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

A. Context and purpose

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 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.

Current research tells us that mental health issues are one of the key factors to address in substance abuse treatment. Concurrent disorders or co-occurring disorders are the terms used to refer to individuals who suffer from a mental illness and a substance use disorder at the same point in time[1]. Studies have found that between 75 percent and 100 percent of those seeking treatment for substance abuse have a concurrent mental health issue[2].

In response to the growing trend within addictions delivery systems to better integrate and provide mental health services, NNADAP developed a platform to integrate and further coordinate services. This initiative will enable addiction treatment and prevention services to benefit from mental health approaches, services and supports.

The overall purpose of this research paper was to explore opportunities for improving the integration of mental health and addictions programming within NNADAP.

B. Sources of data and methodology

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 for integrating mental health services into addictions programming.

The interview process involved a series of semi-structured telephone interviews conducted between January and April of 2009. Initial analysis of the data was undertaken concurrently with data collection and emerging themes were identified. The formal analysis involved 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.

[1] Centre for Addiction and Mental Health, 2008. Centre for Addiction and Mental Health. (2008). Information about Concurrent Disorders. Retrieved from http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html

[2] CCSA, 2006? Nothing in reference list for CCSA, provide complete reference here.

For the literature review the researchers identified a selection of documents using web-based resources 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.

C. Findings

The literature review found that there were several arguments for the integration of addiction and mental health services — it is already taking place in most provinces and in some FNIHB regions; a significant population has co-occurring disorders and would benefit from an integrated system; 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 in the literature that would need to be addressed should FNIHB move to integrate and/or improve mental health services/supports in NNADAP. Two documents[3] best describe the gaps and challenges to integration. Some of the major points include:

- There was a general consensus among [Senate Committee] 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 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.

- Addiction and mental health services are too frequently separate enterprises pursued by different systems, different people, different cultures, different ideas and different models.

- 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).

[3] Standing Senate Committee on Social Affairs, Science and Technology (2004). *Report 3: Mental Health, Mental Illness and Addiction: Issues and Options for Canada*. Retrieved from http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report3/repintnov04vol3-e.pdf
Health Canada, Integration of Mental Health and Addictions Working Group and the First Nations and Inuit Health Branch. (2003). *Integration of First Nations and Inuit Addiction and Mental Health Services:A Discussion Paper* Toronto: Healthy Horizons Consulting.

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

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

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 affecting the NNADAP mandate, programming, and human resources as well as the broader mental health system and community attitudes and knowledge.

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

The interviews also identified a number of best practices currently being utilized.

One promising approach to providing mental health services was to contract with mental health professionals, such as psychologists and counsellors, to provide the service. In the B.C. region and in Saskatchewan, treatment centres have funding for contracting mental health service providers. Some participants did note that mental health is being addressed through the use of traditional healing approaches. For example, most treatment centres include ceremonies and cultural events as a key component of their work.

NNADAP treatment centres have a variety of models that are working for them. One centre has five crisis teams and its staff meets every week with representatives from the local school, police and Brighter Futures program. Another centre hired wellness workers who are being mentored by a mental health worker and a counsellor. Still another centre provides treatment through two part-time clinical psychologists and is providing staff with mental health training through videoconferencing and Internet facilities. And at one centre, a resident Elder is available 24/7 to provide traditional healing and counselling.

This centre also offers a six-week trauma healing program to clients who complete the six-week addictions program.

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 or band and/or tribal organizations.

Some potential partnership opportunities include collaborations with local detox centres to facilitate admissions into these treatment centres; discussions with the Canadian Counselling Association regarding the certification of Aboriginal mental health counsellors; affiliation with the First Nations Wellness Addictions Counsellor Certification Board and coordination with professional counselling and psychological associations to assist Aboriginal community mental health workers with clinical consultation and supervision.

Outside of NNADAP, there have been many new Aboriginal specific mental health programs and tools developed over the past 10 years. For example in British Columbia one 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. In addition, a several of the provinces/territories have developed integration frameworks.

Examples of best practices, models and strategies from the six papers examined provide direction in many areas related to the integration of mental health and addiction services and these are described under general strategies. The remaining examples synthesize the best practices literature reviewed for this paper and 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.

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 interviewed for this paper sets 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 etiology and recovery. Participants noted that most workers are trained in addictions, not mental health, and suggested the need for coordinated training approaches and partnerships. Joint training linked to paraprofessional credentials is needed to move toward better and more integrated supportive counselling and aftercare services.

It is extremely difficult to recruit First Nations psychologists due to a virtual absence of First Nations psychologists in Canada. A program based on the InPsych (Indians into Psychology) program in the United States could be developed in Canada as a way of addressing the shortage of Aboriginal psychologists.

Specialized training for workers will be required; training that 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. Other challenges and opportunities around training involve supporting the trainees.

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 to 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.

With 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. 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 and, 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.

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.