Native Addictions and Mental Health

Regional Research Consultation/Forum

(British Columbia, Yukon, Alberta and Northwest Territories)

~ From East to West and North ~

"Identifying priorities Nation-wide to Support

NNADAP's Community-based and Regionally-driven Research."

Meeting Outcomes Summary Report

Sponsored by

- **Anisnawbe Kekendazone – Network Environment for Aboriginal Health Research Centre (AK-NEAHR)**
- **Centre for Addictions and Mental Health (CAMH)**
- **Canadian Centre on Substance Abuse (CCSA)**
- **Network for Aboriginal Mental Health Research (NAMHR)**
- **National Native Addictions Partnership Foundation (NNAPF)**

March 15 to 17, 2011
Best Western Chateau Granville
Vancouver, British Columbia

List of Acronyms/Terminology

ACADRE	Aboriginal Capacity for Research Development Environment Centre
AHRNETS	Aboriginal Health Research Network Secretariat
AK-NEAHR	Anisnawbe Kekendazone – Network Environment for Aboriginal Health Research
AFN	Assembly of First Nations
CAMH	Centre for Addictions and Mental Health
CCSA	Canadian Centre on Substance Abuse
CIHR	Canadian Institutes for Health Research
CIET	Community Information and Epidemiological Technologies
CM	Cognitive Mapping
FNAAP	First Nations Addictions Advisory Panel
FNWACC	First Nations Wellness and Addictions Counsellor Certification
FNIH(B)	First Nations and Inuit Health (Branch)
IKT	Integrated Knowledge Transfer
INMHA	Institute for Neurosciences, Mental Health and Addictions
NAFC	National Aboriginal Friendship Centres
NEAHR	Network Environment for Aboriginal Health Research Centre
NAMHR	Network for Aboriginal Mental Health Research
NNADAP	National Native Addictions and Drug Abuse Program
NNAPF	National Native Addictions Partnership Foundation
KT	Knowledge Translation
KT-NEAHR	Kloshe-Tillicum NEAHR Centre
OCAP	Ownership, Control, Access and Possession
PTSD	(Inter-Generational) Post Traumatic Stress Disorder
YSAC/YSAP	Youth Solvent Addiction Committee / Youth Solvent Addiction Program

Acknowledgements

The organization, funding and direction for this meeting was provided by the Anisnawbe Kekendazone Network Environment for Aboriginal Health Research (NEAHR) Centre under the guidance of Beverley Shea, Wayne Skinner on behalf of the Centre for Addictions and Mental Health (CAMH), and Director Carol Hopkins and very able staff working behind the scenes from the National Native Addictions Partnership Foundation (NNAPF) headquarters at Muskoday First Nation in Saskatchewan. Most appreciated was the additional funding and participation provided by the Canadian Centre on Substance Abuse (CCSA), represented by Rachel Dutton-Gowryluk and the Network for Aboriginal Mental Health Research (NAMHR), represented by Colette Isaac.

The key note presentation the evening of March 15th by Dr. Malcolm King, Scientific Director, Institute of Aboriginal Peoples' Health (IAPH) on 'Two-Eyed Seeing' and Community Knowledge Centres was of interest to all, as was Bev Shea's presentation on the concept mapping sessions, which led to an invaluable discussion on regional research priorities. Panel presentations from Valerie Genaille, Patty Wells, Lori Duncan and Marlene Villebrun provided context from a regional perspective. Others contributed generously of their time and support such as KT-NEAHR's Sharon Thira and Rod McCormick, CAMH's Russell Callaghan, as well as First Nations and Inuit Health (FNIHB) staffers Darcy Stoneadge, Hakique Virani, Carole Patrick and Rupert Ross. Our thanks are also due Wayne Skinner and others in assisting with the planning meetings, as well as the co-facilitation role engaging the likes of Kloshe Tillicum's Sharon Thira, AHRNetS's Alexandra Darnay, and many others.

Lessons learned from Elders Deanna George, Ellen Smith and Agnes Mills supported our efforts from beginning to end, while introductory and summary remarks provided by NNAPF's Michael Martin, CCSA's Rachel Dutton-Gowryluk, and Health Canada's Rupert Ross respectively set the tone and challenge for the consultation's next steps. Lastly, this event would not have been possible without the support and participation of the majority of National Native Alcohol and Drug Abuse Program (NNADAP) Treatment Centre Directors from British Columbia and Alberta, as well as representatives from the Northwest and Yukon Territories. Thanks to all who contributed of their intelligence in this fourth and final regional discussion. We look forward to engaging your involvement in the upcoming year.

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EXECUTIVE SUMMARY

At the present time, the *NNADAP Renewal Process* is being guided by several key documents covering such topics as:

- Culture and Tradition within Addiction Services;
- Review of NNADAP's Prevention Services;
- Improving Mental Health Services and Supports within NNADAP;
- Historical Timeline of NNADAP; and,
- Systems Level Review of NNADAP.[1]

Of these research papers completed to date, one in particular[2] provides the intelligence demanded by mainstream to rationalize the world view held by First Nations, Inuit and Métis relative to the cultural component associated with a 'better' intervention and treatment of clients. Given a poorly documented research gap, NNAPF, in partnership with the AK-NEAHR Centre, CAMH, CCSA and NAMHR, have agreed to collaborate on several regional research consultations, following a similar process used in the Atlantic region in January 2009.

This fourth and final regional meetings invited NNADAP Treatment Centre Directors and other representatives from British Columbia, Alberta, North West and Yukon Territories, as well as federal and provincial addictions and mental wellness program managers, whereby the purpose of the consultation was to identify research priorities that are currently relevant to the Native addictions and mental health field. The objectives were straightforward: to support NNADAP in building their research capacity through partnerships with the research community, and better inform regional research agendas of NNADAP, academia and government, in key areas that are pertinent to regional NNADAP Treatment Centres.

The meeting report provides key points noted in the power point presentations, as well as well received question and answer periods directed to the key note and all panel presenters in Appendix D. Key to the success of the consultation was the cognitive mapping sessions led by Beverley Shea and Wayne Skinner, which served to ignite the discussion leading to concepts, grouping, and research priorities identified. Culturally-based/Traditional Practices was again noted in the top three research areas, with several other priorities identified in detail in the supporting documentation (refer to Appendix E).

Similar to the three prior consultations, the expectation is that these results will serve to build a consensus on regional research priorities nationwide.

[1] For more information on the NNADAP Renewal Process, go to www.nnadaprenewal.ca

[2] Hopkins, C. and Dumont, J. , *Cultural Healing Practice within National Native Alcohol and Drug Abuse Program/Youth Solvent Addiction Program Services, Discussion Paper prepared for Mental Health and Addictions Division*, Community Programs Directorate, FNIHB, Health Canada, February 2010.

INTRODUCTION

On March 15th to 17th, 2011, a fourth and final Regional Research forum was held at the Best Western Chateau Granville, in Vancouver, BC. The meeting engaged NNADAP Treatment Centre Directors and other representatives from British Columbia, Alberta, North West and Yukon Territories, as well as federal and provincial addictions and mental wellness program managers, in a joint meeting session that was cost-shared/co-hosted by the NNAPF (National Native Addictions Partnership Foundation (NNAPF), the Anisnawbe Kekendazone Network Environment for Aboriginal Health Research Centre (AK-NEAHR), the Centre for Addictions and Mental Health (CAMH), the Canadian Centre on Substance Abuse (CCSA) and the Network Aboriginal Mental Health Research (NAMHR) based in Montreal.

The purpose of the consultation was to identify research topics and priorities that are currently relevant to the Native addictions and mental health field. The objectives of the consultation were to support the NNADAP in building their research capacity through partnerships with the research community, and to better inform regional research agendas of NNADAP, academia and government, in key areas that are pertinent to regional NNADAP Treatment Centres.

Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada outlines a comprehensive continuum of services and supports for strengthening community, regional and national responses to substance use issues, and provides direction and opportunities for making this vision a reality.

A critical element for strengthening the system response to substance use issues is a culturally relevant evidence base that values Indigenous Knowledge and practice and which demonstrates a balance with appropriate western theoretical models. Research partnerships and activity are necessary to building such an evidence base. Hence, the priorities identified from the regional research meetings will support the identification and planning of community-based/regional-driven projects, and four goals are proposed:

i) To reflect cultural competency across jurisdictions;

ii) To continue to build relationships, consensus and engagement between NNADAP/YSAP and the research community;

iii) To translate regional meeting outcomes into research priorities that supports community-based/regionally-driven proposals; and,

iv) To begin establishing an evidence base for substance use/misuse informed by indigenous knowledge, and to build the evidence based around cultural interventions.

RATIONALE

What We Did and Why - Background and Overview

- ***What are the ACADRE[3] Centres and what is NNAPF's research-related interest?***

In 2002, the ACADRE Centres were established nation-wide with grant funding from the Canadian Health Research Institutes (CIHR). Since then, the ACADRE Centres have served to build Aboriginal research capacity by providing funding for new and upcoming Aboriginal researchers and research involving Aboriginal Peoples.

On September 18, 2007, in a letter addressed to all ACADRE Centres, NNAPF proposed to address a well-documented research gap, to better inform the addictions research community and government on the efficacy of NNADAP Treatment Centres programs and services. NNAPF's intent was to also identify researchers interested in the field of Indigenous addictions and mental wellness, who could serve as Principal Investigators, and/or Bachelor's and Master's graduates seeking to pursue research in the addictions and mental health field.

- ***What is the connection between the ACADRE Centres and the recent announcement concerning NEAHR Centres?***

In January 2008, CIHR announced a $15.8 M funding grant over three years, to create the Network Environment for Aboriginal Health Research (NEAHR). The works of the NEAHR Centres are directly linked to the ACADRE Centres, with the NEAHR Centres focusing on:

- the enhancement and development of the research environment between Universities, First Nations, Métis and Inuit communities and organizations;
- research themes such as population health, health services, child health and development, as well as ethical issues in Aboriginal health research; and,
- training more than 200 graduate students who are working on a broad range of Indigenous health issues.

After three years in operation, the NEAHR Centres have been successful at renewing a 2 year mandate for 2011/12 to 2012/13, to further their exceptional work and the positive impact they have had in the promotion of research themes that are pertinent to First Nation, Inuit and Métis.

- ***What are the benefits of AK- NEAHR and CAMH to NNADAP Treatment Centres in Saskatchewan and Manitoba, as well as, other regions in Canada?***

Since the 1998 NNADAP Review, one of the roles of NNAPF is the renewal of the addictions system, in order to assist its evolution into a more efficient, culturally-appropriate and relevant program. The NEAHR mandate and connectivity with the regional research community provides a potential process for

[3] For a complete list of acronyms, please refer to page 2 of this document.

building research-capacity as well as overall support to build a strong evidence base for *NNADAP's 2010 Renewal.*

In May 2008, by invite from the NEAHR Centres Secretariat (AHRNETS), NNAPF's CEO and staff presented the opportunity to engage regional Treatment Centres funded under the NNADAP program, to assess processes from client intake to discharge, as well as identify client assessment and best practices that are successful in the treatment of alcohol and substance misuse amongst First Nations, Inuit and Métis peoples. Following further communication, several of the NEAHR Centres, including the Centre for Addictions and Mental Health (CAMH), expressed support.

In January 2009, at the first of four regional consultations, NNAPF was one of several key participants invited to the Atlantic Aboriginal Health Addictions Research Workshop hosted by the Atlantic NEAHR Centre and Dalhousie University, to participate in a brainstorming workshop that brought together key federal/provincial/academic participants, as well as, Atlantic NNADAP Treatment Centre Directors, to identify regional-focused research topics. The agenda model and success of this workshop followed by Dr. Fred Wein's championing set the stage for three future consultations from East to West with a similar agenda, inviting NNADAP Treatment Centre Directors as well as federal and provincial addictions and mental wellness program managers and other invited experts.

PROCESS or METHODOLOGY

How We Did It – Ground Rules followed by Informed Presentations and Discussion

The Program Agenda noted in Appendix C provided for presentations following a format with three basic elements or guiding questions:

1) What their organization does specifically relative to research and practice? For example, did they measure client satisfaction, collect various data and maintain a database." Were quality reviews, or develop client profiles part of their practice, or did they collect or administer regular evaluations relative to accreditation, for example?

2) The second element responded to "How does your organization do the above?" Did they use or follow a conceptual model to do their work, including the evaluation of such?

3) Lastly, what did their organization need in relation to research and practice?

The meeting report provides key points noted in the power point presentations, as well as the well-received questions & answers directed to the key note and all panel presenters in Appendix D. Appendix E provides a record of the information shared to build consensus on research priorities that are pertinent to NNADAP Treatment Centre Directors, policy makers and the research community, using a process known as cognitive mapping.

Building Consensus on Research Priorities using Cognitive Mapping

- ***What is Cognitive Mapping?***[4]

Cognitive Mapping (CM) involves the development of a diagram to illustrate the relationships that exist among factors impacting on a particular issue of importance, as perceived by knowledgeable people or experts. An expert can be any person with knowledge of the issue. In this case, CM is used to identify the priority areas of research of the NNADAP program.

A cognitive map represents the opinions or views of a group of people on a certain issue of importance (e.g. health issue, environmental issues) In using cognitive maps, the views of many people can be obtained and represented, thereby allowing for comparison among community members, stakeholders, government agencies, industry, and/or external views available in the published literature. Cognitive maps were first used in social sciences to represent how people saw a particular issue or to describe their decision-making processes. They were later modified to model different, often conflicting, situations in order to evaluate the outcome of different management or policy options.

For each map, a main issue of interest (also called the 'central concept') is identified. In addition, the map includes a description of issues or ideas (also called 'concepts') that impact on the central concept and one another. The relationships between the concepts are indicated by arrows. Each connection between concepts is assigned a weight or level of significance.

The main benefit of cognitive maps is their simplicity in illustrating, in a clear and easy to understand manner, the varying opinions and views expressed by different groups on a particular issue of importance. As they are relatively easy to create, community members and/or stakeholders can produce cognitive maps either individually or as a group, thereby increasing the range of views and the validity of the resulting map. Producing cognitive maps also allows participants to consider their own views in comparison to others. Similarly, comparing cognitive maps can reveal areas of agreement, as well as, areas of disagreement that will need further discussion and resolution.

- ***Cognitive Mapping Process***

At the Vancouver consultation, five (5) simultaneous cognitive mapping sessions, approximately one-two hours in duration, were conducted with NNADAP Treatment Centre Directors, NNAPF Board representatives, federal and provincial Addictions Managers, and other key stakeholders. The sessions were facilitated by AK NEAHR/ CIET Canada, KT-NEAHR, CAMH, NAMHR, AHRNetS, and NNAPF representatives, and participants were divided into five groups of interest:

1. British Columbia Region Treatment Centres;
2. Alberta Region Treatment Centres;
3. Yukon and North West Territories
4. Researchers / Academics; and
5. Policy Makers / Decision Makers.

The 'central concept' for all five cognitive mapping sessions was guided by two questions:

[4] As defined in Assembly of First Nations and IE in University of Ottawa Report.

What are the interventions, programs, services or projects that you and/or your community or region would like to evaluate or research, to create or generate new knowledge?

What are the next steps that are needed to begin evaluating and/or researching priority areas, and create new knowledge for the NNADAP and related addictions and mental health field?

During each session, participants were asked to produce a cognitive map detailing their views and/or opinions on the priority areas for research relevant to NNADAP and its renewal. Each workshop began with participants identifying concepts in relation to the central concept. These were recorded on small cards by the facilitators and placed on a large sheet on the wall. This continued until all participants felt that they provided all possible concepts. Once completed, each concept was given a weight by the participants on a scale of 1 to 5 (1-very weak, 2-weak, 3-medium, 4- strong, 5-very strong).

In some groups, each participant was able to provide their individual weight which was then averaged out with the rest of the group in that session. After the weighting, the participants identified their top five (5) priority areas for research. Once each session concluded, the groups reported on their identified priorities and a final list of shared priorities was established.

OUTCOMES and FOLLOW-UP

What We Found Out – Regional Research Priorities Identified

As noted in Appendix E, the group caucuses' feedback identified 39 priority areas, with both Research and Policy interests melded with regional research priorities. Although all five groups (in essence three groups) were significantly different, common elements surfaced. Once grouped, research priorities identified by all included 1) Culture in relation to research, including outcomes and impact; land-based programs; spirituality and language as a core elements; family *and* the individual; holistic approaches as well as complex interventions; modeling best practices, community capacity and the engagement of Elders; effective programs and a new definition of success, etc. The second research priority identified related to 2 areas in particular: the first focusing on ethical issues and the importance of OCAP, also known as the Ownership, Control, Access and Possession of data by and for First Nations, and the second area dealing with workforce development, whether training, the use of video conferencing and researching its effectiveness; evaluating the current system (services, departments and organizations); as well as barriers to access services because resources (e.g. human and financial) are already devolved. Lastly, consistent with all prior forums, the issues of aftercare surfaced as a priority, with the need to research the effectiveness of aftercare networks.

In developing guidelines to support NNAPF's research consultation efforts, one of the challenges faced is to build a research framework that will best position the evidence to assist policy and decision makers with the right information at the right time, and to further link the research within NNADAP and NNAPF itself. Such evidence not only helps to educate NNADAP participants on one of NNAPF's roles, but also serves to advocate on behalf of NNADAP using NNADAP-specific research as the foundation of information for optimum advocacy potential. As noted in previous work concerning evidence-based decision-making (EBDM), there is a need to explore assumptions that underlay the gaps and biases in First Nations/Inuit addictions and mental health knowledge.

Creating bridges between Western scientific models and First Nations/Inuit holistic models of well-being is not new, and much of the evidence supports the need for blended addictions treatment and/or prevention where appropriate. Where a blended approach appears to be lacking is in the interpretation and application of health determinants specific to First Nations/Inuit communities, as a precursor to developing and implementing research and policy priorities that are relevant.

> *The challenge revolves around the poor record EBDM has had in accepting Aboriginal knowledge and in the ongoing threat it has posed to Aboriginal evidence. Getting the right mix between Aboriginal evidence of health and well-being and medical and scientific based evidence is therefore, warranted. Given that both need to be seen as valuable and relevant to the improvement of Aboriginal Peoples' health; their interconnectedness must be sought out regardless of structural and cultural barriers.*[5]

Likewise, in *Dimensions of Health Research: The Four CIHR Sectors – Perspectives and Synergies*, the authors' note that historically, much attention has been paid to Sectors I and II (biological/clinical) with recent work being undertaken in the area of society, culture, and population health (Sector III). The lack of tangible work in Sector IV (addictions and mental health services and systems) is highlighted by the following:

> *With the new emphasis on providing community-based health services, there is an urgent need to assess health strategies developed by and for community level participants in the system, and to explore how best to facilitate the interactions of practitioners and community stakeholders.*[6]

A recent literature review evaluating strategies in NNADAP substance abuse programs reiterates the above, noting that "of all the manifestations of ill health that are seen in First Nations peoples, the reality of substance abuse may illustrate most convincingly the need for a convergence of the four components of well-being: physical, emotional, spiritual and mental - in ensuring the health of a community and a person."[7] Its summary observations highlight the need to evaluate, benchmark, qualify, survey and measure health outcomes to assess the success of substance abuse strategies. As noted in one journal, "there is a fair amount of literature on the epidemiology, causes and prevention of inhalant abuse among youth, including First Nations youth. However, there is little information on treatment, and even less on residential treatment."[8]

Summary Remarks and Next Steps

The end-purpose of health research within treatment centres is critical to our understanding of how cultural practices can support research projects so that NNADAP and NNAPF has practice-based evidence to further inform other treatment program practices, and secondly, to monitor and measure the application of evidence-based practices with First Nations/Inuit peoples within the field of addictions. As noted by Lomas, "by treating research as a product instead of a process, decision makers miss the

[5] *Strategic Directions for an Evidence-Based Decision Making Framework,* National Aboriginal Health Organization, October 2001, pg. 5.
[6] Halliwell, J. and Lomas, J., *Draft Discussion Paper Dimensions of Health Research: The Four CIHR Sectors – Perspectives and Synergies,* July 1999, pg 6.
[7] *Literature Review: Evaluation Strategies in Native Substance Abuse Programs: A Discussion,* Health Canada, First Nations and Inuit Health Branch, 2000.
[8] Dell, C., et al, *Resiliency and Holistic Inhalant Abuse Treatment,* Journal of Native Health, Vol. 2, Issue 1, March 2005.

opportunity to influence both the topics under investigation, and the approaches adopted."[9] Hence, it is important to remember the end-use of research is not about health standards but rather, the holistic health outcomes of First Nations/Inuit peoples and communities.

As noted in prior regional consultations, when considering the research agenda that NNAPF hopes to influence, it is critical that the Foundation be inclusive and respectful of traditional knowledge and cultures as well as non-Aboriginal or Western contributions to the addictions field. Specific to NNADAP treatment centres, research itself should be presented as a way to inform/influence policy and legislation, since this is an important method that the latter can participate in the process through their own research activities, in collaboration with the expertise and range of academics from all of the National NEAHR Centres (inclusive of AK-NEAHR and NAMHR), CAMH and CCSA alike.

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[9] ISUMA, *Connecting Research and Policy*, Jonathan Lomas, 2000, pgs. 140-144.

Appendix A Summaries of NNADAP Renewal Research and Evidence-based Research Papers[10]

To support the First Nations Addictions Advisory Panel (FNAAP) in developing the Renewed Program Framework, the FNAAP has commissioned a series of research papers on key information needs within NNADAP. Researchers will engage a variety of individuals who have involvement with NNADAP (community members, Elders, service providers, users and administrators, etc.) through a wide range of research methods (e.g., literature reviews, key informant interviews, talking circles). The synthesis of this information will be used to identify key priority areas within the program and to provide strategic direction for its renewal. The NNADAP Research Papers will focus on the following topics:

- Cultural and Tradition within Addiction Services;
- Review of NNADAP's Prevention Services;
- Improving Mental Health Services and Supports within NNADAP;
- Historical Timeline of NNADAP; and,
- Systems Level Review of NNADAP.

For more information on the NNADAP Renewal Process and upcoming framework, please go to www.nnadaprenewal.ca for more information.

Paper #1: Culture and Tradition - Authors: Carol Hopkins and Jim Dumont, 2009

NNADAP was established as an alternative to mainstream addiction services based upon the recognition that culturally-relevant programming, grounded in an Aboriginal Worldview, is essential for many Aboriginal clients to heal from substance use and other related problems. The 1998 NNADAP Review final report identified that "Most centers use the cultural model but do not identify it as such due to the reality that cultural programming is seen as a way of life, not a model." The Culture and Tradition paper will explore the role of Indigenous Culture within NNADAP from a structural, process and outcome perspective. The paper will outline some of the key concepts that set the foundation for establishing the cultural evidence base for cultural practice specific to addictions services both within the community and within residential treatment. It will also identify key guiding principles for renewal of NNADAP services, including respect for both traditional Indigenous knowledge and western knowledge as relevant and appropriate evidence in renewal activities.

Through a comprehensive literature review and an analysis of strengths and gaps, as well as a series of key informant interviews and focus groups, the Culture and Tradition Research Paper was commissioned to explore how culturally-based and traditional practices are used within NNADAP service and highlight how and why these approaches help individuals, families and communities encountering substance use-related problems. It will also identify examples of culturally-based programming and provide specific recommendations for how culturally-relevant approaches can be better recognized within the program and promoted to mainstream addiction services as a best/promising practice.

Paper #2: Review of NNADAP's Prevention Services - Author: Dr. Heather Gifford, 2009

The goal of NNADAP is to support First Nations and Inuit people and their communities in establishing and operating programs aimed at arresting and offsetting high levels of alcohol, drug, and solvent abuse among their target population living on-reserve. Based on the NNADAP treasury board submissions, First Nations communities should have access to primary, secondary and tertiary prevention activities for alcohol and other drug abuse. However, the types of services offered by NNADAP prevention programs

[10] As referenced from information available at www.nnadaprenewal.ca

at the First Nations community level varies from one community to another depending on a variety of factors. This paper provides a comprehensive review of this component of the program and provides recommendations on how the program can better align with current best/promising practices for prevention, while maintaining the programs cultural base. In the original vision of NNADAP, it was proposed that the prevention component would be integrated with the continuum of care for alcohol and other drug abuse, and that there would be frequent and close working relationships between community-based prevention workers and treatment centres. Despite periodic, well-intentioned efforts, the prevention and treatment component have remained separate. However, the original vision for a clearly structured, well-trained, and connected prevention component remains valid.

Through a review of the literature, focus groups and key informants interviews the Prevention Research Paper will aim to identify existing evidence-based best/promising practices and strategies for the prevention of substance abuse in Aboriginal and non-Aboriginal settings; identify gaps and challenges of the NNADAP prevention program; and propose various short and longer term strategies to improve and revitalize the NNADAP prevention component over the next ten years.

Paper #3: Mental Health - Authors: Dr. Rod McCormick and Darryl Quantz, Spring 2010

Access to mental health services within NNADAP continues to be a priority concern for First Nations communities in Canada. It is generally accepted that about half of all people who present with a substance use problem have had a mental health problem at some point in their lives – and it is believed that these rates may be higher among First Nations and Inuit populations due to historical and societal factors. However, many NNADAP services, particularly those in rural and remote areas, do not have access to the necessary mental health services to support clients with co-occurring substance use and mental health problems. This paper will focus on strategies and best/promising practices for improving mental health services and support within NNADAP.

Through a review of the literature and key informants interviews the Mental Health Research Paper will review existing strategies, both mainstream and Aboriginal-specific services, to help ensure appropriate, evidence-informed and culturally-relevant mental health services and supports within NNADAP. The paper will identify gaps in service; highlight existing best/promising practice models, partnerships and agreements; potential partnerships and agreements to enhance mental health service delivery; and provide recommendations for integrating mental health and addiction prevention and treatment components.

Paper #4: Historical Timeline of NNADAP - Author: National Native Addictions Partnership Foundation, Assembly of First Nations, First Nations and Inuit Health Branch, 2010

NNADAP has undergone several reviews at both regional and national levels since it was established in 1982. These reviews have identified key recommendations/comments/models that are still relevant today. By detailing key events in the history of NNADAP, FNIHB and its partners will be in a better position to determine how to renew the program under the ongoing Renewal process.

The Historical Timeline will include a document review of NNADAP to identify milestones and successes throughout the Program's history. This overview will be developed through the analysis of previous research and documentation, including policies, needs assessments, best/promising practice documents and discussion papers. As well, key informant interviews will be conducted with key stewards/leaders that have been instrumental in NNADAP's history.

Paper #5: Systems Level Review of NNADAP - Authors: Dr. Peter Menzies, Wayne Skinner, Dr. David Brown, 2010

The addictions field in Canada, as well as internationally, has increasingly focused on improving the coordination of services at a systems level. This intersects sectors, such as health, social services, housing, and education jurisdictions. These models advocate offering services and supports across a continuum of care whereby more intensive services are reserved for individuals with the highest level of need and less intensive service and supports are reserved for individuals with less severe needs.

The First Nations Addictions Advisory Panel has consistently highlighted the need to develop a conceptual model to capture how NNADAP prevention and treatment services can be optimized at a systems level. The purpose of this project is to develop a culturally-relevant and evidence-informed conceptual model for NNADAP prevention and treatment services at a systems level. This model will be based upon: the outcomes/findings of the Regional Needs Assessment reports; key findings from the NNADAP Renewal National Forum, the NNADAP Renewal Research Papers; key informant interviews; a comprehensive literature review of systems models; and a review of national and international frameworks/models that combine mainstream and Indigenous approaches to mental wellness.

This research will form a central component of the NNADAP Renewal Framework report and will identify specific strengths, limitations, and opportunities for providing prevention and treatment services within NNADAP.

Appendix B Program Agenda

BC / YK / AB / NWT Addictions and Mental Health
NNADAP Regional Research Forum
Best Western Chateau Granville
1100 Granville Street, Vancouver, British Columbia

Co-hosted/sponsored by:

- Anisnawbe Kekendazone – Network Environment for Aboriginal Health Research Centre (AK-NEAHR)
- Centre for Addictions and Mental Health (CAMH)
- Canadian Centre on Substance Abuse (CCSA)
- Network for Aboriginal Mental Health Research (NAMHR)
- National Native Addictions Partnership Foundation (NNAPF)

Evening: Day 1 - Tuesday, March 15th, 5:00 - 8:00 p.m.

- Welcoming remarks / Opening prayer, Elder Deanna George
- Keynote address – Dr. Malcolm King, Scientific Director, Institute of Aboriginal Peoples' Health, Canadian Institutes for Health Research
- Round of introductions, networking and light buffet served at 6:00 p.m. approximately

Day 2 - Wednesday, March 16th, 8:15 a.m. - 4:45 p.m.

8:15 Coffee, tea and treats – come early / come network!
8:30 Brief overview of agenda – chaired/presented by Michael Martin, Research Manager, NNAPF, with background/context of regional research meeting process relative to knowledge exchange and regional validation
8:45 Panel Presentation #1 – First Nations - Regional and Territorial - Priorities for NNADAP's and Mental Health / Addictions Renewal
- Valerie Genaille, Executive Director, Association of BC First Nations Treatment Programs
- Patty Wells, Alberta Mental Health and Addictions Sub-Committee, and NNAPF Board Member, Alberta Region
- Lori Duncan, Director, Health and Social, Yukon First Nations
- Marlene Villebrun, Mental Health Specialist Addictions, Government of Northwest Territories

9:45 Panel Question and Answer Period (15 - 30 minutes)
10:15 Coffee/tea break
10:30 Panel Presentation #2 – Researchers and Academics - Linking Front Like and Strategic Planner Needs
- Dr. Russell C. Callaghan, Scientist, Social and Community Prevention Research Unit, CAMH
- Dr. Rod McCormick, Principal Investigator, Kloshe Tillicum NEAHR Centre, University of British Columbia

11:30 Panel Question and Answer Period (15 - 30 minutes)
12:00 Lunch
1:15 Group discussions on concepts or project / research ideas

Introduction to Concept Mapping:

- Dr. Beverley Shea, Co-Director, AK-NEAHR (10 minutes)

Four Groups, facilitated by:

- Dr. Beverley Shea, AK-NEAHR / Garry Carbonnell, Partnerships and Networks Manager, NNAPF
- Wayne Skinner, Deputy Director, CAMH Addictions Program / Sharon Thira, Director, KT-NEAHR
- Michael Martin, NNAPF / Colette Isaac, Coordinator, NAMHR
- Alexandra Darnay, Program Director, Aboriginal Health Research Network Secretariat (AHRNETS) / Myrtle Morin, Executive Assistant / Network Liaison, NNAPF

2:15 Group discussions continued to identify priorities / ranking
2:45 Coffee/tea break
3:00 Group Presentations on priorities / ranking / process outcome
4:15 Wrap-Up Day 1 and Linking NNADAP'S Renewal with the National Framework

- Wayne Skinner, CAMH Addictions Program, and Rachel Dutton-Gowryluk, National Priority Advisor; First Nations, Inuit, Métis / Northern Canada, CCSA

Day 3 - Thursday, March 17th, 8:15 a.m. – 12:00 p.m.

8:15 Coffee, tea and treats – come early / come network!

8:30 Panel Presentation #3 – Health Canada / Federal & Regional - NNDAP'S Renewal Framework in Perspective

- Dr. Hakique Virani, Deputy Minister Officer of Health, First Nations and Inuit Health Branch - Alberta Region, Health Canada
- Carole Patrick, First Nations and Inuit Health Branch, Pacific Region, Health Canada
- Darcy Stoneadge, Senior Policy Analyst, Mental Health & Addictions, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada, Ottawa

9:30 Panel Question and Answer Period (15 - 30 minutes)
10:00 Coffee/tea break
10:15 Facilitated group discussions to identify regional next steps and action plan supporting research priorities identified. Re-Introduction: Dr. Beverley Shea, Co-Director, AK-NEAHR
Four Groups, facilitated by:

- Beverley Shea, AK-NEAHR / Garry Carbonnell, NNAPF
- Wayne Skinner, CAMH / Sharon Thira, KT-NEAHR
- Michael Martin, NNAPF / Colette Isaac, NNAMHR
- Alexandra Darnay, AHRNETS / Myrtle Morin, NNAPF

11:00 Group summaries on proposed action plan, next steps and opportunities for collaboration
11:30 Overview of Group Discussions on Research Priorities and Wrap-up Day 2

- Rupert Ross, Special Advisor, Director General's Office, First Nations and Inuit Health Branch, Health Canada, Ottawa
- Closing Remarks: Carole Hopkins, Executive Director, NNAPF

12:00 Closing prayer - Elder Deanna George

Appendix C Invitées and Contact List

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Appendix D Summary of Power Point Presentations and Panel Qs & As

Panel Presentation Format: (15 - 20 minutes each Panel Presenter guided by 3 questions, with an additional 15 to 30 minutes for a Panel Question and Answer period):

1) What does your organization/region do specifically as it relates to NNADAP and/or other addictions and mental health projects or research priorities and practice?

2) How does your organization/region do the above and what have been your observations over the last decade as it relates to NNADAP and/or other addictions and mental health projects or research priorities and practice?

3) What does your organization/region need to apply these observations research into NNADAP and/or other addictions and mental health projects or research priorities and practice, both regionally and nationally?

Key Note Dr. Malcolm King, PhD, Scientific Director, CIHR Institute of Aboriginal Peoples' Health, on "Pathways to Health Equity for First Nations, Inuit and Métis Peoples - A Business Case for Action"

Dr. King's opening address began with denoting some of the components of Aboriginal health research, and addressing the ongoing challenges to First Nations, Inuit, and Métis wellness, whether it be infectious or chronic diseases, mental diseases/ addictions, injuries & violence, barriers to access to health care, or the effects of colonization and post-colonialism. The Institutes of Aboriginal Peoples' Health (IAPH) is one of 13 Canadian Institutes of Health Research (CIHR), and through its recent strategic reform, has identified 7 initiative or business cases under development including:

- Clinical Trials Networks/ Support Units
- Personalized Medicine
- Community Based Primary Health Care
- Pathways to Health Equity for Aboriginal Peoples
- Alzheimer's
- Epigenetics
- Inflammation in Chronic Disease

CIHR-IAPH is a national organization and through its virtual network, is in constant contact with the nine (9) NEAHR Centres nation-wide (Network Environment for Aboriginal Health Research Centres), whose unifying themes include: community-based health research & action; non-medical determinants of health (poverty, racism, housing, environment); historical & intergenerational trauma; community-owned knowledge; and o*verarching theme such as sustainability, fairness, inclusivity.*

As proposed by Elder Albert Marshall, "Two-Eyed Seeing – A Model for Co-Advancement - Addressing Pathways to Health Equity for Aboriginal Peoples," was presented by Dr. King as a way of moving forward in research development through capacity building with First Nations, Inuit and Métis communities; through fostering broad coalitions of researchers and knowledge users; through intervention research: designing, testing, refining interventions to improve Aboriginal health, and through knowledge translation: applying the research knowledge to define best practice to improve health

As for IAPH's current status, CIHR currently spends about 3.5% of its budget on Aboriginal health research. One percent is base budget (IAPH ISI) and 2.5% is due to successful response to funding

initiatives, including open competition. Dr. King notes that IAPH has achieved health research equity, given that the Aboriginal (FNIM) population of Canada is about 3.5% and this is a major achievement in the first 10 years of CIHR. With the business case for Aboriginal health, CIHR's financial commitment to Aboriginal health will increase to the 5-6% level over the next few years, and CIHR is asking its partner organizations to join with them in matching this commitment. In order to close the gap in Aboriginal health, Dr. King notes how we need a *population plus* approach = equity based on population and health burden.

Community Knowledge Centres (CKCs) were also explored as a model for research. With First Nations, Inuit or Métis community organizations developing their own professional and administrative capacity, as well as experience in research, knowledge translation and ethics, they are ready to take on a leadership role in Aboriginal health research, and the translation of that knowledge into the improvement of health for their community and other communities. CKCs are expected to be active participants in community-based health research, and could fill the *knowledge assertion* gap that currently prevents effective participation in community health development and uptake of health knowledge.

As for pathways to health equity for Aboriginal Peoples, outcomes and risks include, an improved framework for addressing health inequities through research and knowledge translation; improved health indicators related to interventions and application of knowledge; the risk of doing nothing leading to a continued *widening* of the health gap. To address this, next steps need to include continued discussions with partners and potential partners; f*unding partners, KT partners, community engagement partners*; meeting on CKCs with NEAHR network and IAB business case advisors; national partnership meetings in Spring 2011, and a launch of *Pathways* scheduled for late 2011.

Question and Answer Period directed at Dr. Malcolm King:

Question from Patrick Davis, Namgis Treatment Centre, Alert Bay, BC: Is there any way of encouraging scholarships in this area of research?

Response from Dr. King: There has to be the opportunity for communities' to get started in the research field, and to encourage students who have their Bachelor's to move forward and get their Master's and PhD's. Malcolm noted how CIHR Meeting Planning and Dissemination grants of up to $25K could be a useful way for communities' to get together and develop a business plan for a strategy toward research, also noting that the National Aboriginal Achievement Foundation has been approached to become involved in awarding grants toward graduate education.

Question from Wayne Skinner, CAMH: Can you discuss or expand on the statement of knowledge earned versus knowledge learned?

Response from Dr. King: In the Western world, knowledge is a learned process, whereas in the Indigenous world, knowledge is an earned process through Elders and cultural practitioners and is a gift, passed on from Elders that cannot be attributed to a learned process.

--- End of Key Note Presentation Question and Answer Session ---

Agenda Overview, Michael Martin, Research Manager, National Native Addictions Partnership Foundation (NNAPF) - "From East to West and North - Identifying priorities nation-wide to support NNADAP's community-based and regionally-driven research"

Historical context was provided for the meeting, noting how NNAPF and the AK-National Environment for Aboriginal Health Research, Centre for Addiction and Mental Health, Canadian Centre on Substance Abuse, and Network for Aboriginal Mental Health Research, have supported regional discussions with the National Native Alcohol and Drug Abuse / Youth Solvent Abuse Treatment Centres on research needs and interest. The objectives of the discussions are to support NNADAP in building capacity through partnerships with the research community; and to better inform regional priorities and research agendas of NNADAP, academics and government, in key areas that are relevant to regional NNADAP Treatment Centres.

A segue into the panel presentations noted that all presenters were to be guided by 3 questions, with an additional 15 to 30 minutes for audience questions and answers intended to inform discussion on what the or organization/region does in relation to research, and how as it relates to NNADAP, what has been their observations over the last decade as it relates to NNADAP, and what do they need to apply these observations into NNADAP, both regionally and nationally? Key to the success of the regional meetings were the concept mapping sessions serving to guide discussion on what interventions, programs, services or projects that communities or regions would like to evaluate or research to create or generate new knowledge, and what are the next steps that are needed to action plan.

NNAPF is now planning to co-host a national meeting tentatively set for September 27 to 29, 2011, in Ottawa. Priorities identified from the regional meetings will support the identification and planning of community-based/regional-driven projects. Four end-goals are proposed: i) to reflect cultural competency across jurisdictions; ii) to continue to build relationships, consensus and engagement between NNADAP /YSAP and the research community; iii) to translate regional meeting outcomes into project priorities that supports community-based / regionally-driven proposals; and iv) to begin establishing an evidence base for substance use / misuse informed by indigenous knowledge, and to build the evidence base around cultural interventions.

Panel Presentation #1 – First Nations Regional and Territorial – Priorities for NNADAP's and Addictions and Mental Health Renewal

Panel Presenter 1a: Valerie Genaille, Executive Director, Association of BC First Nations Treatment Programs

As for what the Association of BC First Nations Treatment Programs (ABCFNTP) does specifically as it relates to NNADAP research priorities, the main focus is on program delivery utilizing cultural programming and evidence-based therapies. Specific to accreditation, this is achieved through, higher level of documentation and improvements in operations and programming; documentation of evidence-based modalities, a shift towards evidence-based decision-making, with 9 of 12 treatment centres have been accredited by Accreditation Canada and one accredited by CARF. Specific to First Nations and Inuit Health, BC engages Member Programs in program evaluations and reporting.

Sharing of research on pilot programs and project reports conducted at Treatment Centre level, such as:

- A research project in partnership with NECHI, with a subsequent report exploring the facilitation of healing of sexual and physical abuse in residential schools, including the intergenerational impacts and the cycle of abuse that began in residential schools (2002).
- A Participatory Evaluation of a First Nations Substance Abuse Treatment Centre. (Namgis Treatment Centre 2008)
- Towards Effective Aftercare. (Nenqayni Wellness Centre 2007)

- How does treatment affect the quality of life for First Nations people and what then are the cost savings to government agencies. (Tsow Tun Le Lum Treatment Centre)
- Trauma Treatment (Tsow Tun Le Lum Treatment Centre, Round Lake Treatment Centre)
- The Next Generation Solvent Abuse Community Intervention and Resource Project: A Demonstration Project to Test a Community Based Solvent Abuse Intervention Model. (Round Lake Treatment Centre 2004)
- Research on Native Adolescents and Substance Abuse--A product of The Next Generation Native Adolescent Substance Abuse Project (Round Lake Treatment Centre)

Specific to Knowledge Transfer and Dissemination, the ABCFNTP encourages:
- Sharing policy, best/promising practices, knowledge exchange through the Treatment Directors' Network.
- NNADAP Treatment Centre Mental Health Services: The framework includes philosophy, clinical principles, description of mental health issues, objectives, mandate, levels of service, legal issues, ethics, management practices, clinical files, quality assurance and reporting.
- Past activities include cross fertilization of treatment philosophy, programming, standards, ethics, etc. by Treatment Centres, and an annual Think Tanks hosted by Treatment Centres for local resources to address issues in the Addictions Field

As for what the ABCFNTP needs to apply research better, a short list of items includes:
- Funding for research training and projects;
- Education on research methodology, methods, data collection, data analysis, data management software;
- Policy development to guide research protocols, projects, and partnerships;
- Development of partnerships and linkages with researchers, research institutes, universities and funders;
- Opportunity to link researchers with specific research projects;
- Support for participatory research and involvement of front-line and individuals who use services in research initiatives;
- Opportunity to build long-term relationships for engaging communities as partners in research;
- Evidence-based research ;
- Improved processes for the documentation of evidence and the dissemination of results;
- Improvements in technology and services, particularly in rural and remote communities;
- Consistent addictions data collection and management programs for both treatment centres and community programs;
- Translation of proven effective cultural interventions into practice;
- Funding for program development; and the
- Development and delivery of trainings to build skills in the workforce

Panel Presenter 1b: Patty Wells, Alberta Mental Health and Addictions Sub-Committee, and NNAPF Board Member, Alberta Region

As background on Alberta's co-management structure, the Co-Management Committee is the decision making authority specific to addictions and mental health in Alberta and membership is comprised of two Chiefs from each of Treaty 6, 7, 8, reps from Health Canada - Regional & Associate Regional Directors, FNIH, and the Co-Management Committee meets at least quarterly or as needed. They oversee a cluster of programs, including NNADAP Community Based Programs, NNADAP Treatment Centres, Brighter

Futures, National Aboriginal Youth Suicide Prevention (NAYSPS) , and Indian Residential School (IRS).

As for roles and responsibilities, the terms of reference of the Co-Management Committee indicate that the committee will make decisions based on recommendations / advice from sub-committees and will give direction for follow-up action; have the ability to delegate authority; provide an Alberta Region perspective; provide overall guidance and leadership; share all relevant data and information; regularly consult with Chiefs; and produce an annual report within 90 days of the end of the fiscal year.
Alberta's 2009 NNADAP Regional Needs Assessment had identified the addiction service needs of specific target audiences such as gender, youth, pregnant women and mental, health (co-occurring disorders), and the scope of the assessment was limited to in-patient and out-patient non-medical treatment services and community-based prevention, promotion and aftercare programming. The underlying premise of the needs assessment is the establishment of a renewed addictions system that ensures First Nations are receiving the best possible care. The Assessment was completed in May 2009, and provided evidence based information that was captured from the grass root level of Alberta First Nations, Treatment Centers and Service Providers.

Approximately 103 community services providers and interested community members were involved, and in total, over four hundred people participated in the data collection process. Community surveys were completed by 127 service providers, and thirty-seven focus groups were conducted involving 250 community members. Of the250 community participants 44 were youth and 49 were seniors, with the balance reflecting an equal representation of men and women. Additional primary research was drawn from other studies that were specific to the demographic groups on alcohol and drug use.

As for the assessments findings, recommendations specific to youth included community support for youth groups; increased funding for youth programs; creating gender specific youth treatment centers; expanding youth treatment continuum; developing youth leadership councils; strengthening traditional and cultural practices; facilitating relationship between Elders and youth to share knowledge, history and culture; and including youth in identifying issues and problem solving. Recommendations specific to men included increased communication with community members; coordinated services; encouraging individuals to take responsibility for leadership roles; mentorship; traditional teachings on the culture and the role of men in their society; safe houses for men; sensitizing the community to the needs of people in recovery, as well as job readiness and job training.

Recommendations specific to women included developing gender specific treatment program; re-profiling one NNADAP Treatment Centre specifically for women; providing after care support to women in areas of childcare, counselling, financial management, life skills, job readiness, housing and protection against family violence; including transportation and childcare in community workshops, along with the recommendation that NNADAP Workers to receive gender specific training on addictions. Recommendations in support of seniors included more community education programs for seniors; better collaboration among service providers; the development of a comprehensive community plan to address older adults needs; community education on aging and changing needs of the aging; peer-led social groups to help build social relationships; age specific interventions; service providers trained in gerontology, family and substance abuse issues; facilitating the relationship between seniors' and their physician; building collaboration among health and social services professionals to create a comprehensive continuum of care for seniors, as well as developing new assessment tools to accurately reflect the needs of seniors.

At the community level, to address substance abuse, it is recognized that there is a need for committed & supportive leadership, aftercare programs, recreation facilities, qualified youth support coordinators, more

family involvement in Treatment programs, harm reductions programs, a trauma treatment centre, as well as community support, to name but a few. Likewise, mental health and related issues include better coordination among service providers; the development of a national and provincial aboriginal mental health plan policy; better understanding among service providers of the distinction between urban and rural First Nations; clinical supervision for front line workers; more resources for those recovering from Residential School Trauma; travel funds for those requiring specialized services outside of the local area, and for service providers to be trained in Cultural Safety.

As for the conclusions drawn from the assessment, there are many positive changes occurring in Alberta First Nation communities. There is a higher awareness of the social determinants to health and how that applies to substance abuse, and overall, people were satisfied with the current addiction services available and believed that the treatment centers are effective. The greatest need is for more detox and after care programs. Gender and age specific treatment and service options are required, with community mobilization needed as a driving force. This requires awareness, information, knowledge, community discussions, mentoring opportunities and political support. Culture is to form the foundation for strategies and services, with increases in funding for community programs and infrastructure. Access to prescription drugs should also be investigated, while reviewing existing resources, especially evening and weekends in terms of adequacy. Community alcohol policies that guide whether and how alcohol is made available and public awareness activities are the most common universal prevention measure being considered.

Implementation efforts following the findings have included such efforts as the re-profiling of treatment centres such as Kapown Treatment Center being re- profiled to Concurrent Disorders, whereas the Mark Amy, Footprints, Kainai Adolescent Treatment Centre and Beaver Wah Pow Treatment Centers are in the first phase of re- profiling their centres to include Trauma and Abuse, with St. Paul's Treatment Center to be re-profiled sometime in 2011. Alberta Region is also in the process of developing a strategy to address the issue or prescription drug misuse, and the Alberta Region Co-Management committee also approved the Mental Health and Wellness Strategy developed in Alberta Region in 2010, with key themes identified including:

- Community Based Practices;
- Traditional Healing/Health, Knowledge and Medicine;
- Comprehensive Wellness Services;
- First Nation Human Resource Capacity;
- Cultural Competency and Health System-wide Acknowledgment;
- Inter-jurisdictional Collaboration;
- Research; and,
- Data Collection and Evaluation

Panel Presenter 1c: Lori Duncan, Director, Health and Social, Yukon First Nations

Concerning NNADAP and the Yukon, Ms. Duncan noted how the North is half the land mass of Canada, but, they are constantly left out of programming. Reasons offered are many, including such as issues as most First Nations in the Yukon are self-governing; they do not live on reserve; the Federal Government transferred health services to the Territorial Government and when this was done, Yukon First Nations were signatory to the transfer agreements, however, were left out of any decision-making; and lastly, the Territorial Government operates under a universal health perspective.

As for Yukon's First Nation demographics, there are 14 First Nation communities, representing 25% of the population (7,500). Yukon has reserve lands although they are not formally recognized as living on-

reserve, but rather referring to “land set aside” or “settlement land” when referring to Yukon reserves. Eleven of the 14 First Nations are self-governing, meaning they have signed land claims agreements, and have become governments. Many call this a modern day treaty. Historically, the Government of Canada transferred health services to the Territorial Government in 1993, and have jurisdiction over health services including alcohol and drug treatment. The Yukon Government has alcohol and drug services including programs management, alcohol and drug treatment services, detoxification services, prevention services, and community outreach. None of the programming is in conjunction or collaboration with NNADAP dollars that the First Nations receive, and none of the programming is First Nation specific.

A lesson on self-government informs us that when you become self-governing, you have the authority to draw down any programs that are offered by other governments. As well they have the authority to develop and adopt their own legislation. Federal Transfer dollars are given directly to the First Nation from the Government of Canada so no longer go through Health Canada. For programs however, First Nations have to negotiate a program transfer agreement where the amount of dollars to be transferred and the parts of the program are decided upon. A key point: when First Nations become self-governing, they do not relinquish their rights as a First Nation person. Specific to self-government in Yukon, under section 35.1 of the Constitution, the Federal Government is obligated for Health, and self-government arrangements do not absolve this fiduciary obligation.

As for NNADAP in Yukon, 10 out of 11 First Nations that are self-governing have drawn down their NNADAP, meaning they have negotiated with the Government of Canada and have settled on a dollar amount to take over that program. The resources they receive come directly from Treasury Board and do not go through a secondary government department. The dollars however are based on the numbers of status First Nations and is very small. The remaining four First Nations have contribution agreements with Health Canada.

As for what Yukon First Nations would like to see, their goal is to ensure that regardless of differences, First Nations are not left out of any program development, and to also ensure that legislation, authority, policy or directive that is developed recognizes these differences. Specifically, the Yukon wish list would include:

- A NNADAP treatment center in the Yukon;
- A renewal that includes jurisdictional differences;
- A NNADAP renewal that is land based;
- A preamble that explains the complexity and diverse nature of the Yukon to ensure that anything developed is inclusive of the Yukon;
- Focus on community level services;
- Include community based services that work from cultural values as best practice examples;
- Need to have culturally relevant standardized assessment tools;
- Recognition that the Non-Insured health benefits program criteria is a huge barrier for us;
- Support for family participation;
- Focus and support for FASD clients;
- Policy that non-completion should not be punishable;
- Emphasis on grief counseling;
- Focus on suicide prevention;
- Encourage video-conferencing;
- Inclusion of harm reduction as abstinence may not be realistic;
- Framework needs to be responsive to different needs of people and shifts form one size fits all to be more specific to changing needs;
- Focus on case management/care facilitation;

- Participate in data collection and management;
- Focus on community and aftercare in the community as a community responsibility;
- Inclusion of Elders; and a
- Focus on strengths.

Panel Presenter 1d: Marlene Villebrun, Mental Health Specialist Addictions, Government of Northwest Territories: NNADAP & Mental Health & Addictions Projects in the NWT

In 2004, the Department of GNWT Health and Social Services moved to an Integrated Service Delivery Model, with Mental Health & Addictions Services identified as a core service to be available to all residents, and the Community Counselling Program to be delivered by Regional Authorities. For example the Nats'ejée K'éh Treatment Centre provides adult alcohol & drug treatment programs, and individuals requiring highly specialized addictions treatment & support services that are unavailable in the NWT are referred to the Out-of-Territory Review Committee.

NNADAP funding is specifically earmarked annually for referrals for southern treatment for Aboriginal adults & youth dealing with addictions. The remainder is used each year for proposal-driven community-based addictions focused programming. In 2010-2011, proposals funded by NNADAP includes the Tlicho Government for mental health and addictions services via the Tlicho Community Services Agency; Beaufort-Delta Health & Social Services Authority (BHSSA) training for front-line service providers in trauma and addictions; and the Sacred Circle Project to promote healing through the use of traditional Aboriginal healing practices, teachings and ceremony. Other Addictions and Mental Health Projects have included the Foundation for Change, developed to assist individuals in making healthy choices and finding ways to address their addictions issues, as well as to ensure we have the appropriate community-based, culturally relevant programs to support individuals and communities

Community-based / Culturally-relevant Addictions Programming included a project in 2009-2010 with the Gwich'in Tribal Council (GTC), aimed at enhancing existing community based mental health and addictions counselling and support services through Tl'oondih Healing Society in Fort McPherson, involving on the land programming and workshops around addictions awareness. GTC is also working on a new proposal for an Aklavik Aftercare Support Programming for 2011-2012. Likewise in 2009/2010, the Inuvialuit Regional Corporation (IRC) ran community workshops on traditional parenting & life skills to support parents struggling with addictions. As well, the IRC led comprehensive community-based consultations to identify needs for mental health and addictions services in the Beaufort-Delta region, and in 2010/2011, Health and Social Services also funded the IRC for their Addictions Aftercare Pilot Project in Tuktoyaktuk.

Other GNWT initiatives include:

- Reviewing proposals in response to an RFP to culturally adapt and pilot the Mental Health First Aid program to meet the needs of NWT, as well as agreement with Health Canada to fund a Youth Treatment Project through the Dehcho Health & Social Services Authority via Nats'ejée K'éh Treatment Centre;
- Addictions Campaigns, such as the "Not Us!" Drug Awareness Campaign, and the NWT Addictions Social Marketing Campaign, engaging youth in 3 communities around addictions, and using messaging from the youth's creativity for a territorial-wide campaign;
- NWT 3-Week Suicide Prevention Training Program, developed by and for NWT resident, which has been revised and condensed to a 7-day program;

- A Mental Health and Addictions Review, to develop recommendations for an action plan to ensure mental health & addictions programs & services are current, accessible, meet the needs of communities throughout the NWT & are appropriately structured given our available resources; and,
- 2009 NWT Addictions Report, noting how although the proportion of current drinkers who reported consuming 5 or more drinks on a single occasion increased from 34% in 1996 to 43% in 2009, the proportion of current smokers dropped from 44% in 1996 to 36% in 2009.

As for proposed research areas, there are three that top the GNWT list specific to addictions and mental health, including the delivery of services in small remote Aboriginal communities; determining how culture can become an inherent part of the foundational structure of programming; and lastly, collaborative and community-based initiatives that are culturally safe

Question and Answer Period for Panel Presenters #1

Question from Colette Isaac, NAMHR, to Lori Duncan, Yukon region: What you would like to see for Yukon First Nations (YFN) relative to NNADAP and what do you mean by land-based treatment?

Response from Lori Duncan, Yukon region: Specific to NNADAP, to be included in NNADAP's Renewal. As for land-based treatment options, refers to treatment and programming that is delivered on-the-land/in the bush, around campfire, because that's where YFN believes where healing begins.

Question from Patrick Davis, Namgis Treatment Centre, Alert Bay, BC, addressed to all the speakers: When we talk about community-based programs, what has been the response from the communities in terms of turn-out and attendance. Namgis has noted that a lot of people need it, but not a lot of people want it, so in terms of turn out, can the speakers give an idea of response, even as a percentage?

Response from Valerie Genaille, BC region: Not able to comment on behalf of the community since that is not her area of work.

Response from Lori Duncan, Yukon region: The offer or request has to come from the community for YFN to respond; that is what the community would like is to have the programming developed with them and not for them.

Response from Patty Wells, Alberta region: Funding is an issue in Alberta; they do the regular programming such as AA, but one program in particular that is land-based, many take advantage. Because they are located near Cardston, there are many homeless and workers will typically gather up these individuals for the 2 week land-based program at Chief Mountain where they engage in such activities as sweats, tee-pee/pole building, etc., and at the end of the 2 weeks, they typically do not want to go home because they are returning to the same setting with the same problems, so much of Alberta regions efforts in regards to land-based programming is based on funding availability.

Response from Marlene Villebrun, NWT region: Feedback derived the GNWT projects indicate that these are very well received and attended in the North.

Question from Ellen Smith, NWT rep for NNAPF, to Marlene Villebrun, GNWT: Is there a report being shared concerning the North, who wrote it and when it will be shared, and secondly, when speaking of the community consultations, was there any advertisement of these consultations, and have heard of the report or the consultations.

Response from Marlene Villebrun, NWT region: The mental health and addictions review was completed by McDermot Consulting, and though there was limited consultations, the review made use of recent staff and client surveys and two additional site visits, and looked at what had already been done and where to go from here. There are no additional plans to do community consultations at this time, although Ellen Smith reiterated the importance of additional funding and support for the community-based projects.

Question from Theresa Howell, Institute of Aboriginal Health Research at UBC: Question to the panel and floor concerning research on the NNADAP treatment centres – is there any available?

Response from Valerie Genaille, BC region: A PhD dissertation is available concerning a review of NNADAP treatment centres in BC, and likewise, Mike Martin indicated that he could forward a listing of FNIH-related research that may be relevant pending interest.

Question from Agnes Mills, Yukon Territory: Agnes noted her long time involvement with the NNADAP program and her knowledge of the importance of the cultural component of the program, and shared how they are still looking at ways and means of improving the treatment and aftercare elements. At 75, Agnes noted how important it is to make programming culturally-relevant, with a focus on youth. Agnes asked the panel, what would they recommend how the academic researchers and others involve culture into research, because there is a great deal of traditional knowledge, and in order to work in this field, we need to combine culture into research, and 40 years is a long time to wait!

Response from Marlene Villebrun, GNWT region: Incorporating culture into research is still a challenge they are grappling with; how to capture that date and incorporate culture into research, expand and build upon it is something the GNWT is still figuring out.

Response from Lori Duncan, Yukon region: In the Yukon, they have adopted OCAP (Ownership, Control, Access and Possession of data) as a means of addressing being 'researched to death', so prior to research taking place, questions that are asked of researchers include why they are doing this research, who is involved, and who is benefitting from the research - because if the community is going to benefit, they need to be involved. Processes are in place to ensure that researchers meet with Chief and Council initially, while recognizing that the information to be collected is to benefit the community and is owned by them, not the researchers. That is how culture becomes incorporated into research, with the understanding that traditional knowledge is sacred and owned by the community.

Response from Valerie Genaille, BC region: A research project on Intergenerational Trauma conducted by the BC Association of Treatment Centre Directors in collaboration with NECHI (head researcher Rod McCormick), focused on participants who had undergone treatment through healing programs, and this information in terms of how culture was incorporated in the interview process is outlined in the report.

Response from Patty Wells, Alberta region: In Alberta, they use a similar process as Yukon specific to OCAP, and understand the challenge of trying to incorporate culture into research. Reference made by the meeting Chair to CIHR Guidelines specific to research involving Aboriginal Peoples.

--- End of Panel #1 Presentations Question and Answer Session ---

Panel Presentation #2 – Researchers and Academics - Linking Front Like and Strategic Planner Needs

Panel Presenter 2a: Dr. Russell C. Callaghan, Scientist, Social and Community Prevention Research Unit CAMH: Mobility and Transmission of Infectious Disease in Northern British Columbia

As for background concerning how this line of research began, Dr. Callaghan made reference to data from the Prince George Inpatient Detoxification Unit 1999/2000, and noted how many patients traveled from throughout northern BC to access inpatient treatment. His research led him to question what could be the prevalence of HIV and Hepatitis C among people who inject drugs (IDUs) in Prince George, and therefore, could residential mobility serve as an important vector in the transmission of HIV and Hepatitis C into more northern and rural communities/towns/cities throughout northern British Columbia? Prior research has shown that IDUs are a mobile group, and that IDU mobility has played a key role in the spread of HIV/Hepatitis C in other regions Scotland, Australia and China.

An overview of the results from several projects is provided for perspective:
1) The Prince George, BC - I-Track Study followed ethical guidelines for research involving Aboriginal peoples (CIHR, OCAP), with local hiring, data ownership/interpretation, blood sample processing, knowledge exchange, and capacity building being exemplary. In the Prince George sample (n =151), overall HIV rate was 18% (27/151). This rate was the 2nd highest across all I-Track sites in the country (PHAC, 2006). For example:

- Among Aboriginal IDUs, the HIV rate was 23% (21/92).
- Among non-Aboriginal IDUs, the HIV rate was ~ 10% (6/58).
- Among males: Aboriginal 23% (8/35) v. non-Aboriginal 5% (2/43)
- Among females: Aboriginal 21% (12/57) v. non-Aboriginal 25% (4/16).

2) The Cedar Project and I Track Comparisons showed that among the 276 participants that used injection drugs, HIV prevalence was significantly higher in Vancouver (17%) than Prince George (7%). Although the Prince George I-Track shows higher HIV rate among Aboriginal IDUs (~23%), the average age of participant in I-Track was 39 years old, and the initiation of IDU for I-Track participants began at age 24 years old.

3) Specific to Hepatitis C (HCV) Results, in the Prince George sample, overall HCV rate was 77% (116/151). This rate is the highest across all I-Track sites in the country (PHAC, 2006), and to note, a positive result indicated past or present HCV infection, and did not discriminate acute from chronic or resolved infections.

4) As for HCV infection among Aboriginal and Non-Aboriginal participants, there was no significant differences in HCV antibody positive status between Aboriginal and non-Aboriginal participants. Among Aboriginal IDUs, 76% (70/92) tested positive for HCV antibodies, and among non-Aboriginal IDUs, 78% (46/59) tested positive for HCV antibodies.

As for the influence of Residential Mobility, participants were classified as mobile if they lived in more than one location of residence in the previous six months. In the Prince George sample, 38% (58/154) reported residential mobility in the last 6 months, and this proportion is much higher than the national proportion across other I-Track sites (22%). As for mobility among Aboriginal and non-Aboriginal participants, the rate of mobility was significantly higher among Aboriginal IDUs than non-Aboriginal IDUs, and whereas among Aboriginal IDUs the mobility rate was 46% (43/94), among non-Aboriginal IDUs, mobility rate was 25% (15/60). Hence, specific to mobility and spread of infectious diseases, in the Prince George sample, IDU mobility was significantly associated with a self-report of never having any prior HIV testing: as many as 17.2% (10/58) of mobile IDUs reported visiting the Downtown

Eastside (DTES) of Vancouver in the last 6 months, acknowledging that the DTES has one of the highest prevalence rates of both HIV and hepatitis C among IDU in Canada.

In his summary of findings, Dr. Callaghan notes that the Prince George I-Track Study found that Aboriginal IDUs were more mobile and had much higher rates of HIV than their non-Aboriginal counterparts, and that IDUs in Prince George had high rates of mobility and high rates of HIV and HCV compared to other I-Track sites across Canada.

Considerations for future research relative to these results is that residential mobility of IDUs plays an important role in the spread of HIV and other infectious diseases from high to low seroprevalence areas, and reciprocal movement of Aboriginal IDUs between urban and reserve settings may serve as a critical vector for the continuing spread of HIV within Aboriginal communities. Relative to service provision, in hub towns like Prince George, the focus could be: on providing easily accessible HIV testing and counselling to mobile IDUs, as well as drug users in treatment; as well as education, health services outreach and awareness programs throughout northern British Columbia, to address the interrelated issues of mobility, HIV, and Hepatitis C.

Presenter 2b: Dr. Rod McCormick, Principal Investigator, Kloshe Tillicum NEAHR Centre, University of British Columbia: Kloshe Tillicum: Healthy People/Healthy Relations

Kloshe Tillicum: Healthy People| Healthy Relations is one of nine Network Environments for Aboriginal Health Research (NEAHR). Funded through the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, Kloshe Tillicum's four research themes include traditional knowledge, ethics, public health and health promotion, as well as complex interactions. Community Identified themes also include chronic diseases, diabetes, nutrition and food security, mental health Issues, trauma, sexual abuse and residential school healing.

As for KT's list of distinguished Co-Principal Investigators, these include:

- Rod McCormick, a Mohawk psychologist and Counselling Psychology Professor based at UBC. Rod is an expert in Aboriginal mental health and his work integrates cultural, social, and environmental components of health (complex interactions). In exploring indigenous psychologies and traditional ways of healing, Rod's research also intersects with KT's theme of Indigenous knowledge and traditional medicine. Dr. McCormick also works as a consultant and researcher to several Aboriginal and non Aboriginal governments and organizations in the areas of program and policy development and evaluation. Rod is the Nominated Principal Investigator of Kloshe Tillicum.
- Laura Arbour is a paediatrician and medical geneticist at UBC, based at the UBC Island Medical Program in Victoria. She has a cross affiliation with the University of Victoria. Well known for her work in carrying out genetic research with Aboriginal people in BC and northern Canada (Long QT Syndrome, primary biliary cirrhosis, Carnitine-palmitoyl-transferase type 1a),
- Jody Butler Walker is a community-based research innovator who has lived and worked in the North for over 25 years. In her 12 years in the Yukon, she has worked with many Yukon First Nations communities, and since founding the Arctic Health Research Network-Yukon in 2007, she has been building on recommendations garnered directly from Yukon First Nations communities, with a focus on complex interactions, ethics and health promotion.
- Eduardo Jovel is an indigenous ethno-botanist at the University of British Columbia with specific interest in indigenous knowledge and medicines as well as public health and health promotion through food safety and nutrition, organic farming and environmental health. He has research projects in BC, the Andes and Ecuador.

- Chris Lalonde is a psychologist at the University of Victoria with a focus on Aboriginal health, specifically the relations between identity formation and suicide risk among Aboriginal adolescents and young adults. His work includes ethics research in an indigenous context and a significant Aboriginal post-secondary student retention study.
- Nadine Caron is the first indigenous woman to graduate from UBCs medical school and since then has made increasing Aboriginal representation in the Medical Profession a career goal. As a General and Endocrine Surgeon, Dr. Caron is a UBC Assistant Professor, Surgery who works with its Northern Medical program.
- Richard Vedan is Secwepemc and is an Associate Professor in Social Work and Family Studies at UBC. His interests include mental health, best practices for Aboriginal health, health promotion, homelessness, Aboriginal traditional cultural knowledge, capacity building and establishment of service delivery methods that integrate traditional and non-indigenous practices.

Kloshe Tillicum's previous activities as examples from the last 2 years include:
- development of a research mentorship program for medical students;
- international collaborations with the International Congress of Circumpolar Health, and the Center for Indigenous Health Research at the U of Washington;
- the design of an evaluation survey and data analysis process for community Truth and Reconciliation events in British Columbia (BC);
- the hosting of an international Global Indigenous Research Symposium;
- a conference to examine the BC Provincial Health Officer's Report on the Health of Aboriginal Peoples;
- a provincial conference for Child and Youth Mental Health workers and Provincial Health Officers;
- the co-hosting of the 2nd Annual International Diabetes in Indigenous Peoples Forum; the development of a monograph for the Aboriginal Healing Foundation on "traditional healing";
- the development of a training program for counselling support workers at Truth and Reconciliation Commission events;
- the production of 3 Aboriginal health videos;
- participation in multi-agency provincial health worker trainings via Telehealth and;
- the co-development of an Indigenous peoples partnership project between two indigenous communities in BC and Ecuador.

KT's student trainee program included the allocation of 63 fellowships, 3 student conferences, 2 student writing workshops, 8 mentorship sessions and funding to present at national and international conferences. Seven communities also received support to implement research capacity building projects while knowledge translation activities included 2 traditional medicine workshops and traditional knowledge and medicine projects in Westbank, Boston Bar, Bella Bella and Neskonlith

Kloshe Tillicum planned activities for the next 2 years include such initiatives as:
- National networking Initiatives
- 8 projects over 2 years with each NEAHR plus AHRNetS
- Project with NAMHR – traditional knowledge and mental health initiative
- 8 Research Network Meetings

Community Initiatives including:
- 3 seed grants
- 2 regional trainings
- Internet based research course

- 5 regional gatherings
- 4 community workshops
- 2 indigenous healers gatherings
- Tele-health
- Videoconferencing networks

Student Training, including:
- Promotional activity
- Awards-masters, doctoral, clinical
- Teaching releases
- 3 mentorship sessions
- SAGE partnership
- 18 sessions at 4 universities
- Workshops e.g. Ethics, proposal writing, writing retreat
- Annual Forum
- Post-Doctoral Fellow mentorship

An excellent example of drug and alcohol research conducted by Kloshe Tillicum students and investigators include Dr. Kim van der Woerd's (Namgis band member) PhD Dissertation entitled: "A participatory evaluation of a First Nations substance abuse centre," which examined the program impact of the Namgis Treatment Centre (NTC). In brief, a telephone follow up survey was conducted with 91 former clients. Of the 91 surveyed: 24 remained abstinent and 67 had relapsed. Relapse time was on average 155 days following completion of treatment. Pre treatment variables such as age, gender, history of abuse, etc., were not found to be related to relapse. Post treatment variables such as support from friends, family, drug and alcohol counsellors, AA/NA meetings, AA/NA sponsors, were also not associated with time to relapse.

An aggregate of support items however did influence what happened after relapse. It was determined that the greater the number of supports clients had, the more likely they were to be abstinent, and the less supports they had the more likely they were to completely relapse. Based on these findings it seemed that follow up and aftercare are critical for effective treatment and lasting behavioural change. Although most of these supports are not connected to NTC as they exist in varying degrees in the client's home community, it is nevertheless possible that the 6 week program offered by NTC could be adapted to provide clients with strategies on how to attain and maintain these supports after they return to their home communities.

As for the future and Kloshe Tillicum research specific to Drug and Alcohol, these include:
- The role of technology in providing peer support options for aftercare e.g. cell phone, texting, etc.;
- Piloting the use of videoconferencing for aftercare, community worker consultation, and training;
- The development of peer support programs for aboriginal youth (outreach, referrals); and,
- Exploring the impact of issues such as unresolved grief and loss, survivor guilt, and abandonment issues (e.g. attachment disorders) on addiction.

Question and Answer Period for Panel Presenters #2

Question from Connie McKee, Kapown Treatment Centre: Often data is collected and compiled and is not used to benefit the programs, and the question from Connie is who is willing to partner with Kapown on doing some longitudinal research studies.

Response from Rod McCormick: Made reference to Cora Weber-Pillwax, Alberta NEAHR centre as the ideal person to respond to that question.

Question from Valerie Genaille to Russell Callaghan: Why is there a discrepancy between Aboriginal men and women in terms of the HIV statistical evidence presented?

Response from Russell Callaghan: Because it is a small sample of 150 people, when genders are compared between Aboriginal and non-Aboriginal women, it is difficult to make clear and definitive relationship (e.g. why is it higher for women versus men). Is it driven by the sex trade, use of drugs – a question that needs to be addressed in the next round of research?

Question to Ellen Smith, NWT region to Russell Callaghan: Is there any consideration to doing similar research in the North?

Response from Russell Callaghan: Certainly a future project that could be considered!

Question from Richard Mayuk, Stehiyaq Healing and Wellness Village, to Rod McCormick: What is meant by genetic counselling?

Response from Rod McCormick: Genetic counselling refers to helping individuals and families who have genetic disorders to deal with it.

Question from Richard Mayuk, Stehiyaq Healing and Wellness Village, to Russell Callaghan: Was there any age cut-off in the IDU research conducted?

Response from Russell Callaghan: Lower age cut-off was 16 and at the upper level, it was surprisingly high into the late 50's, and request to have the information broken down by age group. Comment from Richard Mayuk to all noted the importance of a personal follow-up as an important aftercare element in a treatment program.

Comment from Bev Shea, AK-NEAHR to Russell Callaghan: Rates of HIV-Aids amongst Aboriginal women in Canada are much higher and not equitable to non-Aboriginal women rates. Likely the Prince George rates are lower/equitable because of the small sample size as noted by Russell.

Question from Patrick Davis, Namgis Treatment Centre: Is there any chance that the Prince George HIV-Aids study being repeated elsewhere in BC? How can testing be incorporated into treatment?

Response from Russell Callaghan: BC Centre for Disease Control has a rapid test that could be incorporated into treatment. Recommended contacting the BC-CDC to determine the protocol and Russell offered to follow-up.

Question from Kim Hallick, Kapown Treatment Centre to Russell Callaghan: Is there any evidence that the education element relative to HIV-Aids is making a difference?

Response from Russell Callaghan: There is a review that shows that education does reduce the rate of HIV-Aids, and added that 'mobility' is a factor that reinforces that counselling needs to be offered as it has shown to reduce risk of transmission.

Question from Hakique Virani to Russell Callaghan: Impressed by the research and noted the relationship between opioid and IDU, and whether safe-sex education should be considered as an element

of HIV-Aids education to reduce transmission. Likewise, should Hep-C vaccination be considered as a public health intervention given the risk of transmission through IDU?

Response from Russell Callaghan: Depends on whether the benefits could be communicated to high-risk populations – not sure on uptake.

Question from Darlene Hoffman, BC region: Question as to where a 'social network' such as Facebook could be used to improve uptake and education specific to aftercare.

Response from all presenters: What a great idea!

--- End of Panel #2 Presentations Question and Answer Session ---

Panel Presentation #3 – Health Canada / Federal & Regional - NNDAP'S Renewal Framework in Perspective

Presenter 3a: Dr. Hakique Virani, Deputy Minister Officer of Health, First Nations and Inuit Health Branch - Alberta Region, Health Canada: "A Prescription for Pain - Prescription drug abuse in our First Nations, and considerations for the World of Research."

Hakique opened with a distinctive conflict of interest disclosure and disclaimer, noting that decisions on the direction of health programs and endeavours in FNIH Alberta are made in a co-management context, and that his presentation is based primarily on observations of his own and his colleagues, and do not represent thorough discussion, weighing of evidence, and decisions made by engaged partners. Rather, considering the trajectory of an individual through an addiction, a social environment, and a system, Hakique furthered his explanation as identifying important questions that need answers, or assumptions that need verification.

Dr. Virani's presentation began with 'The Story of Cody', in an attempt to raise questions, assumptions, and opportunities to change the ending, as well as spark new activities to address prescription drug misuse in Alberta. Cody in this case was raised in a large on-reserve community, his paternity unclear, had a mother with chronic alcohol abuse history and unsuccessful treatment attempts, unstable guardianship (primarily maternal grandmother), completed high school on/off-reserve, a smoker and leaves his community at the age of 19 for large municipal centre in search of high-paying work. Cody subsequently finds work in construction industry, has a limited social circle and social activities with peers, and indulges in infrequent binge drinking. By the age of 20, Cody meets Mandy and is introduced to a new social circle. Mandy becomes pregnant a year later; however a motor vehicle collision leaves Mandy dead when 6 months pregnant and Cody with a compound fracture. Cody is subsequently discharged after one week admission to orthopaedics' with a short prescription for Percocet.

Cody and his involvement with the health system lends itself to him seeing a walk-in physician for continuation of pain control medications, with a prescription for Tylenol #4 leading to early refills, early renewals. Because he is noted as "having a problem" he is discharged from care. Despite his attempts to inform doctors that "it still hurts", the physician prescribes OxyContin in an attempt to manage pain with time-release agent, again leading to early refills, early renewals, and again, discharged from care. Cody then turns to the street, where he turns to illicitly obtained opioids at the age of 22. He also turns to illicit activities to pay for pills, which leads to injection drug use, crack cocaine, through which he succumbs to infectious endocarditis. After 8 weeks' of hospitalization for the disease, he is admitted and recovers through a methadone maintenance treatment program where he achieved abstinence from illicit opioids

within one month. Cody's story does not end well in that although he began looking for work and engaged addiction counselling through a residential treatment facility where he felt conflicted in traditional and spiritual ceremonies and unfortunately, 3 months after leaving treatment facility, was found dead in Edmonton of a polysubstance overdose.

The summary of the story presents interesting opportunities for future consideration, such as:

- In what ways can we identify and address risks for vulnerable individuals in the lives of people we treat?
- In what ways can we support, prepare and protect FN individuals leaving reserve communities?
- To what extent may we work with FN communities to understand and employ the broad array of harm reduction interventions?
- How may we make residential treatment programs for FN individuals both valuable and acceptable?
- How do we improve risk-screening and prescribing on the part of health professionals?

New activities in Alberta region include an education project on 'Drug Utilization Prevention and Promotion', a partnership between First Nations, FNIH, College of Physicians and Surgeons of Alberta, and the University of Calgary, Faculty of Medicine, looking at a joint educational needs assessment for multiple disciplines, with a focus on guidelines, sensitization, skills development, a commitment to change and follow-up.

Panel Presenter 3b: Carole Patrick, First Nations and Inuit Health Branch, Pacific Region, Health Canada: No power point presentation provided.

Panel Presenter 3c: Darcy Stoneadge, Senior Policy Analyst, Addictions Programs, First Nations and Inuit Health Branch, Health Canada, Ottawa - Overview of NNADAP National Research Activities and Opportunities for Renewal

The objective of Darcy's presentation is to provide brief overview of the role of NNADAP National Office with respect to research, with an emphasis on opportunities identified through the NNADAP Renewal Process. Currently, the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) are the primary network of addiction treatment and prevention services accessible to all First Nations. This network includes 58 treatment centres (as of August 2010), 550+ community-based prevention programs, and 1,000+ treatment counsellors and community-based workers. Most treatment programs use a variety of approaches, which often blend cultural and mainstream approaches. Program length can vary between 29 to 42 days for NNADAP, and 3 to 24 months for NYSAP. Of the 58 Centres, there are 49 NNADAP and 9 NYSAP treatment centres, some of which provide family specific programming; Youth specific programming; and Gender specific programming either on an ongoing basis or for specific intakes. Other specialized programs include out-patient, day or evening programs, as well as specific programs for couples, pregnant women, and people with FASD.

Specific to north of 60 services, NNADAP funding was transferred to the Governments of Northwest Territories and Nunavut under the 1988 Northwest Territories Health Transfer Agreement and through the creation of Nunavut in 1999. When health care services were transferred to the Yukon Government in 1997, NNADAP was not considered a universal health service, but rather a targeted First Nations specific community-based approach to addictions. NNADAP was not transferred to the Yukon Government and remained a First Nations specific program to administer. Currently Yukon First Nations receive both the prevention and treatment components of the NNADAP funding. Northern First Nations and Inuit can

either attend an alcohol and drug treatment centre operated by the respective Territorial Government or are transported to the closest, appropriate treatment centre south of 60, as per NIHB policy.

As for the role of NNADAP National Office, in collaboration with First Nations and Inuit partners and Regions, National Office works on national policy development and program planning to ensure the effective delivery of addictions programming. Areas of responsibility include National program funding allocation; National program monitoring, data analysis, reporting and evaluation; creation and continuation of National programming coordination and communication; and the provision of advice and/or guidance on program delivery.

For example, the National Anti-Drug Strategy (NADS) announced in 2007 is providing $30.5 million over five years, and $9.1 million ongoing, to strengthen the quality, effectiveness and accessibility of First Nations and Inuit addictions services. Key investments include the NNADAP Renewal Process, workforce development, updating treatment approaches, mental wellness teams, and a national data collection system for Treatment Centres. Specific to NNADAP's Renewal, the process itself began in 2007 as a result of a partnership between the Assembly of First Nations (AFN), the National Native Addictions Partnership Foundation (NNAPF), and Health Canada. With a goal of enhancing, renewing and validating on-reserve addiction prevention and treatment services, the process has 5 key components:

- Regional Addiction Needs Assessments, completed in 2009/10, and identified key gaps, strengths and duplications within services;
- First Nations Addictions Advisory Panel;
- NNADAP Renewal National Forum;
- 5 key NNADAP Renewal Research Papers on Prevention, Mental Health, Culture and Tradition within Addiction Services, a Historical review of NNADAP, and a NNADAP Systems Review; and,
- An Indigenous Knowledge Forum.

NNADAP's Renewal Process Framework, also known as "Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada", describes an integrated, culturally-relevant, client-focused system of services and supports for addressing substance use issues among First Nations people in Canada. The framework:

- identifies best and promising practices and will support strengthened programming at the community, regional and national levels and across related jurisdictions;
- highlights the shared responsibility of different jurisdictions (community, province, federal) in addressing the determinants of health from a First Nations perspective in order to improve the health status of First Nations people;
- is broad enough to be applicable nationally and incorporate the variation that exists within First Nations communities across the country; and,
- includes guiding principles, a continuum of care model, and supporting elements to the continuum as integral parts of the overall system.

Under the renewed framework to address substance use issues among First Nations, 6 elements of care are identified, including Community Development, Universal Prevention, and Health Promotion; Early Identification, Intervention and Aftercare; Secondary Risk Reduction; Active Treatment; Specialized Treatment; and Care Facilitation. Specific to performance measurement and research, the current status of the program notes that there is:

- Limited population-level data specific to First Nations to support monitoring or addictions related program planning;
- No defined indicators to guide data collection and performance measurement within addictions system;

- Broad recognition for a strengthened evidence-base for both treatment and prevention, drawing on both mainstream and Indigenous knowledge;
- High level of interest to validate existing practices through research, particularly culturally-based;
- High level of interest in determining preferred approaches specific to various populations (e.g., women and youth, specific substances, methadone and prescription drugs); and,
- Significant appetite for knowledge exchange and translation to support effective service delivery and planning

Specific to performance measurement and research, key renewal opportunities focus on 4 areas:

1) *Population Health Information, involving a s*trengthened approach to both gathering and making use of population level data (e.g., 2008-10 RHS) to inform needs-based planning.

2) National Research Strategy, that addresses:
- The need for a coordinated, long-term research strategy to ensure that First Nations-specific research is conducted in a systematic, sustainable, and culturally safe manner;
- Promotes community capacity for research, including enhanced opportunities to profile 'wise practices' and support effective knowledge exchange;
- Draws upon priorities identified through NNADAP Renewal Process, as well as research engagement activities carried out by NNAPF; and,
- Encourages partnerships with a wide range of research organizations, such as the Canadian Institute on Health Research.

*3) Integrated Performance Measurement, through the i*mplementation of a information management system, and a strengthened approach to tracking and reporting of activity data, such as service availability and rates of use, results data, and client outcomes, and lastly,

*4) Knowledge Exchange and Translation, that provides s*upport for information sharing and mentorship between communities, as well as a planned approach to knowledge exchange that supports networks and processes and that would review research and performance measurement data.

National Office research priorities for 2011/2012 include:
- Improved approach to knowledge exchange of all national mental health and addiction programs;
- Research to support Framework implementation;
- Screening, assessment, referral and case management approaches;
- Indentifying key basket of community addiction and mental health services;
- Strengthened program-level information;
- Client demographics & outcome data;
- Implementing a national information management system;
- Examining literature and approaches to addressing prescription drug abuse;
- Describing the impact of the NADS investments; and,
- Developing a National Research Strategy

Question and Answer Period for Panel Presenters #3

Question from Yvonne Rigby-Jones, Tsow Tun Le Lum Treatment Centre, BC for Hakique Virani: Has there been research done in the area of disassociate personality disorders and their medical condition, given the residential school history of First Nations?

Response from Hakique Virani: Haven't seen disassociate personality disorder per say, but have seen associated disorders where persons have multiple-personalities, specific to post-traumatic stress disorders relative to residential schools, survivors of physical and sexual abuse. A question that had been asked of 'Cody' and denied as having ever experienced any physical or sexual abuse, but then became a sex trade worker, so there was likely some form of abuse that was never disclosed. Does it feed into post-traumatic stress disorder (yes) and is it a factor in drug abuse, absolutely, and something that needs to be considered when treating individuals with multiple disorders.

Question from Yvonne Rigby-Jones, Tsow Tun Le Lum Treatment Centre, BC, again for Hakique Virani: With permission to share their journey, Yvonne presented information concerning her husband and his experiences as a residential school survivor, and specific to post-traumatic stress disorders (PTSD), if individuals with this condition have the ability to leave their bodies and crash back in, how would one assist or what is the process in treating individuals with this disorder? With so many of TTLN client groups suffering from this disorder, how can the medical profession assist people with this disorder, specifically when addressing their medical disorders?

Response from Hakique Virani: I find that challenging and even in his practice when they apply Cognitive Behavioural Therapy (CBT), part of the journey is to help the patient recognize the tendencies or behaviours to escape the problem. Not that CBT is the be all and end all to address PTSD, and it is more the skill set of mental health counsellors and concurrent disorder counsellors that are needed in this case. An additional note from Carole Patrick is that the first goal in treating individuals with PTSD is to do grounding work to get them back in their body, as a prerequisite to addressing PTSD.

Question from Theresa Howell's partner to Hakique Virani: Discussed the analogy of the pine tree being hit by lightning producing multiple pine cones as a survival technique, relative to First Nations having many children (not that he is advocating this point), but more, why we ignore some of the basic wisdom behind our actions in the case of Cody's story. Secondly, why didn't the Correctional system become involved at some point?

Response from Hakique Virani: Cody did describe the pregnancy as unplanned, the stresses on the relationship, and whether he had the skill set to become more engaged in family planning is unknown. As to why Corrections did not get involved, no idea why.

Comment from Rupert Ross, FNIHB, Ottawa: Noted the excellent paper on the NAHO website by Lori Haskell and Melanie Randall concerning the impact of residential schools, relative to the disassociation arising through/from PTSD.

Question from Isaac Hernandez, Dawson Creek Treatment Centre to Hakique Virani: Have you considered a comparative approach involving spirituality in treatment? At the Dawson Creek Treatment Centre, they do not promote a specific religion or set of values, and they allow individuals to determine for themselves what religious value-set best works for them. Was that a consideration when it came to Cody?

Response from Hakique Virani: It was tragic that Cody felt revulsion to his background/culture and that he wasn't provided with the chance to explore those options as Isaac described. On the one hand, his family didn't like him because he was Indian, while on the other hand, his doctor advised that he should acknowledge his identity as an Indian. An approach that allows him to be a human being and explore his spirituality in such a way could have been more effective, acknowledging that these are just assumptions

on Hakique's part. Both experiences need to be addressed through the research agenda and further explore this option.

Comment from Carol Hopkins, Executive Director, National Native Addictions Partnership Foundation: I am not sure I have a question, but I am compelled to make a comment. The presentation you made and the Story of Cody was very profound, a very good story and a great presentation, but I felt I lost my breath when the story ended with conflict over culture, and then he died. Because ending the story on that note in an audience that you don't really know how they will respond to that [ending] makes me want to respond in this way. The lack of understanding of what culture means and I'm not talking to you specifically, but generally, that culture is not just a behaviour or an activity like a sweat lodge or sitting down with and Elder – culture is much more than that – and one of the foundational principles of culture is about connections, so as you reviewed the story, at every single arrow that you had, the question from a cultural perspective is where is the connection.

Even going back to the very beginning of the story and his mother, this led me to another thought concerning language, and when we talk about helping people to address issues, addictions or mental health, complicated post-traumatic stress or whatever it might be, we often use language about an individual, and that's not necessarily the case because we have an individual's life that we are trying to assist, but it narrows our perspective. From a cultural perspective, when we talk about an individual, it's always with the understanding that culture refers to the individual within and environment, so inherent with that idea is that culture is the connection. When we get to the end of the story and we're talking about doing some cultural activities that are designed around behaviour, it narrows the view of culture and it leads to some assumptions that a cultural approach is flawed, and it is not the approach that is flawed, but the way it was facilitated.

Perhaps this can lead to all those kinds of assumptions in terms of what the treatment centre did. But if the focus is on the treatment centre because that's where the story ends, that is misleading. So when you go back to the beginning of the story when we talked about his mother, and in looking back at discussions yesterday when we talked about parenting, parenting itself narrows our perspective again because we think of the biological parent, and parenting from a cultural perspective is a function, an activity of many people, not just the individual. And so we've designed programs around parenting to take care of the biological parents, and were missing the boat - it's not a cultural approach – it's more of the same. So I just wanted to make that comment because the end of the story was very stark and led to all kinds of assumptions that could be misleading, and I wanted to offer the notion of connections and the significance and importance of when we are talking about helping individuals, it's individuals in the context of an environment within a system.

--- End of Panel #3 Presentations Question and Answer Session ---

Appendix E Cognitive Mapping Results and Research Priorities

GROUP CAUCUS FEEDBACK – BRITISH COLUMBIA TREATMENT CENTRES		
CONCEPT	**GROUPED CONCEPT**	**RESEARCH PRIORITY**
1a. Elder-related research priority **1.** Equal billing/value for earned and learned **2.** Equal value and equal pay for traditional as with academic education **3.** Educating Elders in current drug use	•	•
1b. Workforce development **4.** Certification of counsellors **5.** Training of workforce **6.** Education on effects of substance abuse…; prescription drug abuse **7.** Mental health training of addictions counsellors **8.** Best value for money concerning NNADAP human resources	•	•
2. Aftercare **9.** Addictions recovery **10.** Projects on low/no cost aftercare **11.** Spirituality to treat trauma during/in aftercare	•	•
3a. Family **12.** Family versus individual treatment **13.** Family dynamics **14.** Family supports for clients after treatment **15.** Parenting **16.** Breaking cycles **17.** Intergenerational trauma	•	•
3b. Youth **18.** Youth communication **19.** Youth treatment versus cultural camp effectiveness **20.** New healing methods versus traditional **21.** Bridging gap between youth and elders (culture, language)	•	•
4. Overarching areas of research **22.** Continuum of care – before, during and after **23.** Bio-psycho/social approach from intake to aftercare **24.** Harm reduction redefined from traditional perspective **25.** Funding formulas **26.** Outreach	•	•
5. General **27.** Pre-treatment or before-care research **28.** Current processes for research and protocols for what works **29.** Assessment re: criteria for research	•	•
Best Practices to consider: Program networking...; more sharing of knowledge between Centres	•	•
Practices to start: Results of research...; follow-up on research effectiveness Challenge government on who is the expert...; research on evidence-based research How to measure capacity building...; accreditation effectiveness	•	•

GROUP CAUCUS FEEDBACK – ALBERTA TREATMENT CENTRES		
CONCEPT	**GROUPED CONCEPT**	**RESEARCH PRIORITY**
1. System	•	•
2. Those not being served	•	•
3. What's available	•	•
4. Effective programs (new definitions of success)	•	•
5. Complexity of issues (determinants of health)	•	•
6. Pilots defined and programmed by First Nations	•	•
7. Money evaluations	•	•
8. Bringing together West and Indigenous approaches for programs and services	•	•
9. Land based programs with traditional knowledge and Elders and youth	•	•
10. Lack of outreach programs	•	•
11. Holistic programs with community ownership that are communication based	•	•
12. Evaluate current system (services, departments and organizations)	•	•
13. Barrier to access services because resources are already devolved	•	•
14. Suicide	•	•
15. Research link between mental health illnesses and addictions and substance abuse	•	•

GROUP CAUCUS FEEDBACK – YUKON and NORTHWEST TERRITORIES		
CONCEPT	**GROUPED CONCEPT**	**RESEARCH PRIORITY**
1. Bringing together mainstream and culture and tradition	•	•
2. Develop programs that bring together western and indigenous approaches	•	•
3. Incorporate traditional knowledge	•	•
4. Land based programs – simple spiritual program	•	•
5. Holistic programs with community ownership	•	•

6. More education of health professionals regarding the link between mental health issues and substance abuse – educate both perspective western and indigenous	•	•
7. Acknowledge and validate indigenous knowledge in families and communities by Canadians, by the system – a critique	•	•
8. New knowledge clinicians, mainstream approaches but the experiential, somatic approaches – how effective is mainstream therapy and the other therapy integrate approaches and enhance outcomes	•	•
9. Evaluate capacity within communities and train people, take ownership of programs – community based	•	•
10. Increased rates of suicide in the Yukon	•	•
11. Research – ACTION – need ownership	•	•
12. Research what are the servise providers doing to meet community needs. Evaluation to assess service providers, train community people to do it themselves, give resources to hep themselves	•	•
13. Evaluate current modules (G'wichin)	•	•
14. Evaluate community treatment and/or residential care	•	•
15. Research on number of departments and organizations working with individuals	•	•
16. NWT research services available and how they are networking	•	•
17. Residential vs out-patient care research what is effective	•	•
18. Individual vs group approaches heal faster in groups group becomes more powerful than an individual intervention	•	•
19. Link between mental health illness and substance abuse	•	•
20. Concern about the environment and climate change, impact on fish and animals, rain storms and mud slides	•	•
21. Those involved in justice system are struggling with addictions and historical struggles – residential school, in care, incarceration	•	•
22. Looking at addiction mental health stop intergenerational issues with use of parenting skills and empathy in parenting	•	•

23. Youth homelessness in White house housing shortage and housing crisis	•	•
24. Residential schools and interrelated issues	•	•
25. Elders are getting tired and need help – have lived it and need to be heard	•	•
26. Compensation for Elders and knowledge shared in western society experts and consultants are compensated	•	•
27. Use elders, youth and community residents, communicate with council	•	•
28. Even when we get our own community based program we are our own worst enemies	•	•
29. Lack of outreach programs to assist with returning to community	•	•
30. Give the people the resources to heal recover and to be empowered	•	•
31. Money goes to colleges and academics who in turn take knowledge from elders for minimum contribution and no mileage	•	•
32. What will it take to slow down the industry non-indigenous people – the answers from the grass roots are not found in the material and resources.	•	•

PRIORITIES IDENTIFIED	BC	AB	YK/NWT	RESEARCH	POLICY
1. Ethical issues in researching urban Aboriginal populations (OCAP, Tricouncil)			X		
2. Mapping continuum of care (issues)			X		
3. Locus of intervention (person, group, community)			X		
4. Youth treatment costs (justifying investment)			X		
5. Culture in relation to research -outcomes and impact - land based programs			X		
6. Community counsellors (training, referral workers)			X		
7. Aftercare networks (researching effectiveness)			X		
8. Use of video conferencing (researching effectiveness)			X		
9. Spirituality as a core element			X		
10. CIHR Aboriginal intervention research grant call (April 1st)			X		
11. Language "Drawing from spirituality" vs. "treating with"			X		
12. Family and individual	X				
13. Youth	X				
14. Holistic approaches	X				
15. Harm reduction	X				
16. Complex interventions	X				
17. Research to action	X				
18. Modeling best practices	X				
19. Community capacity	X				
20. Elders	X				
21. Workforce	X				
22. Research (prevent, treat, rehabilitate)	X				
23. OCAP	X				
24. Aftercare	X				
25. System		X			
26. Those not being served		X			
27. What's available		X			
28. Effective programs (new definition of success)		X			
29. Complexity of issues (health		X			

determinants)					
30. Pilots defined and programmed by First Nations		X			
31. Money evaluations		X			
32. Bring together West and Indigenous approaches for programs and services.		X			
33. Land based programs with traditional knowledge and Elders and youth.		X			
34. Lack of outreach programs		X			
35. Wholistic programs with community ownership that are communication based		X			
36. Evaluate current system (services, departments and organizations)		X			
37. Barrier to access services because resources are already devolved		X			
38. Reseach link between mental health illnesses and addictions and substance abuse		X			
39. Suicide		X			

Appendix F Selected Bibliography

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