Nations and Inuit Health Branch (FNIHB) and the National Native Alcohol and Drug Abuse Program (NNADAP). The project was approached as an opportunity to identify specific strengths, limitations, and opportunities for providing mental health services, supports, and/or partnerships within NNADAP. Specifically, the objectives of this work were to:

a. Identify gaps and challenges for providing appropriate mental health services and supports within NNADAP;

b. Highlight existing best practices/promising models, partnerships, and agreements within NNADAP for providing appropriate mental health services and supports;

c. Identify potential partnership opportunities to facilitate additional mental health services and supports between NNADAP and other sectors;

d. Identify, from the literature, examples of best practices/models at systemic, program, and service delivery levels for the provision of appropriate mental health services, supports, and approaches within addiction prevention and treatment services.

The results of this project will provide counsel to those who administer and deliver addiction prevention and treatment services in First Nations communities.

B. Sources of data and methodology: Key informant interviews and literature review

Two data sources were utilized to develop this report. The primary data source is a set of key informant interviews with NNADAP staff to gather their perspectives, expertise and recommendations on how best to approach the integration of mental health services into NNADAP. The second source of data is a set of examples from the literature of approaches, principles and practices for integrating mental health services into addictions programming.

Key informant interviews

Participant recruitment

The success of this work depended upon the feedback of the wide range of staff and personnel from FNIHB and NNADAP. As such, the researchers attempted to identify participants from a variety of positions, as well as participants from each of the geographic regions. Researchers sent out a letter of invitation to directors and managers outlining the project goals and asking for participation. The letter requested either direct

participation in an interview, or the nomination of another staff person whom they felt could contribute to the project.

From this strategy, 16 participants were recruited to participate in a semi-structured interview. Participants included treatment centre directors, program managers, program coordinators, team leaders and policy consultants from FNIHB and provincial offices and treatment centres. The average number of years that participants had been working in the addictions field was 12. Some of the treatment directors had worked in the field considerably longer than 12 years, while some of the FNIHB participants had only worked in their positions for a few years. Geographic participation was four from Manitoba, one from Saskatchewan, four from British Columbia, two from Alberta, and one each from Quebec, Saskatchewan, Ontario, the Atlantic region and the National Office. It is unfortunate that the interviewer was not able to recruit four participants from each region as certain regions are under-represented in providing feedback particularly with regards to best practices.

Data collection and analysis

The project consisted of a series of semi-structured telephone interviews. To facilitate this process, an interview guide was developed and included a set of questions about current NNADAP programming and policies and general mental health services available to clients (a copy of the interview guide can be found in Appendix B). Telephone interviews were conducted between January and April of 2009. Any necessary follow-up communication was undertaken by email. One research assistant conducted all of the interviews.

Initial analysis of the data was undertaken concurrently with data collection. Through this review, emerging themes were sought and additional prompts and questions were identified for future interviews. The formal analysis process began with an independent review by both authors of all transcripts; during which, units of data were coded by themes and issues. Emerging themes were explored between the interviews in an effort to search for relationships, consistencies and/or inconsistencies. Both authors met regularly to compare and contrast analysis results in order to ensure that all themes were captured.

Review of the literature

The literature review represented an opportunity to identify examples of existing models, practices and policies for integrating mental health services into addictions. The researchers identified a selection of documents using web-based resources such as search pages (i.e., Google scholar); web pages of mental health organizations (i.e., Canadian Mental Health Association, Centre for Addiction and Mental Health, Centre for Applied Research in Mental Health and Addiction, Public Health Agency of Canada); academic search engines (i.e., pubmed, ERIC, medline, multisearch, psychinfo, etc); and government reports and other gray literature. The researchers chose a selection of literature that reflected regional, provincial and national settings. Documents were also selected based on their potential utility for increasing partnerships and collaboration between NNADAP and external organizations to move the integration process forward. It

should be noted that very little published literature exists that specifically addresses integration of mental health services with Aboriginal addictions services.

Through the efforts of both government and non-profit organizations, there has been a growing awareness of the impact of mental health issues. The focus, within these efforts, has been on the need to reorient addictions approaches to take into account concurrent mental health issues. The intent of this literature review was to identify learning opportunities and processes that focus on integrating mental health and addictions approaches.

C. Findings

1. Rationale for integration

The following quotes represent the main arguments found in the literature for the integration of addiction and mental health services:

a. **It is already taking place.** Collaboration and integration of addiction and mental health services are already taking place in some First Nations and Inuit communities. The integration process is being furthered, but not limited to, communities that have transfer agreements with the federal government and healing centres sponsored by the Aboriginal Healing Foundation[21].

b. Experts in the area of organizational behaviour would suggest that the movement toward improved integration of mental health and substance use services and systems also reflects the two main factors underlying most inter-organization network development[22]. These are (1) uncertain environments whereby organizations evolve and seek stability in response to changes in the complexity of the environment; and (2) competition for resources whereby organizations will strive to cooperate and coordinate based on their mutual needs to secure resources[23].

c. **Concurrent or co-occurring disorders**. The most significant movement toward integration of addiction and mental health services pertains to the treatment of a significant population of people who have both addiction and mental health problems. These people have what is called "concurrent disorders" and require treatment for both addiction and mental health problems[24].

d. Most, if not all, published work in the peer-reviewed media[25] , as well as the major research syntheses[26], uses evidence on the high overlap and complex needs of people

[21] Health Canada, Integration of Mental Health and Addictions Working Group and the First Nations and Inuit Health Branch, 2003, p.18.
[22] Mandell, 1984
[23] Rush, et al., 2008, p.4.
[24] Health Canada, Integration of Mental Health and Addictions Working Group and the First Nations and Inuit Health Branch, 2003, p. 18.
[25] e.g., Minkoff, 2001; O'Brien et al. 2004; Flynn & Brown, 2008.
[26] Substance Abuse and Mental Health Services Administration, 2002; Centre for Substance Abuse Treatment, 2005.

with co-occurring mental health and substance use disorders as the starting point of the integration discussion[27].

- The rationale for integration of mental health and addiction services is strongest when presented in relation to the target population with co-occurring disorders, and especially the narrower and more clinically severe sub-group. The research literature, as well as the academic and lay arguments for integration, draws attention to the high overlap in the two populations, the negative impact on treatment and support outcomes, and the challenges for people with co-occurring disorders navigating two disparate systems of services[28].

- **Expansion and increased access to mental health services.** For First Nations and Inuit people, addiction treatment services are better developed and easier to access within First Nations and Inuit communities than are mental health treatment services. The integration of addiction and mental health services would contribute to the expansion and improvement of mental health treatment services[29].

- Advances in the use of information technology for example e-health, which facilitates the sharing of health information, as well as other integration activities and strategies supported by tele-health, on-line testing, and other applications[30].

e. **Cost effectiveness**. To reduce duplication of services, reduce gaps in service and optimize the use of scarce resources, an integrated addiction and mental health service system seems warranted[31].

- Economic pressures and the need for a variety of cost-containment strategies and, in particular, strategies to decrease the use of in-patient services and a corresponding increase in need for collaborative, community-based, continuum-of-care models[32].

f. **The consumer movement**. A stronger consumer movement that demands more client-centred, user-friendly services and improved access to information for educated decision-making; a more prominent role for consumer satisfaction as a performance and accountability indicator, which, in turn, makes service providers more open to being flexible and adaptable in the treatment and support package they offer[33].

[27] Rush, et al., 2008.
[28] Rush, et al., 2008, p.2.
[29] Health Canada, Integration of Mental Health and Addictions Working Group and the First Nations and Inuit Health Branch, 2003, p. 18.
[30] Rush, et al., 2008.
[31] Health Canada, Integration of Mental Health and Addictions Working Group and the First Nations and Inuit Health Branch, 2003, p. 19.
[32] Rush, et al., 2008.
[33] Rush, et al., 2008.

2. The challenge of definitions

As the literature on integration illustrates, a challenge to integration can be found in the lack of clear definitions for mental health and for addictions. Is mental health viewed diagnostically in terms of the disorders defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or dimensionally in terms of psychological distress, impairment, functioning and/or wellness? Should we also refer to the DSM-IV definition of addiction? Can co-occurring disorders include problem gambling, sex addictions, Internet addiction?

3. Gaps and challenges identified in the literature

Upon a review of the literature regarding integration, the following two documents best describe the gaps and challenges to integration. Some of the major points mentioned in these documents are paraphrased/abstracted in this section.

A. Standing Senate Committee on Social Affairs, Science and Technology — *Mental Health, Mental Illness and Addiction: Issues and Options for Canada*

- There was a general consensus among witnesses that the current funding levels for mental health services and addiction treatment in First Nations and Inuit communities are inadequate and disproportionate to the burden of illness.

- There is a poor distribution of human resources in this field, which leads to particular concerns related to access to necessary services and supports in Canada's rural and remote regions.

- Mental health and addictions systems are highly fragmented for Aboriginal communities. Services and supports are provided by different levels of government, different departments and collaboration is limited.

- There is a critical shortage of adequately trained Aboriginal mental health and addictions professionals. Generally, there is also a lack of culturally appropriate services.

- Some provinces have integrated Aboriginal issues with their provincial mental health strategies creating barriers to access.

- Witnesses to the Senate committee stressed that the "one size fits all" approach to program and service delivery has not met the needs of Aboriginal peoples effectively. What this means, in structural terms, is that it would be far more preferable for government departments to delegate to Aboriginal communities the authority to customize services and react flexibly to local circumstances. Accordingly, Aboriginal peoples should be supported in developing their own solutions, rather than having solutions imposed upon them from the "outside."

B. Health Canada, Integration of Mental Health and Addictions Working Group — *Integration of First Nations and Inuit Addiction and Mental Health Services: A Discussion Paper*

- Two solitudes, two service silos: addiction and mental health services are too frequently separate enterprises pursued by different systems, different people, different cultures, different ideas and different models (professional/medical model versus self-help/peer support model — cognitive/behavioural model versus twelve-step model).

- Addiction and mental health service development: First Nations and Inuit addiction treatment services are better developed than First Nations and Inuit mental health services. Whereas addiction treatment services are provided in First Nations and Inuit communities (on reserves), mental health treatment services are usually provided through FNIHB and the provincial mental health services (off reserves).

- Defining the problem: the nature, prevalence and incidence of addiction and mental health problems among First Nations and Inuit people has yet to be studied thoroughly.

- Problem nature, prevalence and incidence data: planning and evaluating are complicated by the absence of studies and data on the nature, prevalence and incidence of addiction and mental health problems among First Nations and Inuit people.

- Mental health service development: addiction treatment services are better developed than mental health services and mental health treatment services need to be expanded and improved.

- Dominance of addictions or mental health: it would be easy for either addictions or mental health to dominate the other. Furthermore, because of the greater presence and development of addiction treatment services in First Nations and Inuit communities, addictions is the one likely to dominate.

- Medical-related services and non-medical services: mental health services are often associated with medical services, medical personnel, and professional personnel, while addiction services are associated with non-medical services and paraprofessionals.

- Traditional healers: There is a need to define the roles and to recognize the contributions of traditional healers.

- Clinical consultation and supervision: since services are frequently needed in small, remote communities and provided by paraprofessionals, effective means of providing clinical consultation, advice and supervision need to be developed.

- Concurrent disorders: very frequently First Nations and Inuit people have both addiction and mental health problems and addiction and mental health services serve the same population (i.e., frequently individuals who have addiction problems also have mental health problems and people who have mental health problems also have addiction problems).

- Collaboration with other services and service providers: it is often difficult to develop collaborative working relationships with other services and service providers (e.g., provincial/territorial addiction and mental health services, off-reserve professional personnel funded through FNIHB).

4. Gaps and challenges identified in interviews

This project was an opportunity for NNADAP personnel from a variety of positions to share their perspectives on the integration of mental health services into current NNADAP programming. Participants were asked to discuss how mental health is currently viewed/approached within NNADAP, as well as both the challenges and opportunities for improving mental health care within NNADAP.

Participants identified several issues of concern regarding gaps and challenges. As pointed out earlier, the participants were from different regions and therefore their comments can not necessarily be generalized to all regions. In a few cases a comment made by one participant will in fact contradict a comment made by another participant.

a. Participants identified several issues of concern regarding the current NNADAP mandate

   - There does not seem to be a clear mandate for mental health services within NNADAP.
   - Brighter Futures, Building Healthy Communities programs and NNADAP all have different mandates.
   - There is a lack of collaboration between FNIHB programs and confusion concerning who provides mental health services and addictions.
   - The current mandate creates a barrier with regards to jurisdictional issues by restricting funding/services to on-reserve centres.
   - NNADAP was created to address alcohol and drug abuse, not mental health…we will need a new mandate because there is currently no room for the melding of the two.
   - NNADAP has not really looked at the mental health piece in a comprehensive way. Mental health and addictions are one and the same, so they should not be separated.
   - Just because a First Nations person does not live on-reserve, they do not cease to be First Nations. The policy dealing with non-jurisdiction has to change because 50 percent of First Nations persons now live in urban centres.
   - In some of the major centres, the difficulty has arisen from mental health services thinking they are more important than the addictions services, causing a turf war.

- Mental health treatment has been promoted over the last 10-15 years but there is a big fear of losing addictions funding to mental health in the treatment centres' community.

- It is also really important that addictions not get lost in new movement of combining mental health and addictions. The addictions work is really crucial — there is concern amongst people working in addictions that if the mental health envelope is pushed, already insufficient budgets will get chipped away at even more.

b. Participants identified several issues of concern regarding NNADAP programming

The primary theme in participants' responses was the lack of capacity to provide mental health services and supports. They easily identified examples from their work of the gaps they see in mental health services within their centres. For example, there is a lack of expertise in dealing with complex mental health issues, such as grief and loss and post-traumatic stress disorder.

- A professional mental health diagnosis for some clients would help treatment centre workers better understand them.

- Some participants pointed out that they do not have the ability to monitor certain clients at treatment centres, e.g., suicidal clients.

- Participants expressed a lack of ability to provide aftercare and family supports, particularly when community members have to leave their community to seek treatment.

- Dealing with medications was noted as a reality for many clients, yet NNADAP staff were generally not trained to assist in managing medications. Some centres may even have restrictions on accepting clients if they are on certain medications.

- The remoteness of treatment centres only exacerbates these issues, as supporting services are often not available within geographic reach.

- Transportation for clients to access accompanying services to addictions treatment, particularly primary care, was noted as an issue by several participants.

- Transportation issues were cited as a barrier for external health professionals to access remote areas (this is a non-insured health benefit issue that continues to be problematic in some regions).

c. Participants identified several issues of concern regarding human resources

- A major challenge related in the capacity for providing mental health services, as well as any future plans for increasing a mental health mandate, is the inability of many centres to hire qualified personnel.

- Participants noted a lack of educated, qualified staff to work in existing programming and pointed out that this would be an added challenge if the provision of mental health services were added to this workload.

- Serving rural and remote communities is a huge challenge. Many isolated communities are small and cannot attract qualified individuals to provide care.

- What are the criteria for hiring, salary, supervision, case management? What are the training and qualifications for health directors?

- Human resources is also an issue at the band level because one person in each community cannot do primary intervention, secondary intervention, treatment and follow up. If we add mental health services officially to NNADAP, there needs to be a budget for training and hiring additional workers.

d. Participants identified several issues of concern regarding the broader mental health system

   - There are often long waiting lists for mental health services, such as detox and assessment. In many cases, services may not even exist for certain populations — particularly around youth. These services are often needed to admit clients to treatment and/or provide information on concurrent disorders that would facilitate client treatment.

   - Within the mental health system, participants also noted the lack of Aboriginal mental health professionals, particularly psychiatrists.

   - Jurisdictional challenges at several levels were identified as an issue. The federal/provincial jurisdictional issue was raised in that some provincial services are not available for First Nations persons. For example, one participant pointed out that their client could not afford a physical exam, which was a prerequisite for admission to treatment.

   - Participants noted the lack of culturally appropriate care in the broader mental health system. Participants emphasized the need to balance both western medical approaches and traditional healing in NNADAP programming.

e. Participants identified issues of concern regarding community attitudes/knowledge concerning mental health and mental health services

   - Creating awareness in communities is essential so that people can recognize mental health issues in others and themselves.

   - There is always room to do education around mental health, especially because many people have personal embarrassment or shame around the issue.

   - In smaller communities there is a need to ensure the confidentiality of clients seeking mental health services.

- Organizing and utilizing Elders would provide a huge resource in addition to the mental health services provided by NNADAP.

5. Examples of best practices/promising models, partnerships, and agreements

Examples within NNADAP

Due to the limited number of participants interviewed in this study, there are undoubtedly many examples of best practices/promising models, partnerships, and agreements that have not been mentioned. The following examples do, however, serve to demonstrate the variety of best practices that are currently utilized.

- One promising approach to providing mental health services was the contracting of mental health professionals, such as psychologists and counsellors, to provide the service. In the B.C. region, for example, 11 of the 12 treatment centres have funding to contract mental health service providers. Saskatchewan also provides clinical support funding to all treatment centres to contract mental health services and supervision. In Quebec, some clients are referred to private centres for mental health care.

- Some participants also expressed that mental health is being addressed through the integration with traditional healing approaches. For example, most treatment centres include ceremonies and cultural events as a key component of their work.

- Some best practice examples found in NNADAP treatment centres include:

  - Onion Lake First Nation — This community has a treatment centre with five crisis teams. They hold inter-agency meetings every week between NNADAP staff and representatives from the local school, police and Brighter Futures program.

  - Okanese First Nation — This community approached addictions issues through the hiring of wellness workers. Both a mental health worker and a counsellor act as mentors for these wellness workers.

  - Round Lake Treatment Centre — This centre provides treatment through two part-time clinical psychologists and mental health training through videoconferencing and Internet facilities.

  - Tsow-tun le lum Treatment Centre — A resident Elder is available at the treatment centre 24/7 to provide traditional healing and counselling. A six-week trauma healing program is offered to clients who complete the six-week addictions program. Approximately one third of the clients in each program are Corrections Canada clients, which provides the centre with an additional source of revenue. The centre partners with the Indian Residential School Support Program, which provides the centre with three staff positions for community outreach and support of residential school survivors.

Examples outside of NNADAP

Aboriginal mental health — There have been many new Aboriginal specific mental health programs and tools developed over the past 10 years. The following examples from British Columbia represent only a few of the many mental health programs developed:

- White Haven Healing Centre incorporates western and traditional healing and has an addictions specialist and a psychologist who provides clinical support. It also works to provide a continuum of care including assessment, counselling and aftercare.

- Green and McCormick have developed an Aboriginal specific grief and loss support group facilitator guide and training program for use in communities.[34]

- McCormick and France developed an Aboriginal peer support participant manual and facilitator guide for use in communities.

Integration frameworks — A few of the provinces/territories have developed integration frameworks. The following examples from Manitoba and the Northwest Territories represent such frameworks and strategies:

- Addictions Foundation of Manitoba, Co-occurring Disorders Initiative (CODI) has developed clinical training guidelines for co-occurring disorders and revised the policies and practices across participating mental health and addiction service programs. Across the system, clients are now being screened and assessed for co-occurring disorders and integrated treatment plans are being developed for clients with co-occurring disorders.

- Northwest Territories Mental Health and Addictions Services will be integrating mental health and addictions staff and other service providers into primary community care. Mental health and addictions services will provide a continuum of services that will allow clients to continue living in their community or region. There will be investment in mental health and addictions at the community level where most prevention, out-patient treatment and aftercare should take place. Mental health and addictions services will include a multi-disciplinary team including community and wellness workers, social workers, nurses, mental health workers, addictions counsellors, etc. There will also be ongoing development of an integrated service delivery model to address duplication of services and implement best practices.

6. Examples of potential partnership opportunities

Partnerships constituted another way in which treatment centres were able to increase the capacity of their current staff. For example, in some treatment centres, NNADAP staff were able to participate in training programs offered through health authorities, such as risk assessments and processes for referrals to appropriate mental health services.

[34] McCormick, nd, Slide 57.

- In Manitoba, there are examples of health authorities working on reserves, demonstrating that jurisdictional issues can be overcome through partnerships.

Examples of potential partnership opportunities:

- One participant described an ongoing collaboration with the local detox centre to facilitate admission into their treatment centre.

- Workers from some NNADAP treatment centres and community offices are able to participate in existing training opportunities with their band and/or tribal organizations.

- The Canadian Counselling Association (CCA) has indicated an interest in discussing certification of Aboriginal mental health counsellors. At present the CCA is the only body that certifies professional counsellors at the national level.

- The Association of BC First Nations Treatment Programs established an independent society to facilitate the Aboriginal addictions worker certification process, which became known as the First Nations Wellness Addictions Counsellor Certification Board. The board has partnered with the Nicola Valley Institute of Technology and their Chemical Addictions Counselling Studies Program. This program offers the core skills required for First Nations Wellness Addictions Counsellor Certification and includes Aboriginal specific content.

- Professional counselling and psychological associations have expressed some interest in providing community service volunteer hours to assist Aboriginal community mental health workers with clinical consultation and supervision.

- The Canadian Executive Council on Addictions paper, *On the Integration of Mental Health and Substance use Services and Systems,* identifies and describes various partners, levels and strategies for integration. At a national level, organizations such as Health Canada (under Canada's Anti-Drug Strategy), the Mental Health Commission, the Canadian Centre on Substance Abuse, and the Canadian Executive Council on Addictions could provide collaborative leadership in this area, in partnership with various stakeholder organizations. Provincial and territorial jurisdictions should also be proactive in supporting integration activities, for example, with demonstration projects and incentives.

7. Best practices/models at systemic, program, and service delivery levels found in the literature

This section describes some of the best practices, models and strategies found in the literature that pertain to systems, programs, and service delivery levels. Examples from the six papers examined provide direction in many areas related to the integration of mental health and addiction services and are described under general strategies. The remaining examples constitute an attempt to synthesize the best practices literature reviewed for this paper. Specific examples and recommendations from the literature that the writers feel are relevant to this research paper are provided. These remaining

examples are organized into 13 categories: research, policy, human resources capacity building, salaries, accreditation/certification, support, treatment, supportive counselling, crisis intervention, culturally based approaches, clinical services, aftercare, and public education.

i. General strategies

Paper 1: Integration of First Nations and Inuit Addiction and Mental Health Services: A Discussion Paper (Integration of Mental Health and Addictions Working Group)

The integration of addiction and mental health services can span a continuum, ranging from a single cross-referral linkage through cooperation, consultation and collaboration to a single setting or treatment model that contains all three levels. The three levels of service provision are classified and defined as follows:

1. Integrated treatment — interaction between the addiction and/or mental health clinician(s) and the individual. Integrated treatment addresses both the substance abuse problems and mental health needs of the individual.

2. Integrated program(s) — the organizational structure for providing integrated treatment. The addiction and/or mental health program is responsible for ensuring that an array of staff or linkages with other programs is available to address all of the needs of its clients. The program is responsible for ensuring that services are provided in an appropriate and easily accessible setting, and are culturally competent, etc.

3. Integrated system — the organizational structure for supporting an array of programs for people with different needs, including individuals with concurrent substance abuse disorders and mental disorders. The system is responsible for ensuring appropriate funding mechanisms are in place to support the continuum of service needs; addressing credentialing and other issues; establishing data collection/reporting systems and needs assessment; planning and other related functions.

Paper 2: NNADAP Renewal Framework for Implementing the Strategic Recommendations of the 1998 General Review of NNADAP (National Native Addictions Partnership Foundation).

This paper generated several recommendations to enhance addiction services on-reserve, including:

- Pursue the integration of addiction and mental health services by integrating the existing addiction and mental health services.

- Develop baseline information on existing number of mental wellness workers/healers and set targets for the future.

- Clarify the meaning of integration and ensure that addictions programs do not become lost in new mental health programming.

- Clarify the NNADAP mandate around mental health. Create and apply systematic funding and strong national direction for mental health services and supports.

- Ensure a population health lens is used for integration decisions. Assess and treat clients in the context of the non-medical determinants of health.

Paper 3: Mental Health, Mental Illness and Addiction: Issues and Options for Canada (Standing Senate Committee on Social Affairs, Science and Technology)

The Senate report identified a number of steps to integration, including:

1. Build on commonalities for services and practices

2. Focus on recovery

3. Create self-help and peer support programs

4. Strengthen non-medical community-based services

5. Consider the determinants of health.

Paper 4: Strategic Action Plan for First Nations and Inuit Mental Wellness DRAFT September 2007. Developed by the First Nations and Inuit Mental Wellness Advisory Committee.

The Mental Wellness Advisory Committee has identified five priority goals within the First Nations and Inuit Mental Wellness Strategic Action Plan. Although broadly pertaining to mental health services for Aboriginal peoples it discusses the development of a coordinated continuum for mental health as well as the need for collaboration between mental health and addictions.

1. To support the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit that includes traditional, cultural and mainstream approaches.

2. To disseminate and share knowledge about promising traditional, cultural and mainstream approaches to mental wellness.

3. To support and recognize the community as its own best resource by acknowledging diverse ways of knowing and by developing community capacity to improve mental wellness.

4. To enhance the knowledge, skills, recruitment and retention of a mental wellness and allied services workforce able to provide effective and culturally safe services and supports for First Nations and Inuit.

5. To clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal, provincial, territorial and First Nations and Inuit delivered programs and services.

Paper 5: On the Integration of Mental Health and Substance use Services and Systems (Canadian Executive Council on Addictions)

Adopt a strengths-based paradigm that can systematically assess the similarities across the respective mental health and substance use sectors and leverage them to the benefit of different types of integration and for different sub-populations.

Examples of similarities build upon include: the use of the "continuum of care" approach to system planning and the need for individualized treatment and support within that continuum; the importance of a coordinated network of services in the community that includes specialized services as well as other services required on a referral basis; the importance of self-help resources and family supports; and the sharing of common ground in the fight against stigma and discrimination.

A population health perspective is needed that acknowledges the full range of health problems experienced by people with mental health and substance use disorders. Such a perspective argues persuasively for a broader approach to service and system integration and also points to the need for closer integration with other health care services (in particular the primary care physician and emergency services). This approach would address people's needs in a truly holistic fashion and avoid the multiple, disparate pathways through the health system patients must now follow to seek services and support.

It is essential that any integration effort be adequately resourced and supported since many of the changes required are in the realm of organizational and systems culture and, therefore, require sustained efforts and ongoing corrective feedback loops to ensure the goals are being met for people needing services and supports. In the end, it will be functionally integrated services that make a difference to people's lived experience.

Paper 6: Integration of First Nations and Inuit Addiction and Mental Health Services: A Discussion Paper (Integration of Mental Health and Addictions Working Group)

In recommending the integration of addiction and mental health services, the Health Canada, Integration of Mental Health and Addictions Working Group strongly suggests that the integration processes and operations be guided by major client-related, service provider-related and service-related principles.

Client-related principles

- Family and community-centred — family and community are central to service delivery.

- Client-directed — services respond to the needs of clients, families and communities rather than to the needs of the service system.

Service provider-related principles

- Responsiveness
- Strengths-based
- Diversity
- Most vulnerable served
- Traditional healing and indigenous knowledge
- Continuous quality improvement
- Confidentiality
- Service standards
- Accountability
- Continuous professional development.

Service-related principles

- Accessibility
- Sustainability
- Partnership
- Evidence-based
- Community control
- Community safety
- Consistency
- Viability
- Adequate resourcing.

The Integration Mental Health and Addictions Working Group adopted the Holistic Wellness Continuum as the central model for the integration of addiction and mental health.

- The major components and sub-components of the Continuum of Care are as follows:
    - Prevention and promotion
    - Intake, screening and referral

- Community and facility-based healing
- Supportive counselling
- Crisis intervention
- Specialized healing services
- Culturally-based approaches
- Clinical services
- Facility-based treatment
- Intensive services for complex needs
- Aftercare and rehabilitation
- Case management.

ii. Research strategies

- Create links between community mental wellness workers/healers and the research community in order to support an evidence-based approach, including indigenous knowledge, ways of knowing and life experience.

- Increase First Nations and Inuit capacity to take a lead role in evidence-based research, surveillance and practices by increasing the number of First Nations and Inuit health researchers, health planners, health statisticians and epidemiologists.

- A program of research is needed to identify the most helpful and, if possible, the essential types of systems-level supports that translate into more accessible, effective and cost-effective treatment and support at the services level.

- Greater emphasis is needed on program and policy evaluation given the need for more evidence concerning integration strategies at the systems-level. More evaluation will help mitigate the risk of pseudo-integration, that is, the development of new structures and processes created in the spirit of better integration, but without a thorough assessment of risks and benefits to all concerned, and without any substantive difference being made on the ground for the person and families in need of treatment and support.

- A program of research and evaluation is needed that first catalogues and describes what has been done to date and what lessons have been learned regarding integration. Such a compilation should be done for the integration efforts at both the services and systems levels. This would provide "normative" data with which to contrast results from a local or jurisdictional integration process.

iii. Policy

- Develop comprehensive and consistent policies for the national integration of addiction and mental health.

- Standardize policies, procedures and programming to ensure a systematic approach to any integration initiative.

- Integrated regional administration could improve coordination of supportive counselling services by means of more integrated funding and accountability mechanisms.

- Policy development needs to recognize and address integration, accountability, concurrent disorders, traditional healers (recognition and contribution) and drug use in treatment (frequent use in mental health treatment and frequent use of methadone in narcotic addiction treatment), and abstinence from drug use in treatment (frequent in addiction treatment).

iv. Human resources capacity building

- Funding should be available to First Nations and Inuit education and training institutions to develop curriculum and courses consistent with a personnel certification process for mental health and addictions workers.

- Compile a list of accredited training institutes that provide appropriate programs, as part of the overall accreditation process.

- Undertake a scan of post secondary mental wellness training opportunities, including distance learning and ensure that all institutions/programs meet acceptable standards.

- Ensure that opportunities for continuing development are available to enhance competencies and currency of present mental wellness staff until the pool of qualified First Nations and Inuit workers is sufficient.

- Specialized training that incorporates mental health, addictions and cultural knowledge is required. The Saskatchewan Indian Institutes of Technologies, for example, develops programs to meet the needs of Saskatchewan NNADAP workers.

- Explore national partnerships with post-secondary institutions that have existing "mental health/addictions" programming to develop Aboriginal mental health/addictions professional training degree programs.

- Integrate supportive counselling services by providing joint training (linked to paraprofessional credentials) in areas such as basic counselling skills, case management, family counselling, basic knowledge of addiction and mental health issues. This could be linked to training in screening and records keeping as indicated under the Intake, Screening, and Referral component of the continuum. Training could be geared to addiction and mental health generalists or provide some scope for specialization in one area or the other, with a common knowledge base.

- Community-based initiatives must be accompanied by the development of community capacity to deliver programs effectively. A key strategy to accomplish this is training an increased number of Aboriginal health professionals. Barriers to seeking various mental health services could be overcome and providing more culturally relevant care could be accomplished.

v. Salaries

- A review of current prevention and treatment salaries should be undertaken and a new, national salary grid that is based on training, experience and remoteness indices should be established.

- Participants noted that increasing the rate of pay set by First Nations and Inuit Health for psychologists would facilitate contracting out of these services.

- Increased funding for NNADAP workers would improve opportunities for recruitment and retention; increases would also be necessary if higher training requirements are put in place.

- Support communities to provide competitive compensation for mental wellness workers/healers, including coverage of costs for tuition, travel, sustenance, books, etc.

vi. Accreditation/Certification

- A certification process for both prevention workers and counsellors should be established as part of the larger accreditation process. Addictions Counsellor Certification should include a core of general counselling skills, supplemented by specialization in substance abuse and addictions counsellor training.

- Create First Nations and Inuit based certification/re-certification processes for individuals providing mental wellness services to First Nations and Inuit.

- The question of liability as it relates to programs, centres and the system needs to be considered, taking into account issues related to professionals and paraprofessionals, licences, standards, accreditation, qualifications, roles, labour standards, safety, supervision and consultation.

- As mentioned earlier in this paper, the Association of BC First Nations Treatment Programs established an independent society to facilitate the Aboriginal addictions worker certification process, which became known as the First Nations Wellness/Addictions Counsellor Certification Board. The board has partnered with the Nicola Valley Institute of Technology and their Chemical Addictions Counselling Studies Program. This program offers the core skills required for First Nations Wellness Addictions Counsellor Certification and includes Aboriginal specific content.

vii. Support

- Problem-solving "Hotlines" and Internet links should be established to ensure that NNADAP workers have ready access, when necessary, to 24-hour, professional advice regarding addictions problems/solutions and mental health problems/solutions.

- Make available resources for "debrief" (peer consultation), mainstream, cultural and traditional (e.g., EAP supports and clinical supervision).

- Videoconferencing methods need to be utilized for clinical supervision, case consultation and for training of community mental health and addictions workers.

- Build and fund a support network for mental wellness workers/healers (tele-health, website, annual conferences, similar to Aboriginal Children's Circle of Early Learning).

- Empower community mental wellness workers/healers with information and data to inform their programming.

- The example of using Elders in a residential treatment program was suggested as a support opportunity.

viii. Treatment

- There is a clear need to document what works and what does not work in terms of mental health and addictions treatment for Aboriginal clients. Available evidence needs to be documented and empirical studies need to be funded to examine efficacy in treatment.

- Two options were outlined to address the treatment needs of rural and remote communities. One is the development of "centralized staff" and the second is to build on growing videoconferencing capabilities.

- Supports in the community would assist families in providing aftercare for loved ones. A helpline for communities was suggested as an idea to provide additional support.

- In order to move toward a more integrated continuum of services, facility-based treatment centres would need to broaden their mandate to include the treatment of mental health issues and increase their capacity accordingly. Some centres have already begun to move in this direction. For example, treatment centres could be supported to hire or contract clinical service providers to provide psychotherapy, assessment, supervision or case consultations. Trauma treatment programs could be further developed and more widely offered.

- Support for integrated treatment plans is needed, including intensive case management, training and protocols for a team approach, individualized funding, central and/or regional resource centres, and strong links with crisis intervention services, facility-based addictions services, tertiary mental health services, and justice

services. For this team approach to work, and also to be able to advocate for appropriate services for people with concurrent disorders, expertise in both addictions and mental health is required.

- Case management is central to the holistic continuum of wellness services. Capacity for case management can be built through accredited training and through clinician-led, hands-on case conferencing for people with complex needs.

ix. Supportive counselling

- Integration of supportive counselling services could be achieved through provision of joint-training, linked to paraprofessional credentials, in areas such as basic counselling skills, case management, family counselling, basic knowledge of addiction and mental health issues. This could be linked to training in screening and records keeping as indicated under the Intake, Screening, and Referral component of the continuum. Training could be geared to addiction and mental health generalists or provide some scope for specialization in one area or the other, with a common knowledge base. Integrated regional administration could also improve coordination of supportive counselling services by means of more integrated funding and accountability mechanisms. Currently, addiction and mental health services are administered by different parts of some FNIHB regional organizations.

x. Crisis intervention

- Addiction and mental health crisis intervention needs to be totally integrated as part of the integrated community service team response. All the paraprofessional service providers require intervention skills, clear protocols, debriefing and supervision. There needs to specific responsibilities and requirements for documentation and follow up. There is a clear need for a more consistent, proactive approach to crisis intervention that builds on community capacity and develops a national monitoring and intervention service that can be drawn upon as required. Clearly, crises in First Nations and Inuit communities require the combined efforts of addiction and mental health services, as well as other services such as justice, child protection, housing and other services.

- With regards to crisis intervention, all of the paraprofessional service providers require intervention skills, clear protocols, debriefing and supervision. There needs to specific responsibilities and requirements for documentation and follow up.

xi Culturally based approaches

- A holistic approach to healing is a hallmark of culturally based approaches, and a driving force behind this integrated framework. There is an important need to integrate culturally based approaches, culturally appropriate approaches, indigenous knowledge and traditional healing, as an accessible and critical part of the overall integrated community continuum of care services.

xii. Clinical services

- Clinical services that are able to address both addiction and mental health issues need to be brought into the continuum of care and the case management process. This will provide more continuity of care in the transition from facility-based treatment services back to the community, and also help to prevent the need for residential treatment in the first place. Clinical services can build the capacity of paraprofessionals in prevention and promotion, intake, screening and assessment, supportive counselling, aftercare and rehabilitation, by providing training, supervision, and case consultations, and by supporting case management processes.

xiii. Aftercare

- Joint training linked to paraprofessional credentials is needed to move toward better and more integrated supportive counselling and aftercare services. The same support for integrated treatment planning is needed to move toward better and more integrated rehabilitation services and intensive services for people with complex needs.

D. Opportunities

The key aim of this project was to create an understanding of what was needed to move forward in the integration of mental health services. Guidance provided by both the best practices literature and by the experts who were interviewed for this paper set out many different routes through which this could be accomplished.

First and foremost, there is a significant need for education and training around mental health for existing staff. Considering the relationship between mental health and addictions, there is a need to ensure an understanding of the impacts of mental health conditions on both addictions causes and recovery. Participants pointed out that most workers training is in addictions, not mental health and suggested the need for coordinated training approaches and partnerships. In some cases, this is done by participating in existing training opportunities with local health authorities. Joint training linked to paraprofessional credentials is needed to move toward better and more integrated supportive counselling and aftercare services. A program based on the InPsych (Indians into Psychology) program in the United States could be developed in Canada as a way to address the shortage of Aboriginal psychologists. The United States Indian Health Service funds five InPsych programs in five different U.S. universities in an effort to train/recruit/prepare Indians to serve as psychologists for the Indian Health Service. FNIHB in Canada has extreme difficulty in recruiting First Nations psychologists due to a virtual absence of First Nations psychologists in Canada. An InPsych type program at a Canadian university could address this need.

Other challenges/opportunities around training involve the support of trainees. Training that deals with issues such as suicide and sexual abuse may trigger trainees who have unresolved trauma. Professional mental health support will need to be available for some trainees during and after the training as well as education around triggers, shutting down, containment, and self care. Practical training concerns such as training delivery style, level of reading comprehension, writing skills, English as a second language will also have to be considered.

Closely related to training is how the human resources requirements for NNADAP can be met. Participants noted the need for a "Statement of Qualifications" to ensure that appropriate mental health services can be provided. Unfortunately, there appears to be variable hiring criteria between FNIHB initiatives and a comprehensive, systematic approach was requested. Participants also noted the need to develop unique training that would incorporates mental health, addictions and cultural knowledge. Clinical services that are able to address both addiction and mental health issues need to be brought into the continuum of care and the case management process. Competent and culturally appropriate clinical services can build the capacity of paraprofessionals in prevention and promotion, intake, screening and assessment, supportive counselling, aftercare and rehabilitation by providing training, supervision, and case consultations and by supporting case management processes.

From a mandate perspective, in order to move toward a more integrated continuum of services, facility-based treatment centres would need to broaden their mandate to include the treatment of mental health issues, and increase their capacity accordingly.

Cultural training is also critical for all staff and contracted professionals and the criteria for counselling, addictions training, assessment, etc. all need to be clear. In summary, a standardization of policies, procedures and programming is needed to ensure a systematic approach to any integration initiative.

In regards to addressing the needs of rural and remote communities, two options were outlined. One is the development of "centralized staff" and the second is to build on growing videoconferencing capabilities. One community is currently undertaking a pilot project to integrate these capabilities. The idea behind centralized staff is that two or more communities could pool their resources to hire mental health specialists, such as counsellors or psychologists, who have specialized training and experience in addictions and mental health.

Supports in the community need to be developed to assist families in providing aftercare for loved ones. A helpline for communities was suggested as an idea to provide additional support. The example of using Elders in a residential treatment program was suggested as a support opportunity. In one treatment centre, an Elder is available 24/7 to provide traditional healing and counselling. Supports also need to be provided to mental health and addictions workers.

Funding changes were also seen as a strategy for improving needed mental health services. For example, participants noted that increasing the rate of pay specified by Health Canada for psychologists would facilitate contracting out of these services. Increased funding for NNADAP workers is also critically needed in order to increase opportunities for recruitment and retention. Increased salaries and supports will also be necessary if higher training requirements are put in place. The cost of this integration is a critical issue and solutions may require partnerships between federal and provincial services.

No matter how the integration of mental health services and addiction services is approached, participants noted the need to ensure that addictions funding is not lost. As was stated by the Canadian Executive Council on Addictions:

> *Integration efforts need to be adequately resourced and supported since many of the changes that are required are in the realm of organizational and systems culture and, therefore, require sustained efforts and ongoing corrective feedback loops to ensure the goals are being met for people needing services and supports.*

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Appendix A: Introduction Letter

Dear _____:

We would like to invite your participation in a project to explore opportunities for improving the integration of mental health and addictions programming. This project was commissioned by Health Canada First Nations and Inuit Health Branch (FNIHB) and the National Native Alcohol and Drug Abuse Program (NNADAP) to identify gaps in programming and policies.

Over the past two decades, the relationship between substance use and mental health has emerged as an important issue for addiction prevention and treatment services. While estimates vary, it is generally accepted that about half of all people who present with a substance use problem have had a mental health problem at some point in their lives. Despite the complex interrelationships between these problems, mental health and addiction issues have historically been treated as separate conditions, often provided by separate systems of care.

This project is part of a recent movement to integrate and further coordinate services, enabling addiction treatment and prevention services to benefit from mental health approaches, services, and supports. The purpose is to identify specific strengths, limitations and opportunities for providing mental health services, supports, and/or partnerships within NNADAP. Data from this project will be collected from key informants and a review of existing published literature and program/policy reports.

The results of this research will provide recommendations directed at those who administer and deliver addiction prevention and treatment services in First Nations communities. The results and recommendations from this project will be presented to a national committee and a copy of the report will be made available to all participants.

If you have any further questions, please contact the Principal Investigator, Dr. Rod McCormick (Email: mccormic@interchange.ubc.ca; Tel: 604-822-6444).

Thank you very much for your participation in this project.

Appendix B: Interview Guide

Improving Mental Health Services and Supports within NNADAP

Preamble: The purpose of this project is to identify opportunities for providing mental health services and supports within NNADAP programming. As a NNADAP worker, I'd like to ask about your experiences and opinions on how these services could be incorporated into NNADAP, as well as potential partnerships for achieving this goal. The results and recommendations from this project will be presented to a national committee. A copy of the report will also be made available to you. We won't be recording the interview, but I'll be taking notes and would like to give you an opportunity to review a summary of our interview, which I expect will take about 20 minutes. Do you have any questions before we begin?

Questions

1. Please describe your current position? How long have you been in this position?

2. Can you please describe how well you feel mental health services and supports are currently a part of NNADAP programming? What do you feel is NNADAP's mandate/vision for providing mental health services?

3. In your centre, what do you feel are some of the best examples of programs that integrate mental health services/supports and addictions treatment? (These can be either within NNADAP or external. Can you provide any documentation or contacts for documents on this program)?

4. What are the current needs/gaps (or what opportunities do you see) for providing mental health services within NNADAP (e.g., service recommendations, partnerships, etc)?

5. What are the biggest challenges to incorporating mental health services into NNADAP programming? Could you comment on any (or all) of these challenges in three different areas:

   Systemic Issues (e.g., jurisdictional issues, lack of mandate, etc).

   a. Program Areas (e.g., funding, human resources, serving rural/remote communities, etc).

   b. Community Related (e.g., awareness, human resources).

6. Are there any additional comments you would like to make?