Record of Discussions of the *Honouring Our Strengths:* National Renewal Forum

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Contents

Introduction

Over the past several years, the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) have been involved in a comprehensive renewal process, engaging all regions and a variety of partner organizations. A series of regional needs assessments was followed by a national forum in 2010, at which participants shared perspectives and laid the groundwork for a revised approach to services and support related to substance use for First Nations in Canada. The effort culminated in the development of a comprehensive national framework entitled *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, released in November 2011, at the Assembly of First Nations (AFN) National Health Forum.

The Framework places First Nations culture at the centre of all activities. From there, it divides the continuum of care into six elements, running from prevention and community development, through brief interventions, up to specialized forms of treatment. For each of these elements, it describes the ideal services and supports, the current situation, and the opportunities for renewal. The Framework also identifies six supporting components (such as governance/coordination of system and accreditation for treatment centres) that underpin the continuum of care. Finally, it identifies the principles that should guide intervention, such as shared responsibility and cultural safety (Figure 1).

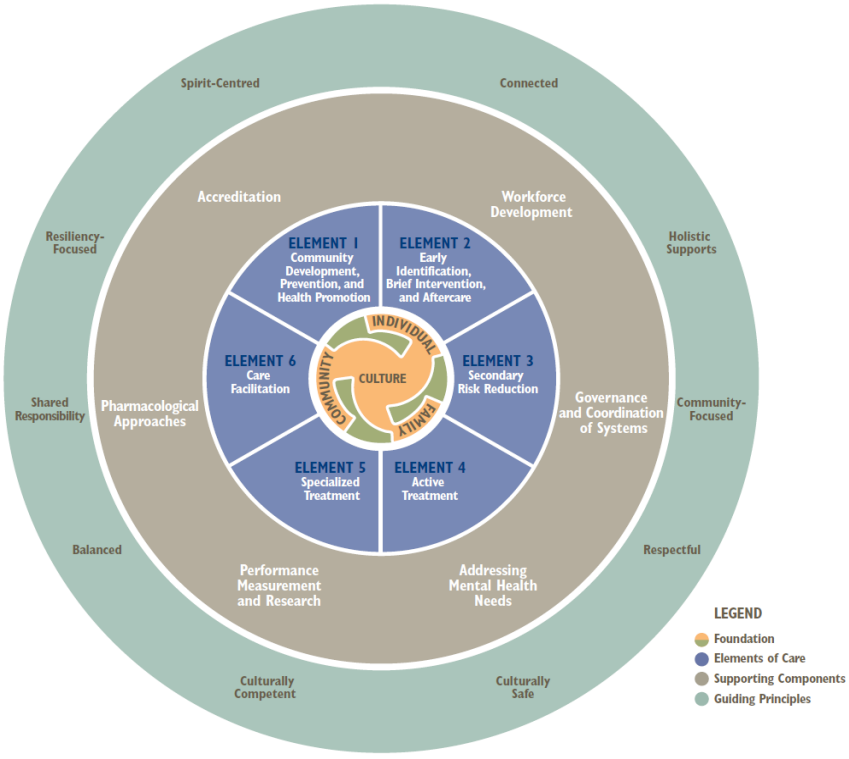


Figure 1: Systems Model from *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*

The *Honouring Our Strengths* Framework has led to a range of implementation activities at community, regional, and national levels. Many of these implementation activities are supported nationally by the NNADAP/NYSAP Renewal Leadership Team and the national partners in the renewal process—the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF), and Health Canada (HC).

The 2012 *Honouring Our Strengths*: National Renewal Forum was intended to sustain this renewal process by allowing participants to highlight successes, identify areas where they could collaborate, and determine how services and supports for First Nations could be further strengthened. It featured a variety of activities, including presentations, speaker panels, and small-group discussions on each of the elements of the Framework.

The purpose of the present report is to provide a detailed record of the forum's discussions and decisions, which will help to guide future renewal efforts and be circulated to partners and stakeholders for information. The report is based on notes taken during the forum, on transcriptions of the flipcharts from the small-group discussions, and on a summary report prepared by the forum's facilitators.[*]

[*] See Catalyst Research and Communications, *Honouring Our Strengths: National Renewal Forum, January 24, 25 & 26, Ottawa, ON*. (Draft of February 14).

Welcome/opening remarks from National Renewal partners

The forum opened with a welcome from the three partner organizations spearheading NNADAP renewal at the national level: the AFN, the NNAPF, and Health Canada's First Nations and Inuit Health Branch (FNIHB).

Sonia Isaac-Mann, Assistant Director of Health and Social Development, Assembly of First Nations (AFN)

Sonia noted that addictions are a widely recognized problem among First Nations, and that the AFN is working with leaders to change policies in this area; a recent example is a resolution on prescription drug abuse (originating out of Akwesasne) that was passed at the Special Chiefs Assembly in December 2011. The AFN continues to advocates for a comprehensive mental wellness continuum that covers addictions, gambling, mental health, and other issues as they relate to the social determinants of health. Sustainable, non-siloed funding for such programs is the biggest issue, so that a continuum of care can be offered.

The NNADAP renewal process is recognized as a very collaborative one, and the AFN sees it as a model to follow in partnerships, either those involving government, or partnerships between different First Nations communities and organizations. The AFN, through its National First Nations Health Technicians Network (NFNHTN), will be involved in trying to further renewal and continue with next steps. The AFN is looking to this forum to propose concrete actions that will have an impact on First Nations health and wellness.

Chief Austin Bear, President, NNAPF

Chief Bear echoed Sonia's recognition that addictions are one of the largest issues facing First Nations communities. In some communities, he said, people are now rating alcohol and drug abuse as a larger problem than housing and employment; this is significant. The renewal process is an opportunity to strengthen NNADAP, solvent abuse services, and mental health programs. Chief Bear suggested that we are now at the end of the "long winter" Elder Dumont spoke of in his opening remarks; we are the generation that can bring hope and improve the situation for our children. We need to work towards wellness by building on our many strengths. He therefore thanked participants for bringing their expertise to this forum, which will provide an opportunity to support the workers and to "celebrate the strength of our partnership." He praised the Framework that has been developed for being versatile, and for placing culture at the centre of practice.

Chief Bear then described some of the work in which NNAPF is currently engaged. NNAPF is composed of representatives from all regions, and from NYSAP. It has long supported some of the recommendations from the 1998 NNADAP review, such as those calling for regional partnership boards, accreditation of treatment centres, and equitable salaries for workers. At present, it is working on culturally appropriate screening and assessment tools for mental health and addictions.

In closing, Chief Bear spoke of the need for partnerships, emphasizing that substance abuse is a problem in all communities—both First Nation and non-Aboriginal—so everyone should work together and share the responsibility. He concluded by presenting artwork to AFN (represented by Sonia Isaac Mann) and FNIHB (Kathy Langlois), in recognition of an effective partnership.

Kathy Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch (FNIHB), Health Canada

Kathy similarly acknowledged the strength of the partnership between AFN, NNAPF, and FNIHB, and spoke of NNADAP's many strengths and successes. She said that NNADAP and NYSAP have become models for community-driven programming than includes culture as a central component of care. She also acknowledged that the 85% success rate achieved by some NYSAP centres is "unheard of" in other sectors, and is drawing international attention. She cited other successes such as the Mental Wellness Teams, which are "pathfinders" for multidisciplinary approaches to care involving both First Nation and mainstream care providers; the efforts to re-profile the existing treatment centres in line with community and regional needs; and improvements in workforce development, including training. These initiatives were made possible by funding provided under the 2007 National Anti-Drug Strategy (NADS), which resulted in an investment of $30.5M over five years, with 9.1M ongoing, to improve the quality, effectiveness, and accessibility of addiction services for First Nations and Inuit.

Kathy then spoke of how nice it is to see people actually implementing the Framework that was developed just last year. Today's forum is one part of a larger implementation process. Kathy sees the Framework as a comprehensive and useful document, citing the example of its section on prescription drug abuse, which sets out information on prevention and treatment so that this problem can be properly addressed. Further, Kathy indicated that the Framework's benefits extend beyond the NNADAP program. She said that provinces and Regional Health Authorities are now looking at the NNADAP Framework as a model, and this will bring First Nation traditional values and holistic approaches into the larger Canadian health system. Finally, other groups are seeking to replicate the process that resulted in this successful Framework. For instance, the Mental Wellness Advisory Committee now plans to follow the same structure, i.e. regional needs assessments, a national forum, and an advisory committee tasked with developing a national mental wellness framework.

The role of cultural practices in the Honouring Our Strengths Framework

Presented by Carol Hopkins, Executive Director, NNAPF

What does it mean to lead or govern from an Indigenous perspective? Carol suggested that, first, it means acknowledging that we, as First Nations have inherent gifts. It means talking about the impact of culture, and building an evidence base for the use of cultural approaches. It means consulting our own consciences, and asking ourselves what values drive our programs and actions. Finally, it means looking

at evidence: what is says, where it comes from, and how it can be used. We need to be wary of blindly applying western evidence. Instead, we should be asking: whose evidence is this, and how is it relevant to our people? When we do these four things, Carol stressed, we are governing in a decolonized fashion. To decolonize, we also need to understand the stages of colonization, which included not just the residential schools era, but also, separation from land, from traditional ways, and from traditional medicines. We need to teach our children about this and recreate a role for culture; it is not sufficient to rely on "motherhood" statements about culture, or to employ specific practices like smudging. Instead, we need to engage in culture, as in the example of "John." John was a youth who had to take part in a spiritual assessment with an Elder when he started at a treatment centre. With the help of the centre and the Elder, he learned to recognize, control, and eventually replace aggressive behaviours by using peanuts and blueberries as medicines. Carol emphasized that in the attempt to apply a more inclusive understanding within psychiatry, conventional models of service and health promotion must be fundamentally rethought so that they are consistent with Indigenous realities, values, and aspirations.

Carol suggested that there are two dimensions to an approach based on cultural evidence. First, such an approach takes as a given, that there is a spiritual reality that influences physical reality. Second, it is based on the premise that there is always a teaching that will help us to understand spiritual reality, because the Creator made the universe with everything that humans would need. She offered the example of a young woman who learned to change her thinking patterns and abstain from substance use through a combination of strategies, including prayer and techniques that could be described as cognitive-behavioural. Cultural practices that can help people to improve their health include prayer; Indigenous teachings; ceremonies; use of fire, water or Indigenous foods and medicines; and social activities such as singing, dancing and crafts. A core set of values have survived acculturation: in this sense the process of change can be seen as reconnecting to identity, rather than as fixing a deficit.

Finally, Carol spoke of how culture is intrinsically tied to community. An advantage of the *Honouring Our Strengths* Framework, is that it moves the focus up from the individual to the family and community and uses a definition of health that includes family and community. This too is part of a culture-based approach. Concretely, this means inviting communities into the treatment process; providing community based prevention, intervention and maintenance programs; and training addictions staff in cultural competency (i.e. how to recognize their own world views and how those interact with other world views).

Findings from the 2008-2010 Regional Health Survey on addictions, substance use, and wellness

Presented by Jane Gray and Jennifer Thake, First Nations Information Governance Centre (FNIGC)

Jane began with some background on the Regional Health Survey (RHS) and the First Nations Information Governance Centre. The Centre is mandated by the AFN's Chiefs Committee on Health and now leads a set of formally constituted centres, consisting of a national office and a set of regionally-

created centres. The objectives are to build capacity, provide information and promote the principles of First Nations ownership, control, access, and possession (OCAP) of data.

The RHS has been in existence for some years now, beginning with a pilot project in 1997, a Phase 1 survey in 2002-03 and a Phase 2 in 2008-2010. Further phases are planned for 2012 and 2016. The survey covers all First Nations areas across Canada, except for the James Bay Cree and the Labrador Innu areas. Phase 2 included 21,757 First Nations children, youth and adults, living in 216 communities. This survey of individuals was complemented by a survey of community characteristics, completed by the relevant community workers.

The main findings with respect to substance use[*] were as follows:

- Overall, 80% of respondents said that alcohol/drug abuse was a problem in their community, making it the top-ranked problem

Among youth

- Smoking rates are high as compared to non-Aboriginal youth, and have not dropped over time. A higher proportion of young females smoke compared to young males; however, males appear to smoke more *heavily* (more cigarettes per day). Smoking rates are lower among youth who live with their biological parents; whose parents have a high school education; who live in homes that contain fewer people; and who live in smoke-free homes.
- Rates of abstinence from alcohol are higher among First Nations youth than in their non-Aboriginal peers; however, the First Nations youth who *do* drink are more likely to engage in "binge" drinking (defined as consumption of five or more drinks on one occasion). First Nations youth are more likely to be abstinent if they are living with both parents and if their parents have completed high school. However, once youth have actually begun drinking, these factors are no longer associated with binge drinking.
- Rates of daily or almost-daily cannabis use are similar to those observed in the general Canadian population, at around 10%.
- Fewer than 5% of youth report past-year use of other drugs (i.e., cocaine, amphetamines, inhalants, sedatives, hallucinogens or opioids).
- Just 1% of youth admit to having used solvents or inhalants in the previous year.

These findings suggest that interventions might focus on decreasing smoking prevalence, especially among females, as well as encouraging smoke-free homes and healthy lifestyles. Youth who choose to drink may also benefit from tools to help decrease consumption (avoid binge drinking).
Youth whose parents did not complete high school or are no longer living together may require greater support with respect to substance use prevention.

In adults

[*] Jane and Jennifer also presented some of the findings on demographics, language, employment, food security, and related issues; these have been omitted from this summary, but can be found in the original presentation.

The findings among adults are similar to those for youth. Smoking prevalence remains high among adults. In addition, although First Nations adults are more likely than other Canadians to abstain from alcohol, the prevalence of binge drinking is significantly higher among First Nations people who do drink.

An appreciable 15% of adults also report using other drugs (hard drugs like cocaine or prescription drugs such as sedatives, opioids, hallucinogens, or amphetamines). Illicit drug use (including cannabis) was more prevalent among men, while misuse of prescriptions sedatives/sleeping pills was more frequent among women. Approximately one fifth (17%) of First Nations adults reported having been in alcohol treatment at some time. The community-level survey revealed that, 39% of First Nations communities have alcohol/drug treatment programs and 16% have residential treatment facilities.

The results suggest that interventions to reduce the use of cannabis and harder drugs should focus on males, while those aimed at misuse of prescription sedatives or sleeping pills should focus on females. Smoking rates remain very high, especially among those with lower incomes. People should be encouraged not to smoke in the home and smoking-cessation programs should emphasize the health benefits of quitting. The findings also suggest that interventions are needed to encourage stopping or less risky patterns of cannabis and alcohol use.

Regional presentations on plans and key achievements to date

NNADAP renewal in Atlantic Region

Presented by Cindy Ginnish

Main achievements in Atlantic

The Atlantic Region's main achievements include modernizing treatment programs to address the needs of specific groups; introducing initiatives related to prescription drug abuse and mental health and workforce development.

Modernizing treatment programs

- Nova Scotia's two treatment centres are now alternating to provide cycles specifically for women and for residential school survivors.
- Tobique First Nation (New Brunswick) is providing a youth camp with a focus on cultural development.
- The Rising Sun Treatment Centre has developed a day program specifically directed at prescription drug abuse, which is a huge concern in the Atlantic Region.

Addressing prescription drug misuse

Besides the Rising Sun day program, the Atlantic Region has organized several other activities directed at prescription drug misuse (funded through the Drug Utilization Prevention Program). Tobique First Nation has hosted two projects and Elsipogtog First Nation has hosted one. Also, the Native Alcohol and Drug Abuse Counselling Association (NADACA) is piloting a seven-week program to be offered in every community in Nova Scotia.

Addressing mental health needs

The Atlantic Region has introduced three mental wellness projects, provided respectively by the Maliseet Nations, Tui'kn, and Nunatsiavut Mental Wellness Teams; each with a different theme. The Maliseet model focuses on cultural learning, while the Tui'kn takes a case-management approach and the Nunatsiavut team chose to do away with its existing inpatient program and move to a community-based day program in which workers visit the various communities.

Workforce development

The Atlantic Region now has 52 workers certified out of a possible 84. The region also hosted its third Warrior Spirit Conference, which provided 20 hours of certified training in addictions.

Challenges to renewal in the Atlantic Region

Challenges relate to the Atlantic Region's size and diversity and to specific needs that are not being met. Because the Atlantic region covers a large and heterogeneous area, the differing needs of northern and

southern groups are an ongoing issue, as is the speed of communications. A further concern is a predicted large increase in the Micmac population of Newfoundland, which will need support.

As for unmet needs, the Atlantic Region has some concerns about practices that are being created within very short timeframes and perhaps insufficiently tested. Currently, no treatment centre in the region offers a program for entire families, so this continues to be a gap. Aboriginal people are hugely over-represented among methadone users, as evidenced by the fact that 400 of New Brunswick's 1200 methadone patients are Aboriginal. Yet there is a lack of awareness about methadone and about harm reduction programs in general. A conference to take place in March 2012, is expected to help remedy this issue. Finally, there is still a problem with prevention initiatives for young people; as the current programs are somehow missing youth.

NNADAP renewal in Quebec Region

Presented by Marie-Eve Cournoyer, FNIH Québec Region, and Claudie Paul, *Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador* (CSSSPNQL)

Main achievements in Quebec

In Quebec, the emphasis has been on developing a full continuum of services. Accordingly, the speakers organized their presentation according to the six elements of the Honouring Our Strengths Framework, from prevention through to active treatment and coordination of care.

Achievements related to Element 1 of the Framework: Community development, health promotion, and prevention

Quebec has undertaken prevention activities ranging from public-education campaigns to action on some of the underlying causes of addictions. Activities in this area include:

- Developing a health promotion/prevention program that can be inserted into the school curriculum. (This initiative grew out of a summit last year that brought Chiefs, police, economic development staff and other workers together to discuss addictions.)
- Carrying out an annual prevention campaign on alcohol, drugs and gambling. This campaign is a joint effort with Quebec's Ministry of Health and Social Services but is tailored to the realities of First Nations communities.
- Supporting good First Nations parenting. The region has worked with the *Université du Québec à Chicoutimi* to develop a training program on parenting. This training will be offered to the educators working in community child care services.
- Implementing front-line prevention services to reduce the number of children placed in care.

Achievements related to Element 2 of the Framework: Early identification, brief intervention, and follow-up

- Development of training for workers on how to complete forms, follow up and evaluate client results. The objective is to have all NNADAP workers in the communities use the same set of

practices. To this end, the region has developed standardized forms and guidelines on things like the duration of follow-up and the average number of clients to be seen per day.

- Development of a continuum of services model that will integrate NNADAP with other related services and help communities to:
    - establish a single point of entry for clients;
    - clarify the roles of the various sectors; and,
    - promote better coordination between intervenors, so that clients receive the right service at the right time.

Achievements related to Element 3 of the Framework: Secondary risk reduction

- Development of a train-the-trainers program on how to conduct a motivational interview.
- Awareness-raising for workers about harm-reduction vs. total abstinence approaches, delivered in the context of the training on forms, follow-up and evaluation mentioned above.

Achievements related to Elements 4 and 5 of the Framework: Active and specialized treatment

- Continued lobbying for the establishment of a First Nations-specific detoxification centre.
- Development of Memoranda of Understanding (MOU) between individual communities and the province, to allow access to the specialized addictions and mental health services available in the provincial system. The Atikamekw communities have already signed MOUs of this type with respect to mental health services. The goal now, is to do the same for addictions and to do it for all communities.
- Giving First Nations workers access to provincial training programs relating to mental health, addictions and concurrent disorders.

Achievements relating to Element 6 of the Framework: Care facilitation

- Beginning to standardize the admission forms for the various NNADAP treatment centres, with the goal of replacing the five forms currently in use for the adult centres with a single one.
- Formation of a working table to bring together the CSSSPNQL, the Quebec Ministry of Health and FNIH-Quebec. The goal is to develop a service agreement that will enhance First Nations access to the specialized addiction and mental health services run by the province. (E.g., one possibility would be to assign a specified number of psychiatrists to work with First Nations clients.)

Initiatives to support the continuum of care

- *Governance and coordinatio*n: the CSSSPNQL has several roundtables that focus on maintaining relationships between the community, regional and national levels and has obtained the support of the Chiefs.
- *Workforce development*: Band Councils are being made aware of the need to provide job descriptions, training and fair salaries for the prevention/intervention workers.
- *Mental health*: Two treatment centres now have the capacity to support other centres and communities by videoconference as they address mental health needs. All communities now have videoconference links.

- *Performance measurement*: The software used in Quebec's Local Community Service Centres has been adapted and is being introduced into communities. Among other things, this will help create a single point of entry into the system. The data will belong to the communities and is maintained on a server located at the CSSSPNQL.
- *Prescription drug abuse*: Quebec's PharmaCare system has an alert function that warns all pharmacies when specific drugs have been prescribed and thus makes it impossible for a patient to fill more than one prescription for these drugs. NNADAP is lobbying for more medications to be added to the alert list. This is a precautionary measure, as prescription drug abuse is not presently a major problem or immediate issue in Quebec's First Nations.
- *Accreditation of treatment centres*. Three of Quebec's five adult treatment centres are currently accredited, as is the Walgwan Youth Rehabilitation Centre.

NNADAP renewal in Ontario Region

Presented by Lynda Roberts, FNIH Ontario Region, and Wanda Smith, Ontario Region Addictions Partnership Committee

Lynda and Wanda began with a review of the political situation in Ontario, which covers 133 communities represented by 18 Tribal Councils and five political treaty organizations. Ontario's renewal process was based on information from many sources, including the regional needs assessment, feedback from NNADAP workers about their skill levels and training needs and input from the Network of Treatment Centre Directors, the Chiefs of Ontario Health Coordination Unit, as well as many others. Out of all this information, Ontario outlined three key themes:

1. Workforce development and retention (all the issues around training, certification, wages and retention of workers);
2. Prescription drug abuse (Planning for community-based models to address this issue, with a conference scheduled for this year); and,
3. Land-based, culturally appropriate programs.

Main achievements in Ontario

Achievements during the recent period include:

Modernization of treatment centres

Eight of Ontario's ten treatment centres are now accredited and several centres have revised their models. More specifically,

- Dilico Anishnabek Family Care Adult Residential Treatment Centre has moved to a strength-based approach.
- Ngwaagan Gamig Recovery Centre has adopted a new model that includes a mix of cognitive-behavioural therapy and culture-based approaches and plans a formal evaluation of this model.
- The Native Horizons Treatment Centre and Sagashtawao Healing Lodge have both revamped their programs to include treatment for families.

Mobilizing communities to provide community-based treatment

Prescription drug abuse is a major concern in Ontario and communities are now using the Framework to identify models that focus on families and communities rather than on individuals. Twelve communities presently have initiatives on prescription drug abuse; some of these initiatives are stand-alone, while others involve Tribal Councils and similar organizations.

Improving collaboration

The Framework is now informing plans, and there are more joint planning processes, region-level partnerships and collaborative processes than ever before. Ontario has undertaken some joint training programs with the Centre for Addictions and Mental Health (CAMH) and some with welfare workers. In short, the presenters said there is more and more cross-pollination.

Challenges to NNADAP renewal in Ontario

- Prescription drug abuse continues to place pressure on social, health and community resources. The Trilateral First Nations Health Senior Officials Committee, a forum that looks at issues of common concern between the Chiefs of Ontario, FNIHB and the provincial government, is now working on a joint plan to tackle mental health and addictions.
- The policies set by FNIHB to govern travel to and from treatment continue to cause difficulties.
- Supports for community workers, especially case management systems, still need to be improved.
- Lack of resources (both capacity and financial) still impedes quality programs.
- The underlying determinants of health in the communities (poor schools, housing, etc) are unchanged and continue to create a situation where people are vulnerable to addictions.

Plans for the coming years involve

- Developing further partnerships and reinforcing existing ones with particular emphasis on closer integration of addiction and mental health services.
- An ongoing focus on training and certifying workers, both in the communities and in the treatment centres. It must be noted that many of these workers leave for other jobs as soon as they are trained; but at least the NNADAP program is developing people's capacities.
- Developing sustainable programs to address prescription drug abuse, including community detox and introduction of pharmacological supports.
- Continued emphasis on accreditation of treatment centres.
- Strengthening the links between treatment centre staff and those in the communities, with the goal of improving pre- and post-treatment coordination. Some progress has been made on aftercare but prevention is still receiving less attention than it deserves.

NNADAP renewal in Manitoba Region

Presented by Peter Constant, Cree National Tribal Health Centre Inc. and Bertha Fontaine, National Addictions Council of Manitoba

In the Manitoba Region, NNADAP renewal is guided by the Manitoba First Nations Addictions Committee, made up of representatives from all Tribal Councils (plus one FNIHB employee, ex-officio).

Main achievements in Manitoba

- Introduction of partnerships in which FNIHB's Non-Insured Health Benefits (NIHB) unit works with communities that appear to have problems of prescription drug abuse. There has been an outbreak of prescription drug abuse in Manitoba and communities are now partnering with regional health authorities, pharmacists and doctors to address it. NIHB's biostatistician creates profiles for individual communities that allow them to target the specific types of drugs being abused.
- Continued emphasis on accreditation, with four of Manitoba's five treatment centres now accredited.
- Increasing the capacity of Sagkeeng's Mino Pimatiziwin Family Treatment Centre from 10 to 15 beds.
- Increased clinical support for treatment centres. A therapist toured Manitoba's centres to assess needs and each centre focused on a specific issue (e.g., prescription drug abuse, Fetal Alcohol Syndrome, etc.). Specialists were then called in to build a team that could provide support with these issues. One centre has signed a formal MOU with a provincial clinic to provide psychological services and training; others may follow suit in future.
- Continued emphasis on training of prevention and treatment workers. Seventy-three percent of NNADAP workers in Manitoba are now certified, with the only drawback being that other organizations immediately poach the trained workers. Telehealth equipment has now been installed in four of the treatment centres, an initiative that is expected to cut the training budget by two thirds by reducing travel costs.
- Telehealth is also being introduced in communities, where it can be used for inter-community Alcoholics Anonymous meetings; for pre-treatment interviews between the client, the community worker and the treatment centre worker; for family visits during residential treatment; for aftercare; and possibly for case management. At present, 12 remote communities have access to telehealth equipment.
- Completion of an Opal Fuel[*] demonstration project in Shamattawa during the June-August period. Nursing Station records and the Royal Canadian Mounted Police (RCMP) reports suggest that the community had fewer problems with sniffing during the trial period but a longer test would be useful.
- Collaboration with the Addictions Foundation of Manitoba and Manitoba Public Insurance to facilitate the process of re-acquiring a driver's license for clients living on-reserve.

[*] Opal fuel is a form of gasoline from which the compounds that make people "high" have been removed. It has been used to reduce gas sniffing in some of Australia's Aboriginal communities.

Challenges to NNADAP renewal in Manitoba

Manitoba Region identified three main challenges to its renewal efforts. The largest challenge is the travel costs inherent in providing clinical support to treatment centres; however, telehealth is expected to address this problem. Certification poses some challenges relating to whether community leadership actually raises workers' pay once they have achieved certification. Finally, the efforts to help clients regain their driver's license will require the provincial crown corporation to create exceptions to its standard processes—a difficult undertaking.

NNADAP renewal in Saskatchewan Region

Presented by Jeremy Shaw, FNIH Saskatchewan Region, on behalf of Ernest Sauvé, White Buffalo Treatment Centre, and Freda Ahenakew, Cree Nations Opioid Replacement Therapy Program

Saskatchewan has 74 communities and ten Tribal Councils, but no regional-level advisory board for NNADAP. Consequently, decisions about priorities are based on the regional needs assessment, on the discussions of various groups and gatherings and on the recommendations from a symposium organized by the Saskatchewan Indian Institute of Technology (the region's main training institute). These sources led the region to conclude that the priorities fall into four main areas:

1. Children and families (offering family treatment and training workers in short interventions and in how to work with families and youth);
2. Re-landscaping of services (developing a degree program to supplement the current diploma one; increasing collaboration between communities, FNIHB and provincial services; and revising policies to recognize and fund cultural supports);
3. Managing information (collecting data on mental health and addictions and providing training on ethics and confidentiality); and,
4. Strengthening community (introduction of cultural approaches such as land-based camps and reallocation of funding away from crisis intervention towards other components of the continuum of care).

Main achievements in Saskatchewan

Training initiatives and worker certification

Saskatchewan has a highly trained workforce and the region has been trying to reinforce this strength by working with the Northern Inter-tribal Health Authority (NITHA), to create a degree program for mental health and addiction workers. In turn, NITHA is collaborating with five educational institutions on this initiative. The Saskatchewan Region has also been providing training on ethics and confidentiality. Certification levels are high but NNADAP constantly loses trained workers to other programs.

Clinical support to treatment centres and tribal councils

The region has been allocating funds to treatment centres to allow them to contract clinicians (mental health therapists, psychologists, psychiatrists, etc.) to have on staff, to supplement the treatment

process and to provide support and supervision to workers. Some but not all tribal councils receive funds to hire Mental Health Therapists who can support staff and assist with crisis intervention.

Modernizing and diversifying treatment
Of the region's ten treatment centres, seven have been modernized and all now have access to telehealth. Specific treatment services in Saskatchewan now include family treatment, gender-specific-treatment, opioid replacement therapy in a treatment setting, enhanced and expanded outreach services across the region and six fully accredited centres.

Collaboration and program integration
There has been progress on Indigenous governance and some communities are now starting to develop First Nations-specific management structures. More broadly, the region has devoted funds and attention to improving the collaboration between communities, FNIHB and provincial services, especially Regional Health Authorities. Communication, accountability and trust between stakeholders have all increased, although there is still room for progress.

Challenges to NNADAP renewal in Saskatchewan

The biggest challenges to renewal in the region relate to:

1. Jurisdictional issues;
2. Integration of programs;
3. Recognizing and supporting cultural resources;
4. Fear of change; and,
5. Program sustainability

NNADAP renewal in Alberta Region

Presented by Tanya Churchill and Coreen Everington, FNIH Alberta Region

The Alberta Region has a formal co-management structure, with a subcommittee specifically dedicated to mental health and addictions. Based on the 2009 regional needs assessment, this subcommittee has been focusing on mental health and on community support to reduce substance abuse.

Main achievements in Alberta

- The Kapown Treatment Centre has re-profiled to provide treatment for concurrent disorders and has added mental health supports to its programs.
- All treatment centres and communities have been trained in how to deal with trauma and abuse. The region is using a two-day program based on Harvard University's "Seeking Safety" course.
- Telehealth equipment is being installed in all treatment centres.
- The region is initiating a collaboration between communities, the University of Calgary and the Alberta College of Physicians and Surgeons to address prescription drug abuse. The first step is

for the university to develop a curriculum for community members, physicians and pharmacists. This is presently being pilot-tested in five communities.

- The region hired a psychologist to develop a Mental Health and Wellness Strategy (in consultation with the various partners). The resulting report contained 64 recommendations spanning a variety of areas and has now been endorsed by Alberta's co-management committee. The relevant subcommittees are now beginning to implement those recommendations.

Challenges to NNADAP renewal in Alberta

Some areas remain problematic despite progress. Specifically,

- Detox is still an issue, although the region has been using money from the Health Services Integration Fund to try to build links with provincial services.
- Staffing is an ongoing problem. The Northern Lakes College trains workers for certification but they get "snapped up" as soon as they are trained.
- Capital budgets for the treatment centres are still insufficient.
- Information Management is still imperfect, although the region has been upgrading its forms.
- Moving from residential to community-based treatment is difficult. New "cluster funding" agreements give communities more flexibility to combine mental health and addiction activities and it is hoped that this will facilitate progress.

Over the coming year, the focus will be on continuing to implement the 64 recommendations of the Mental Health and Wellness Strategy; introducing the prescription drug abuse curriculum; helping communities and centres to act on the "Seeking Safety" program; maintaining the number of certified workers; and pilot-testing a life-skills training program in three communities.

NNADAP renewal in the British Columbia Region

Presented by Catherine Seymour, Sts'ailes (Downtown Eastside Pilot Project); Delena Tikk, NNAPF BC Region; Don Leeson, Nisga'a Valley Health Authority; Isaac Hernandez, North Wind Healing Centre; and Nicole Gibbons, FNIHB BC Region

The B.C. Region has 203 First Nations communities and 13 treatment centres, of which ten are accredited. Two centres offer women-only programs and two others are re-orienting their activities this year, with one to focus on youth and the other on aftercare. The top priorities in the B.C. Region are capacity-building, aftercare and, above all, tripartite governance. Management of all health services for First Nations communities in B.C. will come under a tripartite Health Council during the next 12–18 months, so major effort is being directed to this aspect.

Main achievements in B.C.

Training and workforce development

B.C. has a fairly high percentage of uncertified NNADAP workers. However, both a certificate and a diploma course are now available to NNADAP workers through the Nicola Valley Institute of Technology. Courses are offered for one week every month, thus allowing students to maintain their work activities. The curriculum covers the impacts of intergenerational trauma and develops counsellor skills in 12 core areas. All credits can be transferred to universities and colleges and the training increases students' wages and job opportunities, in addition to offering them personal development. Challenges associated with this training program include funding, the difficulties of marketing the training to remote communities and the fact that, at present, the training is only available in urban areas.

This year, the Association of BC First Nations Treatment Programs also arranged four days of training facilitated by staff from the University of British Columbia. This training was offered to all staff in the treatment centres (counsellors, directors, cooks, etc.) —a total of 144 people—and provided the 30 hours needed for workers to recertify. The session was very well received and is to be repeated for frontline workers in March (year). It covered topics such as how to prepare clients for treatment and how to work with them; future sessions may be expanded to include more information on abuse of prescription drugs.

Aftercare

The region is building a new centre for aftercare where 30 people will be able to live for up to two years after treatment, as they prepare for the job market.

Active treatment

The Sts'ailes Wellness Centre has initiated a four-year pilot project in Vancouver's Downtown Eastside. The Downtown Eastside is noted for high rates of poverty, crime, violence, drug use and HIV infection and Aboriginal people make up 40% of its residents. This is an extremely high-need population. Clients from this area tend to be homeless and culturally and spiritually disconnected; they are survivors of residential schools, foster care and the judicial system; and typically have long histories of substance abuse and complex mental and physical health issues and all require easy access to treatment and comprehensive aftercare.

The Telmexw Awtexw (Medicine House), a new five-bed facility, is intended to fill a gap by giving Aboriginal men living in the Downtown Eastside access to culturally relevant treatment. The centre is running at 100% capacity, with a waiting list. It provides treatment based on cultural and community immersion, with seasonal activities to restore connections to the land, traditions and identity and an emphasis on moving from survivor to contributor. Key collaborating organizations include FNIHB, Native Court Workers, service workers in the Downtown Eastside and local health care providers (doctors, dentists, optometrists, pharmacists, methadone providers). The centre began with a three-month treatment model but has since moved to continuous intake and a 28-day program with the option to renew for up to six months. The average stay is three months. So far, the program has admitted 76 men and five women. Of these, about half have chosen to relocate away from the Downtown Eastside.

Challenges to NNADAP renewal in B.C.

The Telmexw Awtexw centre is facing some challenges in relation to

- Securing housing for clients;
- Reintegrating people with cultural support;
- Training staff while maintaining 24-hour services;
- Outreach and aftercare. Follow-up with this particular population is especially difficult, and additional funds are needed to provide it; and,
- Accreditation. To be eligible for accreditation, the centre first needs to obtain core funding.

However, regional mechanisms are supporting the renewal process. A process evaluation, funded by FNIHB, has identified gaps and produced recommendations for future programming; and a business case plan, funded by the First Nations Health Society, is providing a road map for how to make the program sustainable.

Principles in practice: the example of a Yukon land-based treatment program

Presented by Gaye Hanson, Program Consultant, Kwanlin Dün First Nation

Gaye presented the experience of the Kwanlin Dün First Nation, which has been running short-term land programs at Jackson Lake for 20 years and is now expanding to a more sustained intervention. The community ran three pilot projects at the site in 2010–2011. An evaluation showed that the program had high retention rates and improved most participants' mood and well-being, life skills and patterns of substance abuse. It recommended further development and more attention to the challenges of using an integrated approach with clients who potentially come from any one of seven different Aboriginal cultures, or from a non-Aboriginal culture. The evaluation also recommended better documentation of the program and policies, winterizing the site and seeking out program evaluation instruments that are culturally relevant and not too burdensome.

The result was a program whose mission is "to provide a supportive, land-based, holistic and compassionate environment based on the integration of traditional and modern knowledge in order to create balance and self-empowerment." The program is based on traditional knowledge, values and ceremonies, supplemented with mainstream clinical practices. It has four streams:

1. First Nations therapy (cultural teachings, traditional ceremonies);
2. Land-based healing (traditional activities, traditional arts and crafts, language);
3. Clinical therapy (an informal approach rather than individual sessions); and,
4. Complementary healing (such as yoga for women).

The program offers separate streams for men, women, youth, and families and is able to include clients with Fetal Alcohol Spectrum Disorder (FASD) and other disabilities and to encompass harm reduction approaches. Its components are divided into four steps:

1. Getting ready (assessment and pre-treatment) — 2 weeks;
2. Land-based healing — 6 weeks;
3. Building supportive community (intensive aftercare) — 6 weeks or longer; and,
4. Living in Connection — ongoing support.

Funding is provided by the Justice Department, therefore the program has good links with the justice system (which in Yukon is also responsible for child welfare).

Overview of key national renewal activities

Presented by Carol Hopkins

Carol pointed out that the NNADAP renewal process has a Leadership Team, whose members were chosen on the basis of specific leadership qualities rather than simply to ensure representation from all regions. This team is now planning activities for the upcoming year, which makes this a good time to check in with participants at the forum.

She began by underlining what the renewal process has achieved so far, a significant widening of scope and vision. The Framework, she said, has broadened the focus

- From individual treatment to community needs;
- From an emphasis on deficits to an emphasis on strengths;
- To include all the related sectors such as justice or employment; and,
- To include an understanding of the impact of colonization.

This is a much more comprehensive vision than merely saying, "We need better aftercare." We are now dealing with community and an entire system and using culture as the foundation rather than as an add-on.

For the coming year, activities will focus on four priority areas:

Priority 1: Strengthening the system of care
In practical terms, this means improving the quality of care all across the continuum. The activities planned for 2012-13, emphasize the development of tools, templates and standard procedures that can be used during the care process:

- Mental health and addiction screening and assessment tools;
- Standard referral and intake packages;
- Discharge/Aftercare Planning Template/Protocol;
- Treatment/Care Planning Template;
- Template of available services; and
- Manitoba Early Intervention Project .

Priority 2: Improving the quality of programming
Guides are planned on worker wellness, on how to do non-medical detox and on community alcohol policies with the Canadian Centre for Substance Abuse (CCSA). A needs-based planning project is underway in collaboration with the Centre for Addictions and Mental Health (CAMH). This project will look at how we define and measure need, so that we can make good decisions about how to allocate the available funds.

Priority 3: Ensuring better measurement, oversight and research
Several projects have been completed or are underway in this area:

- A national forum on First Nations and Inuit addiction research is scheduled for March 2012 and is expected to generate a plan for research;
- Existing materials on prescription drug abuse have been synthesized into a single document;
- A scan of the modernization projects and what they have achieved has been completed;
- A NNADAP treatment centre outcome study pilot is underway to assess the outcomes of past treatment; and,
- A project is underway to identify data needs based on the Framework.

Priority 4: Enhancing coordination at all levels
Plans in this area include:

- Defining a Community Basket of Services (per the Framework);
- Literature review and development of a Cultural Safety/Competence tool or guide; and,
- Development of an E-based community of practice for workers (a place for workers to share information on successful models).

Besides these, there is a long list of proposed projects for 2012-13 and later years that do not fit neatly under a single heading:

- Implementation of a treatment centre Information Management System;
- Increasing capacity to address trauma related to residential schools;
- Development of a change management/knowledge exchange strategy;
- Pre-care Guide/Analysis;
- Scan/analysis of brief intervention tools (looking at tools for families, caregivers, and care providers);
- Development of a curriculum of therapeutic approaches ;
- Identification of care facilitation/case management models;
- Development of a Concurrent Capable Centres Guide;
- Development of a Concurrent Capable Communities Guide**;**
- Review/analysis of home detoxification needs and opportunities;
- Criteria for Well Treatment centres;
- Aboriginal Health Intervention: Assessing the Impact of Culture in Addictions;
- Development of an aftercare guide for cultural practices; and
- Manitoba First Nations school-based early intervention project.

Partnerships will be essential to complete all these projects. There are many parallel initiatives in mainstream Canada and this creates lots of opportunities for collaboration. In particular, the NNADAP renewal projects will be able to collaborate with Canada-wide initiatives on addictions and mental health and with the First Nations and Inuit Mental Wellness Advisory Committee.

NNADAP Implementation Partnership and Process

Summary of themes from the regional and national presentations

The forum's facilitators (Joan Riggs and Lynne Tyler) summarized the key themes emerging from the regional and national presentations as follows:

- Culture is at the centre of NNADAP renewal;
- Despite sobering statistics, there is hope: culture-based programs are happening in every region
- Collaboration is going on at every level: "silos" are being broken;
- Much work is underway to train the workforce, although "poaching" of trained workers by other organizations is a recurring problem;
- Prescription drug abuse is a growing problem and many regions are now moving to address it; and,
- The *Honouring Our Strengths* Framework is now being used as a community planning tool.

World Café sessions

A substantial amount of time at the forum was devoted to small-group sessions. The purpose of the World Café sessions was to create a venue in which forum participants could brainstorm and discuss key opportunities to strengthen services in line with the direction set out in the Honouring Our Strengths Framework. Participants circulated among groups devoted to each of the six elements and six supporting components of the Honouring Our Strengths Framework. Some of the results were as follows.

Discussions on Element 1: Community development, prevention, and health promotion

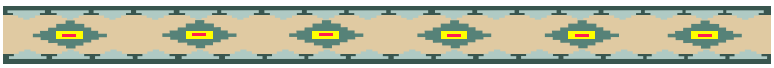
Featured Program: The *Mino Bimaadiziwin* Program (Manitoba)

To set the stage for the discussions in this group, participants were offered the example of the *Mino Bimaadiziwin* program. This program, operating in a Winnipeg boarding school for First Nations students, seeks to "tune the hearts of every participant…to that universal rhythm of unity and spirit," thus banishing hopelessness, disunity and addiction. Originating out of the protocols around a traditional hunt, the program inspires participants to seek the "good life" and to realize that community health and balance is not only possible but inevitable. The youth themselves are of course the central figures but the program also involves a wide range of other partners such as parents, teachers, community members, elected representatives (both "mainstream" and First Nations), NNADAP staff and academics.

The discussions on this theme revolved around relationships, forgiveness and empowerment. They emphasized individual initiative and the need to rekindle the spirit starting with oneself, but to broaden out from there to include family and community. Participants spoke of the need for youth to learn their roles and responsibilities in the circle of life and to participate in rites of passage.

Comments on community development and prevention

- Under-serviced youth
    - Human and material/financial resources
    - Family
- Individual initiative
- First Nations Education
    - Cultural rites of passage
    - Circle of life/roles/responsibilities
- Rekindling spirit/start with self



Discussions on Element 2: Early identification, brief intervention, and aftercare

Featured Program: NNAPF Screening & Assessment Literature Review (National)
Participants in this group were reminded that both screening and assessment play a central role in deciding what type of care will be best for a client. In recognition of this, staff at NNAPF have reviewed the screening and assessment tools currently being used by NNADAP and NYSAP workers and carried out a literature review on the topic. The results provide insight into the role of culturally-specific tools and practices.

Participants' ideas on this topic fell into several groups. Starting from the observation that western screening tools are not always appropriate, they considered *why* we screen and what should be screened for. From there, they described the characteristics of an ideal set of screening tools: tools that are scientifically rigorous yet culturally adapted; that help build the therapeutic relationship; that cover a range of conditions; and that are freely available. A final set of suggestions dealt with the *process* for developing such culturally adapted tools.

Problems with standard "western" tools

- Western tools can be dangerous. The Substance Abuse Subtle Screening Inventory (SASSI) is hit or miss because of lack of cultural relevance. Also, those using the tools may have substandard literacy levels
- Mental health issues—e.g. depression, anxiety, etc—do not always look alike in different populations
- Degree of risk – scales not useful; need proper psychometric evaluation
- Difficulties with the clinical language imposed by the tools and with the way the tools "label" people

Why we screen and what we should be screening for

- Standardizing intake process – centre –community. Patient does not have to tell his/her story over and over. But one potential danger: at present, the intake screening helps build relationship and trust—if removed, something should replace this process
- Better communication through systems, screening, treatment, aftercare
- Health – mental health education
    - Collaboration and screening across systems
    - Recommendations for service in other systems
- Screen for strengths and assets as well as risks/problems
- Consideration of etiology
- Culturally informed – screen for mental, physical, emotional, spiritual dimensions
- Life stages screening: learning, vision, speech i.e., childhood screening
- Alternative indicators – school – connections to tradition; "What indicates success in a given community?"
- More togetherness – many communities lacking festivities / celebrations

- Goals / dreams – community process – help to build dreams
- Hopelessness indicator

Desiderata for screening tools

- Availability of comprehensive assessment is limited – blend western & culturally-based.
- Recognition of need for rigorous tools to access "mainstream service"; validated and credible across jurisdictions, e.g. Children's Aid Society
- Be clear on purpose of tools and provide range of tools:
    - Culturally based tools e.g. genogram – Euro-centric family structure vs. who lives in your house?
    - Clinical and evaluation tools
    - Monitoring
    - Designed for multiple use
- Relationship building – client-counsellor rapport
- Does the tool contain "ways of knowing"
- Training and acceptance – certificate
- Open source tool – no cost – paper and computer

Process for creating/adopting better tools

- Communication of tools etc. among care providers
- Assess: What tool? What parts work? What parts don't?
- Make use of students for research/evaluation
- Build capacity
- Collaborate with universities/colleges
- Defining cultural appropriateness is not straightforward or necessarily do-able – need Elders here to define and discuss

Discussions on Element 3: Secondary risk reduction

Featured Program: Big River First Nation Health and Wellness Initiative (Saskatchewan)
Participants were given the example of Big River's initiative on human immunodeficiency virus **(**HIV). Big River is a large, traditional community in Saskatchewan that has identified HIV as a priority. Working with a team of federal, provincial and First Nations partners, the community developed a multidisciplinary intervention that covers the entire continuum of care from outreach through to treatment, support and case management. The program is holistic in approach and helps participants to reclaim their language, culture and spiritual identity.

Perhaps because the example was HIV, much of the discussion focused on ways to reduce stigma. Participants also considered some specific services that clients with HIV would require and discussed what is needed to change the current situation. As with many of the other topics discussed at this forum, the solutions were seen to lie in strong leadership, good partnerships and a mix of western and First Nations cultural approaches.

Reducing stigma

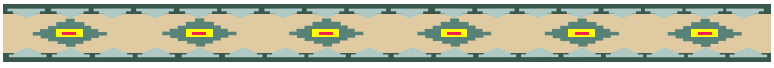
- Titles of initiative; change name
- Educate client and family
- Community needs to be open; leadership involvement is key
- Invite community to information/education sessions
- Working with our cultural people to take away the shame
- You can live with the stigma or live with the fear

Program requirements

- Who do you need in place in order to run programs? Is the programming (in the community) meeting the needs?
- Creating supports for the client; you need family support
- Developing relationships within community and regional
- Communities used to meet when there was a problem, we have lost this
- It is the whole person: all the trauma, all the violence
- Pre-test counselling – prepare client

Achieving change in this area

- Know the status of your community in regards to sexually transmitted infections (STI)
- Educate about STIs: “How to talk to your children about safe sex”
- Connections with healers
- Culture based
- Integrating approaches to health (western vs. traditional)
- Developing partnerships – getting out of the silos
- Strong leadership; opening up avenues between leadership and programs



Discussions on Element 4: Active Treatment

Featured Program: Dilico Adult Residential Treatment Centre (Ontario)

Discussion in this group built on the example of the Dilico Anishnabek Family Care Adult Residential Treatment Centre. Beginning in 2008, the Centre positioned itself to offer expanded treatment, training its staff on topics such as gender-based treatment, strength-based treatment, motivational interviews

and concurrent disorders. This was followed by a series of links with outside organizations such as other treatment programs, Corrections Canada and Lakehead University. The Centre is now able to accommodate clients with concurrent disorders and mental health problems that require medication. Completion rates are high, clients are satisfied and referrals from neighbouring communities have gone up. Centre staff feel that their example shows that treatment can be evidence-based while still maintaining cultural integrity. Training is key to success and change must be instituted across the entire continuum of care.

Much of the ensuing discussion focused on two issues: detox and how concretely to make changes to a treatment program and convince staff to buy into the new model. Comments included:

Components of treatment

- Early identification, screening, assessment
- Withdrawal management
- Case management
- Discharge planning and aftercare
- Responsive to community needs

Program and Human Resource issues

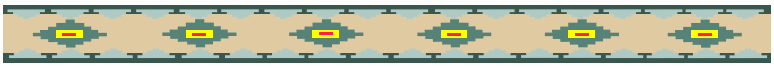
- HR is an issue; 50% loss of staff in 3 years
- Translate system-level plans to staff/programming
- Cultural priority – retained through all other program change
- Necessary to overcome staff barriers to becoming client-centred
- Change in model philosophy – need to challenge personal beliefs or set them aside
- New Conversation
    - Elevated
    - How do you still get heart and soul
    - Staff can be engaged and educated
- Relation within organization: permission to give feedback, openness

Detoxification

- How do you assess risk of people who have not detoxed?
- Some experience is that people coming out of detox have not actually withdrawn
- Ceremonies during detox are showing success

Other comments

- Methadone is a question
- Suboxone – lessons to be learned
- Strong leadership – collaborate with community leadership
- Partnership and information exchange with other services
- Gender-security issues for land-based



Discussions on Element 5: Specialized treatment

Featured Program: *Tsow-Tun Le Lum* Treatment Centre (British Columbia)
Participants were told about B.C.'s *Tsow-Tun Le Lum* Treatment Centre. Since 1990, *Tsow-Tun Le Lum* has had an agreement with Corrections Canada to treat some of its clients. As a result, it was the first centre to offer routine mental health services from a psychologist. Over time, it became evident that the centre needed to offer programs to address issues such as sexual abuse and residential schools. An initial pilot project grew into one that received five years of funding from the Aboriginal Healing Foundation and is still active today. The centre uses a mix of traditional and western therapies, with strong leadership from a group of traditional healers and Elders. Good relationships with partners and funding agencies, a willingness to try new pilot projects and thorough and fair staffing policies have all contributed to the centre's success.

This example led participants into detailed discussions of specific needs that might require specialized services and of what makes for a strong and well-managed program. One specific aspect of program management, how to actively promote respect for cultural differences, received particular attention.

Types of specialized services needed

- Specialization reduces recidivism – attends to the need
- Understand addictions as the presenting issue
- Multi-level shift in understanding substance abuse as an element of disorder, need to formalize understanding and reflect in policy; integrate alcohol and drug addiction with mental health
- Specialized services are needed to address:
    - Sexual abuse
    - Trauma
    - Grief
    - Residential schools
    - Food/eating disorders
    - Sex addiction/early sexualisation
    - Gambling
    - Opiate addictions
- Gay/lesbian/transgender population have specific needs

Program structure

- Need funding to support
- Need partnerships

- Need specialist workers – can work with alcohol/drug and mental health services and those that can assess or can refer out
- Labeling services impacts engagement— de-stigmatize with titling in a different way e.g. sexual abuse – trauma treatment, codependency – paddling your own canoe
- "Specialization" also needs to provide basic living/life skills
    - Occupational therapy
    - Recreational/activity therapy
    - Dietician needed to attend to chronic disease and eating disorders/allergies
- Spiritual counselling and ceremony to attend to spiritual impact and needs related to trauma
- Gender-specific programs – especially for corrections programs
- Overlapping intakes are key to success – facilitates natural/mutual support

Strong administration and management

- Need good management and financial controller
- Good data / evaluation
- Build capacity with staff to engage in data collection/analysis/use
- Build credibility so that organization is trusted / looked at when additional funding is available or when partners have interest
- Need dedicated people to do fundraising
- Need positive people to make networking work for results
- Interpretation of policy is an issue across regions/territories— need consistency to remove barriers
- Values consistent across organization i.e. Board of Directors support sobriety
- Enforcement of requirements for abstinence? Is testing the most effective way or is a "relational" approach more effective? Is it unethical to use substances and be an addictions counsellor and what role does moderate/social drinking play?
- Training for worker safety in community services and within residential environment
    - Safety can be health or violence related
    - On-call staff to support safety
    - Panic alarms to support safety
- Need skills for grounding clients who open up in assessment phase

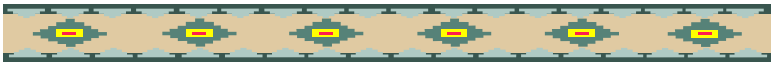
Promoting respect for cultural differences within the program

- Facilitating respect for cultural differences
    - Recognizing there are various pathways
    - Healthy Elders
    - Based on pride for identity
    - No requirement for Elder to do, instead they decide how and what they contribute
    - Elders present from their own gifts
    - Foundation is "honouring" the ways of the land while recognizing others are "invited"
    - Set the foundation through discussion

- Variety of Elders teaches respect for differences and that Elders have different qualifications/scope of practice
- Collaboration through visits and ongoing dialogue
- Recognize that control issues related to culture are influenced by colonization/residential school

Other thoughts on specialized treatment

- Loss of funding through partnership agreements and sustaining service e.g. Aboriginal Healing Foundation (use of AHF funding formula for cultural supports)
- Need more consistent FNIHB policy re: access to mental health supports, i.e. funded vs. NIHB
- Most risk comes from unknown therefore important to spend time to assess and prepare
- Ontario – Sexual Assault Centre of Brant (county) Safe Places program
    - Training validated population it intends to serve. CAMH also has resources
    - Energy work is needed – blending western and traditional practices
- Funding activities within treatment can be facilitated through the crafts/art work produced by clients
- Sometimes, it's time to stop talking and rest into the body with movement—becoming more aware of how the body feels because our inner knowing rests here. Body and breath awareness have enormous potential for managing intense emotion



Discussions on Element 6: Care facilitation

Featured Program: Tui'kn Case Management Model (Atlantic)

To start the discussions in this group, participants were presented with an example drawn from Cape Breton's case-management system, which operates in 15 communities. The case study described a young man who had slipped through the cracks in the system for almost five years. He was an un-medicated schizophrenic; had received a transplant but was not taking immunosuppressants; abused substances; and was suicidal. Following an emergency call to the crisis line, he was admitted to hospital and assigned a case manager. As a result, within 24 hours the young man had been assessed, accepted into an addictions program and placed on the list for a "small options" home. The case manager later arranged aftercare services, psychiatric follow-up and nutritional counselling. Eventually, the client was able to realize a long-time ambition by entering adult education to obtain his high school diploma.

This case generated a great deal of discussion about the groundwork and conditions necessary to combine and "de-silo" different services; about how to make partnerships work; about the qualities to look for in a case manager; and about ways to minimize the barriers to a coordinated approach.

Paving the way for case management

Paving the way with partner agencies

- Strategic mental health forum and invited all players to learn about MWT approach; internal/external agencies were invited to forum, more than 200 attendees. The forum helped to design the process
- Work with Cape Breton Health Authority—CEO brought in neighbouring group to show that case management worked elsewhere. This helped convince Cape Breton Health Authority boss that it was a good idea
- Provincial / hospital coordination – on steering committee level —staff told provincial/hospital the project was doing this work

Paving the way within the communities

- A spate of suicides in 2008-2009 provided the impetus to eliminate the silos between programs. The new, coordinated approach amalgamated and co-located 21 workers in five departments. Two directors were let go; the remaining staff saw value in the approach and all came together. A healing circle helped allay staff fears
- Communication within community— service providers developed referral assessment form.
- Lunch and learn, RCMP, Driver License, CFS – every community had opportunity to know about Mental Wellness Team and TV, radio ads, schools – everyone

Making case management work effectively

- Health Canada Request for Proposals– not prescriptive re: what activities/who is hired
- Funding policies – Non Insured Health Benefits (NIHB) sits on MWT steering committee
- Cape Breton District Health Authority day program would be funded upon a letter to NIHB – authority to fund program as only way to deliver services
- Elders recognized/chosen as part of team by the community for that community
- All partners sit in on case-management meetings about the client (although client particulars may be suppressed). Partners include probation department, community, NADACA, housing, welfare
- Video conferencing for group meetings to keep travel costs down
- With silos eliminated, developed resource directory for all 13 Nova Scotia bands
- Consent forms – client signs all 10 release forms so he/she can access services from all the agencies involved
- Find out from client what you can be successful at – many issues/demands competing for client's energies

Qualities to look for in a good case manager

- Male and female, native and non-native, upbeat, energetic, sense of humour, able to talk
- Professional qualifications, Bachelor degree
- Develop relationships, integrity, honesty, trust, good sense of culture
- Liaison between communities— trustworthy
- Recognize and respect educational qualifications
- Training from community perspective speak and write fluently / know the community and how it works / clients' needs / coverage of clients when needed

- How to use strengths of community, crisis management based on strengths

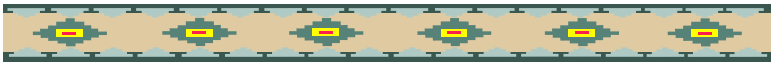
Dealing with barriers to effective case management/coordination

Barriers

- Sustainable funding necessary to ensure client safety and continuity of services; many of the suicides that took place in 2008 involved clients who had been involved in programs whose funding had ended
- NIHB and relationships very "strategic"
- Staff turnover
- Not respecting requests to meet
- No meeting room
- Transferred services – Territories – 1 treatment and program, no cultural component

Breaking the barriers

- Key team members apply and sit on Boards; keep applying to everything to get your voice heard at the highest level possible
- Seat on Board—executives committee offering— send applications to all Board openings
- Breaking barriers—share a meal after the meeting—people loosen up and build "human relationships"
- Boards of local universities—need to provide programs at your school so the students come back to communities to do those jobs



Discussions on Supporting Component 1: Workforce development

Featured program: Youth Solvent Abuse Committee (YSAC) workforce development program (National)

The discussions were launched with a description of YSAC's planning and training initiatives. YSAC brings together the ten youth-specific treatment centres in Canada. For years now, YSAC has been working on human resource issues. Its successes include:

- Recruitment/orientation: Preparation of a common document for interviews, staff exchanges, and staff orientation
- Assessment: Annual survey on core competency, and templates for human resource planning and for leadership training
- Development: Development of training modules on topics like resilience, emotional intelligence, clinical supervision; on-line training modules on ethics, incident reports, how to measure outcomes and how to use the YSAC database
- Retention: Annual survey of staff satisfaction and a manual of best practices.

Each of these tools has helped to make someone's job easier, to meet an accreditation standard or to improve service to clients

This example generated a lively discussion of the many ways to increase staff skills, from workshops to online training modules to mentoring and of the role of good human resource policies in making people feel that they are part of a team and reducing turnover. There was also some discussion of the best ways to encourage certification bodies to recognize cultural competencies.

Developing staff skills

- Competency to job descriptions – yearly component survey – adding cultural component to this year's (2012) survey
- All YSAC management 4x/year
- Opportunities for competency
    - Recruitment strategy for mentors, job shadowing
    - Job descriptions in all areas: Justice / Health counselor, treatment, support staff
- Recommendation – policy barriers to be removed to get into First Nation/Inuit health funded addiction courses (for courses funded by Health Canada, you have to be in the field already; people wishing to enter the field cannot get their studies funded)
- Curriculum development specific to staff
- Share research on youth development re: sleep to encourage change in treatment centre's schedule → reduction in incidents
- Staff training at other centres across Canada: upgrading, new hires, promotions
- New online ethics module – REQUEST module for adult focused centres
- Recommend that others have access to YSAC resources and training – could be fee partnerships – book resource - fee for service, open training seats
- Training in Emotional Intelligence has been useful to NYSAP staff, and there is demand for this training from other areas. Consider a train-the-trainers approach
- Build capacity with possible workforce development conference
- Career laddering with developed curriculum with college/university
- Community workers require support to meet and more opportunities to do so.
    - Idea: meet as regional team. Hold national directors' meeting every three years

Human Resource practices & policies

- Governance with belief in workforce development
- Teach difference with governance and management
- New staff oriented to criminal justice system issues
- Key lessons – group cohesive improves optimism and belief
- HR best practices – personal wellness / not much turnover. Possible geographic (North) issues with turnover
- Developing more facilitators
- Promote NNADAP as a career: How many youth wake up and say "I'm going to be a NNADAP worker"?

- Benefits – full time and part time / relief. Need consideration of benefits/retirement plans/sick leave for staff
- Need: develop succession and transition plans for aging workforce; retirement package for NNADAP workers; worker awareness for self-directed RSP
- Shared intake form suitable for all, available online. Shared interviews?
- Core components have been shared with adult centres. The components are not necessarily youth specific

Action on recognizing cultural competency

- Advocate: certification bodies to have standard for cultural competencies
- Possible statement from leadership team – we will support certification bodies who adopt cultural competency as a first step

Discussions on Supporting Component 2: Governance and coordination of systems

Featured program: Alberta Region Co-Management Committee

Participants were given the example of Alberta's co-management structure, in which Chiefs and Health Canada jointly govern health programs. The committee has a number of sub-committees, including one on Mental Health and Addictions that oversees the Brighter Futures, Building Healthy Communities, NNADAP, NYSAP and Youth Suicide Prevention programs. The co-management approach has proven to be a good way to identify common issues, influence policies and programs, foster unity among partners and develop capacities.

This example generated discussion about what types of partnerships are needed and how they should be initiated; about governance and inclusion of culture; and about the key activities required to lay the foundation for good partnerships.

Initiating partnerships and coordination

- Work with provincial, federal, and First Nations people
- Partnership with province needed
- NNAPF committee/working groups =key partners
- Outside experts may help in working through barriers
- Engage political system in bringing about change
- Terms of reference, guidelines that can be shared; more written agreements
- BC model – Treaty area determine Contribution Agreement holder

- Politics and health – relationship between Assembly of Treaty Chiefs / co-management / subcommittee
- Agreement between Minister of Health and Chiefs
- Structure has to be flexible enough to facilitate differences/community specific initiatives (using agreements as well)
- Sharing information with other regions
- Regional process must feed into national discussions and policy changes, e.g. AFN
- Discussion at Chiefs level for surplus, growth
- Sub-committee reps at national tables; crossover between programs and sub-committees

Governance of projects at local level

- First Nations Health Managers have produced some work that can be used for internal support work
- Review to identify issues / recommendations – learn from struggles and share with others
- Change driven by the people who define the structure and process
- Partnerships can begin through project specific actions – helps to establish relationship – can build from there
- If one approach does not work – redefine it to a different process that will work– recognize as a starting point
- Share information
- Two tiers – regional & communities
- Needs to be initiated by leadership
- Communities are the decision markers
- Politics at community level – changes made by new leadership

Inclusion of culture

- Culture within the system and coordination of the system
- Governing body is informed by the culture; come with this knowledge or learn it
- Cross cultural/awareness training cultural competency; cultural competencies for partners
- Respect cultural differences
- "Wisdom Council" – working group to include culture and FN perspective, Elders and Youth – advise on what is needed

Key opportunities / activities required

- Mental Wellness Strategy
- Address the caps on growth funding
- Health Services Integration Fund
- Breaking down silos between programs
- Management model

Discussions on Supporting Component 3: Addressing mental health needs

Featured program: Battleford Tribal Council Indian Health (Saskatchewan)

The discussion began with a description of the Battleford Tribal Council's Wellness Program. Concerns about the quality of the NNADAP program in the Battleford area led to it being replaced with a more comprehensive Wellness program in 2011. The new program has strong support from the Chiefs and a partnership with the Regional Health Authority that allows providers to coordinate care and reduce duplication of assessments. The new program uses a multidisciplinary team and a solid strategic plan with provision for evaluation. It is currently building toward accreditation.

Participants in this discussion group followed the format suggested by forum organizers, meaning that they discussed first the requirements for change, then the key activities, partnerships and resources that can help in overcoming some of the barriers. The discussion of requirements focused on the partners who must be involved, on the need to emphasize teamwork, on making sure the program reflects community needs and on training workers. Strong planning and teamwork were seen as essential to addressing mental health needs and a long list of possible partners were identified. Although there are some barriers, participants were also able to list resources that would assist in the process of change. These including strong leadership, use of the Honouring Our Strengths Framework to plan programs and the existence of the Health Services Integration Fund.

Requirements for change

Partnerships and communication

- Working with internal and external resources
- Acknowledging and using community / Indigenous knowledge
- Relying on Elders' knowledge to build the program
- Educating other levels of the systems (i.e. provincial)
- Communication strategy
    - Chief and council consult
    - Community newsletter (quarterly), radio
    - Community education
    - Partner education about new programs, referrals etc.
- Good team communication

Program approach

- Policy development
- Taking risks to make change in program delivery

- Planned roles and responsibilities for new workers
- Letting roles go and work together as part of a team
- Collaborative team approach to draw upon group expertise
- Changing labels to be more positive and/or more embraced by the community (i.e. change NNADAP to community wellness workers)

Requirements internal to the community

- Defining community needs and expectations
- Recognizing and enhancing community strengths
- Client/community focused – "wrap-around" program
- Common vision with leadership and community
- Community owned
- Belief that cultural knowledge and community vision is seen as practical and realistic

Workforce requirements

- Workforce development –
    - Common knowledge on mental health and addictions
    - File management
    - Ethical / legal practices
    - Working with all sectors of the population
- Healthy workers
- Training of workers – skills are up-to-date to meet changing needs of the community
- Workforce development and wage parity

Key opportunities/activities to strengthen this supporting component

- Leadership support (political, administrative, PTOs)
- Relying on / using community knowledge to define key program activities; sharing of resources, land, infrastructure
- Good planning
    - strategic planning to develop/redefine program;
    - develop policies, procedures, communication strategy
    - community participation; community development, forgiveness
- Trust (about the vision) within communities, by communities, organization
- Tapping into skills of existing workers to assist during transition
- Embedded evaluation of new program
- Case management
- Develop infrastructure (laptops, practical resources)
- Creating / enhancing relationships with external resources
- Accreditation
- Models of community treatment – make treatment accessible to entire community

- Work force development; workers have common knowledge on mental health and addiction issues; cross-training of mental health workers, addiction workers, other workers
- Training and certification of NNADAP (and other) workers
- Supervision for front line workers
- Shared intakes, common language, shared case conferences
- Integrated team approach
- Share clients through a seamless system based on client needs

Key partnerships and collaborations

- Multi-disciplinary teams
    - Addiction counselors
    - Mental health workers
    - Maternal and child health nurse
    - Psychiatric supports (psychiatric nurses, psychiatrist)
    - Youth workers
    - Dietician
    - Exercise component
- Bringing together the work of internal and external resources (community resources, hospital services)
- Treatment centres
- Government / funders support
- Provincial regional health authorities -- build on existing partnership agreement on primary care to bring mental health and addictions to the table
- Child welfare
- Justice
- Community leadership support and direction
- Support of PTOs, Tribal Councils
- Elders' council using knowledge of different tribes

Key opportunities / collaborations to work through barriers

- Community readiness; accountability to community
- Strong administrative leadership and support
- Outstanding leadership to guide the Tribal Council in directing mental health and addiction programming
- Commitment to change by board, administration, staff and community
- Existing staff working to reduce gaps in services
- Worker retention (i.e. wage parity)
- Elders' council
- Agreement with the provincial health centres
- Use of the Framework to guide strategic planning

- Health services integration fund to develop a comprehensive, culturally relevant intake assessment process

Discussions on Supporting Component 4: Performance measurement and research

Featured Program: NNAPF Regional/National Research Forums (National)

The *Honouring Our Strengths* Framework identifies the need to build an evidence base for culturally-informed practices. As a first step, NNAPF and its partner organizations hosted discussions with NNADAP/NYSAP workers in every region on research needs. These forums assisted all partners (treatment centres, policymakers and researchers) to clarify roles: what should be researched, who should conduct the research and with what partners. The forum results suggest that a national research strategy will need to consider four goals:

1. Nurturing cultural competency across jurisdictions;
2. Building relationships between NNADAP/NYSAP and the research community;
3. Setting research priorities that support proposals from communities and regions; and,
4. Building the evidence for cultural interventions.

The discussions on this topic revolved around research partnerships, the best ways to incorporate Indigenous knowledge into research and how to be certain that research truly serves the needs of the program and the community. Participants said that if research is going to be useful, it must be linked to program activity, be strength-based and holistic, respect OCAP principles and embody First Nations knowledge and methodology. Participants discussed ways to increase community access to research funding, including preparing a list of funding sources, training in how to develop research proposals and assistance in developing partnerships with research institutions such as the Canadian Institutes of Health Research (CIHR). Another approach is to "take the researcher out of the research," that is, to see research as ongoing reflection and data collection embedded in program work.

Key opportunities (partnerships/collaborations):

- Working with industry
- Subscribing to CIHR funding opportunities
- Engaging with FNIH regional offices, universities – getting them to commit to research partnerships
- List of funding agencies

Partnerships:

- Natural opportunities with mental health, addictions, chronic disease (HIV/AIDS) – collaboration

- Provincial partnerships
- Medical professions: pharmacological
- Educational partnerships – learning from partners
- Partners:
    - Canadian Mental Health Commission
    - First Nations Communities
    - Corrections Canada
    - First Nations leadership
    - Schools, universities

Activities:

- Different ways of measuring performance – healthy life outcomes
- Holistic research
- Using developmental approaches to evaluation

What is needed for change?

Training

- Training to develop research proposals
- Training to include cultural component (cross cultural training)
- Learning/understanding policy research

Research topics

- Research to ask the right questions; get away from "bean counting"
- Research to understand and deal with turnover
- Stop defining problems with research – solution/strength based research; FN researched "back to life"
- Research that correlates with funding cuts and program enhancements

Research process

- Proactive research partnerships; knowledge transfer and exchange
- Greater collaboration between Western and traditional
- Indigenous research methodology
- Respecting oral tradition
- Cannot assume that culture is not inclusive of science
- Follow up by research community
- Clarity on intents and OCAP
- Reflective research: take researcher out of research; incorporate researching into programming; have researched piece embedded in program so that research is for/by First Nations; validate qualitative piece as it applies to program improvement
- Realistic timelines for proposals
- Solid feedback on proposal refusals

Other comments on research

- Engage leadership – provincial, territorial, First Nations
- Practice to research – practice has evidence – mind shift
- Celebrating solid evidence prior to research
- Maternal and child health models of success – learn from or teach (inform)
- Documentation, sharing (the NIMKEE example)
- Involve youth, educate youth around research purpose and outcomes

Discussions on Supporting Component 5: Pharmacological approaches

Featured program: Cree Nations Opioid Replacement Therapy (Saskatchewan)

Discussions began with description of a successful model: the Cree Nations Opioid Replacement Therapy Program in Saskatchewan. The program brings together numerous partners to cover all aspects of care:

- Doctors from the Parkland Regional Health Authority provide prescribing, oversight, and evaluation;
- The Shellbrooke Pharmacy takes care of dosing;
- The Cree Nations Treatment Haven administers the program and provides counselling services; and,
- The Ahtahkakoop nursing staff provide program support and medical assistance.

The program offers case management, on-site and outpatient treatment and links to other community services. As a condition of receiving opioid replacement, clients are obliged to accept counselling; as a result, the program now has 60 clients and is beginning to see an improvement in how clients contribute to family and community life and in how much they use other community services.

Participants' comments reflected the diversity of views on pharmacological approaches and the persistent desire for a wider range of alternatives. In some areas of the country, the concern seemed to be that clients are offered pharmacological treatment but not counselling or follow-up; in others, methadone is deemed not sufficiently available. Participants emphasized the need for good planning and careful assessment, for partnerships with clear roles and for other forms of support (such as support from peers, family, or a counsellor).

What is required to achieve change in this area?

- Time for planning; long-term, comprehensive plan
- Comprehensive/complete assessments; careful approach to address continuum of care
- Funder commitments/support for new approaches – sustainable funding

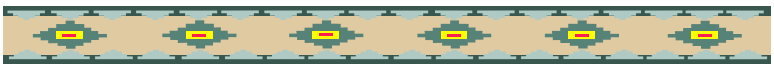
- Respectful approaches
- More/other pharmacological approaches – beyond methadone and suboxone
- More flexible access to suboxone

Opportunities to strengthen this element

- Connection to employment
- More pilots – health service model
- Sweats/cultural elements

Partnerships and collaborations that are critical to advancing these opportunities

- Capacity building accredited /change management
- Leadership involvement (whole community)
- All clearly defined roles/responsibilities
- Strong links with physicians, nurses and pharmacists
- Links with PTOs
- Single doctoring
- Strengthened access to methadone in remote areas
- Succession planning
- Stronger with better client education, program staff education
- Consideration of community and client safety/security
- Counseling as required – initially and ongoing
- Chance to bring in / engage the family
- Peer to peer support
- Ongoing aftercare



Discussions on Supporting Component 6: Accreditation

Featured program: the accreditation process

The discussions on this topic suggest that many participants had questions about what accreditation is and how a centre would go about becoming accredited. Much of the discussion centered on the relative advantages and costs of accreditation and how it fits with other efforts to ensure quality such as operational plans, the National Treatment Strategy or the standards set by addiction organizations. There were also thoughts about how treatment centres could help one another through the accreditation process and questions about the implications of accreditation for staffing.

Why accreditation?

- Concrete outcomes – do we have something tangible that we get following accreditation? What are the key incentives?
- Importance: the prestige with accreditation and acknowledgement of your centre or services community
- Accreditation can create unbiased evidence – if across the board there are similar / identical recommendations, that may be the impetus for change / for an issue being experienced all over to be addressed (e.g. policy may change / individuals or groups may use data as an advocacy tool)
- Accreditation or its recommendations remain regardless of worker turnover – acts as a workplace/pathway/strategic plan
- Some development in our treatment centres has led to acting as an example for other services or service providers in the community relating to health

Forms of accreditation and how accreditation links to standards and plans

- Inconsistent across the country—needs to be consistent with same opportunities for all
- Deciding on a body really depends on best fit for your centre. It's important to research each body yourself
- Is there cultural accreditation? Look at Canadian Accreditation Council (CAC) – have a section for culture
- Can you be accredited without a building? Yes. You can be accredited as a service. What standards do you reach in the delivery of service; what is in place for your employees etc. This is an option for mobile treatment service that focuses on remote communities
- Difference between certification and accreditation must be clear. Different programs use terms differently e.g. accreditation in education means something very different than for us. Accreditation not always understood by other bodies. Something to consider – knowledge exchange for those with different accreditation bodies
- Coordination with criteria from other organizations – e.g. Canadian Centre on Substance Abuse
- Linkage with health planning and national treatment strategy
- Challenge and benefit: integrating accreditation into your daily process

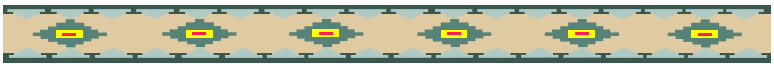
Navigating the accreditation process

- Risk management and case studies
- Real costs of accreditation?
    - In process
    - In employing a coordinator – fulltime?
    - What about funding available to address a specific recommendation that was made
- All the capacity in accredited centres – there's a lot of expertise but no means of sharing that knowledge with centres who are not accredited and who don't know the process / don't know the benefits / don't know what to expect
- Partnership –

    - Must be open to change
    - Seek out positive outcome advice from those who were successful
- Peer review is important to seek – e.g. people from a FN health service would come to see another health service currently undergoing process
- When explaining accreditation, it is difficult to show/measure the success of capacity building and quality of care; it's important for us to highlight the real value of the non-monetary components
- Try to follow up on the recommendations you receive; or you can explain what the recommendation is; how you need to achieve it (or) how you are unable to address it (because of simple essential barriers e.g. funding). Don't be discouraged by not being able to achieve all recommendations right away

Staffing issues related to accreditation

- Keeping staff – sometimes hard with other opportunities
- Can you have staff with criminal record? This ties in with certification, which may require a criminal record check; this can be a barrier, especially for employees whose criminal activity dates back 30 years, and who are now excellent workers
- Treatment centres require criminal records checks just to know; this is part of risk management/minimizing risk



Summary of the World Café sessions

The forum's facilitators noted that the World Café sessions demonstrated the richness that results from the combination of regional/community diversity and common goals. Highlights of the sessions include:

- Community development/health promotion: Acknowledgement that community development starts with "rekindling the spirit" and recognizing the role of history.
- Early intervention: Emphasis on the need for tools that are free, strength-based, culturally adapted, and credible across jurisdictions.
- Secondary risk reduction: Attention to issues of stigma and dealing with the whole person. Interventions to reduce secondary risks require strong leadership and partnerships across the various "silos."
- Active treatment: Experience shows that it is possible to successfully combine culturally based treatments and western evidence-based models. To do so requires serious attention to training and to staff policies that promote teamwork.
- Specialized treatment: There are many specific needs that might require specialized treatment. Sound management and policies that actively promote respect for cultural differences help immensely.

- Care facilitation: Case management can make a huge difference to clients' lives, but to abolish the silos between different services requires concerted effort, and may not happen until impetus is provided by some type of crisis. Maintaining partnerships requires both formal structures (meetings, leadership contact, formal agreements) and informal ones (such as sharing a meal after a meeting).

Certain themes recurred throughout the discussions in every group. The need to blend cultural approaches and evidence-based ones was mentioned in all contexts, from program development through to evaluation. Participants repeatedly grappled with what it means in practice to integrate culture into healing.

Partnerships at all levels were a persistent theme: between different services within the same community; between community, regional and national levels; and between First Nations communities/organizations and provincial ones, be they Regional Health Authorities or local doctors, pharmacists or other care providers.

Training and knowledge-development were mentioned in every discussion, often in connection with the need to learn how to blend different approaches or to provide concrete evidence for the effectiveness of specific treatments. There was a related emphasis on the need to *share* knowledge, training and information on successful models more effectively across the country.

Federal/provincial/territorial panel on opportunities for collaboration

Presenters: Barbara Whitenect, Executive Director, Addiction and Mental Health Services, New Brunswick; Eva Sock, Primary Health Care Manager, Elsipogtog First Nation, New Brunswick; Gaye Hanson, Program Consultant, Kwanlin Dun First Nation, Yukon

Barbara opened the session by mentioning her own personal growth from working with First Nations partners. The provincial role in addictions is critical, she said and therefore she felt honoured to be one of the few provincial representatives at the *Honouring Our Strengths:* National Renewal Forum. Addictions are a priority issue in New Brunswick and it is crucial that all partners work together to create action despite the jurisdictional barriers.

New Brunswick has both formal and informal mechanisms for collaboration between First Nations and other partners. The formal mechanisms are often inspired by tragedies and in recent years they have included:

- A tour of all 15 First Nations communities in New Brunswick by the provincial Ombudsman. The tour's purpose was to listen to community concerns, especially around child welfare. The result was a 2010 report entitled, *Hand in Hand*, followed by an update of the report in 2011 and a series of recommendations about how communities and the province can and must adapt their approaches to work together.
- An 18-month task force on gaps in mental health services, led by Judge McKee, which spent a lot of time in First Nations communities. The resulting Mental Health Action Plan for 2011-2018 has a large section on "Diversity" that explicitly directs provincial agencies to include First Nations communities and work collaboratively with them—"You ***will*** work together."

Because of these initiatives, all of New Brunswick's health-related departments now have First Nations consultants working in them.

The *informal* collaborations are also showing promise, with leaders in communities, provincial agencies and FNIHB increasingly taking a strength-based and collaborative approach. An example is the Elsipogtog project (described below), in which leaders brushed aside all the jurisdictional and policy issues and focused instead on what could be done.

Eva Sock then described Elsipogtog's project to address addictions and mental health. The journey began in 1992, when seven youth in the community committed suicide (the problem of suicide has affected the community ever since, with four in 2011). At the time, Elsipogtog had almost no relationship with the province, but it badly needed crisis workers to cope with the fallout from all the suicides. The inquest sensitized residents to the impact of what we now call the "social determinants of health" and led them to decide that the community had to build a relationship with the province. This eventually developed into a tripartite forum. Since that time, other health integration initiatives—such

as the Aboriginal Health Transition Fund—and other crises have furthered the integration process. Elsipogtog now has provincial involvement in many areas, including FASD and methadone programs.

What have the partners learned throughout this process? First, that collaborations require lots of patience. They have also learned that participants have to take chances and that it helps to create and develop "champions." Both sides have to be educated and to share a common vision which in turn, means lots of meetings. Finally, all partners have to acknowledge that a problem needs attention and commit resources to it.

Barb and Eva were then asked to think beyond their individual collaboration and comment on how one can encourage an entire government agency to collaborate with a community. Their replies acknowledged that this is difficult at first, but underlined the importance of being committed to an ongoing relationship, rather than relying on written agreements. In the case of Elsipogtog, the relationship began with a Chief Executive Officer (CEO) at the local hospital's psychiatric unit who explicitly ruled out a written agreement on the grounds that it would delay or halt action and exclaimed "Let's just do it!" As the leaders gained confidence in the relationship and their ability to work things out with each other, they gradually began to involve their staff and neighbouring communities. Beyond this, Barb noted that collaboration must be built into agencies' existing structures, so that First Nations issues are part of the system rather than an afterthought. As an example, in her department, it is now standard to discuss First Nations issues as part of the roundtable at the monthly management meetings.

Gaye Hansen spoke of collaboration in terms of a balance of spirit, heart, mind and body, with an ethical space for sharing at the centre. She pointed out that there are various forms of collaboration, from one-time collaboration, to time-limited collaboration on a specific project, to an ongoing commitment to the relationship. She also suggested that collaborations go through stages, like a river, so it is important to be flexible. All collaboration, she said, begins with a "spirit of leadership"; it is important for the team that assembles under that leadership to include people with different kinds of knowledge (Elders, academics, etc.), and to meet frequently.

Finally, Elder Agnes Mills emphasized that partnerships must also be active at the level of individual regions and communities. Information is not circulating well inside communities, she said and she implored participants to make sure that help actually reaches the community level, rather than focusing solely on higher-level organizations such as tribal councils.

Maintaining the momentum on renewal

Following the panel presentation, participants broke into groups to discuss how to maintain the momentum of NNADAP renewal. There were a few suggestions for renewed focus on specific areas and quite a few about leadership and collaboration. The latter tended to emphasize the need to sustain and broaden what has already been created, rather than fundamentally questioning the current approach. Overall, participants appeared happy with the Framework and pleased with what has been achieved so far; many of their suggestions dealt with better communication to draw others into the process and celebrate the successes to date.

Addressing neglected areas

- Must get community workers involved in the renewal process
- Go beyond treatment centres to focus on youth and prevention

Leadership

- Sustained funding for the NNADAP renewal work to continue
- Provide resources for knowledge translation
- Realign government policies to facilitate the *Honouring Our Strengths* Framework
- Focus on shared goals, and question limiting assumptions rather than emphasizing the barriers to action
- Lead by example
- Plan for succession

Collaboration

- Make a commitment to hold forums like this one, but that include more people from provincial agencies, from band councils, and from mental health organizations
- Maintain the relationship between NNAPF and Health Canada
- Honour our diverse cultures
- Identify Elders and community champions who want to be involved

Communication

- Highlight what has been accomplished for each of the elements in the Framework
- Publish the positive and get it into the media; have common, key messages so that everyone is singing from the same songbook
- All partners should have marketing and communication plans in which they distribute materials to “ambassadors” and connect with related organizations such as social workers or police
- Translate the *Honouring Our Strengths* Framework into Aboriginal languages and/or produce audio versions
- Need more communication—to leaders, communities, organizations and people outside NNADAP. Material should be put into user-friendly formats such as stories or pictures, and circulated to schools, family service departments, etc.

- Develop synthesis materials that can be circulated to communities; anchor some of the information with examples of individual success, relate the information to what people know.

Closing reflections on the forum

Presented by Carol Hopkins

Carol thanked the Elders and participants for their presence at the forum and reflected on how the *Honouring Our Strengths* Framework has provided a vision that takes us beyond the everyday details. She noted the energy in the room throughout the forum, as participants brought a range of interpretations within a single common framework and particularly mentioned the many stories people had told about working together.

She then reflected on some themes that had recurred throughout the forum. The first is the responsibility to act despite obstacles. The group engaged in renewal has grown with time and now we are many. Each participant is responsible for change; we all have to do something. Clearly, some issues such as low salaries and loss of workforce remain. Despite this, we should not fall into the habit of blaming lack of funding, ineffective policies, etc., since the examples shared during this forum show that change can happen despite such roadblocks. The second key theme is the centrality of culture. All the participants in the needs assessments told us that this was essential. Now we have to believe in ourselves, and figure out *how* to place culture at the centre, and how to navigate the rocky path of combining traditional and western approaches.

Elder Jim Dumont then closed the meeting with some words of guidance and a prayer. He pointed out to participants that the opening prayer of a meeting,"the words that come before any other words are spoken,"is not a petition. Rather, it's an acknowledgement to the Creator that we still remember the things that have been provided and know that during the upcoming discussions the spirit and the earth will continue to help us. This being so, Elder Dumont found it surprising that no one spoke of the animals and the earth during the forum; to solve the huge problem of addictions, we will need their help. The animals adopted humans into their clans to protect them and any worthwhile healing program will need to connect people back to the earth and the animals and clans. Elder Dumont wondered whether participants had sufficiently thought of the spirit during the meeting and spoke of the need to educate even First Nations leaders and people so that culture truly permeates everything we do. He also warned of the dangers of too much accommodation: while collaborative processes are fine, he said, the direction must always come from our people and our culture.

Appendix 1: Participants' commitments to the renewal process

Participants were asked to consider what they personally could do to further NNADAP renewal, and to post this commitment on the wall of the meeting room. The resulting commitments were as follows:

- To share the elements of care with frontline workers, regional committee members and our staff and other agencies in the communities.
- Communication to community
- Share information
- Learning and sharing information
- I will ensure that the goals of renewal are reflected in all the work I do
- Share information truthfully, promote honouring our strength with passion
- Continue to communicate information and process – share successes and create buy in –
- Promote market and communication honouring our strength
- Ensure renewal is communicated to all our communities including school, child and family, justice, etc. and front line workers, leadership and community members, start leading by example
- Actively plan with my board of directors a succession plan for my retirement by 2013. I will continue to mentor and encourage career planning and personal growth. I will stay in touch with health Canada and stay informed of any new initiatives.
- I will commit to share my knowledge with those in communities in my area and in my region where I can
- I will ensure our municipal and first nation drug strategy committees are informed and educated on how to incorporate the renewal Framework into their respective strategic work plans
- Initiate a ceremony that will seek spiritual guidance and sustain positive energy of next steps
- To involve all levels of leadership including NNADAP network and the local communities youth need to be involved because they are the majority of our population
- Share information, incorporate culture and continue with optimistic energy
- Commit to work with youth to promote a healthy lifestyle
- I will align all workplan goals with renewal elements and report on momentum each year. And will add renewal slide to all our teaching sessions
- Ensure that all FN leadership is aware of the Framework
- Promote, keep it alive
- Promote within my circle network
- Project development will be collaborating, will outreach to this broader networks to inform and direct work

- Communication and networking with all stakeholders, partnerships, communities and Inuvik - get the word out
- Facilitating communication, sharing stories and opportunities to collaborate
- Personal commitment – commitment sometimes implies time i.e. once the commitment is fulfilled, then one can move on – my life is wedded to this moment, it is my life that will support this process
- Sharing information and knowledge with colleagues
- I will commit to communication of the diversity of our culture, regionally and nationally
- Engage in more relationship-building experiences
- Don Leeson – my commitment is to bring the Framework to our village government. FN have chemical addictions problems on their tables but no structures on how to deal with it. The Framework brings structure. Who can speak from the Framework team in regions to PR it? Regional conferences would be useful
- Maintain and further develop linkages with mainstream services and FN communities
- Ensure our leadership , chief, council, department directors are informed of renewal Framework and implementation working group is initiated (integrated service)
- I am committed as a NNADAP renewal team rep to bring this change to my chief and council in my area as well as community level
- NNAPF take lead on regional discussion on Framework. Rationale – organizing keeps momentum going: consistency carried across regions; add training opportunities; maximize benefits. Included leadership team members in the regional discussions. Encourage participation of more people
- Maintain energies and recognize need to be open and patient while engaging others
- Continue to talk about the importance of culture as we engage with others. The spirit is important for helping us to move forward and be able to respect the different routes communities can take

Appendix 2: List of participants

Participant	Region/Organization
Ahenakew, Freda	SK – Cree Nations Opioid Replacement Therapy Program
Alexander, Shanelle	Renewal Leadership Team
Barron, Liz	NNAPF
Bear, Chief Austin	NNAPF
Bighorn, Jordan	MB - The Mino Bimidiziwin Program
Bobet, Ellen	ON - Consultant
Brown, Robert	SK - Health Canada
Churchill, Tanya	AB - Health Canada
Cincotta, Jim	Inuit Tapiriit Kanatami (ITK)
Constant, Peter	MB – Cree Nation Tribal Health Centre Inc.
Cournoyer, Marie-Eve	QC - Health Canada
Dell, Debra	ON - Renewal Leadership Team; YSAC
Dixon, John	ON – Dilico Treatment Centre
Dreaver, Lorette	SK – Big River First Nation Health and Wellness Initiative
Dumont, Elder James	Renewal Leadership Team
Everington, Coreen	AB - Health Canada
Fontaine, Bertha	MB – National Addictions Council of Manitoba
Gagnon, Jennifer	NNAPF – NU Region
Gardipy, P.Jenny	NNAPF
Gibbons, Nicole	BC - Health Canada
Ginnish, Cindy	ATL – Regional Atlantic Partnership Committee
Grandmaison, Sandra	QC – Conseil des Montagnais du Lac-St-Jean
Gray, Jane	First Nations Information Governance Centre (Regional Health Survey)
Hanson, Gaye	YK - Kwanlin Dun First Nation
Hernandez, Isaac	BC Region
Hopkins, Carol	Renewal Leadership Team; NNAPF
Hutt-McLeod, Daphne	ATL – Eskasoni FN, Tui'kn Case Management Model
Isaac-Mann, Sonia	Assembly of First Nations (AFN)
Jesseman, Rebecca	Canadian Centre on Substance Abuse (CCSA)
Kyme, Gladys	Renewal Leadership Team
Leeson, Don	BC – Nisgaa Valley Health Authority ; Gingox Health Centre
Lyons, Donna	Mental Health Commission of Canada (MHCC)
MacDonald, Sarah	Assembly of First Nations (AFN)
Martin, Michael (Mike)	NNAPF; NNADAP /YSAP Addictions/Mental Health Workshop
McKay, Dianne	Renewal Leadership Team
McLeod, Wayne	MB - The Mino Bimidiziwin Program
Mills, Elder Agnes	Renewal Leadership Team
Morin, Myrtle	NNAPF
Mushquash, Chris	Renewal Leadership Team
Nicholas, Charles	Renewal Leadership Team

Paul, Claudie	QC – Labrador Health and Social Services Commission
Penashue, Jack	ATL – Sheshatshiu Innu First Nation
Pittis, Rose	ON – Leadership Team; Dilico Treatment Centre
Poulin, Christiane	ATL – Health Canada
Prudent, Jose	SK – Battleford Tribal Council Indian Health
Restoule, Brenda	Leadership Team
Richard, Marcy	MB – Health Canada
Rigsby-Jones, Yvonne	BC – Leadership Team, Tsow-Tun Le Lum Treatment Centre
Roberts, Lynda	ON – Health Canada
Sauve, Ernest	SK – White Buffalo Treatment Centre
Schopf, Theresa	Health Canada –ON Region
Seymour, Catherine	BC – Sts'ailes (Down Town Eastside Pilot Project)
Shaw, Jeremy	SK – Health Canada
Small Legs, Carolynn	AB – Alberta Region Co-Management Committee
Small Legs-Nagge, Patrick	ATL – Health Canada
Smith, Ellen	NNAPF – NT Region
Smith, Leslie-Anne	SK – Health Canada Nursing
Smith, Wanda	NNAPF – ON Region
Sock, Eva	NB – Elsipogtog First Nation/Big Cove
Sullivan, Linda	NNAPF; Screening and Assessment Literature Review
Thake, Jennifer	First Nations Information Governance Centre (Regional Health Survey)
Tikk, Delena	NNAPF – BC Region
Wells, Patty	NNAPF – AB Region
Whitenect, Barbara	NB - Addictions and Health Services
Williams, Elder Barney (Joseph)	Leadership Team
Wolfe, Helene	AB – Treaty 7 Management Corporation
Woods, Kassandra	Assembly of First Nations student

Appendix 3: Evaluation Responses on the Honouring Our Strengths National Renewal Forum

Forum participants were invited to complete evaluations on the last day. The following is the compilation of their comments. Further comments will be received and considered for future events, meetings, and any forum taking place.

1. **What did you like about the Honouring Our Strengths: National Renewal Forum?**
    - The participants- community front line workers, provinces/territories, national and academic. Excellent groups
    - In our case – simply the opportunity to present our story and share
    - 1) regional presentations with key achievements; 2) world café discussions/recommendations; 3) collaboration presentations/discussion; 4) networking opportunities; f) the real life successes of presentations (i.e. BC – the challenge)
    - Networking opportunities
    - Sharing of information
    - Dialogue opportunities
    - The networking was the best part of this for me
    - The energy in the room was very encouraging and hopeful
    - All the strengths that were shared from the regions
    - Culture presentation was great
    - Maintaining the momentum
    - Communication
    - The sharing
    - The World Cafés
    - Planning and moving forward
    - Learned about all our commonalities across this land – we are a great people!
    - The café: presentations/feedback/discussions
    - Presentations: copies were given
    - Opportunity to network
    - It was work!
    - World café – great to learn from others
    - Network – listen, share, gather
    - Coming together – all partners in one room and discussions were good
    - Power point presentation and finally renewal world café sessions were excellent
    - But never forget the spirituality and our culture and traditions “Wow” ☺ Beautiful
    - Opportunity to hear/see current and emerging projects that are moving HOS forward on the ground. Networking. Sharing NNAPF projects and receiving feedback and direction
    - Hearing of all the progress and the people who are striving for a common goal
    - Participation; seeing the work past, present, and future; collaborating
    - All aspects, but most specifically the world café sessions

2. **What did you not like about the Honouring Our Strengths: National Renewal Forum? What could have been done differently?**
    - Organizers/staff were note takers from some groups, and all that was responded on were those comment from staff and organizers not the comments from the participants. E.g. Performance measurement and birthday month groups from day 3
    - The world café sessions were far too short. Presenting the program prior to discussion needs 45 minutes. Discussion could be 30 minutes. Less options = more in depth consultations
    - Everything was good. Keep up the great work. Thank you
    - World café sessions while beneficial seemed to be in too close proximity hence speakers had to speak over top of each other and at times limited discussion
    - Some world cafes more presentation than dialogue – clarify purpose with presenters in advance
    - I felt that the world café sessions could have been about 15 minutes longer. Needed a bit more time to develop discussion
    - Northern issues, concerns. The leaders were not prepared
    - More regional reps committed to staying
    - The short time frame for discussions
    - Regional presentations too long
    - Little time for feedback on presentations in Café
    - Food (choices)
    - Hard to hear the breakout groups with so many people in the room
    - Not enough time for Café Sessions
    - The food was horrible
    - All in general was good but if not approached to be a part of world café how would I learn from all the good work and share ideas need other here. A way of taking /capturing this for others not here
    - There's nothing that I didn't like, but not enough time in the renewal café sessions
    - Would have liked to receive more information on the world café sessions, but it was great nonetheless
    - The short discussions but it is understandable with the time frame
    - Would have loved to hear more about some other progresses
    - Put a wall around the Alberta table. Disrespectful so that others could not hear the presentations. Otherwise great job to all the NNAPF employees and FNIH employees. Hats off
    - It was excellent! If there is a future forum perhaps we could invite some provincial/territorial folks so they can learn more about the renewal strategy and our services

3. **What information from the Forum is helpful to the work that you currently do?**
    - To hear from other areas of the country where provinces and territories are engaged and partnering on services E.g. New Brunswick model
    - To know how *little* it seems work is focussed on youth. More importantly, the genuine goodness and health of youth
    - Collaboration efforts/processes; 2) care facilitation; 3) workforce development
    - While our region is engaged in collaborative integrated projects there are still many steps to take and work to begin
    - Nice to see that our region projects are following renewal objectives
    - Many opportunities for collaboration identified through concrete project info shared

- A couple of communities doing outcome research on the same program. We have just begun. Also changing program to be more culturally based – good info and networking possibilities
- The leadership that YSAC provides
- Networking
- Partnership
- Some information gave us ideas on how we may improve our own services, independently and regionally and nationally (Go beyond the box)
- What works in other regions(cafés) learning specifics
- Knowing the work of the other regions; wise practices
- What's working and working well – taking from others
- Sometimes I feel all alone, feeling discouraged and ready to quit and I come here – from this perspective I feel re-energized and it's not too blurry and I don't feel all alone anymore
- All of it, especially topics on collaboration, partnerships and common/standard tools being used and/or implemented to streamline service delivery
- The networking and understanding of other organizations' progress
- The solutions offered by other projects to the challenges experienced by most of us

4. **Based on your knowledge of Honouring Our Strengths: a Renewed Framework to Address Substance Use Issues among First Nations People in Canada and experience at the forum, are there any specific actions or activities that you think would enhance the renewal efforts? If so, what are they?**
   - Concrete examples from each province/territory where those efforts have already been implemented. Not comments from FNIH that implementation is already taking place. Front line/ grassroots workers do not see this
   - Engage youth – specifically junior youth (10-15 yrs)
   - Communication to be flowed to community workers, leaders and service providers
   - Increased research and accessing those agencies that are already funded to contribute to validating the work of renewal
   - Validate role of cultural and work towards standardization of treatment and community referral and assessment tools
   - Communications focussed to decision makers and communities. Concrete steps and objectives – not just *what* but *how*
   - Communicating to chief and Council and frontline workers in a way that engages them
   - Communication
   - Leadership team communication
   - 6 Elements moving from the 13 priority areas. Concern with wage parity getting lost
   - More communication/information to all stakeholders (i.e. clients, workers, leadership inclusive of government)
   - Cultural relevance is key to involving First Nations at any part of this renewal
   - More forums like this – regionally as well as nationally
   - The renewal Framework to be sent to communities (First Nations) awareness
   - Benefits of implementing this Framework
   - Information of examples of how and what has been done so far on the implementation of Framework
   - Report from this forum
   - Visual and appealing

- Social networks
- Funding/resources/sustainability
- Reach out regionally to inform at community level
- We can do the same. What else can I say – coming together and partnership – on and on. It's all here
- More sharing (virtual and face to face) of projects and initiatives – keep us moving forward and engaged. Community(ies) of practice
- NNAPF does a lot of wonderful work
- Informing and including more provincial/territorial folks on Framework and providing opportunities for FN and provincial folks to come together at these types of sessions more often … to move the process forward faster

5. **Beyond the Forum, how do you think we can best engage with you on the implementation of Honouring Our Strengths?**
    - Keep contact via social media – papers pile up, email gets filtered, Facebook, texting, and media happens 24/7
    - Additional invitations to ongoing renewal gatherings
    - Add more regional activities, presentations specific for community best practices, programs, services in relation to renewal efforts
    - Just ask. All regional decisions are based on regional and national priorities and renewal elements and supporting elements are always considered when implementing projects and initiatives
    - Send info, success stories, etc.
    - Allow cross posting of info on partner websites for example
    - On LDHP Team
    - The Leadership team needs to communication with the regions. That is not taking place. It deeply concerns me
    - The commitment
    - By partnering with all the levels of government, community, municipal, provincial and federally.
    - By informing as many people as possible at the grassroots level for whom this renewal is intended and for forum are the strengths of this initiative
    - To especially engage the youth
    - E-mail network
    - Invite to forums are great (central location)
    - Good meals (Simple!)
    - Visual aids
    - Simple, clear and to the point
    - Continued communication. List serves for website perhaps as new info is posted, e-mail alert is given in everyday busy life you forget to check – need a reminder.
    - Hurray!! For these chiefs and council that care so much about their people's holistic wellbeing but not all leaders understand or care about that. (not to be critical). We need to convince them that in order to with this "war" we have to come together and address the well-being "holistically" of our people. God Bless
    - Email/virtual forums/webinars/ community of practice
    - Sharing a networking list with organizations, contact names and e-mail
    - Carry on with how it is currently being done. E-mails-website-forums are working

- More opportunities to have mental health and NNADAP folks collaborate to achieve Framework goals

Other Comments provided on the HOS Forum

- Concern with FNIH regions presenting without First Nations voice
- Ensure all participants know their individual roles and are provided with all necessary materials
- These issues contributed to a perception that the second renewal forum was more Health Canada driven
- Dynamic that may have contributed to the perception that the forum was Health Canada driven relates to the facilitation and the agenda. At the first renewal forum, Rod Jefferies facilitated and Richard Jock made opening comments which all set people at ease because they talked so much about history and because they are both trusted as being passionate about NNADAP. The Catalyst facilitators didn't speak with any knowledge or ongoing acknowledgement about NNADAP specifically and then they weren't Native so people may have perceived them as Health Canada
- Sense of a lack of involvement or reflection of FN communities' needs - i.e., need more focus on community development, community prevention and aftercare