



**FIRST NATIONS AND INUIT HEALTH,
SASKATCHEWAN REGION
MENTAL HEALTH AND ADDICTIONS
NEEDS ASSESSMENT**

**VOLUME I
FINAL REPORT**

**FOR DISCUSSION PURPOSES –
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Prepared for:

First Nations and Inuit Health, Saskatchewan Region

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EXECUTIVE SUMMARY

Purpose of the needs assessment

Recently, an evidence-based process guided by the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF), and First Nations and Inuit Health (FNIH) of Health Canada has been implemented. The purpose of this process is to develop a comprehensive national program framework that will enable Health Canada and its community partners to improve the coordination and integration of services offered by the National Native Alcohol and Drug Abuse Program (NNADAP). As a first step in the process, each FNIH Region was required to complete a needs assessment of its addictions services. Saskatchewan Region included a review of mental health services (broadly defined) in its assessment, recognizing that the addictions and mental health service systems are complementary.

FNIH Saskatchewan Region hired PRA Inc. to conduct the needs assessment on its behalf. This report summarizes and analyzes the findings from data collection activities completed as part of the regional needs assessment, draws conclusions, and provides recommendations.

Methodology

An Oversight Committee composed of 12 members provided guidance and advice on the needs assessment process. As a first step, PRA prepared a research framework (i.e., a matrix of research issues, questions, indicators, and data sources) to guide the needs assessment. The framework is based closely on the Regional Mental Health and Addictions Needs Assessment Guidelines for Saskatchewan Region. The framework covers several main issues including scope of need, service provision, culture and best practices, human resources, governance and integration of services, and resource allocation. To enhance the reliability and validity of the findings, multiple data sources were used to respond to the research questions. Data collection methods included:

- ▶ A document, data, and literature review
- ▶ In-depth interviews with key stakeholders (n=35)
- ▶ Talking circles with community members in six First Nations communities across Saskatchewan (n=103 participants)
- ▶ A survey of addictions treatment centres in the province (n=9 completions)
- ▶ A survey of First Nations Community Health Directors (n=22 completions)
- ▶ A survey of front-line mental health and addictions workers in First Nations communities (n=78 completions)
- ▶ A survey of projects currently being funded by the Aboriginal Healing Foundation in Saskatchewan (n=11 completions).

In consultation with the Oversight Committee, PRA developed a series of data collection instruments based on the research framework. The needs assessment was carried out between November 2008 and June 2009.

Limitations of the research

A major limitation of this needs assessment is a lack of comprehensive quantitative data on scope of need, budgets, staffing levels, staff qualifications, service availability, service utilization rates, waiting lists for service, and outcomes at the community level. Such information does not appear to be systematically collected at the community level as a routine aspect of program administration. The survey of Community Health Directors was intended to collect much of this data, but, for a variety of possible reasons, that survey elicited an extremely poor response. In the absence of comprehensive community-level information, it is extremely difficult to draw meaningful conclusions about the adequacy of current services and human resources, or make recommendations on the optimal allocation of resources. Many of the conclusions and recommendations of this needs assessment are therefore necessarily based on qualitative information. That being said, much of the qualitative information substantiates the findings of previous studies, so there is good reason to have confidence in the overall conclusions.

Findings

Scope of need

The available statistics on acute and chronic alcohol and drug-related harms show that substance abuse, addictions, and other mental health problems are major issues for First Nations across Canada. However, without regional prevalence data, the extent of these problems is unknown. Moreover, without comprehensive information on rates of service utilization and wait times, the extent to which First Nations people with mental health and addictions problems in Saskatchewan are currently receiving some level of service cannot be determined. Although there is widespread consensus that the need for mental health and addictions services among First Nations people is great, the true scope of that need is unknown, due to a lack of the necessary data.

Similarly, a comprehensive understanding of the mental health and addictions services available to First Nations at the community level is still lacking, despite concerted efforts through this research to collect this information. In the absence of complete data, it is not possible to make an accurate assessment of service gaps, needs, and priorities, or to make recommendations on the optimal allocation of resources within Saskatchewan Region.

Recommendation 1. Renewed efforts should be made to gather the information necessary to inform decision-making on program redesign and optimal configuration of resources. This information includes:

- ▶ **data on scope of need, such as prevalence rates, rates of service utilization, and wait times for services; as well as**
- ▶ **comprehensive information about the mental health and addictions services available at the community level including budgets, staffing levels, staff qualifications, service availability and utilization, and outcomes.**

Recommendation 2. In the immediate term, in order to supplement the partial information obtained through this research, FNIH could follow up with Community Health Directors in order to obtain a completed survey from those who did not submit one as part of this needs assessment. If complete, the survey data set would provide a reasonably solid basis for planning.

Ideally, data collection should not be a "one-off" task conducted as part of a specific research assignment, but a routine aspect of program administration at the community, Tribal Council, and FNIH levels. At the community level, the complexity of the current governance structure and the political and practical realities of Health Transfer may, in some cases, mitigate against a consistent approach to data collection. Complicating the problem is that, in many communities, there is evidently a need for implementation of and training in information technologies such as basic computer programs, the Internet, and financial systems to facilitate program administration, record-keeping, and reporting.

Recommendation 3. In the short and medium term, several practical measures could be taken to encourage systematic data collection and reporting as a routine aspect of program administration at the community level. These measures could include:

- ▶ **Developing guidelines regarding the specific pieces of data that should be routinely collected at the community level and providing training on these guidelines to First Nations communities.**
- ▶ **During training, explaining the benefits of improved data collection, as a means of ensuring buy-in on the part of First Nations communities.**
- ▶ **Ensuring that every community has the technological infrastructure and human resource capacity for data collection. This could include providing funding for computer hardware, software, and Internet connections, as well as providing computer training to community-based managers and front-line workers.**

Service gaps, needs, and priorities

Notwithstanding the limited information available to this needs assessment, certain observations about service gaps, needs, and priorities can be made with some confidence. For example, it is clear that addictions services are more readily available in First Nations communities than mental health services. Addictions education and prevention, screening and assessment, and counselling are available in many communities, whereas mental health services are focused primarily on providing referrals, cultural support, and crisis-related services such as intervention, counselling, management, or training; incident debriefing; and crisis team planning and delivery.

This imbalance is due to the way in which funding for mental health services is structured and delivered. Whereas NNADAP functions as the primary source of funding for addictions programming for First Nations, mental health services are funded through a variety of programs – including Brighter Futures, Building Healthy Communities, Non-Insured Health Benefits, the Indian Residential Schools Health Resolution Support Program, and the Aboriginal Healing Foundation – and are delivered at either the community or Tribal Council level. This approach produces a lack of consistency in the nature and quality of mental health services at the community level.

Moreover, it appears that the current system emphasizes crisis response and intervention at the expense of other needed services along the continuum of care, such as promotion, prevention, early intervention, treatment, aftercare, and long-term rehabilitation and healing. NIHB, in particular, makes funding available primarily in response to crisis: funding for mental health counselling under NIHB was less than half a million dollars in 2008-2009. The need for more mental health counsellors or funding for this purpose was the most frequently mentioned priority by participants in this research; many communities clearly do not have adequate access to mental health counselling services. The situation is all the more urgent since AHF project funding, which focuses specifically on addressing the long-term and intergenerational impacts of the residential school system, is sunsetting in 2010, and survey results suggest that many funded projects do not have plans in place for long-term sustainability.

Given the scope and magnitude of the mental health and addictions-related issues affecting First Nations, many individuals and communities require fairly intensive mental health support and healing. The current system of mental health services for First Nations falls considerably short of the type of comprehensive program and sustained continuum of care that many First Nations communities would require. A major priority emerging from this research is the need for a more coordinated and comprehensive approach to mental health services; for example, through the development and implementation of a single mental health program for First Nations, with elements spanning the entire continuum of care.

Some stakeholders within the Region would go further, eliminating the multiple funding programs for mental health and addictions services – including NNADAP – and developing a single, comprehensive mental health and addictions program. However, such dramatic restructuring is probably not feasible in the short- and mid-term.

Recommendation 4. A more coordinated approach to mental health services for First Nations should be developed. One possibility might be to rationalize the current approach to funding by eliminating the multiple sources of funding for mental health services and restructuring them into a single mental health or wellness program for First Nations. Ideally, the new program would include elements spanning the continuum of care, including promotion, prevention, crisis response and intervention, early intervention, treatment, aftercare, and long-term rehabilitation and healing.

Recommendation 5. Given the small amount of money spent on mental health counselling under NIHB, consideration should be given for phasing out funding for mental health counselling as part of that program and focus on developing mental health counselling as an element of a new mental health program .

Providing a continuum of care does not necessarily mean that all services should be available in all communities. That is clearly not feasible with existing resources, nor is it the reality in non-Aboriginal communities within the Region or elsewhere in the country. That being said, efforts should be made to ensure that a basic level of service is available everywhere and that all services along the continuum of care are accessible to all First Nations communities with relative ease.

Recommendation 6. Determine what mental health and addictions services should comprise a "basic package" available in all communities. Tentatively, these services could include prevention, crisis response and intervention, referrals, basic addictions and mental health counselling, cultural support, and aftercare.

Recommendation 7. Experiment with innovative ways of delivering services. Some possibilities include:

- ▶ **Developing health promotion and prevention public service announcements, in First Nations languages as well as in English, and broadcasting these via the Aboriginal Peoples' Television Network (APTN)**
- ▶ **Implementing travelling interdisciplinary teams of service providers to visit communities on a regular schedule to provide clinical or specialized services**
- ▶ **Making greater use of telehealth services.**

The need for a dedicated focus on and investment in First Nations youth is another major priority emerging from this research. Although FNIH was interested in knowing the extent to which existing services are appropriate for youth, pregnant women, and individuals with concurrent disorders, as well as the extent to which these services are gender-appropriate, participants in this research were primarily concerned about the situation facing First Nations youth. Children and youth age 24 and under make up close to 60% of the First Nations population in the province and, as a group, experience multiple issues – including high rates of school drop-out, early exposure to substances, substance use, early sexual experiences, teenage pregnancy, parental neglect, family breakdown, abuse, gang involvement, loss of cultural identity, and suicide – that speak to the need for mental health intervention.

At present, there does not appear to be a systematic plan in place for addressing their needs. Moreover, most mental health and addictions services are not designed for youth, and addictions and mental health workers are seldom trained to work with this population. Indeed, youth are among the most underserved segments of the population and rarely seek out the formal mental health and addictions services available in their communities, considering these unresponsive to their needs and a potentially destructive force in their lives.

Many stakeholders regard health promotion and prevention initiatives for youth as especially important. Prosocial recreational activities and initiatives to reconnect youth with their cultural heritage – such as linking youth with elders in their communities – were identified as major priorities. That being said, given that many First Nations youth are already involved in substance use and/or have mental health issues requiring intervention, prevention services for youth should be balanced with specialized early intervention, treatment, and aftercare services.

Recommendation 8. Develop a comprehensive strategy to address the mental health and addictions needs of First Nations youth. Among other things, such a strategy could involve:

- ▶ **developing specialized mental health and addictions services for youth**
- ▶ **developing innovative strategies to reach youth; possibilities might be youth outreach programs, peer support programs, and school-based programs**
- ▶ **providing more prosocial recreational activities for youth**
- ▶ **increasing the number of NNADAP and mental health workers specially trained to work with youth**
- ▶ **developing a "youth and elders" program to reconnect First Nations youth with their cultural heritage, expose them to cultural teachings and traditional ways of life, provide them with positive role models in their communities, and engage them in healthy pastimes.**

Finally, a third major priority identified by this needs assessment was the need to support entire families and, indeed, communities as part of efforts to address mental health and addictions problems, rather than focusing on individuals. At the prevention and early intervention stage, a focus on families could mean more widespread implementation of positive parenting programs, support for the role traditionally played by extended families, and other similar supports. At the treatment stage, the concept could mean having entire families, rather than individuals, enter residential treatment centres (at present, only one treatment centre provides specialized programming for families). Alternatively, it could mean employing more outpatient treatment that includes all family members. Finally, a strong at-home program to support individuals and entire families after treatment could help to maintain successes achieved in treatment and prevent relapse. Recognizing the importance of family is consistent with acknowledged best practice for First Nations populations.

Recommendation 9. Recognizing that mental health and addictions problems affect individuals within a family context, greater use of family supports and family-based interventions is warranted as a matter of best practice. For example:

- ▶ **positive parenting programs and other similar supports for families, as a prevention and early intervention strategy**
- ▶ **family-based residential treatment, or alternatively, and perhaps preferably, outpatient treatment that includes all family members**
- ▶ **strong aftercare programs to support entire families once treatment is completed, to maintain successes achieved in treatment.**

Barriers to access

Like previous studies, this needs assessment identified numerous barriers preventing First Nations people from accessing the available mental health and addictions services, the most significant of which is concern at the community level about lack of confidentiality and trust. Our findings suggest that this is a complex problem. There is often a practical issue of a lack of private office space for workers to meet with their clients. But the larger problem stems from the reality that most front-line workers are members of the communities in which they work. While this is perceived as a real strength of the system, the fact that front-line workers usually know their potential clients or may even be related to them is also a shortcoming. Among community members, there is reluctance to access community-based workers for fear that private affairs will become public knowledge. Moreover, many are reluctant to be seen accessing these services because of the stigma associated with these problems and out of fear that gossip and rumours will be generated about them. Exacerbating the problem, nepotism is reportedly still a factor in hiring, so that many people lack confidence in the experience and qualifications of front-line workers.

It is probably not overstating the point to say that in some communities there is such significant apprehension about lack of confidentiality that the available services are not being used to their full capacity. There is an urgent need to address this issue, since the entire system is premised on workers providing services in their own communities.

Recommendation 10. While the issue is unlikely to disappear in the short-term, the barriers to access stemming from concerns about confidentiality could be mitigated through a multi-pronged approach. Among other things, elements of this approach could include:

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

The cultural inappropriateness of some services was also identified as a major barrier to access. This barrier has been identified by numerous prior studies, and in this research was highlighted by key informants as well as talking circle participants. They observed that the system of mental health and addictions services, based on Western clinical approaches to health, is often uncomfortable for First Nations people. Provincial services delivered by the regional health authorities are seen as particularly inappropriate and unapproachable for First Nations. This is problematic, given that First Nations people make up a significant proportion of clients of provincial mental health and addictions services. Previous studies, as well as individuals interviewed as part of this needs assessment, have observed that communication and collaboration between First Nations service providers and provincial services, which might help to mitigate these difficulties, are very limited.

Recommendation 11. Given the number of First Nations people accessing provincial mental health and addictions services, efforts should be made to improve their experience of these services. These efforts could include:

- ▶ **encouraging collaboration and cooperation between First Nations service providers and provincial service providers**
- ▶ **developing supports for First Nations people who access provincial services.**

Culture and best practices

In 2000, the NNADAP Renewal Framework acknowledged the importance of integrating both First Nations culture and evidence-based practice. This dual commitment may seem paradoxical because there is little scientific research demonstrating the effectiveness of culturally based approaches. A related issue is a lack of evidence on practices and treatments that are effective specifically for Aboriginal populations. Many key informants emphasized that there is an urgent need for research to establish support for the role that culture can play in healing, and also for research into effective practices specifically for Aboriginal people. White Raven Healing Centre is currently engaged in a pilot project called Culture Heals, funded by Health Canada, which has these very objectives.

Recommendation 12. To improve the evidence base, more evaluation of culturally based approaches should be undertaken, as well as research to determine what practices and treatment approaches are effective for Aboriginal populations.

The importance of integrating cultural and traditional approaches into service provision for First Nations has been identified in the literature as best practice. At the community level, and within addictions treatment centres, it appears that culture is already an important aspect of service provision and, to this extent, services are reflective of best practice. Within Saskatchewan Region, White Raven Healing Centre may offer a model for service provision elsewhere in the province. The Centre offers a holistic healing program of wraparound services delivered by an integrated, interdisciplinary team of staff including a psychologist, mental health therapists, addictions counsellors, and elders. Within the Centre's model, cultural/spiritual services are the central component. The focus is on integrating traditional healing practices and First Nations philosophies and beliefs into a clinical setting.

Recommendation 13. As a matter of best practice, service provision should strive to integrate cultural or traditional approaches with Western, clinical approaches to mental health and addictions services. The specific cultural approaches used, as well as the appropriate balance between Western and cultural approaches, should be a matter for individual communities to determine.

Although community-based information is missing, the needs assessment did find some examples of evidence-based or promising models within the treatment centres, such as cultural, biopsychosocial, whole person, resiliency, and holistic models. Three treatment centres use the Matrix Model of addictions treatment, and one uses Equine Assisted Learning, an emerging field of psychotherapy in which horses are used as a tool for emotional growth and learning. The research findings also show that many of those working in First Nations communities and treatment facilities have training in evidence-based techniques, including Applied Suicide Intervention Skills, Suicide Intervention, Critical Incident Stress Management, Relapse Prevention, Motivational Interviewing, Mental Health First Aid, Emotional Intelligence, Therapeutic Crisis Intervention, and SafeTalk.

Harm reduction is one area where current practice among First Nations service providers is not necessarily congruent with acknowledged best practice. Although the predominant addictions treatment philosophy in Canada favours harm reduction over abstinence, many Aboriginal communities and programs still adhere to models of abstinence and prohibition. Our survey of addictions treatment facilities confirmed that all of the treatment centres currently take an abstinence approach to treatment, with the exception of Leading Thunderbird Lodge, which requires abstinence during treatment but teaches harm reduction for return to the community. Similarly, we did not find much evidence of harm reduction approaches at the community level. While harm reduction is not a policy approach favoured by the current federal government, from a public health and best practice perspective, it does merit consideration.

Human resources

This needs assessment was not successful in obtaining the quantitative information needed to determine if current human resources are adequate to respond to needs. This information includes data on current human resource levels, service utilization rates, and wait times for service, as well as prevalence data. That being said, previous studies have found that there are not enough First Nations practitioners, especially mental health therapists and mental health and addictions workers who specialize in working with youth, and the qualitative information collected by this needs assessment certainly supports that finding. Of the 91 mental health therapists approved by FNIH, only a small number are Aboriginal, and more mental health therapists was one of the most important needs according to participants in this research. Beyond that, qualitative data from this research suggest that apprehension about confidentiality at the community level has produced some underutilization of the services provided by community-based workers, although the extent of the problem is not known.

Recommendation 14. Measures should be taken to increase the number of qualified First Nations practitioners, in particular mental health therapists and mental health and addictions workers with specialized training to work with youth.

Recommendation 15. Work with First Nations post-secondary educational institutions to develop and implement a certificate or degree program in mental health. Consideration should also be given to developing specialized programs to train mental health and addictions workers to work with youth.

Recommendation 16. To facilitate an assessment of the adequacy of current human resources, further research should be undertaken to determine whether existing community-based services are being used to their full capacity.

Previous studies have also concluded that the existing workforce is relatively untrained. The data available to this needs assessment suggest a growing professionalization of the First Nations workforce. Almost half (47%) of front-line workers surveyed have at least one type of addictions certification, and according to FNIH, 43% of NNADAP workers in the Region are certified, which compares favourably with 39% of NNADAP workers nationally. By the end of 2009, FNIH expects that 54% of NNADAP workers in the province will be certified as a result of its Workforce Development Initiative.

Over the years, FNIH Saskatchewan Region has taken several measures to improve the qualifications of the First Nations mental health and addictions workforce, including developing a certification program for addictions workers in partnership with the Saskatchewan Indian Institute of Technologies and funding annual conferences for NNADAP workers in the province. Nonetheless, many people are evidently still working without adequate qualifications and training, and key informants reported that nepotism continues to be a factor in hiring. Counselling skills and general mental health training for addictions workers, as well as cultural training and computer training, are among the most important professional development needs, and training in ethics, to begin addressing confidentiality concerns, is also clearly required. There is also a need for clinical supervision of community-based workers, given that many are paraprofessionals.

Recommendation 17. The ongoing professional development and training of mental health and addictions workers should be supported. Areas that merit particular attention include basic counselling skills and mental health training for addictions workers, cultural training, computer training, and training in ethics.

Recommendation 18. Enlisting mental health therapists to provide clinical supervision and training to community-based workers should be considered. Such a strategy could include deploying in-person support on a rotating basis to First Nations communities and developing a 24-hour telephone line for workers to access for clinical supervision, advice, and guidance.

Finally, previous studies as well as participants in this research have observed that current pay rates are insufficient to recruit and retain qualified personnel. Our research found average pay rates among community-based workers and treatment centre personnel (excluding those with management responsibilities) of approximately \$16 per hour, although these rates are based on limited information and we lack data against which these rates could be compared. Nevertheless, given the demands of front-line work in mental health and addictions, the \$2,600 one-time payment that FNIH is providing to each worker who completes certification as part of its Workforce Development Initiative is probably insufficient to resolve the problem. In the medium term, a process to adjust the salaries of workers who complete advanced training is needed as an incentive for retention and advancement.

Recommendation 19. In the medium term, a process to adjust the salaries of workers who complete advanced training as an incentive for retention and advancement should be developed. This would require developing job classifications and corresponding salary levels for community-based workers.

Integration

Over the past few years, a consensus has developed that integration of mental health and addictions would increase service efficiency and effectiveness by reducing gaps in service and optimizing the use of scarce resources. However, recent studies have suggested that in First Nations communities, mental health and addictions services continue to operate, for the most part, in isolation from one another. Mental health and addictions services are funded through different funding envelopes, administered and delivered by different organizational entities, and staffed by different people.

This needs assessment found considerable support for integrating mental health and addictions services at the community level. Integration is widely seen as desirable, with numerous advantages for clients, including "one-stop shopping" for clients; ease of information sharing; the ability to use the different skills and talents of workers to their maximum potential; and the potential to reduce staff burnout. Among front-line workers and Community Health Directors surveyed, only 24% believe that mental health and addictions services are too different to be integrated.

Similarly, our findings suggest that some First Nations communities have already gone some way toward integration. Many key informants reported that integration has already occurred within their own communities or organizations, describing interagency teams, collocation and

co-management of services, and development of integrated case management and treatment plans. Similarly, most survey respondents said that, in their communities, mental health and addictions workers are familiar with each other's roles and regularly refer clients to one another, and that these services are managed and delivered by the same organization. However, fewer said that mental health and addictions workers take a team approach to working with clients or meet together regularly, suggesting room for improvement in this regard.

Despite some progress toward greater integration, therefore, obstacles remain. These include the fragmented delivery and administrative structure for mental health and addictions services; turf wars and territoriality; and historical differences in philosophy, approach, and the characteristics of the respective workforces (i.e., mental health workers tend to have more formal education and professional training, and are more often non-Aboriginal, whereas addictions workers tend to be paraprofessionals and are mostly First Nations people). Most key informants were confident that all of these barriers could be overcome with concerted effort. Many of the recommendations made above, particularly those related to program restructuring and human resources, would help to promote greater integration of mental health and addictions services.

Recommendation 20. In addition to the other recommendations of this report, additional measures could be undertaken to promote integration of mental health and addictions services. Possibilities include:

- ▶ **Encouraging mental health and addictions workers to take cross-disciplinary training**
- ▶ **Inviting mental health workers to the annual NNADAP conferences for professional development and networking purposes**
- ▶ **Inviting program managers from communities where integration has occurred to present their models to other interested communities.**

Governance

Related to the question of integration, this needs assessment examined the impact of the current governance structure for mental health and addictions services on service delivery. Within Saskatchewan Region, the NNADAP program is delivered at the community level by individual First Nations communities, the majority of which operate under Health Transfer Agreements or Integrated Service Agreements. Under this decentralized structure, First Nations have the authority and independence to manage and deliver addictions programming, with little administrative unity across the Region. The disadvantages arising from this structure, including a lack of service quality standards, a lack of regional service coordination and support (such as research, planning support, and capacity development), and an inability to move forward with recommended system changes, have been well documented in other reports.

In 1980, in an attempt to address these problems, a Regional Advisory Board (RAB) was implemented as a formal mechanism for First Nations representatives to advise FNIH Saskatchewan Region on NNADAP. Despite some successes, including the establishment of a long-term mandate for NNADAP in Saskatchewan, the development and delivery of the SIIT addictions training program, and the development of regional standards for prevention and intervention, the RAB did not have the legal authority to insist on program upgrading and to ensure standards. It was disbanded in August 2008. The relatively few key informants who commented on the subject of governance agreed on the need for a regional policy-making,

service coordination and support body similar to the RAB. In their view, such a body would also provide a needed forum for input into decision-making on mental health and addictions services, and would ensure that any input provided is taken into account in program planning.

Strengths

Notwithstanding the many barriers, limitations, gaps, and obstacles that this needs assessment has identified, many strengths and assets of the existing system also came to light. Some of the most important perceived strengths of the current system are the cultural aspect of the services; the diversity, qualifications, and dedication of community-based workers; and the degree of teamwork and integration of services that has occurred in some communities. Freedom from political interference and competent program management are also seen as strengths, although these conditions do not prevail in all communities. In addition, the support that FNIH Saskatchewan Region has provided over the years for professionalization of the workforce, reprofiling of treatment services to meet current priorities, and regional coordination of services through the Regional Advisory Board is clearly a strength within the Region. However, the biggest perceived strength is the fact that services are community-driven and community-based, and provided in large part by First Nations people who speak the local language and are familiar with the local culture and traditions. At the same time, the community-based approach also appears to generate some very real barriers to access, which must be addressed if this model of service delivery is to be truly effective.

1.0 Introduction

Recently, an evidence-based process guided by the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF), and First Nations and Inuit Health (FNIH) of Health Canada has been implemented. The purpose of this process is to develop a comprehensive national program framework that will enable Health Canada and its community partners to improve the coordination and integration of services offered by the National Native Alcohol and Drug Abuse Program (NNADAP). As a first step in the process, each FNIH Region was required to complete a needs assessment of its addictions services. Saskatchewan Region included a review of mental health services (broadly defined) in its assessment, recognizing that the addictions and mental health service systems are complementary.

FNIH Saskatchewan Region hired PRA Inc. to conduct the needs assessment on its behalf. This report summarizes and analyzes the findings from data collection activities completed as part of the regional needs assessment, draws conclusions, and provides recommendations.

1.1 Outline of the report

The report is divided into several sections. Section 2 provides a detailed description of the methodology used to complete the needs assessment, while section 3 provides the findings from all data collection activities carried out as part of the research. Section 4 concludes and provides recommendations.

Several appendices follow this report:

- ▶ Appendix A – Research Framework
- ▶ Appendix B – Data Collection Instruments
- ▶ Appendix C – Selected Bibliography

In addition, Volume II of this report (Technical Appendices) contains results from various data collection methods completed as part of this needs assessment, and should be consulted for more detailed information.

2.0 Methodology

This section of the report provides a detailed description of the methodology used to complete the needs assessment.

2.1 Oversight Committee

An Oversight Committee composed of 12 members provided guidance and advice on the needs assessment process. The composition of the Oversight Committee was:

1. One FNIH Regional Consultant
2. One Elder
3. One NNADAP/YSAP Treatment Centre Director
4. One NNADAP Prevention Worker
5. One Addictions Consultant
6. One Mental Health Consultant
7. One Mental Health Therapist
8. One Health Director
9. One Youth Suicide Prevention Coordinator
10. One Resolution Health Support Worker
11. One Federation of Saskatchewan Indian Nations Representative
12. One Province of Saskatchewan Representative

The role of the Committee was to provide feedback on the needs assessment work plan, design, and process; and to identify gaps, provide advice, and make suggestions on appropriate additions or deletions on assessment instruments, with particular attention to the protocol and cultural needs of First Nations. More generally, the Committee was a forum for the exchange of ideas, information, advice, and expertise to facilitate the needs assessment process.

2.2 Research framework

In consultation with FNIH and the Oversight Committee, PRA developed a research framework (i.e., a matrix of research issues, questions, indicators, and data sources) to guide the needs assessment. The framework is based closely on the Regional Mental Health and Addictions Needs Assessment Guidelines for Saskatchewan Region. The framework covers several main issues including scope of need, service provision, culture and best practices, human resources, governance and integration of services, and resource allocation. The framework is in Appendix A.

2.3 Initial communication to stakeholders

To inform stakeholders about the purpose and objectives of the needs assessment, and to advise them that they might be contacted by PRA to participate in the research, FNIH Saskatchewan Region sent notification to relevant stakeholders in December 2008. The purpose of this initial communication was to generate awareness of the needs assessment among those working in the field of addictions and mental health, to highlight the importance of the research, and to secure

the willingness of stakeholders to participate. The letter was signed by the FNIH Regional Director for Saskatchewan.

2.4 Time frame of the research

The needs assessment took place between November 2008 and June 2009. The first few months were devoted to research design and communications activities; data collection took place between January and May 2009.

2.5 Data collection methods

To enhance the reliability and validity of the findings, multiple data sources were used to respond to the research questions. Data collection methods included:

- ▶ A document, data, and literature review
- ▶ In-depth interviews with key stakeholders
- ▶ Talking circles with community members in six First Nations communities across Saskatchewan
- ▶ A survey of addictions treatment centres in the province
- ▶ A survey of First Nations Community Health Directors
- ▶ A survey of front-line mental health and addictions workers in First Nations communities
- ▶ A survey of projects currently being funded by the Aboriginal Healing Foundation in Saskatchewan.

Each of these methods is described below. The data collection instruments, designed by PRA in consultation with FNIH Saskatchewan Region and the Oversight Committee, are in Appendix B.

2.5.1 Document, data, and literature review

The document, data, and literature review report was completed as an interim deliverable and forms a technical appendix to the final report. Relevant materials were, for the most part, identified and provided to PRA by FNIH. However, PRA identified additional sources of information as the research proceeded.

The document, data, and literature review report provides background and contextual information for the needs assessment, and responds directly to some of the research questions identified in the needs assessment research framework. Information from the document, data, and literature review report has been incorporated into this report; the full report is included in Volume II (Technical Appendices).

2.5.2 Key informant interviews

PRA interviewed 35 individuals with extensive experience in or knowledge of the system of mental health and addictions services for First Nations in Saskatchewan, using the interview guide in Appendix B. Key informants were identified by FNIH in consultation with PRA and included Directors of First Nations-operated addictions treatment centres, Tribal Council Health Directors, Tribal Council Addictions Workers, Mental Health Therapists, and other key stakeholders (e.g., representatives from the Federation of Saskatchewan Indian Nations and the National Native Addictions Partnership Foundation).

The purpose of the key informant interviews was to obtain insights from selected individuals with experience and expertise in the area of mental health and addictions for First Nations in Saskatchewan Region. The interviews covered the full range of topics addressed by the needs assessment, including scope of need; current services; gaps, needs, and priorities; integration of culture and best practices; human resources; governance and integration of services; and resource allocation.

The majority of interviews were conducted by telephone. However, some addictions treatment centre directors participated in a group interview completed during one of their regular meetings (held at North Battleford on February 12, 2009). Findings from the interviews have been integrated into this report.

2.5.3 Talking circles with community members

PRA conducted 12 talking circles in six First Nations communities across the province, with participation from a total of 103 community members. The purpose of the talking circles was to obtain the perspective of First Nations communities on the mental health and addictions issues affecting them; the services available in their communities and the strengths of these services; and service gaps, needs, and priorities. The talking circle guide is in Appendix B.

Communities were selected to participate in the talking circles based on several criteria including population, Tribal Council affiliation, and geographic location. The Oversight Committee, charged with the task of guiding the needs assessment process, was responsible for nominating communities to participate in the talking circles, and the final selection was made through consultation among PRA, FNIH, and members of the Oversight Committee.

To facilitate the site visits, FNIH sent a letter to the Chiefs of the selected communities (with the exception of Poundmaker First Nation. This community was completed early in data collection as a pre-test; the decision to send letters to the Chiefs was made subsequent to that site visit). PRA made the actual logistical arrangements for the site visits with the assistance of a primary contact within each community. The primary contact was responsible for recruiting participants, identifying a suitable location for the talking circles, ordering refreshments, and making any other necessary logistical arrangements.

PRA conducted two talking circles in each community. In five communities, we conducted one talking circle with adults and one with youth (ages 12-17); in the sixth community, both of the talking circles consisted of adult and youth participants. Participants were current or past users of addictions or mental health services, or their family members and friends. In total, 103 First

Nations community members participated in the talking circles. [Table 1](#) provides a summary of the communities that participated, the number of participants at each site, and the dates the site visits were completed.

Community	Number of participants	Date of site visit
Poundmaker First Nation	19	February 11, 2009
Onion Lake First Nation	20	March 17, 2009
Carry the Kettle First Nation	18	March 18, 2009
Canoe Lake First Nation	22	April 7, 2009
Black Lake First Nation	18	April 8, 2009
Shoal Lake First Nation	16	April 15, 2009

The talking circles were conducted by Larry Morrissette, PRA's Aboriginal Consultant. A second member of the PRA research team also attended in order to take notes. Participants received \$25 each at the conclusion of the talking circle, and refreshments were also provided at PRA's expense.

2.6 Survey of addictions treatment centres

PRA distributed a survey to all 10 First Nations-operated addictions treatment centres in Saskatchewan at the meeting of treatment centre directors in North Battleford on February 12, 2009. The purpose of the survey was to gather detailed, factual information about the services provided by each of the treatment centres (the survey instrument is in Appendix B). The survey was restricted to gathering objective information and did not solicit the opinions of the treatment centre directors, since they were also identified as key informants and had the opportunity to express their opinions in that forum. Respondents were asked to return the survey to PRA by toll-free fax.

A total of nine treatment centres completed and returned their surveys. Ekweskeet Healing Centre did not submit a completed survey, since it had been closed since January 2008 and was scheduled to reopen in May 2009. Detailed results from the survey can be found in Volume II, and findings have been integrated into this report.

2.7 Survey of Community Health Directors

PRA conducted a mail survey of all First Nations Community Health Directors (n=70) in Saskatchewan. Communities affiliated with the Battlefords Tribal Council (n=7) do not have Community Health Directors, and so the survey was directed to Band Council members with Health Portfolio for those communities.

The purpose of this survey was twofold. First, it gathered detailed information about the mental health and addictions services and related human resources available in First Nations communities, with the objective of compiling an inventory of the available services. Second, it asked respondents for their perspectives on strengths, gaps, and priorities related to mental health and addictions services in their communities, as well as their attitudes towards integration of these services. The survey instrument is in Appendix B.

FNIH was responsible for providing PRA with the list of Community Health Directors and their contact information. A total of 70 names was provided by FNIH and, with the exception of the BTC communities, PRA sent these individuals the survey directly. For the BTC communities, at the request of the BTC Health Director, PRA provided survey packages to the Health Director, who distributed them to the appropriate Band Council members.

Survey respondents had the option of returning the survey in a self-addressed, postage-paid envelope included with the survey or by toll-free fax. The survey was mailed on February 27, 2009. PRA placed numerous reminder phone calls to encourage recipients to respond to the survey. By mid-April, we had received 19 completed surveys. In an effort to increase the response rate, FNIH sent an email reminder with the survey attached to all Tribal Councils, asking them to send the survey out to Community Health Directors. This resulted in three additional surveys being returned to PRA. In total, PRA received 22 completed surveys.

It is not clear why the survey of Community Health Directors elicited this poor response. Some possible reasons include the Regional Health Survey and other assessments currently underway in the Region, the timing of the survey, other pressing priorities within communities, the fact that participation in the survey was voluntary rather than mandatory, and a lack of understanding of the potential benefits to First Nations communities associated with completing the survey. We can also assume that inaccuracies in the contact information provided to us by FNIH contributed, at least in part. During the course of field operations, it came to our attention that some of the names on the list of Community Health Directors were inaccurate (i.e., the individuals identified were no longer in that position or had passed away), and in some cases the addresses and phone numbers provided by FNIH were inaccurate. We were able to obtain accurate contact information in some cases, but not others. To our knowledge, 10 of the 70 individuals identified on the list were no longer in the position of Community Health Director at the time of the survey, and we were unable to obtain the name of an alternate. To calculate the response rate, we have removed these 10 individuals from the survey sample, since we can assume they never received the survey.

In total, we received 22 completed surveys out of a valid sample of 60, which represents a response rate of 37%. This is a disappointing result, particularly since the purpose of this survey – and one of the central tasks of the needs assessment – was to obtain a comprehensive picture of the mental health and addictions services available in communities across the province. That comprehensive picture is unfortunately still lacking.

The survey results were data entered and analyzed using SPSS, a statistical software package commonly used in social science research. Detailed tabular results from the survey are in Volume II. Some results have been integrated into the final report as qualitative information.

2.8 Survey of front-line workers

PRA conducted a mail survey of front-line mental health and addictions workers in Saskatchewan. More specifically, this survey targeted NNADAP, Brighter Futures, Mental Wellness, and Indian Residential Schools Health Resolution Support Program workers, as well as Youth Suicide Coordinators.

Like the survey of Community Health Directors, this survey had two objectives: first, it gathered factual information about services provided, and education and training; and second, it gathered opinion-based information about strengths, gaps, and priorities, as well as attitudes towards integration of mental health and addictions services. The survey instrument is in Appendix B.

FNIH was responsible for providing PRA with an initial list of front-line workers and their contact information. To reduce respondent burden, PRA eliminated from the list any individuals who were also Community Health Directors; these individuals received the survey for Community Health Directors. With the exception of those within the BTC communities, PRA sent the survey directly to front-line workers. For the BTC communities, at the request of the BTC Health Director, PRA provided survey packages to the Health Director, who distributed them to the appropriate individuals. In total, 158 surveys were distributed.

The survey was mailed on February 27, 2009. PRA conducted numerous follow-up reminder telephone calls to encourage recipients to complete the survey; in some cases, the survey was completed by telephone, while in other cases another copy of the survey was mailed, faxed, or emailed to respondents. As with the survey of Community Health Directors, the sample database contained many inaccuracies in names and addresses. Through callbacks, we learned that 15 of the individuals identified in the original sample had left their positions or said the survey did not apply to them because they were not mental health or addictions workers (the actual number may be higher, since we were not able to reach some individuals in the sample due to incorrect phone numbers or no one picking up). We eliminated these 15 individuals from the sample, leaving a final sample of 143.

In total, we received 78 completed surveys, resulting in a 55% response rate. The survey results were data entered and analyzed using SPSS. Detailed tabular results from the survey are in Volume II and selected results have been integrated into the report.

2.9 Survey of Aboriginal Healing Foundation projects

Finally, PRA conducted a survey of the 18 projects currently funded in Saskatchewan by the Aboriginal Healing Foundation. This was a brief survey that captured information on the types of services provided by these projects and their plans for sustainability once AHF funding ends. The survey instrument is in Appendix B. PRA obtained the survey sample from the AHF website. The surveys were mailed on February 27, 2009. We received 11 of 18 surveys, for a response rate of 61%. The survey results were data entered and analyzed using SPSS. Detailed tabular results are in Volume II and selected results have been integrated into this report.

2.10 Limitations of the research

A major limitation of this needs assessment is a lack of comprehensive quantitative data on scope of need, budgets, staffing levels, staff qualifications, service availability, service utilization rates, waiting lists for service, and outcomes at the community level. Such information does not appear to be systematically collected at the community level as a routine aspect of program administration. The survey of Community Health Directors was intended to collect much of this data, but as described above, that survey elicited an extremely poor response. In the absence of comprehensive community-level information, it is extremely difficult to draw meaningful conclusions about the adequacy of current services and human resources, or to make recommendations on the optimal allocation of resources. Many of the conclusions and recommendations of this needs assessment are therefore necessarily based on qualitative information. That being said, much of the qualitative information substantiates the findings of previous studies, so there is good reason to have confidence in the overall conclusions.

3.0 Findings

This section of the report summarizes the findings of all data collection activities completed as part of the needs assessment. Findings are organized according to the issues in the research framework.

3.1 Overview of First Nations in Saskatchewan

First Nations in Saskatchewan are a diverse population consisting of five linguistic groups including Cree, Nakota, Dene, Saulteaux, and Dakota. There are 70 First Nations, comprising 84 communities, of which the majority are affiliated with one of eight Tribal Councils or Governing Agencies, and the remainder are independent bands.

The number of First Nations people in Saskatchewan is difficult to pinpoint. According to 2006 Census data from Statistics Canada, the population of Saskatchewan in that year was 953,850, of whom 91,400, or about 9.6%, reported First Nations status, which includes both Registered or Status and Non-Status Indians.¹ According to Government of Saskatchewan data, the total provincial population in 2005 was 967,241, of whom 103,530 (or 11%) were Status Indians. Indian and Northern Affairs Canada (INAC) estimated the number of Status Indians in Saskatchewan at 119,979 in 2005 and 125,666 in 2007.² The First Nations population within the province is young: according to the 2006 Census, there were 35,790 children aged 0 to 14 and 17,865 youth aged 15 to 24 in the province, constituting 39% and 20%, respectively, of the First Nations population.

First Nations people reside in communities throughout the province. As a percentage of the total population, First Nations are the majority in the northern Athabasca and Mamawetan Churchill River regional health authorities (RHAs), a significant minority in Keewatin Yatthe and the central RHAs, and a small minority in the southern RHAs. However, in terms of sheer numbers, First Nations are concentrated in the Regina Qu'Appelle, Saskatoon, Prince Albert Parkland, Prairie North, and Mamawetan Churchill River RHAs. All of these health regions have First Nations populations exceeding 12,000, and in the Regina Qu'Appelle and Saskatoon regions, the First Nations population is largely urban.³

¹ Statistics Canada. (2006). Statistics Canada acknowledges that the Census may undercount the number of First Nations people in Canada because of incomplete coverage of reserve populations.

² The INAC data may be more accurate than the Census data because departmental population counts determine funding allocations to First Nations.

³ Data from the 2006 Census show that Saskatoon and Regina had 11,510 and 9,495 Status Indians, respectively, and were among the top 10 metropolitan areas in Canada with the greatest number of First Nations people.

3.2 Scope of need

Policy development and program planning are significantly hampered by a lack of statistical data on the prevalence of addictions and mental health problems among First Nations populations in Canada. While the true extent of these problems is unknown, it is recognized that substance abuse, addictions, and mental health problems disproportionately affect First Nations compared to the Canadian population at large. The root of these problems has been traced to a long history of cultural oppression and assimilation policies, which have contributed to the disintegration of traditional cultural and family structures among Aboriginal people in Canada. In its 2007 report, *Addictive Behaviours Among Aboriginal People in Canada*, the Aboriginal Healing Foundation (AHF) used contemporary theories of mental health to show how the residential school system—under which up to five generations of Aboriginal children were forcibly separated from their families; taught that their culture was irrelevant or even destructive; and subjected to emotional, physical, and sexual abuse—has produced mass, intergenerational psychological trauma that is at the root of many of the social disorders facing Aboriginal people. From this perspective, substance abuse, abusive relationships, self-injury, and suicide can be understood as maladaptive mechanisms for coping with psychological trauma.

Addictive behaviours and substance abuse, therefore, are part of the legacy of the residential school system, and have been linked to higher incidences of poor health, family dysfunction, violence, homicide, child abuse, child neglect, suicidal ideation, and suicide among Aboriginal people compared to the general population (Aboriginal Healing Foundation, 2003). The data cited below paint a grim picture of chronic and acute alcohol and drug-related harms affecting First Nations people in Canada:⁴

- ▶ Despite higher rates of abstinence from alcohol and less frequent alcohol use among First Nations than the general population, there are higher levels of heavy alcohol use, including binge drinking, among First Nations (Assembly of First Nations, 2007). Violence, suicide, family problems, employment issues, injuries, property damage, and altercations with police have all been associated with binge drinking (Korhonen, 2004, p. 6).
- ▶ Aboriginal rates of hospitalization for alcohol use are well above national and regional rates for the general population, and the rate of death due to alcohol use by Aboriginal people is almost twice that of the general population (National Native Addictions Partnership Foundation, 2000).
- ▶ Rates of self-injury and suicide are evidence of the impact of substance use and the poor state of mental health among First Nations. In 2000, suicide and self-inflicted injuries was the leading cause of death among First Nations aged 10 to 44 years, accounting for 22% of deaths in youth (10 to 19 years) and 16% of deaths in early adulthood (20 to 44 years) (Health Canada, 2005). Moreover, rates of death from injury and poisoning among First Nations were almost triple the Canadian average in that year (AFN, 2007). Injury was responsible for approximately one-quarter of all deaths and over half the potential

⁴ Recognizing that the terms “First Nations” and “Aboriginal” are not synonymous, this section nevertheless variously refers to “First Nations” and “Aboriginal” people, depending on which group was referenced by the study or research being cited.

years of life lost. Alcohol is a factor in many accidents, injuries, suicides, and incidents of violence.

- ▶ Although there are no national studies on the prevalence or incidence of family violence (including emotional and physical abuse) in Aboriginal communities, evidence from many studies suggests that these rates are higher than in the general population, and that alcohol is a factor in many, if not the majority, of cases.
- ▶ Aboriginal people experience disproportionately high rates of illicit drug use. The rate of illicit drug use among First Nations, although low (7%), was more than double that of the general population (AFN, 2007). Some studies report the rate of death due to illicit drug use among Aboriginal people as almost three times higher than the general population (NNAPF, 2000). There are also concerns about abuse of prescription drugs and solvents in some First Nations communities (the latter, particularly among children and younger adolescents), although the extent of these problems is unknown.
- ▶ Aboriginal people are overrepresented among injection drug users, sex trade workers, street-involved youth, and incarcerated individuals—groups at high risk for HIV and hepatitis C infection. Health Canada (2005) reports that, in 2001, Aboriginal people accounted for 26% of all self-reports of HIV in Canada with a known ethnicity, and over time are accounting for a greater proportion of overall cases.
- ▶ Although the First Nations rate of reported hepatitis C cases is lower than that of the overall Canadian population, it is suspected that the burden of hepatitis C is significantly underestimated, since the disease may remain asymptomatic for 20 years (Health Canada, 2005). Among both Aboriginal and non-Aboriginal populations, the vast majority of new hepatitis C infections are associated with injection drug use.
- ▶ Fetal Alcohol Spectrum Disorder (FASD), caused by maternal alcohol consumption during pregnancy, has been acknowledged as the leading cause of preventable birth defects resulting in developmental and cognitive disabilities among Canadian children. Although there are no national statistics on rates of FASD in Canada, it is estimated that as many as 9 births per 1,000 are affected, and among high-risk populations, the incidence of FASD is suspected to be much higher (Assembly of First Nations, n.d.).
- ▶ Poverty, isolation, inadequate housing, lack of employment opportunities, lack of healthy recreational activities, lower levels of educational attainment, poor nutrition, family dysfunction, and limited access to health care are the reality of daily life for many First Nations people. All of these factors have a bearing on physical, emotional, and mental health.

Many of these themes were echoed by talking circle participants. Community members spoke about the widespread abuse of alcohol and drugs (primarily marijuana, but also ecstasy, painkillers and others pharmaceuticals, crystal meth, crack cocaine, and solvents) by adults and youth in their communities. Community members also spoke at length about the negative consequences of this behaviour, such as parental neglect of children, family violence, suicide, teen pregnancy, school drop-out, gang activity, violence, and property crime. In every community, participants expressed grave concern that youth and children as young as seven or

eight years old were using alcohol and drugs on a regular basis, in some cases obtaining these substances from their parents or other family members. Community members also spoke about the underlying reasons for alcohol and drug abuse in their communities, including lack of economic opportunity, lack of prosocial recreational activities, and a desire to numb the pain of residential school abuse.

While the prevalence of addictions and mental health problems among First Nations is unknown, it is clear from the available statistics and qualitative information that substance abuse, addictions, and other mental health problems are major issues for First Nations throughout Canada. The next sections of this report provide an overview of the mental health and addictions services available to First Nations in Saskatchewan.

3.3 Overview of existing services

The system of addictions and mental health programs that serve First Nations is complex, consisting of a variety of programs and services funded by the federal and provincial governments. This section summarizes federally and provincially funded mental health and addictions services for First Nations.

3.3.1 Federally funded services

Federal funding is delivered through several programs, the most significant of which is the National Native Alcohol and Drug Abuse Program. Federal funding is also delivered through the National Youth Solvent Abuse Program, Brighter Futures, Building Healthy Communities, the National Aboriginal Youth Suicide Prevention Strategy, Non-Insured Health Benefits, and the Indian Residential Schools Resolution Health Support Program. Finally, the Aboriginal Healing Foundation provides grant funding to a number of community-based projects in the province.

National Native Alcohol and Drug Abuse Program (NNADAP)

NNADAP provides funding to First Nations communities in Saskatchewan for addictions and substance abuse projects operating under Annual Contribution Agreements or Health Service Transfer Agreements. All communities in Saskatchewan receive NNADAP prevention funding. Program activities vary by community, but may include education and prevention, early intervention, crisis counselling, treatment referrals, and post-treatment follow-up and aftercare. Services are provided by community-based NNADAP workers. In 2008, there were 149 NNADAP workers in Saskatchewan, of whom 95 were community-based. In addition to funding community-based projects, NNADAP also funds eight First Nations-operated addictions treatment centres or programs in the province. In 2008, 54 NNADAP workers were employed in the addictions treatment centres. Detailed information about these facilities can be found in section 3.5.

National Youth Solvent Abuse Program (NYSAP)

NYSAP provides funding for three youth substance addictions centres in Saskatchewan, namely White Buffalo Youth Inhalant Treatment Centre at Sturgeon Lake, Battlefords Tribal Council Indian Health Youth Outreach at North Battleford, and Leading Thunderbird Lodge at Fort San.

The latter receives blended funding from NNADAP and NYSAP. In total, there are 10 treatment facilities in the Region, funded by NNADAP, NYSAP, or both.

Community-Based Funding Package

Health Canada funds a “community-based funding package” (CBF package) to every First Nation in the province through yearly Contribution Agreements or long-term Health Service Transfer Agreements. Funding is based on a formula that provides for a base amount for each community, an amount based on population, and an amount that recognizes remoteness and isolation. The CBF package, which rolls together Brighter Futures and Building Healthy Communities funding, is the main source of mental health funding for First Nations. Under the CBF package, each First Nations community develops a community-specific plan to meet its needs in regards to mental health. Some employ or contract mental health therapists, others provide services through front-line workers, and others support traditional intervention methods.

Brighter Futures

Brighter Futures is part of the CBF package. It is designed to assist First Nations and Inuit communities in developing community-based approaches to managing mental health and child development. The program consists of five components including Mental Health, Child Development, Parenting, Healthy Babies, and Injury Prevention. Activities offered under the Mental Health component may include information and awareness activities, counselling services, and wellness activities. However, activities offered under the other four program components also touch on mental health and wellness and substance abuse issues. For example, under the Healthy Babies component, communities may undertake awareness and education activities related to avoidance of drugs and alcohol during pregnancy.

Building Healthy Communities (Solvent Abuse and Mental Health)

This program, also part of the CBF package, is intended to assist First Nations and Inuit communities to “develop community-based approaches to youth solvent abuse and mental health crises” (Health Canada, 2007b). Under the Solvent Abuse component, funding is provided for development of local programs to prevent abuse of solvents and to intervene as needed, which could include residential treatment. Under the Mental Health Crisis Management component, which is intended to complement the Mental Health component of Brighter Futures, crisis response and healing activities are funded. Both components of the program also fund training-related activities.

National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)

This five-year strategy consists of primary, secondary, and tertiary suicide prevention elements, as well as knowledge development activities at both the regional and national levels. Working in collaboration with the Federation of Saskatchewan Indian Nations (FSIN) and its Senior Technical Advisory Group, FNIH Saskatchewan Region set priorities and agreed upon activities to fit these four elements. Within the Region, NAYSPS funding is provided via Contribution Agreements beginning in 2006-2007 with all eight Tribal Councils, two large bands, six independent bands, and two third-level service providers that provide coordination, research, and support to the projects.

Non-Insured Health Benefits (NIHB)

This program funds benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health counselling, and medical transportation for eligible First Nations and Inuit, when these are not covered through private insurance or provincial/territorial health and social programs. In 2008, there were 3,494 approved claims for NIHB mental health fee-for-service counselling. Mental health services under NIHB are provided by Health Canada-approved mental health therapists. As of April 1, 2009, there were 91 approved MHTs in the province. NIHB does not track short-term crisis intervention approvals as a separate item, so those figures are not available.

Indian Residential Schools Resolution Health Support Program (IRS-RHSP)

This program was developed to meet the emotional health and wellness needs of former IRS students and their families as a requirement under the Settlement Agreement. The IRS-RHSP coordinates access to professional counselling, transportation to access counselling or elder services not available in the home community, emotional support services of a community-based Resolution Health Support Worker, and cultural support services of an elder. It is important to note that when the program was first established, it made only emotional support services available to survivors. Based on direction from Saskatchewan elders and the acknowledgement of culture as an essential component of healing, Saskatchewan Region advocated for the addition of cultural support services to the program. These efforts were realized in 2007-2008, and funding for cultural support is now available across Canada.

All former students of residential schools and their families are eligible to receive emotional and cultural support services under the program when receiving Common Experience Payments or Advance Payments; resolving an IRS claim through the Independent Assessment Process, Alternative Dispute Resolution, or court process; or participating in Truth and Reconciliation or Commemoration events. In Saskatchewan Region, 21 Resolution Health Support Workers and 10 Cultural Support Workers provide services under the IRS through 10 organizations and/or Tribal Councils. There are approximately 20,000 former residential school survivors in Saskatchewan, all of whom are eligible to receive services under the IRS, regardless of on- or off-reserve residency or status.

Aboriginal Healing Foundation (AHF)

The AHF is an Aboriginal-managed, national, not-for-profit, private corporation established in March 1998 by the Government of Canada as part of *Gathering Strength – Canada’s Aboriginal Action Plan*. The AHF was provided with a one-time grant of \$350 million and given an 11-year mandate, ending March 31, 2009, “to encourage and support, through research and funding contributions, community-based Aboriginal-directed healing initiatives which address the legacy of physical and sexual abuse suffered in Canada’s Indian Residential School System, including intergenerational impacts” (AHF, 2009). The AHF is currently funding 18 projects in Saskatchewan, most of which will end in March 2010 (one project has been extended to September 2011).

3.3.2 Summary of federal funding and human resources

Table 2 summarizes federal funding for mental health and addictions services for First Nations in Saskatchewan for the last two fiscal years, not including AHF grants or short-term crisis intervention approvals under NIHB. Excluding those sources, federal funding totalled approximately \$26.7 million in 2007-2008 and \$27.4 million in 2008-2009.

	2007-2008	2008-2009
National Native Alcohol and Drug Abuse Program – Transferred funds	\$4,201,843	\$4,331,797
National Native Alcohol and Drug Abuse Program – Non-transferred funds	\$ 713,064	\$735,118
National Native Alcohol and Drug Abuse Program – Treatment Centre funding	\$4,818,246	\$4,976,789
National Youth Solvent Abuse Program	\$2,513,261	\$2,588,658
Brighter Futures (all components) and Building Healthy Communities (Solvent Abuse and Mental Health only)	\$6,694,688	\$10,890,250
National Aboriginal Youth Suicide Prevention Strategy	\$1,052,383	\$1,356,244
Non-Insured Health Benefits (fee-for-service mental health counselling only)	\$495,183	\$435,003
Indian Residential Schools Resolution Health Support Program	\$1,436,500	\$2,069,553
Total federal funding	\$26,653,169	\$27,391,412

Source: FNIH Saskatchewan Region.
Notes: NIHB figures are for the calendar year, not the fiscal year, and do not include short-term crisis intervention approvals, since these are not tracked separately. AHF project funding is not included in this table, since annual figures were not available. The Brighter Futures and Building Healthy Communities amounts include Management and Coordination dollars for Tribal Councils, larger bands, and independent bands.

As Table 3 shows, there are approximately 350 federally funded workers providing addictions and mental health services to First Nations in Saskatchewan. It is important to understand that this figure is an estimate based, in some cases, on assumptions. Furthermore, it should be noted that workers in AHF-funded projects are absent from this list, as are elders and a variety of other professionals and paraprofessionals whose main responsibility is not mental health and addictions, but who may provide these or related services as part of their role. The latter category includes Community Health Representatives, physicians, nurses, and home care workers, among others. In short, we do not have an accurate understanding of the number of individuals involved in providing mental health and addictions services to First Nations in the province.

	Human resources 2008-2009
NNADAP Community-Based Workers	95
NNADAP Treatment Centre Workers	54
Brighter Futures Workers/Building Healthy Communities Workers	70
Youth Suicide Coordinators	10
Approved Mental Health Therapists	91
IRS-RHSP Resolution Health Support Workers	21
IRS-RHSP Cultural Support Workers	10
Total	351

Source: FNIH Saskatchewan Region. Note that Brighter Futures workers and Building Healthy Communities workers are often the same person. The figure provided here is based on the assumption of one Brighter Futures/Building Healthy Communities worker for each of the 70 First Nations communities in the province.

3.3.3 Provincial services

In addition to the federally funded programs described above, First Nations in Saskatchewan may also access provincially funded mental health and addictions services. Saskatchewan Health funds a range of alcohol and drug services and mental health services, which are integrated under a single manager in all of the province's regional health authorities (RHAs).

Provincial funding for alcohol and drug services is budgeted at \$47.3 million for 2008-2009 (Saskatchewan Ministry of Health Community Care Branch, 2008). These services include awareness and prevention programs, detoxification (brief and social detox), outpatient treatment, day treatment, in-patient treatment, long-term residential services, harm reduction services (such as needle exchange programs and methadone maintenance therapy), outreach, community mobile treatment, and community supports. While individuals can access some alcohol and drug services in every health region, not all services are available in every region.

Provincial funding for mental health services was \$179.4 million in 2007-2008.⁵ The provincial Mental Health Program is divided into four main service areas: Child and Youth Services, Adult Community Services, Psychiatric Rehabilitation Services, and Mental Health In-Patient Services. In addition, health regions devote resources to mental health promotion. As with provincial alcohol and drug services, some services are not available in every health region. In particular, Heartland, Kelsey Trail, and the northern health regions provide a more limited range of services than the other RHAs.

According to data provided by the Saskatchewan Ministry of Health:

- ▶ Forty-five percent of admissions to provincial addictions services in 2007-2008 reported First Nations status, including 41% who self-reported as Status Indian. First Nations were the large majority of admissions to addictions services in Athabasca and Mamawetan Churchill River, and were majorities in Prince Albert Parkland and Prairie North.
- ▶ In all RHAs except Keewatin Yatthe, Status Indians make up a higher percentage of addictions services clients than one would expect, given their presence in the total population. In some regions, Status Indians are overrepresented among addictions services clients by 30% or more, relative to their proportion of the population.
- ▶ As a proportion of admissions to provincial addictions services, based on self-reported data, First Nations were more than half of all methadone, detoxification, and in-patient admissions (57%, 56%, and 51%, respectively), and more than one-third (38%) of outpatient admissions.
- ▶ Status Indians were 14% of all new/reopened mental health clients in the province in 2005-2006, which is roughly equivalent to their presence in the general population (11% in 2005, according to Government of Saskatchewan data). Status Indians do not seem to be accessing provincial mental health services to the same extent as provincial addictions services.

⁵ All information about provincial Mental Health Services is taken from *Community Program Profile 2007-2008*, provided by Saskatchewan Health.

3.3.4 Summary of federal and provincial funding

Based on rough estimates, federal and provincial expenditures for mental health and addictions services for First Nations totalled approximately \$71 million in 2007-2008. Based on a 2007 Status Indian population of 125,666 (INAC data), per capita spending on mental health and addictions services for First Nations was approximately \$567 in that fiscal year.

	Total funding (millions)
Total federal expenditures	\$26.7
Total provincial expenditures	\$44.5
Total	\$71.2

Notes: Total federal funding is underestimated because it does not include AHF grants or NIHB short-term crisis intervention approvals. Total annual provincial funding was calculated as follows: Provincial funding for alcohol and drugs x Proportion of admissions to provincial addictions services who are Status Indians (\$47.3 million x 41%) + Provincial funding for mental health services x Proportion of new/reopened mental health clients who are Status Indians (\$179.4 million x 14%). Thus (\$47.3 million X 41%) + (\$179.4 million x 14%) = \$19.4 + \$25.1 = \$44.5 million annually.

3.4 Community-based services

As described in previous sections, because of the way in which federal funding for addictions and mental health services is structured, and the way in which this funding is administered and delivered, the nature and extent of mental health and addictions services can vary substantially from one community to the next. The survey of Community Health Directors and the survey of front-line mental health and addictions workers provide some information on the types of services available in First Nations communities. However, caution should be used when interpreting the findings reported below, due to small sample sizes.

Mental health/wellness services

At least half of CHD survey respondents reported that the following mental health/wellness services are available in their communities: referrals to addictions services or treatment; referrals to mental health treatment; mental health promotion and prevention; mental health screening or assessment; crisis intervention, counselling, management, or training; cultural support; resolution support; and counselling for issues related to residential schools or trauma. Among front-line workers, 87% of survey respondents indicated that they provide some mental health/wellness services. A majority provides referrals (72%); crisis intervention, counselling, management, or training (58%); cultural support (58%); and post-treatment follow-up, aftercare, or rehabilitation services (53%). In addition, significant minorities of front-line workers provide other crisis-related services including incident debriefing (49%), and crisis team planning and delivery (32%). Various other mental health services are each provided by fewer than half of survey respondents. See [Table 5](#) and [Table 6](#) for more information.

Table 5: Mental health/wellness services available in First Nations communities Source: Survey of Community Health Directors (n=22)	
Services available in at least half of respondents' communities	Services available in fewer than half of respondents' communities
<ul style="list-style-type: none"> ▶ Referrals to addictions services or treatment (n=18) ▶ Referrals to mental health treatment (n=14) ▶ Mental health promotion/prevention (n=14) ▶ Mental health screening and assessment (n=12) ▶ Crisis intervention, counselling, management, or training (n=12) ▶ Cultural support (n=12) ▶ Resolution support (n=11) ▶ Counselling for issues related to residential schools (n=11) 	<ul style="list-style-type: none"> ▶ Case management (n=10) ▶ Incident debriefing (n=9) ▶ Referrals to non-health-related services (n=9) ▶ Crisis team planning and delivery (n=7) ▶ Post-treatment follow-up, aftercare, and rehabilitation (n=7) ▶ Life skills training or counselling (n=6) ▶ Mental health treatment – psychosocial interventions (n=6) ▶ Mental health treatment – outpatient services (n=4) ▶ Mental health treatment – community residential services (n=3) ▶ Mental health treatment – in-patient services (n=3) ▶ Mental health treatment – pharmacotherapy (n=1)
<p>Notes: Two respondents indicated that there are no mental health/wellness services available in their communities. Due to small sample size, caution should be used when interpreting the results presented in this table.</p>	

Table 6: Mental health/wellness services provided by front-line workers Source: Survey of Front-Line Workers	
Service	Percent (n=78)
Referrals	72%
Crisis intervention, counselling, management, or training	58%
Cultural support	58%
Post-treatment follow-up/aftercare/rehabilitation services	53%
Incident debriefing	49%
Case management	49%
Resolution support (e.g., referrals, attending hearings, completing forms)	47%
Counselling for issues related to residential schools or trauma	44%
Mental health promotion/prevention	44%
Life skills training/counselling	40%
Crisis team planning and delivery	32%
Mental health screening and assessment	26%
Mental health counselling/therapy	3%
Grief recovery	3%
SASSI assessments/addiction screening	3%
Emotional support	3%
Other	5%
Do not provide mental health/wellness services/no response	13%
<p>Note: Total sums to more than 100% due to multiple responses.</p>	

Addictions services

At least half of CHD survey respondents reported that the following addictions services are available in their communities: addictions education and prevention; referrals to addictions treatment; referrals to mental health treatment; addictions counselling; addictions screening and assessment; facilitation of support groups; and crisis intervention, counselling, management, or training. Almost all front-line workers surveyed (94%) indicated that they provide some

addictions services. At least half provide referrals (80%); addictions education and prevention (65%); addictions counselling (63%); facilitation of support groups (62%); addictions screening and assessment (60%); crisis intervention, counselling, management, or training (56%); and post-treatment follow-up, aftercare, and rehabilitation services (56%). Other types of addictions services are each provided by fewer than half of respondents. See [Table 7](#) and [Table 8](#) for the details.

Table 7: Addictions services available in First Nations communities Source: Survey of Community Health Directors (n=22)	
Services available in at least half of respondents' communities	Services available in fewer than half of respondents' communities
<ul style="list-style-type: none"> ▶ Addictions education and prevention (n=18) ▶ Referrals to addictions treatment (n=17) ▶ Referrals to mental health services or treatment (n=16) ▶ Addictions counselling (n=16) ▶ Addictions screening and assessment (n=15) ▶ Facilitation of support groups (e.g., AA) (n=11) ▶ Crisis intervention, counselling, management, or training (n=11) 	<ul style="list-style-type: none"> ▶ Counselling for issues related to residential schools or trauma (n=9) ▶ Referrals to non-health-related services (n=9) ▶ Post-treatment follow-up, aftercare, and rehabilitation (n=8) ▶ Life skills counselling or training (n=5) ▶ Addictions treatment – outpatient services (n=6) ▶ Addictions treatment – psychosocial interventions (n=5) ▶ Addictions treatment – in-patient services (n=3) ▶ Needle exchange (n=2) ▶ Addictions treatment – detoxification (n=1)
<p>Notes: One respondent indicated that no addictions services are available in their community. Due to small sample size, caution should be used when interpreting the results presented in this table.</p>	

Table 8: Addictions services provided by front-line workers Source: Survey of Front-Line Workers	
Service	Percent (n=78)
Referrals	80%
Addictions education/prevention	65%
Addictions counselling	63%
Facilitation of support groups (e.g., AA)	62%
Addictions screening and assessment	60%
Crisis intervention, counselling, management, or training	56%
Post-treatment follow-up/aftercare/rehabilitation services	56%
Case management	49%
Counselling for issues related to residential schools or trauma	47%
Harm reduction services	40%
Life skills training/counselling	37%
Other	13%
Do not provide addictions services	6%
<p>Notes: Total sums to more than 100% due to multiple responses. When asked to explain specifically what harm reduction services they provide, the most frequent responses were suicide intervention, prevention, or awareness (n=10); and education or counselling (n=4). One respondent mentioned a methadone program, and none mentioned needle exchange.</p>	

While it is difficult to generalize based on the limited information available to this needs assessment, it seems safe to say that addictions services are more readily available in First Nations communities than mental health services. Whereas addictions education and prevention, screening and assessment, and counselling are provided by a majority of front-line workers, similar services are less often available in the area of mental health. Based on the survey of front-line workers, mental health services are focused primarily on referring clients to other services,

providing cultural support, and providing crisis-related services including crisis intervention, counselling, management, or training; incident debriefing; and crisis team planning and delivery.

Overall, referrals appear to be the most commonly provided service. Of course front-line workers are not able, nor are they expected, to provide all of the mental health/wellness or addictions services that community members may require. Thus, a critical aspect of their role is referrals to other services. Front-line workers reported that they refer clients to addictions treatment (80%); traditional healers and elders (77%); psychologists, mental health therapists, and counsellors (74%); detoxification (65%); and mental health treatment (64%). With the exception of traditional healers and elders, these services may not be locally available in First Nations communities. It is also telling that one-fifth of front-line workers refer clients to out-of-province mental health/wellness or addictions services, presumably because services available within provincial boundaries are not, for whatever reason, easily accessible.

Cultural elements in community-based services

One of the tasks of this needs assessment was to determine the extent to which culture is incorporated into current mental health and addictions services. The importance of integrating cultural elements was acknowledged by the NNADAP Renewal Framework in 2000, which identified “a system sensitive to and respectful of both traditional and contemporary approaches to healing” as one of the guiding principles of NNADAP Renewal, and explained further that “as determined by clients, families, and communities, both traditional and contemporary approaches to healing will be respected and valued” (NNAPF, 2000, p. 31).

Based on information available to this needs assessment, it appears that cultural elements are an important aspect of community-based services. Results from the surveys of Community Health Directors and front-line workers indicate that culture is incorporated most commonly through talking/sharing circles, as well as through ceremonial activities, counselling and education by elders, and traditional teachings. [Table 9](#) shows the proportion of front-line workers who incorporate various cultural elements into their services.

Table 9: Percentage of front-line workers who incorporate cultural elements into their services	
Source: Survey of Front-Line Workers	
	Percent (n=78)
Talking/sharing circle	95%
Counselling and education by elders	82%
Ceremonial activities (e.g., sweet grass, pipe ceremony, sweat lodges, special feasts)	76%
Traditional teachings (e.g., Medicine Wheel, Tipi teachings)	67%
Traditional recreational activities (e.g., hand games, singing, dancing, pow-wows)	62%
Personal meditation	55%
Use of traditional languages (e.g., counselling or lectures in First Nations languages)	49%
Personal study of nature and environment	42%
Traditional medicines/remedies	3%
Prayer/prayer meetings	3%
Traditional lifestyles/life skills	1%
Other	4%

Note: Total sums to more than 100% due to multiple responses.

3.5 Services provided by addictions treatment centres

In addition to community-based services, FNIH funds 10 addictions treatment facilities in Saskatchewan. Nine of the 10 treatment centres completed a survey providing details about their client groups, approach to treatment, and services. As previously noted, Ekweskeet Healing Centre was closed during the data collection period (it reopened on May 1, 2009) and is not included in the summary below. More information can be found in [Table 11](#).

Client groups

Four of the treatment centres serve only adults, three serve only youth, and two serve youth and adults. Four serve only Aboriginal clients and five serve both Aboriginal and non-Aboriginal clients. Among the latter, Aboriginal clients are the majority (between 85% and 98%) of their current clientele. All of the treatment centres provide treatment for alcohol abuse, and about half provide treatment for cocaine/crack, solvents, prescription drugs, and stimulants. Fewer than half provide treatment for opioids, hallucinogens, and cannabis.⁶ Most serve clients with concurrent disorders as well as correctional clients, and half serve clients on methadone therapy. Reasons for not serving clients on methadone therapy include not being certified to dispense the drug; not having a nurse or doctor on site to administer the drug/transportation costs to nearest town are too high; not having any clients in the service area on methadone therapy; and not being mandated to serve this client group.

Approach to treatment

All of the treatment centres indicated that they take an abstinence-based approach to treatment. However, AHA noted that it is currently undergoing treatment modernization and researching best practices, and that the abstinence-based approach is currently under review. Leading Thunderbird Lodge reported that it requires abstinence during treatment, but teaches harm reduction for return to the community.

Disease-based and cultural models of treatment are most common; each is employed by four treatment centres (AHA noted that the disease-based model is currently under review as part of treatment modernization). Other treatment models include biopsychosocial, whole person, resiliency, equine therapy, life process, and holistic models, each of which is used by one or two centres.

Services provided

All of the treatment centres provide addictions education/prevention, addictions screening and assessment, and case management services. Other commonly provided services include regular access to professional mental health services; crisis intervention, counselling, or management; life skills training/counselling; psychosocial interventions; and aftercare, rehabilitation, or relapse prevention services. Counselling related to residential schools or trauma, and detoxification or stabilization services are provided by a minority of treatment centres. None provide pharmacotherapy.

⁶ Cannabis was not a hard code on the survey, but some treatment centres identified it as a drug for which they provide treatment.

Some treatment centres indicated that they provide other services, such as pre-treatment counselling, suicide intervention/awareness, and youth outreach services. In addition, specialized services for specific client groups, such as youth, women, men, families, pregnant women, clients with concurrent disorders, clients with FASD, and clients with learning disabilities, are available at a few centres.

Cultural elements in addictions treatment

All of the treatment centres surveyed incorporate culture into their programming, most commonly through talking/sharing circles. Ceremonial activities, traditional teachings, counselling/education by elders, traditional recreational activities, and use of traditional languages (in one case, by providing translators as needed) are also often used. Two use wilderness experience or land-based therapy such as cultural camps, youth camps, canoe quests, and spiritual walks; and two teach traditional ways of life (see [Table 11](#)). According to FNIH, treatment centres have integrated cultural components into treatment services without a dedicated budget for this purpose.

3.6 Services provided by AHF projects

Finally, the Aboriginal Healing Foundation is currently funding 18 projects in Saskatchewan, the objective of which is to address the legacy of the residential school system. Of the 18 projects, 11 completed a survey as part of this needs assessment. The services offered by these projects are summarized in [Table 10](#) below.

Table 10: Services provided by AHF projects (n=11)	
Source: Survey of AHF Projects	
Format of program delivery	Topics
Individual counselling (n=11)	Coping with trauma (n=11)
Group counselling (n=11)	Coping with loss and grief (n=11)
Workshops (n=11)	Communication skills (n=11)
Retreats/camps (n=8)	Coping with sexual/physical abuse (n=10)
Informational resources/library/newsletter (n=8)	Coping with emotional abuse (n=10)
Drop-in centre (n=7)	Self-concept/self-esteem/assertiveness (n=10)
Classroom sessions/lectures (n=6)	Healthy decision-making (n=10)
Home visits (n=6)	Suicide prevention (n=9)
Peer support groups (n=5)	Substance abuse (n=9)
	Anger management/impulse control (n=9)
	Parenting skills/healthy family life (n=9)
	Stress management (n=8)

Culture is an important aspect of programming for the AHF projects. Culture is incorporated most often through ceremonial activities, talking/sharing circles, traditional teachings, Aboriginal history and perspectives, counselling and education by elders, and traditional recreation. Less commonly, this occurs through use of traditional languages, personal meditation, and personal study of nature and environment, as well as through other methods such as traditional medicines.

Table 11: Overview of client groups, treatment approach, and services provided by addictions treatment centres
Source: Survey of addictions treatment centres and interviews with treatment centre directors (excluding Ekweskeet Centre, which was not open at the time of data collection). The data presented in this table may differ from FNIH data on the treatment centres.

Treatment centre	Client groups	Substances treated	Approach to treatment	Services provided	Cultural elements
Armand Bekkattla Treatment Centre	<ul style="list-style-type: none"> ▶ Male, female ▶ Adults (18+) ▶ Concurrent disorders ▶ Corrections ▶ Aboriginal, non-Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Cocaine/crack ▶ Prescription ▶ Stimulants ▶ Hallucinogens ▶ Cannabis 	<ul style="list-style-type: none"> ▶ In-patient ▶ Abstinence ▶ Disease-based ▶ Cultural ▶ Whole person ▶ Group 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Pre-treatment counselling ▶ Detox/stabilization ▶ Case management ▶ Access to professional mental health services ▶ Life skills training/counselling ▶ Residential schools/trauma counselling ▶ Aftercare/rehab/relapse prevention ▶ Specialized services for women, clients with FASD, and individuals with learning disabilities 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Use of traditional languages ▶ Traditional way of life (teaches traditional life skills such as hunting and fishing)
Athabasca Health Authority	<ul style="list-style-type: none"> ▶ Male, female ▶ Youth (12-17), adults ▶ Concurrent disorders ▶ Corrections ▶ Methadone ▶ Aboriginal, non-Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Hallucinogens 	<ul style="list-style-type: none"> ▶ Outpatient ▶ Abstinence ▶ Disease-based ▶ Individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Psychosocial interventions ▶ Case management ▶ Access to professional mental health services ▶ Residential schools/trauma counselling ▶ Youth outreach worker 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Use of traditional languages ▶ Wilderness experience/land-based therapy (spiritual walks, canoe quests, youth camp, spiritual gatherings, involvement of parish priest)
Battlefords Tribal Council Indian Health Centre Youth Outreach	<ul style="list-style-type: none"> ▶ Male, female ▶ Youth (10-20) ▶ Concurrent disorders ▶ Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Solvents ▶ Stimulants 	<ul style="list-style-type: none"> ▶ Outpatient ▶ Abstinence ▶ Disease-based ▶ Individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Suicide intervention/awareness ▶ Psychosocial interventions ▶ Case management ▶ Access to professional mental health services ▶ Specialized services for youth 	<ul style="list-style-type: none"> ▶ Talking/sharing circles

Table 11: Overview of client groups, treatment approach, and services provided by addictions treatment centres
Source: Survey of addictions treatment centres and interviews with treatment centre directors (excluding Ekweskeet Centre, which was not open at the time of data collection). The data presented in this table may differ from FNIH data on the treatment centres.

Treatment centre	Client groups	Substances treated	Approach to treatment	Services provided	Cultural elements
Cree Nations Treatment Haven	<ul style="list-style-type: none"> ▶ Male, female ▶ Adults ▶ Concurrent disorders ▶ Corrections ▶ Aboriginal, non-Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Opioids ▶ Cocaine/crack ▶ Solvents ▶ Prescription ▶ Stimulants ▶ Hallucinogens 	<ul style="list-style-type: none"> ▶ In-patient ▶ Outpatient ▶ Abstinence ▶ Life process model ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Case management ▶ Access to professional mental health services ▶ Life skills training/counselling ▶ Counselling for issues related to residential schools or trauma ▶ Aftercare/rehabilitation/relapse prevention services ▶ Specialized services for women, pregnant women, and clients with FASD 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Use of traditional languages (if requested) ▶ Personal meditation ▶ Traditional teachings
Leading Thunderbird Lodge	<ul style="list-style-type: none"> ▶ Male ▶ Youth (12-17) ▶ Concurrent disorders ▶ Correctional clients ▶ Methadone ▶ Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Opioids ▶ Cocaine/crack ▶ Solvents ▶ Prescription 	<ul style="list-style-type: none"> ▶ In-patient ▶ Abstinence (during treatment) ▶ Harm reduction (for return to community) ▶ Biopsychosocial ▶ Resiliency ▶ Stages of change ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Screening/assessment ▶ Psychosocial interventions ▶ Case management ▶ Access to professional mental health services ▶ Specialized services for youth 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Traditional teachings
Mistahey Musqua Treatment Centre	<ul style="list-style-type: none"> ▶ Male, female ▶ Adults ▶ Corrections ▶ Methadone ▶ Aboriginal, non-Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Cocaine/crack ▶ Prescription 	<ul style="list-style-type: none"> ▶ In-patient ▶ Abstinence ▶ Disease-based ▶ Cultural ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Screening/assessment ▶ Psychosocial interventions ▶ Case management ▶ Life skills training/counselling 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Use of traditional languages ▶ Traditional teachings
Sakwatamo Lodge	<ul style="list-style-type: none"> ▶ Male, female ▶ Adults ▶ Concurrent disorders ▶ Corrections ▶ Aboriginal, non-Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Opioids ▶ Cocaine/crack ▶ Solvents ▶ Prescription ▶ Stimulants ▶ Hallucinogens 	<ul style="list-style-type: none"> ▶ In-patient ▶ Abstinence ▶ Biopsychosocial ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Screening/assessment ▶ Psychosocial interventions ▶ Case management ▶ Access to professional mental health services ▶ Life skills training/counselling ▶ Aftercare/rehab/relapse prevention ▶ Specialized services for women, men, and families 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Use of traditional languages (translators as needed)

Table 11: Overview of client groups, treatment approach, and services provided by addictions treatment centres
Source: Survey of addictions treatment centres and interviews with treatment centre directors (excluding Ekweskeet Centre, which was not open at the time of data collection). The data presented in this table may differ from FNIH data on the treatment centres.

Treatment centre	Client groups	Substances treated	Approach to treatment	Services provided	Cultural elements
Saulteaux Healing and Wellness Centre Inc.	<ul style="list-style-type: none"> ▶ Male, female ▶ Youth (12-17), adults ▶ Concurrent disorders ▶ Corrections ▶ Methadone ▶ Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Opioids ▶ Cocaine/crack ▶ Solvents ▶ Prescription ▶ Stimulants ▶ Cannabis 	<ul style="list-style-type: none"> ▶ Outpatient ▶ Abstinence ▶ Cultural ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Case management ▶ Life skills training/counselling ▶ Residential schools/trauma counselling ▶ Aftercare/rehab/relapse prevention 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Traditional teachings ▶ Traditional way of life (in process of developing a model to teach the Saulteaux way of life)
White Buffalo Youth Inhalant Treatment Centre	<ul style="list-style-type: none"> ▶ Female ▶ Youth (12-17) ▶ Concurrent disorders ▶ Aboriginal 	<ul style="list-style-type: none"> ▶ Alcohol ▶ Solvents ▶ Cannabis 	<ul style="list-style-type: none"> ▶ Combined in-patient and outpatient ▶ Abstinence ▶ Cultural ▶ Resiliency ▶ Holistic ▶ Equine therapy ▶ Combined group and individual 	<ul style="list-style-type: none"> ▶ Addictions education/prevention ▶ Crisis intervention, counselling, management ▶ Screening/assessment ▶ Detox/stabilization ▶ Case management ▶ Access to professional mental health services ▶ Life skills training/counselling ▶ Aftercare/rehab/relapse prevention ▶ Specialized services for youth, clients with concurrent disorders, and clients with FASD 	<ul style="list-style-type: none"> ▶ Talking/sharing circles ▶ Ceremonial activities ▶ Counselling/education by elders ▶ Traditional recreational activities ▶ Traditional teachings ▶ Wilderness experience/land-based therapy (cultural camps)

3.7 Barriers to access

Due to the lack of prevalence data and comprehensive information on rates of service utilization, the extent to which First Nations people with mental health and addictions problems are currently receiving some level of service is not known. Key informants estimated that between 10% and 50% of First Nations people in need are receiving some level of service. In some cases, those in need are not receiving *any* mental health or addictions services, while others are not receiving an adequate *level* of service or the necessary *types* of services.

There are a variety of reasons why this is the case. Respondents to the survey of front-line workers identified several factors that limit their ability to provide services in their communities, including a lack of time or staff (24%); distance, travel, and transportation issues (21%); inadequate funding (15%); a lack of confidentiality or private office space (15%); a lack of specific programs or services that could benefit clients (14%); and a lack of political or management support or leadership (12%). Community Health Directors most often identified insufficient human resources, insufficient funding, and insufficient space or facilities as limiting factors within their communities.

In addition, this needs assessment identified numerous barriers that may prevent First Nations people from accessing the services that are available.

Concerns about confidentiality and trust

Concerns about lack of confidentiality and trust is by far the most significant barrier to access at the community level. Among front-line workers who responded to the survey, 41% mentioned lack of confidentiality and trust as a barrier to access – more than any other barrier they identified – and this was also the most important barrier according to Community Health Directors. Talking circle participants echoed this theme in every community we visited.

Several interrelated concepts are salient here. At a practical level, many communities lack private office space for workers to meet with their clients. But the situation is considerably more complicated. Front-line mental health and addictions workers are, for the most part, members of the community in which they work. Community-based workers are certainly perceived as a real strength of the existing system of services, since they are knowledgeable about the culture and history of their community. However, the fact that they usually know their potential clients or may even be related to them is also perceived as a shortcoming. We heard repeatedly that many First Nations people are not comfortable with the idea of divulging their personal problems to a member of their own community for fear that their private affairs will become public knowledge. In this context, it is worth noting that in non-Aboriginal communities, the confidentiality of the client-service provider relationship is simply taken for granted. Some talking circle participants also observed that nepotism is a factor in hiring and that community members therefore have little reason to have confidence in the experience or qualifications of front-line workers.

Talking circle participants also reported that many people are reluctant to be seen accessing addictions or mental health services because of the stigma associated with these issues, and for fear that other community members will spread gossip and rumours about them. In several communities, talking circle participants spoke about jealousy, prejudice, and "lateral violence" among community members. One participant explained the environment in her community like

this: "It's like living in a fishbowl. There's nobody to talk to, everyone is watching you and talking about you." Another said: "If you spill your guts out, it'll come back to you."

As a result of these interpersonal dynamics, First Nations people are reluctant to seek out the services of the mental health and addictions workers based in their communities. In fact, several talking circle participants noted that the only time members of their communities will access formal services such as NNADAP is when they are court-ordered to do so. Some youth noted that "asking for help" effectively means calling in Child and Family Services. Because of concerns about confidentiality and trust, community members are more likely to talk to family members or close friends than formal service providers. Youth, in particular, are extremely reluctant to access formal services, preferring to rely on their peers for support.

We also heard from key informants and talking circle participants that it is difficult for First Nations people to develop long-term relationships of trust with workers, especially mental health therapists. High turnover among mental health therapists, and their sporadic presence in most communities, makes the development of therapist-client relationships difficult. Youth, in particular, noted that it is important they know the person from whom they are seeking help: "I wouldn't go talk to someone about my problems if I didn't know them. They wouldn't understand." Moreover, the development of a trusting relationship is complicated by the fact that many mental health therapists are not First Nations people themselves, an issue that is discussed in more detail below.

Cultural inappropriateness of some services

The cultural inappropriateness of some services emerged as another major barrier to access. This barrier has been identified by numerous prior studies, and in this research was highlighted by key informants as well as talking circle participants. They observed that the system of mental health and addictions services, based on Western clinical approaches to health, is uncomfortable for First Nations people who do not, as a general rule, like going to clinics, sitting in offices, or talking with therapists (especially non-Aboriginal therapists). In short, many First Nations people may not understand nor relate to the techniques that are being applied in their communities. Key informants emphasized that, while the professionalism of Western clinical approaches is important, the concept needs to be redefined so that it takes account of First Nations culture.

Key informants see provincial services delivered by the regional health authorities as particularly inappropriate and unapproachable for First Nations, and many stated that First Nations people are simply not using these services. The Saskatchewan Health data cited in section 3.4 show that, in fact, First Nations people *are* using provincial mental health and addictions services and indeed make up a significant proportion of clients of those services. However, this does not negate the central point, which is that provincial services may not be culturally appropriate to First Nations people or that, for First Nations people, the experience of using these services may be uncomfortable or unpleasant. Moreover, key informants reported that communication and collaboration between First Nations service providers and provincial services, which might help to mitigate these difficulties, are very limited.

Insufficient number of First Nations practitioners

A related barrier is the insufficient number of First Nations practitioners, especially mental health therapists. Of the 91 individuals currently on FNIH's list of approved mental health therapists, only a small number are Aboriginal (the exact number is unknown, since FNIH does not systematically collect this information). Insofar as concepts of personal and community well-being are inextricably linked to culture, the need for mental health service providers who work with First Nations populations to be First Nations themselves is regarded as especially important. Language is a critical aspect of this, since it conditions how we perceive and talk about the world. In some communities, talking circle participants emphasized the need for services to be delivered in the language of the community; they described situations where people have seen mental health therapists and "have not understood anything they were saying." Clearly, effective communication and mutual understanding are essential to the success of the therapeutic relationship. At the same time, some key informants were of the view that cultural background is less important than the relationship of trust that can be established with the client: it is not someone's ethnicity or race that is important, but the type of person they are. For reasons previously described, it appears that relationships of trust are not necessarily being established, even when service providers are First Nations people themselves.

Practical barriers to access

Practical barriers to access, such as lack of transportation and child care, are evidently significant for many First Nations people. Lack of transportation is an issue even within communities, where homes are often spread out over a large geographic area and many individuals do not have a means of transportation. In addition, some communities are geographically isolated or remote, and access to services located in larger centres is limited. Among respondents to the survey of front-line workers, 27% mentioned distance, travel, and transportation issues as a barrier to access (making it the second most frequently mentioned barrier), and 10% mentioned a lack of child care. That being said, because of confidentiality concerns, some talking circle participants reported that they would rather travel to the nearest larger community to access services than access the services of the community-based worker.

Lack of choice in service providers

Among key informants and talking circle participants, the inability to choose one's service provider was seen as a major barrier to access, especially in smaller communities where there may be only one mental health or addictions worker. In these situations, people do not have the option of choosing the gender of the worker. For women, many of whom have experienced sexual abuse, the lack of a female worker may prevent them from seeking out services, while men may not seek help if there is no male worker available. Moreover, in the event of communication, language, or relationship issues, there is usually no possibility of seeking a second opinion. The ability to choose one's service provider and the ability to seek out a second opinion are largely taken for granted in the rest of Canadian society.

Lack of awareness of available services

A lack of awareness of the available services may be a barrier in some cases; front-line workers, community members, and key informants all identified this barrier. Talking circle participants, for their part, were not always able to clearly articulate what services were currently available in their community, which suggests that they may not be fully aware of those services.

Wait times for some services

Long wait times for some services was identified as a barrier in the literature and by some key informants, though not by front-line workers or community members. Community Health Directors, for their part, identified a related issue – insufficient human resources – as a major barrier to access, though nearly the same number of people said there was a waiting list for the services in their communities as said there was not. More than half of front-line workers did not know how many clients are waiting for their services, or gave no response. In the absence of comprehensive information about wait times for community-based services, we cannot draw any conclusions about how significant this issue is at the community level.

That being said, it appears that wait times are a barrier to accessing certain *types* of services. For example, key informants reported that accessing the crisis response services of mental health therapists is complicated and time-consuming, and that MHTs often cannot be reached or are unavailable when they are needed in communities. Talking circle participants reported that crises often occur in the middle of the night, and finding a mental health therapist available at that time is difficult.

Wait times for addictions treatment may also present a barrier to access in some cases. Five of the treatment centres surveyed reported that they currently have a waiting list for services. The number of people on the waiting lists ranges from four to more than 30 people, and the average wait time also varies dramatically, ranging from seven to 10 days at one centre and up to three months at another. Unfortunately, we do not know how these wait times compare with First Nations-operated treatment centres elsewhere in Canada, or with wait times for provincial treatment centres (see [Table 12](#) for an overview of client access to addictions treatment centres). However, based on these data and anecdotal information from key informant interviews, it appears that wait times for addictions treatment is indeed a barrier. Lengthy wait times are a concern inasmuch as individuals' motivation to attend treatment, as well as their life circumstances, may change during the waiting period.

Table 12: Overview of client access to addictions treatment centres
Source: Survey of addictions treatment centres. The data presented here may differ from FNIH data on the treatment centres.

	Frequency of intake	Number of people on waiting list	Average wait time	Maximum capacity	Duration of treatment program	% of clients who complete program	Number of clients served in 2008
Armand Bekkattla Treatment Centre	Every 30 days	30+	2 months	17 beds	28 days	75%-85%	170 (est.)
Athabasca Health Authority	Ongoing	No waiting list	N/A	N/A	Per individual need	70%-80%	402
Battlefords Tribal Council Indian Health Centre Youth Outreach	Ongoing	No waiting list	N/A	Target: 200	N/A	N/A	150 (est.)
Cree Nations Treatment Haven	Ongoing	30	Up to one month	20 in-patient 15 outpatient	35 days	50%	206
Leading Thunderbird Lodge	Every 4 months	No waiting list	N/A	15 beds	4 months	50%	45 (est.)
Mistahey Musqua Treatment Centre	Every 32 days	10+ per intake	2 months	5 beds	32 days	80%	76
Sakwatamo Lodge	Jan-July: weekly Aug-Dec: every 3 wks	4-5	7-10 days	20 beds	28 days	76%-79%	241
Saulteaux Healing and Wellness Centre Inc.	Ongoing	No waiting list	N/A	15 outpatient	20 days	50%	260
White Buffalo Youth Inhalant Treatment Centre	Semi-annually	4	Up to 3 months	10 in-patient 15 outpatient	6 months	50%	34

Poverty and poor living conditions

Finally, many talking circle participants identified poverty and poor living conditions as a barrier to access. Talking circle participants said that the challenges of daily life, such as inadequate housing, lack of employment, and poor nutrition, effectively prevent many First Nations people from even considering accessing services. Although mental health and addictions services may well be needed, meeting basic needs is a far greater imperative.

3.8 Service gaps, needs, and priorities

Over the past few years, a variety of other studies have examined service gaps, needs, and priorities in the system of mental health and addictions services for First Nations in Saskatchewan.⁷ These studies have consistently found that the availability and quality of mental health and addictions services is highly uneven among First Nations communities, with fewer services locally available in remote, isolated, and northern communities compared to those in the south. Specialized services, in particular, are seldom available on-reserve. The needs of specific populations such as youth, pregnant women, and individuals with concurrent disorders are not necessarily being met by the existing system, and services are not always gender-appropriate. Some of the specific service gaps identified by prior studies are:

- ▶ Community capacity for crisis response and intervention, especially in the North⁸
- ▶ Specific community capacity for early identification of individuals with suicidal intentions, as well as preventive and therapeutic responses to suicide attempts
- ▶ Prevention activities, such as prosocial recreational and creative activities for youth
- ▶ Intervention programming for high-risk youth
- ▶ Specialized counselling and support services for youth involved in the sex trade
- ▶ Mental health services for children
- ▶ Specialized counselling and support programs for individuals with FASD (adults, youth, and children)
- ▶ Harm reduction programs for severely addicted, homeless, or other marginalized or high-risk populations
- ▶ Specialized counselling programs for women at risk of drinking while pregnant
- ▶ Specialized addictions in-patient programming for correctional clients
- ▶ Specialized programs addressing problem drinking as opposed to chemical dependency (i.e., substance abuse, rather than addiction)
- ▶ More fully developed pre-care and aftercare addictions programming

⁷ For example, Thatcher (2005 and 2007) and Elias (2006 and 2008b).

⁸ Few communities have adequate crisis response and intervention capacity. According to Thatcher, these services are “extremely inaccessible especially in the north” (Thatcher, 2007, p. 19).

Based on new primary research conducted as part of this needs assessment, there is no reason to suspect that the situation has dramatically improved since these gaps, needs, and priorities were first identified. In fact, similar ones were identified in the course of this research. However, during our research, we also heard a great deal about the need for basic prevention; family-based approaches; and community involvement, development, and sustainability – in other words, strategies that tackle the underlying issues in order to promote community healing. With these considerations in mind, this needs assessment identified the following major gaps, needs, and priorities:

Comprehensive mental health program

The need for a comprehensive mental health program for First Nations is arguably the most pressing priority. What is most notable about federal support for mental health is the absence of any mental health program *per se*. Whereas NNADAP functions as the primary source of funding for addictions programming for First Nations, there is no similar program in mental health. Rather, mental health services are funded through a variety of programs—namely Brighter Futures, Building Healthy Communities, Non-Insured Health Benefits, the Indian Residential Schools Health Resolution Support Program, and the Aboriginal Healing Foundation—and are delivered at either the community or Tribal Council level.

There are two main weaknesses inherent in this approach. The first is the lack of consistency in mental health services available at the community level. In the case of the CBF package, individual First Nations have full discretion to determine what and how services are delivered. Some employ or contract mental health therapists, others provide services through front-line workers, and others support traditional intervention methods. While there is something to be said for this approach, the resulting community mental health landscape has been criticized by Thatcher for being “something of a patchwork quilt of delivery arrangements” with an “uneven, even widely disparate, quality of service net” (2005, p. 9). Many key informants noted that all First Nations communities would require at least one full-time mental health therapist. Almost one-quarter of front-line workers surveyed identified more mental health workers or mental health training as a priority, and among Community Health Directors surveyed, the most frequently mentioned need or priority for their communities was a mental health therapist or counsellor, or funding for this purpose. The situation is all the more urgent since AHF project funding, which focuses specifically on addressing the long-term and intergenerational impacts of the residential school system, is sunsetting in 2010, and survey results suggest that many funded projects do not have plans in place for long-term sustainability.

The second weakness is the focus on crisis response and intervention. Many key informants observed that the system is designed in a way that encourages First Nations to seek out mental health services only after a crisis has occurred. NIHB, in particular, makes funding available only in response to crises. Many key informants were critical of this emphasis on crisis response and intervention, arguing that, while crisis response is important, prevention, early intervention, aftercare, and long-term healing are equally so.

The reality is that, given the scope and magnitude of the mental health and addictions-related issues affecting First Nations, many of which can be traced to the intergenerational impacts of the residential school system, many individuals and communities require fairly intensive mental health support and healing. The current system of mental health services for First Nations falls

considerably short of the type of comprehensive program and sustained continuum of care that many First Nations would require.

Mental health and addictions services for youth

Based on the needs assessment findings, it is clear that mental health and addictions services for youth are a critical need. Children and youth age 24 and under make up close to 60% of the First Nations population in the province and, as a group, experience multiple issues – including high rates of school drop-out, early exposure to substances, substance use, early sexual experiences, teenage pregnancy, parental neglect, family breakdown, abuse, gang involvement, loss of cultural identity, and suicide – that speak to the need for mental health intervention.

At present, however, there does not appear to be a systematic plan in place for addressing the needs of youth. In fact, it appears that youth are among the most underserved segments of the population. In every community we visited, youth told us that young people seldom, if ever, voluntarily seek out the mental health and addictions services available in their communities, doing so only when mandated by the courts. Youth perceive formal services as unsympathetic to and incapable of comprehending their concerns; at worst, they consider these services to be a potentially destructive force in their lives. Moreover, like adults in their communities, many youth also expressed concerns about confidentiality and trust. While some youth told us that they rely on their parents or another trusted relative in their community for help when they have problems, most prefer to confide in their peers. Key informants, for their part, noted that most mental health and addictions services are not appropriate for youth and that NNADAP workers are not trained to work with youth. Services and supports for youth was the main priority identified by front-line workers (mentioned by 27% of survey respondents), and was also one of the main priorities identified by Community Health Directors.

While services for youth are seen as a priority by stakeholders in this study, it should be recognized that, since 2004, FNIH Saskatchewan Region has taken some steps to address the needs of this population by reprofiling two adult treatment centres to offer youth treatment services (Leading Thunderbird Lodge and Ekweskeet Healing Centre). Since this reprofiling, Ekweskeet has reverted back to serving adults as well as youth. At present, three of the 10 treatment centres in the Region serve youth exclusively.

Prosocial recreational activities for youth

Ultimately, many stakeholders in this needs assessment envision a comprehensive spectrum of mental health and addictions services for youth, including prevention, early intervention, treatment, aftercare, and family support. Within this spectrum, youth as well as many key informants identified prevention, in particular prosocial recreational activities, as the most important priority. In many communities, recreational options are evidently limited, leaving children and youth with few healthy outlets for their natural energy. In fact, boredom was the main reason youth gave to explain why young people drink and do drugs: "Basically we're bored. There's nothing to do. Just look around here..." Talking circle participants in virtually every community suggested that a youth centre, offering a variety of activities such as cultural and traditional activities, sports, artistic pursuits, computers, and games, would occupy youth in their free time and divert them from anti-social activities (in two communities, youth suggested a music studio). On the other hand, some key informants said that even when such facilities are

available, they are not necessarily used. Some talking circle participants also identified a need to target youth through education and awareness programming in schools.

Involving elders and community

The need to involve the entire community in efforts to address mental health and wellness was a common theme in this needs assessment. This concept may include a variety of informal approaches such as encouraging natural support networks and involving respected community members – such as elders – who may have skills gained from life experience rather than formal training. These individuals can act as positive adult role models, engage youth in healthy pastimes, impart cultural teachings and traditional ways of life, and encourage the development of healthy interpersonal relationships. Many talking circle participants, as well as key informants, observed that linking youth with elders is especially important because youth have, to a large extent, lost their cultural identity as First Nations people, in some cases taking on the identity of L.A. street gangs and hip hop culture. These stakeholders believe that linking youth with elders in their communities will help to reconnect them with their own culture.

Supports for families

The need to support families and promote healthy family life was a theme we heard consistently in talking circles, key informant interviews, and from survey respondents. Many talking circle participants and key informants observed that many youth are disconnected from, and lack respect for, their parents, adults in their community, and authority figures in general. They attributed this in part to the absence of positive parenting skills among some parents in their communities. Talking circle participants observed that it is the responsibility of parents to show their children by way of example how to live a healthy lifestyle, to devote time to their children, to discipline them, and to demonstrate to them their love and affection as parents. However, many admitted that they were at a loss as to how to interact effectively with their own children. To the extent that the residential school experience has had an impact on parenting ability, parenting programs and other supports for families could help to address this need. It is also important to note that in First Nations cultures, the extended family has traditionally played a significant role in child rearing and these traditional relationships and roles should be encouraged and strengthened. Supports for families was one of main priorities identified by front-line workers (13% of those surveyed identified this as a priority).

Family-based treatment and aftercare

The need to work with entire families to address addictions was identified by many key informants, survey respondents, and talking circle participants. This concept encompasses both treatment and aftercare. At the treatment stage, this could mean having entire families, rather than individuals, enter residential treatment centres, or alternatively, employing more outpatient treatment that includes all family members.

Perhaps even more important is the aftercare component of addictions treatment. Many talking circle participants noted that people usually receive addictions treatment outside of their community and divorced from their family situation and life circumstances. When they return, these are, more often than not, exactly as they left them. In this situation, their chances of maintaining any success achieved in treatment are slim, and in fact, relapse is common. Many stakeholders emphasized the need for a strong at-home program to support individuals and entire families after treatment.

Sharing circles and support groups

The need for more sharing circles and support groups (for women, men, couples, youth, and families) was identified by many survey respondents and talking circle participants. In talking circles, we heard that merely being able to talk about addictions and mental health issues in a group setting was valuable and therapeutic; it was clear that many participants would value more opportunities for such collective venting and sharing of issues. It is worth noting that part of the difficulty with the existing services is that they are premised on an individualized approach. In some communities, this approach has given rise to such significant apprehension about lack of confidentiality that the available services are evidently not being used to their full capacity. Greater use of group approaches could, perhaps, minimize this apprehension and encourage more people to begin accessing service.

Local healing or wellness centres

Many key informants, talking circle participants, and survey respondents identified a need for local healing or wellness centres in First Nations communities. They envision these centres as key gathering places within communities, with a focus on holistic wellness, integration of First Nations culture, and community development. Many of the specific types of services perceived to be lacking, including sharing circles, youth activities, and traditional and cultural activities, could be based in and offered by these wellness centres.

Other needs and priorities

A variety of other service needs and priorities came to light during the course of this research, including:

- ▶ More detoxification and treatment facilities to enable quicker access to addictions treatment
- ▶ Gender-appropriate services, given that men and women face different types of issues and could benefit from different types of services or a different response
- ▶ Rehabilitation services for people with long-term disabling conditions such as schizophrenia, bipolar disorder, and organic brain syndromes, which key informants reported are totally lacking in First Nations communities
- ▶ Services for marginalized populations, in particular injection drug users; individuals with mental disability; long-term solvent users; and homosexual, bisexual, and transsexual people (whose mental health needs are very ill-supported, according to key informants).

In addition, integration of First Nations culture into service provision, greater integration of mental health and addictions services, and development of the First Nations workforce were also identified as priorities. These issues are discussed in the next sections of this report.

3.9 Culture and best practice

In 2000, the NNADAP Renewal Framework acknowledged the importance of integrating both First Nations culture and evidence-based practice. The Framework identified “a system sensitive to and respectful of both traditional and contemporary approaches to healing” as one of the guiding principles of NNADAP Renewal, and explained further that “as determined by clients, families, and communities, both traditional and contemporary approaches to healing will be respected and valued” (NNAPF, 2000, p. 31). Since cultural conflict between the beliefs and values of First Nations and those of the larger society has been identified as a major contributing cause of substance abuse and mental health problems among First Nations, effectively addressing those problems and achieving holistic wellness requires re-establishing contact with traditional values and beliefs (Thatcher, 2005, pp. 35-36). At the same time, the Framework made a commitment to “demonstrably effective prevention and intervention methodologies” (NNAPF, 2000, p. 31).

This dual commitment to culturally based approaches and evidence-based practice may seem paradoxical. Unlike contemporary or Western interventions, there is little scientific research to date demonstrating the effectiveness of culturally based approaches. One key informant put the problem this way: “We know that culture and spirituality are an integral part of healing, but on the other hand, there's no evidence for it.” A related issue is a lack of evidence on practices and treatments that are effective specifically for Aboriginal populations.

Many key informants emphasized that there is an urgent need for research to establish support for the role that culture can play in healing, and also for research into effective practices specifically for Aboriginal people. For example, White Raven Healing Centre in Fort Qu'Appelle is currently engaged in a pilot project called Culture Heals, funded by Health Canada, which has these very objectives. At the same time, some key informants argued that evidence-based practice should not be overemphasized at the expense of other important considerations. For example, one key informant observed that the nature of the relationship that is established between the client and the mental health counsellor is a very important factor in treatment success.

The next section summarizes the available evidence on addictions treatment; we then consider best practices for First Nations populations and youth, and give examples of best practices in service provision within Saskatchewan Region.

3.9.1 The need for a continuum of care

The available evidence suggests that substance issues and mental disorders need to be addressed within a continuum of complementary and mutually reinforcing services (Reist et al., 2004, p. 60; United Nations [UN], 2003, p. 1.2). Substance issues often involve a high degree of complexity and multiplicity. In order to be effective, an addictions treatment system needs to respond to addictions problems within a much wider range of health care and social services, including health promotion, prevention, harm reduction, early intervention, treatment, long-term rehabilitation, and reintegration support (Reist et al., 2004, p. 29).

A recent article prepared for the Centre for Addiction and Mental Health proposed that an effective continuum should:

- ▶ “Recognize the broader harms associated with substance use, not just substance abuse or dependence”
- ▶ “Embody a logic of risk as well as logic of readiness in defining scope of concern”
- ▶ “Be anchored within a broad network of systems of care that respond to the acuity, chronicity, and complexity of harms associated with problem substance use, using a collaborative, multi-system/multi-sectoral approach”
- ▶ “Take a client-centered approach” (Ross, Skinner, Brown, Lefebvre, & Bois, 2007, pp. 3-4).

The first point is important. In conjunction with the rising interest in evidence-based practice, there is also an increasing interest in harm reduction treatment practices. Research indicates that as a person attempts to break an established drug habit, a cyclical pattern of abstinence and relapse is likely to occur (Weekes & Calvert, 2006, p. 5; Reist et al., 2004, p. 40). Harm reduction strategies recognize that many individuals are unwilling and some are simply unable to completely abstain from drugs and/or alcohol, particularly in the short-term. Treatment can recognize and accommodate relapses while at the same time reducing the health and social harms associated with drug and alcohol use. Harm reduction is now accepted in Canada as central to the public health response to substance use (Poulin, 2006, pp. 1-2; Weekes & Calvert, 2006, p. 5).

The last point in the above list is also critical. A key factor in providing evidence-based addictions treatment is to tailor treatments to specific individuals (UN, 2003, p. 1.2). Without consideration (and often treatment) for the numerous factors that contribute to substance abuse issues and/or the mental and physical health issues that may precede or follow addictions, treatments often fail. The next section outlines specific practices in the addictions field that have proven to be effective; the literature review included in Volume II should be consulted for a more comprehensive review.

3.9.2 Best practices in addictions treatment

Generally speaking, there are two broad categories of addictions treatments: psychosocial approaches and psychopharmacological treatments. Many psychosocial approaches fall under the umbrella of “cognitive-behavioural therapy,” which includes a range of group or individual treatments. Most of these treatments are efficient and highly structured, which ensures treatment quality. The other category of interventions—psychopharmacological treatments—have historically been used to treat intoxication and withdrawal; however, new evidence suggests that their application can be much broader (Brown et al., 2005, pp. 23–25). While pharmacotherapy can play an important role in treatment, caution must be used when administering drugs with an addictive potential, and clients must be monitored regularly (Reist et al., 2004, p. 37).

The following table summarizes treatments under these two categories that have proven effective for alcohol and drug use. Most of the treatments listed are outpatient treatments. Residential treatment is warranted and effective for a small number of clients at certain points in their

treatment (Reist et al., 2004, p. 39); however, for the vast majority of clients, outpatient treatment is just as effective. It should be noted that this list is not complete and continues to evolve.

Table 13: Overview of effective treatments	
Psychosocial approaches	
Cognitive therapy	Cognitive therapy is based on the principle that destructive behaviours, emotions, and thoughts can be modified or altered by learning new ways of thinking. Some common cognitive techniques include problem-solving, relaxation therapy, showing by example (modelling), changing distorted ways of thinking, challenging incorrect assumptions, and replacing destructive thoughts with productive thinking.
Behavioural therapy	Behavioural therapy is based on the principle that undesirable behaviours can be replaced by teaching clients new, more desirable ones. Some common behavioural techniques include social skills training, modelling, relaxation techniques, and self-management methods such as rehearsal of new coping strategies.
Structured relapse prevention	Structured relapse prevention is a cognitive-behavioural treatment that involves about 10 to 12 individual or group sessions, followed by maintenance sessions. Program participants are taught to recognize and anticipate their high-risk situations for substance use and implement effective coping strategies to either avoid a slip or relapse, or at least minimize its impact. Structured relapse prevention has proven most effective with alcohol problems, when several substances are being abused, and in conjunction with pharmacotherapy.
Brief intervention	Several recent studies in Canada have shown that shorter treatments can be just as effective as longer ones. Indeed, the type of intervention is much more important than the length.
Motivational interviewing	Research indicates that client motivation is a potent predictor of behaviour change at all phases of the treatment process (Weekes & Calvert, 2006, p. 2). Motivational interviewing is a brief clinical method (involving one to four sessions) that addresses motivational struggles in behavioural change. The goal of this treatment is to establish a partnership between the client and counsellor that respects the client's perspective and strengths. Motivational interviewing has been demonstrated to be a cost-effective intervention for alcohol and drug users.
Community reinforcement approach	Community reinforcement acknowledges the importance of community asset building in addictions treatment (Reist et al., 2004, p. 40), and recognizes the role of a variety of social and environmental events and influences on addictions issues. The goal of community reinforcement is to develop positive resources in the social environment that alcohol and drug users can turn to. One such strategy that has been thoroughly researched is a voucher-based incentive program to promote abstinence, where individuals who submit substance-free urine samples over a certain period of time receive vouchers that can be exchanged for retail items or services. This kind of intervention can reduce drinking and has been particularly effective for treating cocaine abuse.
Behavioural marital therapy	Behavioural marital therapy is aimed at reducing substance abuse directly, and through restructuring dysfunctional couple interactions that are thought to reinforce continued alcohol or drug use. This type of therapy can be applied to other members of the family as well in order to improve communication, problem-solving, and other skills amongst immediate family members and provide support to the family (Roberts et al., 1999, p. 26).
Self-help and Minnesota model programs	Although self-help and Minnesota model programs such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous do not possess the same degree of empirical support for effectiveness as the other treatments listed above, they are still associated with positive outcomes in the longer term.
Psychopharmacological treatments	
Naltrexone (ReVia)	Evidence shows that naltrexone, as an opioid "antagonist," can reduce the rewarding effects of alcohol consumption such as euphoria.
Calcium acetyl homotaurinate (Acamprosate, Campral)	Calcium acetyl homotaurinate appears to be particularly useful in promoting treatment completion, extending the time to a first drink or relapse, and achieving higher abstinence rates than placebos.
Methadone maintenance	Methadone maintenance, as a substitute for heroin addiction, has been found to reduce intravenous drug use, lower risk of HIV infection, improve social and occupational functioning, and decrease criminal activity and mortality.
Buprenorphine	Buprenorphine is another opiate substitute that has proven useful in the treatment of opioid drug abuse.
Source: Brown et al., 2005, pp. 23–25, unless otherwise stated.	

Although many of the treatments described above are both standardized and structured, they are no substitute for individual treatment plans. Appropriate assessment tools (such as the Alcohol, Smoking and Substance Involvement Screening Test; the Addiction Severity Index; or the Drug Abuse Screening Test) should be used to determine the severity of the problem and the appropriate interventions for each individual (Weekes & Calvert, 2006, p. 2). In all cases, evidence-based treatments must be matched to individual and family needs, giving due consideration to gender, age, ethnicity, language, and intellectual abilities.

Maintenance, aftercare, and post-treatment support are also critical for long-term success (Weekes & Calvert, 2006, p. 3; National Treatment Agency for Substance Misuse [NTA], 2006, p. 46). Research shows that if clients have post-treatment support, they are more likely to moderate their substance use and work towards abstinence (Weekes & Calvert, 2006, p. 3). Aftercare can include a range of non-drug-related support such as housing, education, and social care in addition to relapse prevention, self-help programs, and other drug-related supports (NTA, 2006, pp. 46-47).

These treatments are most effective when integrated into a more comprehensive overall treatment structure. One integrated model of outpatient treatment, which incorporates many of the treatments listed above and has proven particularly effective for methamphetamine and cocaine users (although it has also been used to treat stimulant, opiate, and alcohol users), is the Matrix Model of treatment—an outpatient treatment model developed in the 1980s (UN, 2003, p. IV.6). The Matrix Model is a multi-element package of therapeutic practices delivered in structured group sessions as a 16-week intensive outpatient program. Many of the treatment strategies are evidence-based, including cognitive-behavioural strategy, research on relapse prevention, motivational interviewing, psycho-educational information, and 12-step program involvement.

3.9.3 Best practices for First Nations populations

Thatcher (2005, p. 35) observes that the research literature is somewhat limited as a basis for identifying the least and most effective approaches with Aboriginal populations, although he also notes that if outcomes were significantly different for Aboriginal people, these differences would likely be highlighted in the literature, since ethnicity is a standard variable in most studies. That being said, there is a consensus in the literature on the *general principles* that ought to guide mental health and addictions services for First Nations. To a large extent, these principles are consistent with First Nations cultural beliefs and values.

Population health approach – It has been recognized that programs should be based on a population health model, rather than a medical or disease model, of prevention and intervention. In 2000, the NNADAP Renewal Framework embraced the population health model, noting that it “reflects a return to spiritual and philosophical themes that are central to Aboriginal traditions” (p. 28). More specifically, the population health perspective is consistent with the holistic conception of health and well-being that is common in First Nations traditions. Elias (2007) observes that in these traditions, health problems are a reflection of imbalance or disharmony in the circle of physical, emotional, intellectual, and spiritual dimensions of the self, which in turn are closely tied to the social and physical environment. In a similar vein, the NNADAP Renewal Framework

notes that prevention and intervention should be “multi-dimensional, aimed at returning a healthy balance to the various spheres of community, family and personal living” (p. 28).

Culturally relevant – Programs and services should reflect respect for the traditions and values of First Nations people, including respect for different beliefs among First Nations cultures.

Strength-based – Programs and services should be based on and build upon the strengths of individuals, families, and communities.

Importance of family – Programs and services should acknowledge and respect the central role of family, including extended family, in healing.

Thatcher notes that contemporary substance abuse and mental health therapy services offered to First Nations should, upon an indication of interest by the client: incorporate traditional healing practices; involve an elder or spiritual person; use group counselling; emphasize collaboration with the client; and use cognitive-behavioural and socially oriented strategies, because they are less intrusive than many therapies and lack an implicit cultural bias (2005, p. 36).

Finally, because youth comprise a significant proportion of the First Nations population, and because they face unique barriers to treatment, it is also worthwhile to ask what treatment approaches are best for this population. Unfortunately, the research is not clear on this question. Generally speaking, studies show that “providing services that meet young people’s needs (schooling, vocational guidance, recreational activities), integrating motivational and family therapy modules within programs, and offering post-treatment services” show the most promise (Brochu, 2007, p. 24). It is also important to remember that addictions programming for youth, like other age groups, still needs to be tailored to individuals (i.e., one treatment will not work for every youth) (Charles & Alexander, 2007, pp. 39–40). Young people have their own specific needs, which cannot be addressed by merely adapting pre-existing treatments for adults.

3.9.4 Use of best practices within Saskatchewan Region

Based on the data available to this needs assessment and, in particular, the limited response to the survey of Community Health Directors, we do not have a comprehensive understanding of the extent to which evidence-based, best, or promising practices are currently being used to deliver mental health and addictions services within First Nations communities in Saskatchewan Region. However, it is possible to make some observations about general trends and patterns in the Region, with respect to best practices identified in the research literature.

Provision of a continuum of care

The literature on mental health and addictions services notes that it is important to provide a continuum of care. In Saskatchewan Region it is not clear that all First Nations communities have access to a continuum of care. More specifically, many key informants believe that crisis response and intervention are receiving inordinate attention compared to other much-needed services, including prevention, early intervention, aftercare, and long-term healing, along the continuum of care. From a best practice perspective, it is worthwhile to note that recent research has questioned the effectiveness of psychological debriefing – the current standard of care for disaster and crisis response – on the grounds that most individuals confronted with disaster

resolve its impacts with or without intervention. At worst, psychological debriefing may interfere with the natural processing of a traumatic event and inadvertently lead victims to circumvent the support of family, friends, or other sources of social support, which are important factors in resiliency (Deville, Gist and Cotton, 2006). Although community capacity for crisis response and intervention have been identified as a major gap in service, particularly in the North, it is important not to overemphasize these services at the expense of other types.

Integration of cultural elements into service provision

Culture is evidently an important aspect of community-based services and of the services provided by addictions treatment centres (which have incorporated culture into their programs without dedicated funds for this purpose). To this extent, services are reflective of best practice. Key informants and talking circle participants were unanimous in emphasizing the importance of integrating culture into mental health and addictions treatment, while also cautioning that services and service providers must be respectful of the range of life possibilities among First Nations, and not have preconceived notions of who First Nations are as a people. Key informants warned against imposing a particular conception of culture on First Nations communities.

White Raven Healing Centre, at the All-Nations Healing Hospital at Fort Qu'Appelle, is an exemplary attempt to integrate cultural and clinical approaches. The Centre offers a holistic healing program that consists of four elements: cultural/spiritual services; counselling and therapeutic services; addictions counselling (alcohol, drugs, and gambling); and Indian Residential Schools Support Program. Wraparound services are delivered by an integrated, interdisciplinary team of staff, including a psychologist, mental health therapists, addictions counsellors, and elders. Within this model, cultural/spiritual services are the central component. The focus is on integrating traditional healing practices and First Nations philosophies and beliefs into a clinical setting.

Use of harm reduction

Although the predominant addictions treatment philosophy in Canada favours harm reduction over abstinence, many Aboriginal communities and treatment programs still adhere to models of abstinence and prohibition (Dell & Lyons, 2007, p. 3). Our survey of treatment facilities confirmed that all of the treatment centres currently take an abstinence approach, with the exception of Leading Thunderbird Lodge, which requires abstinence during treatment, but teaches harm reduction for return to the community. However, treatment modernization is occurring and the abstinence approach is under review in at least one case (Athabasca Health Authority).

Similarly, we did not find much evidence of harm reduction approaches at the community level. Although 40% of front-line workers indicated that they provide harm reduction services, they most often described these services as suicide intervention, prevention, or awareness (n=10); and education or counselling (n=4). Only one respondent mentioned a methadone program, and none mentioned needle exchange. Similarly, only two respondents to the survey of Community Health Directors reported that needle exchange is available in their communities. However, results from these surveys should be treated with caution due to small sample sizes.

Use of evidence-based or promising treatment models

While about half of the treatment centres use disease-based models of treatment, few use this model exclusively. Other models, some of which have an evidence base, are also being used at some centres, including cultural, biopsychosocial, whole person, resiliency, life process, stages of change, and holistic models. According to Health Canada, three treatment centres – Saulteaux Healing and Wellness Centre Inc., Cree Nations Treatment Haven, and Ekweskeet Healing Centre (since its reopening on May 1, 2009) – use the Matrix Model of addictions treatment. White Buffalo Youth Inhalant Treatment Centre uses Equine Assisted Learning, an emerging field of psychotherapy in which horses are used as a tool for emotional growth and learning.

Engaging youth

Youth comprise a significant proportion of the First Nations population in the Region, face multiple issues that speak to the need for addictions and mental health intervention, and as a group are extremely reluctant to access existing services. Recognizing these realities, in 2007-2008, FNIH funded Meadow Lake Tribal Council Health and Social Development, which then partnered with Youth Launch, the Regional Office of The Students Commission of Canada, to engage Saskatchewan First Nations youth in a series of focus groups to gain their perspectives and ideas to inform the National Aboriginal Youth Suicide Prevention Strategy. In total, some 15 Youth Research Facilitators were trained to conduct focus groups, and 107 youth, 49 adult allies, and five elders participated in the project, representing 39 First Nations communities. Given the high needs of youth and their alienation from the existing system, this project could serve as a framework for engaging them in meaningful ways on the subject of addictions and mental health service delivery.

Training in evidence-based techniques

As we describe below, many of those working in First Nations communities and treatment facilities have training in evidence-based techniques, including Applied Suicide Intervention Skills, Suicide Intervention, Critical Incident Stress Management, Relapse Prevention, Motivational Interviewing, Mental Health First Aid, Emotional Intelligence, Therapeutic Crisis Intervention, and SafeTalk.

With respect to the last point, quality of service is a function not only of the extent to which evidence-based practices are being used, but also of human resources. The next section discusses current human resource issues within the system of mental health and addictions services for First Nations in Saskatchewan.

3.10 Human resources

One of the tasks of this needs assessment was to examine the current state of human resources for mental health and addictions services and to consider whether these resources are adequate to respond to the existing need. Like previous studies that have already examined this question, this research identified a number of significant human resource challenges, all of which have implications for accessibility, quality, and effectiveness of service.⁹ The main challenges are described below.

Insufficient number of First Nations practitioners

One of the most significant challenges, identified by key informants and survey respondents as well as previous studies, is an insufficient number of First Nations practitioners, especially mental health and youth workers. Of 91 approved mental health therapists, only a small number are reportedly First Nations. As we reported earlier, the insufficient number of First Nations practitioners is widely regarded as a major barrier to access.

Inadequate qualifications and training

Previous studies have reported that many individuals are working in the addictions and mental health fields without adequate qualifications or training. It has been noted that there are no minimum professional or paraprofessional qualifications for treatment centre directors, therapeutic staff of treatment centres, community-based addictions workers, or mental health workers (at present, minimum qualifications are set by individual bands or treatment centres that employ these workers). Most addictions workers do not have professional addictions counselling skills or group facilitation skills; and advanced addictions counsellor and advanced specialized training in addictions or addictions-related topics, such as sexual abuse, violence, residential school effects, loss and grief, abandonment issues and post-trauma, are not systematically available. There is also a shortage of addictions workers trained to work with youth.

Similarly, according to the literature, there is a shortage of professionally qualified service providers in mental health. Minimum qualifications for mental health workers do not exist, and many of those working in mental health have little training. Moreover, there are not enough First Nations mental health service providers or youth workers, nor are there enough mental health workers devoted to residential school issues.

This needs assessment was designed to systematically capture objective information about the qualifications and training of those working in the mental health and addictions fields. Unfortunately, the survey response rates preclude any definitive conclusions being drawn. That being said, the survey results show that:

- ▶ Among front-line workers surveyed, many have considerable working experience in mental health and addictions (median 12 years among those surveyed). Only 3% of survey respondents have less than one year of working experience, while about one-fifth have between one and five years of experience, and about two-thirds have six years of

⁹ These include studies by Thatcher (2005 and 2007), Elias (2008b), and the National Native Addictions Partnership Foundation's Workforce Development Strategy (2006).

experience or more. Many key informants emphasized the need for formal recognition of the skills gained from experience.

- ▶ Almost half (47%) of front-line workers surveyed have at least one type of addictions certification. Most commonly, they had completed the SIIT Community Services Addictions Certificate (23%), the Addiction Services Certificate Program (13%), or the SIAST Addictions Certificate Program (13%). Just under one-quarter have a bachelor of social work, a master of social work, or a master of Aboriginal social work (see [Table 14](#)).
- ▶ Although previous studies have observed that continuing education and professional development programs are not fully developed on most reserves, a large majority of the front-line workers surveyed (91%) reported that they have opportunities for ongoing training or professional development on the job. Many have taken such training – most commonly, Suicide Intervention, Applied Suicide Intervention Skills, and Critical Incident Stress Management, as well as Self-Care, Grief and Loss, Relapse Prevention, and Case Management (see [Table 14](#)). Staff of treatment centres most often had training in Applied Suicide Intervention Skills, Suicide Intervention, Self-Care, Cultural Training, Mental Health First Aid, and Case Management.
- ▶ Two-thirds of front-line workers believe that their education and/or training has prepared them very well for their job and responsibilities, while one-third said they were moderately well-prepared. A small majority (58%) feel they have enough training to do their job.

On the basis of the survey results, it appears that front-line workers are a reasonably well-qualified group, particularly when it comes to addictions.¹⁰ However, many key informants acknowledged that although the situation has improved in recent years, the existing workforce is still, to a considerable extent, relatively untrained and nepotism continues to be a factor in hiring. Many key informants emphasized the need for better qualifications and a greater degree of professionalism within the workforce. Basic counselling skills and a minimum set of qualifications for addictions workers were the most pressing priorities from their point of view. Front-line workers, for their part, most often identified basic counselling skills (15%) or general mental health training (13%), computer training (13%), and traditional or cultural training (13%) as potentially beneficial.

¹⁰ However, it is important not to generalize the survey findings to the larger population of front-line workers in the province, since self-selection bias may be a factor.

Table 14: Qualifications, certifications, and training of front-line workers	
Source: Survey of Front-Line Workers	
Type of qualification or certification	Percent (n=78)
Registration with a certifying body/professional membership association	28%
Saskatchewan Indian Institute of Technologies (SIIT) Community Services Addictions Certificate	23%
Bachelor of social work	19%
Addiction Services Certificate Program	13%
Saskatchewan Institute of Applied Science and Technology (SIAST) Addictions Certificate Program	13%
Nechi Advanced Counsellor Training Certificate	10%
Nechi Community Addictions Training Certificate	10%
SIIT Community Services Addictions Diploma	8%
Nechi Aboriginal Addictions Services Certificate	5%
Life skills coach	5%
Master of social work/Master of Aboriginal social work	4%
Grief recovery certificate	4%
Nechi Aboriginal Addictions Services Diploma	3%
Bachelor of psychology	3%
Bachelor of education	3%
Crisis management/intervention certificate	3%
Chemical dependence certificate/program	3%
Other	38%
No response	13%
Type of training and professional development	
Suicide Intervention	81%
Applied Suicide Intervention Skills	74%
Critical Incident Stress Management (levels 1 and 2)	68%
Self-Care	64%
Grief and Loss	62%
Relapse Prevention	55%
Case Management	55%
Computer	53%
Motivational Interviewing	45%
Mental Health First Aid	44%
Evaluation	35%
Peer Counselling	35%
High-risk populations	33%
Working with persons with cognitive impairments	26%
Emotional Intelligence	23%
Therapeutic Crisis Intervention	23%
SafeTalk	23%
Family violence	4%
SASSI	4%
Life skills	4%
Medicine wheel training	3%
White Stone training	3%
Other	13%
No response	3%
Note: Totals sum to more than 100% due to multiple responses.	

Recruitment and retention of qualified staff

Recruitment and retention of qualified staff is another significant challenge, in a context of limited human resources, high workloads, stressful working conditions, and pay rates that lag behind provincial, regional, or other non-First Nation counterparts. The relatively low wages paid to qualified workers was widely seen as the major reason for difficulties with recruitment and retention.¹¹ Key informants reported that as soon as people obtain some qualifications, training, or experience, they leave their jobs because they can get better paying positions elsewhere. Virtually all Community Health Directors and Treatment Centre Directors reported that staff had left in the previous year, most often to take a better paying position elsewhere or because they found the job too stressful. High turnover, especially among mental health therapists, was disconcerting to some talking circle participants, who observed that it takes time to build the kind of trusting relationships that are conducive to healing. A process to adjust the salaries of workers who complete advanced training, as an incentive for advancement or retention, was identified as a priority. Some key informants also identified a need for housing incentives to encourage staff to remain in their positions.

Liability and risk management issues

Liability and risk management issues, such as licences, standards, accreditation, qualifications, roles, labour standards, safety, and supervision and consultation, are major areas of concern. One aspect of this is recognizing and crediting the alternative qualifications and experience of paraprofessional and traditional service providers. In talking circles, as well as key informant interviews, we heard that experience is not considered to be as valuable as degrees and diplomas. McCready (2003) points out that a promising balanced approach is the “elder’s protocols” that some communities have developed, whereby elders identify practice standards for culturally based approaches (p. 35).

Ethical issues

There are a number of ethical issues stemming from the fact that many mental health and addictions workers provide services in their own communities to people known to them. While community-based workers are seen as a real strength of the existing system, it appears that concerns about confidentiality and trust are fairly widespread and are effectively one of the most significant obstacles to access. Given that the entire system relies on community-based workers to provide services, there is a clear need to train these workers in maintaining boundaries, protecting client confidentiality, and other ethical considerations. However, ethics training is unlikely in the short-term to eliminate the reluctance apparently felt by many to seek out services in their own communities. A few key informants suggested experimenting with alternative

¹¹ The survey of front-line workers asked respondents to indicate their hourly pay rate. A total of 47 respondents answered this question, and a median and average pay rate were calculated on the basis of their responses, producing a median hourly pay rate of \$16.90 and an average of \$20.64. The survey of addictions treatment centres asked respondents to indicate the average hourly pay rate of treatment staff, excluding staff with management responsibilities. Based on information provided by eight respondents, the average pay rate for treatment staff is \$16.30. We caution that these results may not be representative of the entire population of front-line workers, nor do we have comparative pay data against which these rates can be assessed. However, a 2004 study by Higgins International Inc. for the National Native Addictions Partnership Foundation found that, for all positions, non-Aboriginal treatment centre salaries were higher than those of First Nations-owned and operated facilities.

approaches to service provision, such as worker exchanges, to allow mental health and addictions workers to serve communities other than their own.

Other human resource issues

Finally, this needs assessment identified a variety of other human resource challenges, including:

- ▶ A lack of clinical consultation, advice, and supervision on most reserves or in most addictions treatment centres. This point is particularly critical, since services are often provided by paraprofessionals.
- ▶ A need for basic training in and implementation of information technologies – such as computer programs, the Internet, and financial systems – to facilitate program administration, record-keeping, and reporting.
- ▶ A need for cultural awareness and competency training, particularly for mental health therapists (the majority of whom are not Aboriginal).

3.10.1 Regional human resource initiatives

All of the human resource challenges described above have been highlighted by prior studies, and Saskatchewan Region has undertaken a variety of initiatives to address them over the past number of years. Since 1983, the Region has been investing in training to update the skills of NNADAP workers. In 1989-1990, the Chemical Dependency Certificate Program was established under a tripartite agreement between FNIH Saskatchewan Region, Saskatchewan Indian Institute of Technology (SIIT), and Saskatchewan Institute of Applied Science and Technology (SIAST), in order to provide a focused, formal training program for existing NNADAP workers. In 1995-1996, the program transitioned to SIIT as the Community Services Worker (Addictions Certificate) Program. The program is recognized by the Canadian Addiction Counsellors Certification Federation. The SIIT also offers the Community Services Addictions Diploma Program in partnership with Keyano College. This year, SIIT graduated 56 students from its first- and second-year programs. In addition, FNIH Saskatchewan Region funds SIIT to hold an annual NNADAP conference to bring together NNADAP workers for networking and skill development workshops, and since 2006-2007, has provided funding to SIIT to support community-based and treatment centre-based addictions workers going through the certification process. This funding can be used to pay for fees, course material, and course preparation support.

Currently, NNADAP is engaged in a Workforce Development Initiative, the goals of which are to develop workforce recruitment and retention strategies, increase the number of certified workers, provide support to prevention workers, enhance access to certified training, and ensure workers advance their skills.¹² According to FNIH, 39% of NNADAP workers nationally are currently certified, and 43% of Saskatchewan NNADAP workers are certified (n=65 workers). By the end of 2009, FNIH Saskatchewan Region expects that 54% of NNADAP workers in the province will be certified (n=81 workers). FNIH is providing a one-time payment of \$2,600 to all workers who complete certification.

¹² Based on information contained in a National Update Presentation to Treatment Centre Directors by Health Canada, First Nations and Inuit Health Branch, Saskatchewan Region. (February 11, 2009).

FNIH has also taken steps to address the shortage of workers with mental health and youth training. In 2006-2007, FNIH funded SIIT to develop a Youth Development Curriculum. The program was piloted in 2007-2008, and 12 individuals graduated from the program. In 2007-2008, FNIH funded SIIT to develop a Counselling Competencies for Working with Indigenous Peoples Applied Certificate, which will be piloted in 2009-2010. Finally, FNIH funded SIIT to develop the Prevention Awareness and Community Education (PACE) on Crystal Meth Program; over 400 workers in Saskatchewan have received this specialized training, and the course has been nationally recognized.

To address liability and service quality issues, in 2006-2007, FNIH began to provide clinical support funding to the treatment centres to address the problem of lack of clinical supervision. In addition, two of the addictions treatment facilities in the Region are currently accredited (BTC Youth Outreach and White Buffalo), and the remaining centres have plans to become accredited, or are currently in the accreditation process, as a risk management and quality assurance initiative.

3.11 Integration of mental health and addictions services

A substantial body of literature has developed over the past decade advocating for integration of mental health and addictions services, both within Saskatchewan and across Canada as a whole, and numerous health forums, organizations, and groups have been working toward this objective. A consensus has developed that integration of mental health and addictions would increase service efficiency and effectiveness by reducing gaps in service and optimizing the use of scarce resources. Moreover, a more collaborative approach is seen as philosophically consistent with the holistic health perspective of traditional First Nations cultures.

Notwithstanding general support for integration, recent studies have suggested that in First Nations communities, mental health and addictions services continue to operate, for the most part, in isolation from one another. There is general consensus in the research literature that the existing system of mental health and addictions services for First Nations is fragmented, and that this fragmentation is a serious impediment to effective service delivery. Thatcher has observed that mental health and addictions “exist in two solitudes on most reserves” (Thatcher, 2007, p. 20). As described in the previous sections of this report, mental health and addictions services are funded through different funding envelopes, administered and delivered by different organizational entities, and staffed by different people. Moreover, the mental health and addictions fields have long held conflicting views on how to approach treatment (Thatcher, 2005, p. 6). Addictions professionals have taken the view that the problem of chemical dependency must be overcome before social or mental health problems can be addressed, while mental health professionals, conversely, have taken the view that the social or mental causes of the addiction must be the priority, or that both the addiction and the other disorder must be treated simultaneously. Addictions and mental health services have also tended to employ different models of treatment, with the former employing self-help, peer support, and twelve-step models, and the latter, medical and cognitive-behavioural models.

Therefore, previous studies have concluded that although the two service systems are to a large extent treating the same population, there is little communication or collaboration between mental health and addictions service providers. Rather, “managers and staff are encouraged by current incentives to work separately rather than together” (Thatcher, 2007, p. 19).

One of the tasks of this needs assessment was to document the degree of support for integration and the extent to which it has occurred in First Nations communities. The findings suggest that, in fact, there is considerable support for integrating mental health and addictions services at the community level. Virtually all key informants believe that integration is desirable and has numerous advantages, including "one-stop shopping" for clients (the majority of whom present with concurrent disorders); the ability to share information and expertise among workers in order to better meet client needs; the ability to use the different skills and talents of workers to their maximum potential; and the potential to reduce burnout among staff. Similarly, a large majority of front-line workers and Community Health Directors surveyed agreed that integrating mental health and addictions services is a good idea (81%), and that such integration makes it easier to meet the needs of clients (81%); only 24% believe that mental health and addictions services are too different to be integrated.

Findings from this needs assessment also suggest that some First Nations communities have already gone some way toward integration. Many key informants reported that integration has already occurred within their own communities or organizations, describing interagency teams, collocation and co-management of services, and development of integrated case management and treatment plans. However, a few said that, although their own organization has integrated mental health and addictions services, on the whole, integration has not yet occurred in most First Nations communities.

At the community level, three-quarters of front-line workers and Community Health Directors agreed that mental health and addictions workers in their communities are familiar with each other's roles and responsibilities; that these workers regularly refer clients to one another; that mental health and addictions services are delivered out of the same location; and that these services are managed by the same organization. About two-thirds reported that mental health and addictions workers take a team approach to working with clients, but fewer (57%) said that mental health and addictions workers meet together regularly, suggesting room for improvement in this regard (see [Table 15](#)).

Table 15: Percentage of survey respondents who agree with statements about integration	
Source: Survey of Front-Line Workers and Survey of Community Health Directors	
	Percent in agreement (n=100)
Mental health and addictions workers in my community are familiar with each other's roles and responsibilities.	76%
Mental health and addictions workers in my community regularly refer clients to each other.	74%
Mental health and addictions workers in my community meet together regularly.	57%
In my community, mental health and addictions services are delivered out of the same location.	76%
In my community, mental health and addictions services are managed by the same organization.	78%
Mental health and addictions workers in my community take a team approach to working with clients.	67%
Integrating or combining mental health and addictions services is a good idea.	81%
Integrating or combining mental health and addictions services makes it easier to meet the needs of clients.	81%
Mental health and addictions services are too different to be integrated or combined.	24%

Key informants acknowledged that there continue to be obstacles to integration, the most significant of which, from their perspective, is the fact that funding for mental health and addictions is delivered through a variety of different programs rather than a single, coherent one. Related to this is the lack of equity in funding between addictions and mental health; several key informants observed that equity in funding would help build relationships between the two fields.

Other key informants observed that turf wars and territoriality remain obstacles to integration, although there have been strides forward in recent years. Within the addictions world, there are fears that Western, scientific models used in mental health may be imposed, to the point of subjugating the traditional or the cultural. On the other hand, a few key informants observed that not all mental health problems are related to addictions; some are simply mental health problems. These key informants worried that integration might result in mental health being subsumed into addictions. Finally, some key informants observed that there is an historical divide between addictions and mental health workers that is a barrier to integration. Mental health workers tend to have more formal education and professional training, and are more often non-Aboriginal, whereas addictions workers tend to be paraprofessionals and are mostly First Nations people.

However, most key informants were confident that all of these barriers could be overcome with concerted effort. Some of their suggestions for overcoming barriers and encouraging integration include:

- ▶ Integrating the philosophies historically used in mental health and addictions
- ▶ Eliminating the multiple funding programs that currently exist for mental health and addictions and restructuring them into a more holistic, comprehensive program spanning the continuum of care
- ▶ Developing a consistent, multidisciplinary training program for community-based workers and reconceptualising these workers as wellness workers, rather than as workers for a specific program; alternatively, encouraging the development of multidisciplinary teams of (program-specific) workers and developing protocols on how team members can work together effectively
- ▶ Developing job classifications, corresponding salary levels, and the prospect of career advancement for community-based workers.

3.12 Governance

Related to the question of integration, one of the tasks of this needs assessment was to examine what impact, if any, the current governance structure for mental health and addictions services has on service delivery. Within Saskatchewan Region, the NNADAP program is delivered at the community level by individual First Nations communities, the majority of which operate under Health Transfer Agreements or Integrated Service Agreements. Under this decentralized structure, First Nations (bands) have the authority and independence to manage and deliver addictions programming, with little administrative unity across the Region. Thatcher (2007) has identified a number of disadvantages arising from this administrative structure, including a lack of service quality standards, a lack of regional service coordination and support (such as research, planning support, and capacity development), and an inability to move forward with

recommended system changes. Similarly, among the relatively few key informants who commented on the subject, there is widespread agreement that the lack of a centralized governance structure has a number of undesirable effects:

- ▶ It produces duplication in service provision and program administration, resulting in inefficient use of human and financial resources
- ▶ It creates a "patchwork quilt" of services, with substantial variation among communities in the type and quality of services available
- ▶ It makes regional meaningful long-term planning difficult
- ▶ Because many decisions are made at the community level, politics can affect service delivery. For example, many key informants noted that human resource decisions are made by Band Councils and that, in some cases, nepotism is a factor in hiring.

Within Canada, Saskatchewan Region is unique in its attempts to address the problems arising from this fragmented governance structure. In 1980-1981, a Regional Advisory Board (RAB) was implemented as a formal mechanism for First Nations representatives to advise FNIH Saskatchewan Region on the NNADAP – the first and only such body established in the country. The RAB was officially disbanded in August 2008.

In a study completed in 2000, Thatcher linked several NNADAP accomplishments within the Region to RAB involvement and direction, including:

- ▶ The establishment of a long-term mandate for NNADAP in Saskatchewan in 1985, which resulted in multi-centre treatment services and a NNADAP project on each reserve
- ▶ The development and delivery of the SIIT addictions training program
- ▶ The development of regional standards for prevention and intervention.

However, in the same study, Thatcher also noted that the RAB did not have the legal authority to insist on program upgrading and to ensure standards. Moreover, in subsequent work, Thatcher notes that despite several attempts over the past few decades to establish a regional policy-making, service coordination, and support body, none have come to fruition.¹³ To date, there has been no consensus on how such an authority would be established, how it would be structured, and who would constitute its membership. This is for various reasons. Communities operating fairly autonomously under Health Transfer Agreements may be reluctant to return to a "top-down" approach (Thatcher, 2005, p. 10), and established governance bodies may be apprehensive about potential threats to their authority or role. Instead of a regional coordinating body, therefore, there continues to be a "fragmented, unnecessarily expensive group of oversight/governance bodies" in place which makes "coordinated delivery and long-term strategic planning and development difficult or even impossible" (Thatcher, 2007, p. 20). As a result, many of the shortcomings in mental health and addictions programming identified in this

¹³ Thatcher (2007) provides a comprehensive overview of the various options that have been put forward for establishing a regional coordinating body.

report, which have long been recognized, have “never been adequately addressed or forcefully pursued” (Thatcher, 2005, p. 11).

The latter theme was echoed by several of the stakeholders interviewed as part of this needs assessment. Although some key informants were satisfied with the opportunities that they and other stakeholders have to provide input into decision-making related to mental health and addictions for First Nations, more were either unsatisfied or said that although they have many opportunities to give input, their input is evidently not being heard because changes to the system have not occurred. Several pointed out that this problem has become particularly acute since the RAB was disbanded in 2008.

3.13 Current strengths

Notwithstanding the many barriers, limitations, gaps, and obstacles that this needs assessment has identified, many strengths and assets of the existing system also came to light. Some of the main perceived strengths of the current system are:

- ▶ The cultural aspect of the services, or the fact that cultural approaches have been integrated with mainstream, Western, or clinical approaches
- ▶ The diversity, qualifications, and dedication of mental health and addictions workers in First Nations communities
- ▶ In some communities, the degree of teamwork and integration of services that has occurred; the fact that service providers collaborate to provide wraparound services to clients
- ▶ In some communities, strong political support, without political interference, for mental health and addictions services
- ▶ Competent program management in some communities
- ▶ The support that FNIH Saskatchewan Region has provided over the years for professionalization of the community-based workforce, reprofiling and modernization of treatment services to meet current priorities, and regional coordination of services through the Regional Advisory Board.

However, the biggest perceived strength is the fact that services are community-driven and community-based, and provided in large part by First Nations people who speak the local language and are familiar with the local culture and traditions. Many key informants and survey respondents emphasized the importance of the community-based approach. However, as this needs assessment found, the community-based approach also appears to generate some very real barriers to access. Confidentiality and other ethical issues must be addressed if the community-based model of service delivery is to be truly effective.

4.0 Conclusions and recommendations

This final section of the report draws conclusions based on the needs assessment findings and provides recommendations. Unfortunately, in the absence of comprehensive quantitative data, we are not in a position to make concrete recommendations on resource allocation, which was one of the main objectives of this assignment. Many of the conclusions and recommendations of this needs assessment are therefore necessarily based on qualitative information. That being said, much of the qualitative information substantiates the findings of previous studies, so there is good reason to have confidence in the overall conclusions.

Scope of need

The available statistics on acute and chronic alcohol and drug-related harms show that substance abuse, addictions, and other mental health problems are major issues for First Nations across Canada. However, without regional prevalence data, the extent of these problems is unknown. Moreover, without comprehensive information on rates of service utilization and wait times for service, the extent to which First Nations people with mental health and addictions problems in Saskatchewan are currently receiving some level of service cannot be determined. Although there is widespread consensus that the need for mental health and addictions services among First Nations people is great, the true scope of that need is unknown, due to a lack of necessary data.

Similarly, a comprehensive understanding of the mental health and addictions services available to First Nations at the community level is still lacking, despite concerted efforts through this research to collect this information. In the absence of complete data, it is not possible to make an accurate assessment of service gaps, needs, and priorities, or to make recommendations on the optimal allocation of resources within Saskatchewan Region.

Recommendation 1. Renewed efforts should be made to gather the information necessary to inform decision-making on program redesign and optimal configuration of resources. This information includes:

- ▶ **data on scope of need, such as prevalence rates, rates of service utilization, and wait times for services; as well as**
- ▶ **comprehensive information about the mental health and addictions services available at the community level, including budgets, staffing levels, staff qualifications, service availability and utilization, and outcomes.**

Recommendation 2. In the immediate term, in order to supplement the partial information obtained through this research, FNIH could follow up with Community Health Directors in order to obtain a completed survey from those who did not submit one as part of this needs assessment. If complete, the survey data set would provide a reasonably solid basis for planning.

Ideally, data collection should not be a "one-off" task, conducted as part of a specific research assignment, but a routine aspect of program administration at the community, Tribal Council, and FNIH levels. At the community level, the complexity of the current governance structure and the political and practical realities of Health Transfer may in some cases mitigate against a consistent approach to data collection. Complicating the problem is that, in many communities, there is evidently a need for implementation of and training in information technologies, such as basic computer programs, the Internet, and financial systems to facilitate program administration, record-keeping, and reporting.

Recommendation 3. In the short and medium term, several practical measures could be taken to encourage systematic data collection and reporting as a routine aspect of program administration at the community level. These measures could include:

- ▶ **Developing guidelines regarding the specific pieces of data that should be routinely collected at the community level, and providing training on these guidelines to First Nations communities.**
- ▶ **During training, explaining the benefits of improved data collection as a means of ensuring buy-in on the part of First Nations communities.**
- ▶ **Ensuring that every community has the technological infrastructure and human resource capacity for data collection. This could include providing funding for computer hardware, software, and Internet connections, as well as providing computer training to community-based managers and front-line workers.**

Service gaps, needs, and priorities

Notwithstanding the limited information available to this needs assessment, certain observations about service gaps, needs, and priorities can be made with some confidence. For example, it is clear that addictions services are more readily available in First Nations communities than mental health services. Addictions education and prevention, screening and assessment, and counselling are available in many communities, whereas mental health services are focused primarily on providing referrals, cultural support, and crisis-related services such as intervention, counselling, management, or training; incident debriefing; and crisis team planning and delivery.

This imbalance is due to the way in which funding for mental health services is structured and delivered. Whereas NNADAP functions as the primary source of funding for addictions programming for First Nations, mental health services are funded through a variety of programs – including Brighter Futures, Building Healthy Communities, Non-Insured Health Benefits, the Indian Residential Schools Health Resolution Support Program, and the Aboriginal Healing Foundation – and are delivered at either the community or Tribal Council level. This approach produces a lack of consistency in the nature and quality of mental health services at the community level.

Moreover, it appears that the current system emphasizes crisis response and intervention at the expense of other needed services along the continuum of care, such as promotion, prevention, early intervention, treatment, aftercare, and long-term rehabilitation and healing. NIHB, in particular, makes funding available primarily in response to crisis: funding for mental health counselling under NIHB was less than half a million dollars in 2008-2009. The need for more mental health counsellors or funding for this purpose was the most frequently mentioned priority by participants in this research; many communities clearly do not have adequate access to mental health counselling services. The situation is all the more urgent since AHF project funding, which focuses specifically on addressing the long-term and intergenerational impacts of the residential school system, is sunsetting in 2010, and survey results suggest that many funded projects do not have plans in place for long-term sustainability.

Given the scope and magnitude of the mental health and addictions-related issues affecting First Nations, many individuals and communities require fairly intensive mental health support and healing. The current system of mental health services for First Nations falls considerably short of the type of comprehensive program and sustained continuum of care that many First Nations communities would require. A major priority emerging from this research is the need for a more coordinated and comprehensive approach to mental health services, for example, through the development and implementation of a single mental health program for First Nations, with elements spanning the entire continuum of care.

Some stakeholders within the Region would go further, eliminating the multiple funding programs for mental health and addictions services – including NNADAP – and developing a single, comprehensive mental health and addictions program. However, such dramatic restructuring is probably not feasible in the short- and mid-term.

Recommendation 4. A more coordinated approach to mental health services for First Nations should be developed. One possibility might be to rationalize the current approach to funding by eliminating the multiple sources of funding for mental health services and restructuring them into a single mental health or wellness program for First Nations. Ideally, the new program would include elements spanning the continuum of care, including promotion, prevention, crisis response and intervention, early intervention, treatment, aftercare, and long-term rehabilitation and healing.

Recommendation 5. Given the small amount of money spent on mental health counselling under NIHB, consideration should be given for phasing out funding for mental health counselling as part of that program and focus on developing mental health counselling as an element of a new mental health program .

Providing a continuum of care does not necessarily mean that all services should be available in all communities. That is clearly not feasible with existing resources, nor is it the reality in non-Aboriginal communities within the Region or elsewhere in the country. That being said, efforts should be made to ensure that a basic level of service is available everywhere and that all services along the continuum of care are accessible to all First Nations communities with relative ease.

Recommendation 6. Determine what mental health and addictions services should comprise a "basic package" available in all communities. Tentatively, these services could include prevention, crisis response and intervention, referrals, basic addictions and mental health counselling, cultural support, and aftercare.

Recommendation 7. Experiment with innovative ways of delivering services. Some possibilities include:

- ▶ **Developing health promotion and prevention public service announcements, in First Nations languages as well as in English, and broadcasting these via the Aboriginal Peoples' Television Network (APTN)**
- ▶ **Implementing travelling interdisciplinary teams of service providers to visit communities on a regular schedule to provide clinical or specialized services**
- ▶ **Making greater use of telehealth services.**

The need for a dedicated focus on and investment in First Nations youth is another major priority emerging from this research. Although FNIH was interested in knowing the extent to which existing services are appropriate for youth, pregnant women, and individuals with concurrent disorders, as well as the extent to which these services are gender-appropriate, participants in this research were primarily concerned about the situation facing First Nations youth. Children and youth age 24 and under make up close to 60% of the First Nations population in the province and, as a group, experience multiple issues – including high rates of school drop-out, early exposure to substances, substance use, early sexual experiences, teenage pregnancy, parental neglect, family breakdown, abuse, gang involvement, loss of cultural identity, and suicide – that speak to the need for mental health intervention.

At present, there does not appear to be a systematic plan in place for addressing their needs. Moreover, most mental health and addictions services are not designed for youth, and addictions and mental health workers are seldom trained to work with this population. Indeed, youth are among the most underserved segments of the population and rarely seek out the formal mental health and addictions services available in their communities, considering these unresponsive to their needs and a potentially destructive force in their lives.

Many stakeholders regard health promotion and prevention initiatives for youth as especially important. Prosocial recreational activities and initiatives to reconnect youth with their cultural heritage – such as linking youth with elders in their communities – were identified as major priorities. That being said, given that many First Nations youth are already involved in substance use and/or have mental health issues requiring intervention, prevention services for youth should be balanced with specialized early intervention, treatment, and aftercare services.

Recommendation 8. Develop a comprehensive strategy to address the mental health and addictions needs of First Nations youth. Among other things, such a strategy could involve:

- ▶ **developing specialized mental health and addictions services for youth**
- ▶ **developing innovative strategies to reach youth; possibilities might be youth outreach programs, peer support programs, and school-based programs**
- ▶ **providing more prosocial recreational activities for youth**
- ▶ **increasing the number of NNADAP and mental health workers specially trained to work with youth**
- ▶ **developing a "youth and elders" program to reconnect First Nations youth with their cultural heritage, expose them to cultural teachings and traditional ways of life, provide them with positive role models in their communities, and engage them in healthy pastimes.**

Finally, a third major priority identified by this needs assessment was the need to support entire families and, indeed, communities as part of efforts to address mental health and addictions problems, rather than focusing on individuals. At the prevention and early intervention stage, a focus on families could mean more widespread implementation of positive parenting programs, support for the role traditionally played by extended families, and other similar supports. At the treatment stage, the concept could mean having entire families, rather than individuals, enter residential treatment centres (at present, only one treatment centre provides specialized programming for families). Alternatively, it could mean employing more outpatient treatment that includes all family members. Finally, a strong at-home program to support individuals and entire families after treatment could help to maintain successes achieved in treatment and prevent relapse. Recognizing the importance of family is consistent with acknowledged best practice for First Nations populations.

Recommendation 9. Recognizing that mental health and addictions problems affect individuals within a family context, greater use of family supports and family-based interventions is warranted as a matter of best practice. For example:

- ▶ **positive parenting programs and other similar supports for families, as a prevention and early intervention strategy**
- ▶ **family-based residential treatment, or alternatively, and perhaps preferably, outpatient treatment that includes all family members**
- ▶ **strong aftercare programs to support entire families once treatment is completed to maintain successes achieved in treatment.**

Barriers to access

Like previous studies, this needs assessment identified numerous barriers preventing First Nations people from accessing the available mental health and addictions services, the most significant of which is concern at the community level about lack of confidentiality and trust. Our findings suggest that this is a complex problem. There is often a practical issue of a lack of private office space for workers to meet with their clients. But the larger problem stems from the reality that most front-line workers are members of the communities in which they work. While this is perceived as a real strength of the system, the fact that front-line workers usually know their potential clients or may even be related to them is also a shortcoming. Among community members, there is reluctance to access community-based workers for fear that private affairs will become public knowledge. Moreover, many are reluctant to be seen accessing these services because of the stigma associated with these problems and out of fear that gossip and rumours will be generated about them. Exacerbating the problem, nepotism is reportedly still a factor in hiring, so that many people lack confidence in the experience and qualifications of front-line workers.

It is probably not overstating the point to say that, in some communities, there is such significant apprehension about lack of confidentiality that the available services are not being used to their full capacity. There is an urgent need to address this issue, since the entire system is premised on workers providing services in their own communities.

Recommendation 10. While the issue is unlikely to disappear in the short-term, the barriers to access stemming from concerns about confidentiality could be mitigated through a multi-pronged approach. Among other things, elements of this approach could include:

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

The cultural inappropriateness of some services was also identified as a major barrier to access. This barrier has been identified by numerous prior studies and, in this research was highlighted by key informants as well as talking circle participants. They observed that the system of mental health and addictions services, based on Western clinical approaches, is often uncomfortable for First Nations people. Provincial services delivered by the regional health authorities are seen as particularly inappropriate and unapproachable for First Nations. This is problematic, given that First Nations people make up a significant proportion of clients of provincial mental health and addictions services. Previous studies, as well as individuals interviewed as part of this needs assessment, have observed that communication and collaboration between First Nations service providers and provincial services, which might help to mitigate these difficulties, is very limited.

Recommendation 11. Given the number of First Nations people accessing provincial mental health and addictions services, efforts should be made to improve their experience of these services. These efforts could include:

- ▶ **encouraging collaboration and cooperation between First Nations and provincial service providers**
- ▶ **developing supports for First Nations people who access provincial services.**

Culture and best practices

In 2000, the NNADAP Renewal Framework acknowledged the importance of integrating both First Nations culture and evidence-based practice. This dual commitment may seem paradoxical because there is little scientific research demonstrating the effectiveness of culturally based approaches. A related issue is a lack of evidence on practices and treatments that are effective specifically for Aboriginal populations. Many key informants emphasized that there is an urgent need for research to establish support for the role that culture can play in healing, and also for research into effective practices specifically for Aboriginal people. White Raven Healing Centre is currently engaged in a pilot project called Culture Heals, funded by Health Canada, which has these very objectives.

Recommendation 12. To improve the evidence base, more evaluation of culturally based approaches should be undertaken, as well as research to determine what practices and treatment approaches are effective for Aboriginal populations.

The importance of integrating cultural and traditional approaches into service provision for First Nations has been identified in the literature as best practice. At the community level, and within addictions treatment centres, it appears that culture is already an important aspect of service provision, and to this extent, services are reflective of best practice. Within Saskatchewan Region, White Raven Healing Centre may offer a model for service provision elsewhere in the province. The Centre offers a holistic healing program of wraparound services delivered by an integrated, interdisciplinary team of staff, including a psychologist, mental health therapists, addictions counsellors, and elders. Within the Centre's model, cultural/spiritual services are the central component. The focus is on integrating traditional healing practices and First Nations philosophies and beliefs into a clinical setting.

Recommendation 13. As a matter of best practice, service provision should strive to integrate cultural or traditional approaches with Western, clinical approaches to mental health and addictions services. The specific cultural approaches used, as well as the appropriate balance between Western and cultural approaches, should be a matter for individual communities to determine.

Although community-based information is missing, the needs assessment did find some examples of evidence-based or promising models within the treatment centres, such as cultural, biopsychosocial, whole person, resiliency, and holistic models. Three treatment centres use the Matrix Model of addictions treatment, and one uses Equine Assisted Learning, an emerging field of psychotherapy in which horses are used as a tool for emotional growth and learning. The research findings also show that many of those working in First Nations communities and treatment facilities have training in evidence-based techniques, including Applied Suicide Intervention Skills, Suicide Intervention, Critical Incident Stress Management, Relapse Prevention, Motivational Interviewing, Mental Health First Aid, Emotional Intelligence, Therapeutic Crisis Intervention, and SafeTalk.

Harm reduction is one area where current practice among First Nations service providers is not necessarily congruent with acknowledged best practice. Although the predominant addictions treatment philosophy in Canada favours harm reduction over abstinence, many Aboriginal communities and programs still adhere to models of abstinence and prohibition. Our survey of addictions treatment facilities confirmed that all of the treatment centres currently take an abstinence approach to treatment, with the exception of Leading Thunderbird Lodge, which requires abstinence during treatment but teaches harm reduction for return to the community. Similarly, we did not find much evidence of harm reduction approaches at the community level. While harm reduction is not a policy approach favoured by the current federal government, from a public health and best practice perspective, it does merit consideration.

Human resources

This needs assessment was not successful in obtaining the quantitative information needed to determine whether current human resources are adequate to respond to needs. This information includes data on current human resource levels, service utilization rates, and wait times for service, as well as prevalence data. That being said, previous studies have found that there are not enough First Nations practitioners, especially mental health therapists and mental health and addictions workers specialized to work with youth, and the qualitative information collected by this needs assessment certainly supports that finding. Of the 91 mental health therapists approved by FNIH, only a small number are Aboriginal, and more mental health therapists was one of the most important needs according to participants in this research. Beyond that, qualitative data from this research suggest that apprehension about confidentiality at the community level has produced some underutilization of the services provided by community-based workers, although the extent of the problem is not known.

Recommendation 14. Measures should be taken to increase the number of qualified First Nations practitioners, in particular mental health therapists and mental health and addictions workers with specialized training to work with youth.

Recommendation 15. Work with First Nations post-secondary educational institutions to develop and implement a certificate or degree program in mental health. Consideration should also be given to developing specialized programs to train mental health and addictions workers to work with youth.

Recommendation 16. To facilitate an assessment of the adequacy of current human resources, further research should be undertaken to determine whether existing community-based services are being used to their full capacity.

Previous studies have also concluded that the existing workforce is relatively untrained. The data available to this needs assessment suggest a growing professionalization of the First Nations workforce. Almost half (47%) of front-line workers surveyed have at least one type of addictions certification, and according to FNIH, 43% of NNADAP workers in the Region are certified, which compares favourably with 39% of NNADAP workers nationally. By the end of 2009, FNIH expects that 54% of NNADAP workers in the province will be certified as a result of its Workforce Development Initiative.

Over the years, FNIH Saskatchewan Region has taken several measures to improve the qualifications of the First Nations mental health and addictions workforce, including developing a certification program for addictions workers in partnership with the Saskatchewan Indian Institute of Technologies and funding annual conferences for NNADAP workers in the province. Nonetheless, many people are evidently still working without adequate qualifications and training, and key informants reported that nepotism continues to be a factor in hiring. Counselling skills and general mental health training for addictions workers, as well as cultural and computer training, are among the most important professional development needs, and training in ethics, to begin addressing confidentiality concerns, is also clearly required. There is also a need for clinical supervision of community-based workers, given that many are paraprofessionals.

Recommendation 17. The ongoing professional development and training of mental health and addictions workers should be supported. Areas that merit particular attention include basic counselling skills and mental health training for addictions workers, cultural training, computer training, and training in ethics.

Recommendation 18. Enlisting mental health therapists to provide clinical supervision and training to community-based workers should be considered. Such a strategy could include deploying in-person support on a rotating basis to First Nations communities and developing a 24-hour telephone line for workers to access for clinical supervision, advice, and guidance.

Finally, previous studies, as well as participants in this research, have observed that current pay rates are insufficient to recruit and retain qualified personnel. Our research found average pay rates among community-based workers and treatment centre personnel (excluding those with management responsibilities) of approximately \$16 per hour, although these rates are based on limited information and we lack data against which the rates could be compared. Nevertheless, given the demands of front-line work in mental health and addictions, the \$2,600 one-time payment that FNIH is providing to each worker who completes certification as part of its Workforce Development Initiative is probably insufficient to resolve the problem. In the medium term, a process to adjust the salaries of workers who complete advanced training is needed as an incentive for retention and advancement.

Recommendation 19. In the medium term, a process to adjust the salaries of workers who complete advanced training as an incentive for retention and advancement should be developed. This would require developing job classifications and corresponding salary levels for community-based workers.

Integration

Over the past few years, a consensus has developed that integration of mental health and addictions would increase service efficiency and effectiveness by reducing gaps in service and optimizing the use of scarce resources. However, recent studies have suggested that in First Nations communities, mental health and addictions services continue to operate, for the most part, in isolation from one another. Mental health and addictions services are funded through different funding envelopes, administered and delivered by different organizational entities, and staffed by different people.

This needs assessment found considerable support for integrating mental health and addictions services at the community level. Integration is widely seen as desirable, with numerous advantages for clients and workers, including "one-stop shopping" for clients; ease of information sharing; the ability to use the different skills and talents of workers to their maximum potential; and the potential to reduce staff burnout. Among front-line workers and Community Health Directors surveyed, only 24% believe that mental health and addictions services are too different to be integrated.

Similarly, our findings suggest that some First Nations communities have already gone some way toward integration. Many key informants reported that integration has already occurred within their own communities or organizations, describing interagency teams, collocation and co-management of services, and development of integrated case management and treatment plans. Similarly, most survey respondents said that in their communities, mental health and addictions workers are familiar with each other's roles and regularly refer clients to one another, and that these services are managed and delivered by the same organization. However, fewer said that mental health and addictions workers take a team approach to working with clients or meet together regularly, suggesting room for improvement in this regard.

Despite some progress toward greater integration, therefore, obstacles remain. These include the fragmented delivery and administrative structure for mental health and addictions services; turf wars and territoriality; and historical differences in philosophy, approach, and the characteristics of the respective workforces (i.e., mental health workers tend to have more formal education and

professional training, and are more often non-Aboriginal, whereas addictions workers tend to be paraprofessionals and are mostly First Nations people). Most key informants were confident that all of these barriers could be overcome with concerted effort. Many of the recommendations made above, particularly those related to program restructuring and human resources, would help to promote greater integration of mental health and addictions services.

Recommendation 20. In addition to the other recommendations of this report, additional measures could be undertaken to promote integration of mental health and addictions services. Possibilities include:

- ▶ **Encouraging mental health and addictions workers to take cross-disciplinary training**
- ▶ **Inviting mental health workers to the annual NNADAP conferences for professional development and networking purposes**
- ▶ **Inviting program managers from communities where integration has occurred to present their models to other interested communities.**

Governance

Related to the question of integration, this needs assessment examined the impact of the current governance structure for mental health and addictions services on service delivery. Within Saskatchewan Region, the NNADAP program is delivered at the community level by individual First Nations communities, the majority of which operate under Health Transfer Agreements or Integrated Service Agreements. Under this decentralized structure, First Nations have the authority and independence to manage and deliver addictions programming, with little administrative unity across the Region. The disadvantages arising from this structure, including a lack of service quality standards, a lack of regional service coordination and support (such as research, planning support, and capacity development), and an inability to move forward with recommended system changes, have been well-documented in other reports.

In 1980, in an attempt to address these problems, a Regional Advisory Board (RAB) was implemented as a formal mechanism for First Nations representatives to advise FNIH Saskatchewan Region on NNADAP. Despite some successes, including the establishment of a long-term mandate for NNADAP in Saskatchewan, the development and delivery of the SIIT addictions training program, and the development of regional standards for prevention and intervention, the RAB did not have the legal authority to insist on program upgrading and to ensure standards. It was disbanded in August 2008. The relatively few key informants who commented on the subject of governance agreed on the need for a regional policy-making, service coordination, and support body similar to the RAB. In their view, such a body would also provide a needed forum for input into decision-making on mental health and addictions services, and would ensure that any input provided is taken into account in program planning.

Strengths

Notwithstanding the many barriers, limitations, gaps, and obstacles that this needs assessment has identified, many strengths and assets of the existing system also came to light. Some of the most important perceived strengths of the current system are the cultural aspect of the services; the diversity, qualifications, and dedication of community-based workers; and the degree of teamwork and integration of services that has occurred in some communities. Freedom from political interference and competent program management are also seen as strengths, although these conditions do not prevail in all communities. In addition, the support that FNIH Saskatchewan Region has provided over the years for professionalization of the workforce, reprofiling of treatment services to meet current priorities, and regional coordination of services through the Regional Advisory Board is clearly a strength within the Region. However, the biggest perceived strength is the fact that services are community-driven and community-based, and provided in large part by First Nations people who speak the local language and are familiar with the local culture and traditions. At the same time, the community-based approach also appears to generate some very real barriers to access, which must be addressed if this model of service delivery is to be truly effective.

**First Nations and Inuit Health, Saskatchewan Region
Mental Health and Addictions Needs Assessment**

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