National Native Addictions Partnership Foundation (NNAPF)

National Workforce Development Strategy

November 1, 2006

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Acknowledgements

Tansi!

The following represents the cumulative effort of several years work of the National Native Addictions Partnership Foundation (NNAPF), its Regional Working Groups, and most important, the front-line Wellness/Addictions Counsellors nation-wide in both treatment centres and communities. In developing a National Workforce Development Strategy, the Foundation has been sensitive to feedback received over the years from various conferences and training sessions, with care taken to preserve the various elements of workforce development identified in these forums.

Acknowledgment is therefore due first and foremost to the Wellness and Addictions Counsellor workforce, by whatever title or job description under which they have devoted their life efforts to working in the field of addictions and wellness. Survey respondents and focus group participants provided exceptional quantitative and qualitative feedback, and without them, the development of this national workforce development strategy would not have been possible.

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Meegwetch!

Chief Austin Bear
President, Board of Directors
National Native Addictions Partnership Foundation

Executive Summary

As the evidence would suggest, being an addictions or mental health worker in a First Nations community or treatment centre requires a specialized skill set, and clearly demonstrates that the certification of that skill set is making a difference. Likewise, the strategy document that follows is intended to be a snapshot of where the National Native Addictions Partnership Foundation's (NNAPF) efforts in workforce development presently stands (Section 1), where they would like it to go (Section 2), and what are some of the common world view perspectives that reflect the elemental needs of the Native Wellness and Addictions Counsellor workforce (Section 3).

Also contained in this report are the cumulative findings of a national competency survey of front line workers, three worker focus groups, and regional reports of the state of addictions workforce development within First Nations and Inuit Health Branch (Section 4). Based on the results of this survey, there is cause to celebrate the last 5 years of training and credentialing efforts by the NNAPF, the First Nations and Inuit Health Branch (FNIHB) and their Regional partners. From the findings of the survey alone, it is envisioned that NNAPF could confidently enter a qualification level comparison study with its provincial counterparts as one objective that would better serve national and provincial certification efforts.

Regardless, any workforce development strategy is only as good as the organization's capacity to mobilize and draw the elements into a cohesive plan that can be actioned and evaluated, and Section 5 reflects a summary of these elements and activities. Each Regional working group and advisory Committee of the Foundation, as well as the diversity which resides with the hundreds of front-line workers in treatment centres and First Nations and Inuit communities, has served as an invaluable resource which the Foundation can draw upon to formulate next steps.

Specific to structural supports, recommendations from the field would encourage that government work in partnership with the Foundation to advance policy in support of the credentialing, accreditation and standardization of both the job itself, and of the core competencies needed to best do the job. Likewise, workforce recruitment again speaks to systems improvements, whether it be the recognition of research concerning the Wellness and Addictions Counsellor workforce to better inform future workforce development activities, or more tangible actionable items such as job placement or scholarship awarding. Progress relative to strategic element 3 has been one of the Foundation's greatest achievements, with improved access to education, training, certification and recognition by the health care system becoming the norm. Information supports have unfortunately, not kept up with expectations, leaving opportunity for improvements yet to be determined, pending federal positioning. And lastly, research in support of both the workforce itself, and to assist the workforce to better do its job – can never occur fast enough. In addition to the community based research workshops taking place at national training symposiums, the NNAPF has embarked on research that is for the community and with community. And with technological advances being outstripped by client demands, the Foundation's future workforce development activities could be better

served by research that is practical to improving program and service delivery, relative to client outcomes and workforce needs.

Introduction – Overview of NNAPF's Workforce Development Mandate

During the mid 1990's, the National Native Alcohol and Drug Abuse Program (NNADAP) served as a national, federally-funded wellness/addictions program for First Nations and Inuit in Canada, designed to provide treatment, prevention, training and research services as a comprehensive federal strategy. Specific to workforce development, the aim was to allow for culturally appropriate training programs, to support prevention, maintenance and treatment in First Nations and Inuit treatment centres and communities, through a cadre of para-professionals and professionals, comprised of advanced and basic level Counsellors.

Independent evaluation and intensive internal review processes were conducted locally, regionally and nationally, culminating in the *NNADAP General Review 1998*. The Review included 37 recommendations, one of which was the creation of National Native Addictions Partnership Foundation (NNAPF), a not-for-profit, non-governmental national Aboriginal organization, to implement all of the strategic recommendations of the *NNADAP General Review.*

Our stakeholders include First Nations, Métis and Inuit Addictions and Wellness Counsellors working in over 800 communities and more than 60 Treatment Centres. It is composed of a multi-sector network of Regional Working Groups, a Youth Services Addiction Committee (YSAC), and other Aboriginal partners with significant expertise in the field of addictions and its related health and social issues. One of the roles of the NNAPF is the renewal of the Aboriginal addictions system, in order to assist its evolution into a more efficient, culturally-appropriate and relevant program, administered and delivered by a trained and experienced Aboriginal Wellness and Addictions Counsellor workforce. These specialists represent the front-line staffs that address the mental wellness and addictions counseling requirements of First Nations, Métis and Inuit nationwide.

Over the years, the Foundation has worked tirelessly to address workforce development issues, to ensure that Wellness/Addictions workers nation-wide maintain standards that are comparable to that of mental health workers and other paraprofessionals working in Canada's health care system. Of late, the Foundation's efforts have included proposals to the Federal government to implement a National Certification of Aboriginal Addictions Counsellors, through a First Nations Wellness/Addictions Counsellor Certification Board (FNWACCB).

As well, the NNAPF has also sought support for a national workforce development survey of all Treatment Centre and community-based First Nations and Inuit Wellness/Addictions Counsellors. Hence, workforce development has been ongoing, and a more detailed overview of the Foundation's efforts are summarized in one of

NNAPF's core documents, the *Position Paper on NNAPF's National Training and the new Aboriginal Health Human Resources Strategy* (Appendix A). Lastly, a national workforce development strategy would not be complete without including the remarkable efforts of the Regional Working Groups of the Foundation. The national certification proposal for example, largely originated from the pilot project spearheaded by the B.C. Regional Working Group. Likewise, the work of the YSAC in the development of core competency curriculum modules for youth addictions training, as well as a standard salary reporting framework, exemplify the dynamism of the Foundation's workforce development activities – with end products that are developed, designed and implemented by and for Aboriginal Peoples! Highlights of the Foundations workforce development activities and a review of issues dating back to RCAP are presented in the following section.

Section 1 – Highlights of NNAPF's Workforce Development Activities

The success of both the program (NNADAP) and the subsequent establishment of the Foundation (NNAPF) are well documented. Since its incorporation, the Foundation has steadily advanced various workforce development activities, aimed at the promotion and advancement of the accreditation of programs/Treatment Centres, as well as the certification of Wellness and Addictions Counsellors in Treatment Centres and communities, nation-wide. An overview of the Foundation's workforce development activities since 2000 is presented below:

National Native Addictions Partnership Foundation **National Workforce Development Activities 2000-2006**	
Directory of Addictions Specific Training in Canada 2001 • Lists current educational institutions that provide addictions training – certificates, diplomas and degrees HR Consultation – Edmonton NNAPF Gathering 2002 • Consultation with Workers on issues, barriers, solutions and NNAPF's role	2001-2002
• National Training Edmonton • National Salary Survey – key Treatment Centre personnel • Re-Profiling Initiative	2002-2003
• National Training Saskatoon • Developed Community Risk Assessment Manual for front line workers • Community Worker Training Needs Survey (Competency Survey) - Based on 12 International Core Competencies - Results summarized • National Human Resource Development Strategy – Draft • Re-profiling Initiative – funded two models for training of treatment centre staff - Training to degree level in psychology - Specialized Crisis Training	2003-2004
• Directory of Addictions Specific Training in Canada revised 2004 • National Training Ottawa	2004-2005

• First National Training Institutes Adhoc Meeting	
• National Training Vancouver – Partnership with CHABC and CAAN • National Training Institutes Meeting to begin development of Addictions Training Network	2005-2006
• National Training Edmonton – Partnership with HOSW • Promotion of BC Certification Process – FNWACCB • Development of Clinical Supervision through Video Conferencing Proposal • Finalize National Workforce Development Strategy (draft HR Strategy) • Host proposed Aboriginal Workforce Development Symposium National Ethics Guidelines, Counselling Guidelines, Prevention Report Guide	2006-2007

Worthy of note is the Foundation's National Human Resource Development Strategy, which identifies that a "certification process for both Prevention Counsellors and Counsellors should be established by the Foundation, as part of the larger accreditation process." The NNAPF strategy further notes that "Addictions Counsellor Certification should include a core of general counselling skills, supplemented by specialization in substance abuse and addictions Counsellor training. Current training must also be supplemented by programs to enhance knowledge/skills in the following:

- Understanding/counselling re: drug abuse
- Intervening with populations with special needs
- Cultural heritage training and Traditional Healing Approaches
- Broad spectrum skills training, e.g., the Community Reinforcement Approach (CRA)."[1]

The NNAPF Regional Working Groups activities have achieved equally amazing results supporting workforce development, such as, but not limited to for example:

- In Alberta region, the development of Prevention Manual for Addictions Counsellors, and where training is provided in required competencies for certification, with funding support for the certification for wellness/addiction Counsellors. Subsequently, more that 80% of Alberta's front line workforce has been certified through CCPC;
- In Manitoba region, the development of Orientation Manual for Addictions Counsellors;
- All regions have supported formal and informal training for addictions Counsellors;
- In British Columbia, the training of treatment Counsellors to a degree entry level; and the implementation of a First Nations Wellness/Addictions Counsellor Certification Board, and many other examples of regional innovation, and last but not least;
- Specific to workforce development, the Youth Solvent Addiction Committee activities "include everything that is meant to improve staffing, staff training, and credentialing or staff management."[2] As noted earlier, the YSAC can boast of the

[1] Courtesy of http://www.nnapf.org/english/projects/national_training/background.shtml
[2] *YSAC Project Report 2003-2004*, pg. 2, available at www.nnapf.org/english/pdf/partners/ysac/ysac_project_report_2004.pdf

development of core competency curriculum modules for youth addictions training that have been CCPC certified, in Research Methods and Client Follow-Up, Clinical Supervision, as well as Resiliency and Client Care, Emotional Intelligence and Addictions.

These and many more examples of regional innovation are what make the Foundation's workforce development activities both validated and field-tested by front-line experience.

Section 2 – A Recap since RCAP of Wellness/Addictions Counsellor Workforce Issues

The Foundation knows that it takes tremendous commitment, dedication and personal growth to work in Aboriginal communities. The Foundation also knows that Wellness and Addictions Counsellors in both the Treatment Centres and in First Nation and Inuit communities have taken a multitude of practical training, workshops and have gained tremendous experience that currently is not being acknowledged. Some of their more formal credentials range from post graduate degrees to limited high school, and to its credit, the NNAPF has recognized that the strength of the Wellness and Addictions Counsellor workforce lies in its cultural competency and traditional knowledge, based on a First Nations and Inuit healing philosophy.

Not surprising, recommendations dating back to RCAP speak to the challenge of addressing gaps in information regarding the Aboriginal health workforce. The *1996 Report of the Royal Commission on Aboriginal Peoples* (RCAP) identified the development of Aboriginal health human resources, as essential to ensure the success of new approaches to health and healing.[3] The RCAP further states that "more services if imposed by outside agencies will not lead to the desired outcomes."[4] Hence, a new approach to improving Aboriginal health was articulated, that identified equity, holism, Aboriginal control and diversity as desirable traits. This approach was espoused as having the power to do what the present system could not: to focus on healing.[5]

In addition, recommendations for an Aboriginal health and healing strategy calling for the mobilization and training of Aboriginal personnel were supported by the logic that "Aboriginal control of human services is necessary because control over one's situation is a major determinant of health."[6] Hence, the RCAP recommended that governments and educational institutions undertake the challenge to train 10,000 Aboriginal people in health, including professional and managerial roles over the next decade.[7] Most important in achieving this goal was the need to undertake the collection of data, which will support the development of Aboriginal health human resources, since the Report

[3] Report of the Royal Commission of Aboriginal Peoples, *Gathering Strength – Volume 3*, pg. 260.
[4] Ibid., pg. 293.
[5] Ibid., pg. 229.
[6] Ibid., pg. 232.
[7] Ibid., pg. 265.

acknowledged that the absence of this vital information is an obstacle to workforce development and planning.[8]

Two years later, the *NNADAP General Review 1998* identified 37 recommendations,[9] of which several touch on workforce development issues of Wellness and Addictions Counsellors. For example:

> *7. To **develop revised scope of duties for the community Counsellors, which should take into consideration advanced and basic counselling.** There should also be recognition and a training strategy developed to assure that NNADAP Counsellors have skills in areas of grief and loss, family violence, sexual abuse, tobacco, gambling, and other areas. Sample protocols should be developed to assist communities in dealing with 24-hour requirements and means for handling on-call within communities. (This should be related to the recommendations on a national accreditation process.)*
>
> *11. As part of an **overall accreditation process**, a group of stakeholders should be involved in developing a code of conduct for NNADAP Counsellors which could be posted in First Nations' buildings and in NNADAP offices. This would outline expectations relating to confidentiality, obligations, possible remedies and penalties where there are violations. (See recommendations on training.)*
>
> *21. Health Canada, First Nations and Inuit organizations should negotiate accreditation with groups such as Ontario Interventionist Association to **utilize certified alcoholism Counsellor title or develop a similar accreditation process.** The program could also consider granting parallel privileges to individuals with certain educational qualifications as well such as Bachelor of Social Work (BSW), Master of Social Work (MSW), psychology, or other fields which would be considered as equivalent.*

Hence, NNAPF's mandate speaks directly to its future role in the development of the Wellness and Addictions Counsellor workforce. From the 37 recommendations of the *1998 NNADAP General Review*, these have been collapsed into seven broad categories of enabling functions, and one of the Foundation's categories speaks directly to workforce development, namely:

> *To establish a networked training system to support the development of the human resources required to ensure effective and efficient addictions services for Aboriginal people regardless of where they live; and, to establish a national certification program for community prevention and treatment centre personnel.*[10]

[8] Ibid., pg. 267.
[9] First Nations and Inuit Health Branch, *National Native Alcohol and Drug Abuse Program General Review*, Final Report, 1998, pgs. 89-92.
[10] Ibid.

Unfortunately, very little qualitative and quantitative information has been collected systematically about the number of Aboriginal Wellness and Addictions Counsellors, their professional titles and roles, etc., by the Federal government. An initial assessment of their competency level relative to certification has been gleaned from the survey discussed in Section 4. And from the field, the Foundation does know that Wellness and Addictions Counsellors tend to obtain specific skills that are related to the tasks of their positions. They tend to prefer practical learning situations - best provided by semi-formal or informal training such as workshops, seminars, training conferences, ad-hoc courses, etc., offered externally or internally. As well, attention must be paid to the recognition of the Wellness and Addictions Counsellors' informal but usually comprehensive training portfolio, coupled by real-life professional experience acquired through this training and through their work. As noted by the Foundation more recently:

> *The field of addictions services...is challenged to sustain a workforce that can meet the demands and needs presented by clients seeking treatment as well as the prevention needs faced by First Nations and Inuit communities. The NNAPF is committed to strengthening the addictions services continuum by supporting coordinated and meaningful workforce development strategies. (NNAPF National Strategy 2004)*

More recently, workforce development issues have been articulated by in the Assembly of First Nations report of the public health system relevant to First Nations. Specific to skills and knowledge enhancements to current health care providers, the report notes:

> *Increased skills and knowledge are recognized as necessary for the improvement of health promotion/prevention efforts at the national, provincial, territorial, regional and community levels. First Nations as well as non-First Nations nurses, physicians, CHRs, **Addictions Counsellors**, Counsellors and others would benefit from a better understanding of cultural knowledge of health and wellness, etc.*[11]

Hence, a recommendation that speaks directly to First Nations and Inuit workforce development, namely:

> *Recommendation #79: Certification and standards for innovative public health para-professionals should be considered to support public health activities that currently demand irrelevant qualifications.*[12]

Of late (2005), Canada equally recognizes and supports the need for workforce development that is culturally relevant. As noted in its *National Framework for Action to Reduce the Harms associated with Alcohol and Other Drugs and Substances*, the Federal government recognizes that "a significant influx of resources is needed to deal with outreach, treatment and aftercare to cover expenses related to the remoteness of northern communities. The need to recruit and retain care Counsellors and to support their

[11] Assembly of First Nations, *Public Health for First Nations: A Framework for Improving the Health of our People and Communities*, November 2005, Chapter 7, pg. 113.
[12] Ibid., pg. 116.

professional development is crucial, especially if holistic and culturally relevant programs are to be designed and delivered effectively."[13]

As noted in the framework, "[n]ecessary) actions identified to date include: establishing national standards and competencies to enhance knowledge and skills."[14] Hence, why "[t]raining and capacity building within First Nations, Inuit and Métis communities and empowering Aboriginal peoples to develop and implement their own culturally sensitive strategies are important to achieving long-term sustainable progress."[15]

Most telling is the support for Aboriginal workforce development, as reflected in the *Strategic Action Plan for First Nations and Inuit Mental Wellness*. Developed by the First Nations & Inuit Mental Wellness Advisory Committee in June 2006, the final report reflects a goal that identifies as one of the activities, the need to "ensure that competency development on the job continues to be available until the pool of qualified First Nations and Inuit is sufficient." [16] With FNIHB, communities and service providers identified as the lead, the overarching Goal #4 reads: "To enhance the knowledge, skills, recruitment and retention of a mental wellness and ***allied workforce***, able to provide effective and culturally safe services and supports for First Nations and Inuit."[17]

Section 3 - Espousing a Native World View - International Perspectives

Since the mid 1980s, there is a mountain of evidence worldwide supporting the need for Indigenous control in the design and delivery of health care programs and services. Primary care is largely a reinvention of holistic care practiced by First Nations and Inuit caregivers, given that now, "interdisciplinary teams serving remote northern and Aboriginal communities comprise a wide range of professionals and paraprofessionals, including local community health representatives, health and social service providers, family service Counsellors, mental health Counsellors and grief Counsellors, as well as traditional healers, elders, band Counsellors and police."[18] Regardless, the status quo is beginning to understand and "discuss the personal, professional and situational issues that influence levels of respect and understanding within these diverse teams."[19]

Likewise, there is a growing recognition of the importance of culturally safe care in improving the health outcomes of First Nation, Inuit and Métis peoples of Canada. It is well documented how the health status of Aboriginal Peoples is well below the national

[13] National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, *Answering the Call*, First Edition, Fall 2005, pgs. 18-19.
[14] Ibid., pg. 19.
[15] Ibid., pg. 22.
[16] *Strategic Action Plan for First Nations and Inuit Mental Wellness*, developed by First Nations & Inuit Mental Wellness Advisory Committee, June 2006, pg. 14.
[17] Ibid.
[18] EICP Initiative, *Enhancing Interdisciplinary Collaboration in Primary Care in Canada*, April 2005, pg. 5.
[19] Ibid., pg. 5.

standard and that of non-Aboriginal people.[20] The experience of many Aboriginal people with the mainstream health care system has been negative, with cultural differences and the inability of health practitioners to appropriately address these differences having contributed to the high rates of non-compliance.

This has further led to reluctance on the part of Aboriginal clients to visit mainstream health facilities, *even when service is needed*, leading to feelings of disrespect and alienation.[21] Hence, as noted by a key informant in the National Aboriginal Health Organization's *Strategic Framework to Increase the Participation of First Nations, Inuit and Métis Peoples in Health Careers:*

> *The development and accreditation of Aboriginal health delivery curriculum that incorporate traditional healing and wellness principles as well as cultural competency and cultural safety in the delivery of health care services to Aboriginal Peoples and communities.*[22]

Mainstream research equally supports the need for culturally appropriate care based on the availability of local workforce resources. Despite decades of repeated observations relative to Aboriginal health and human resources shortages, research is beginning to demonstrate how many successful interdisciplinary health care teams practicing in northern Aboriginal communities, typically include a number of Aboriginal paraprofessionals recruited locally. To that end, factors considered fundamental to effective workforce functioning included, "members' clarity about their own and others' roles, appreciation of their respective 'equal but different' knowledge bases, and confidence in one another's competence".[23] In presenting their findings, the authors further "argue for an extension of the information on interdisciplinary practice included in health science education programs to address these issues, thereby enhancing the utility of paraprofessionals within the health and human resource mix in rural areas."[24]

An example from south of the border speaks to the importance of a holistic approach to workforce development. When examining the factors for success relative to the certification and training of Community Health Workers (CHWs) across the U.S.A., the varied training and certification programs merited a policy recommendation that drew attention to the importance of local design:

> *Advocacy and development of policies and programs for training and certification programs within states should include attention to the breadth and/or range of*

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[20] Shah, C.P. et al., *Visiting Lectureship on Aboriginal Health: An Educational Initiative at the University of Toronto*, Canadian Journal of Public Health, July-Aug. 1996, Vo. 87(4).
[21] National Aboriginal Health Organization, *Analysis of Aboriginal Health Careers Education and Training Opportunities*, January 2003, pgs. 39-41.
[22] Aboriginal Expert Roundtable on Aboriginal Health Careers, 2003, in NAHO's *Strategic Framework to Increase the Participation of First Nations, Inuit and Métis Peoples in Health Careers*, Dec. 2004, pg. 43.
[23] Minore, B. and Boone, M, (abstract) *Realizing potential: improving interdisciplinary professional/paraprofessional health care teams in Canada's aboriginal communities through education*, Journal of Interprofessional Care, May 2002, Vo. 16(2), pg. 139.
[24] Ibid., pg. 139.

substantive and practice skills specializations sufficient to meet the primary expectations and obligations they are intended to fulfill.[25]

This is an especially important workforce development issue for First Nations and Inuit Wellness and Addictions Counsellors, given that any workforce development strategy must include a method for evaluating prior education and experience, to ensure that the applicant has the relevant alcohol and addictions-specific knowledge and skills prior to certification. The Te Takarangi from New Zealand for example, has developed a framework that integrates a cultural basis within their clinical practice, and assumes an improvement in quality within their cultural experiences as valid, and that these require development, monitoring and evaluation. Hence, competence is defined as a "Maori practitioner's ability to work with 'Whanau' [clients] who have addiction related problems, in ways that apply cultural expertise infused with clinical knowledge, practices and standards."[26]

One of the best examples of workforce development comes from Australia, where the *National Drug Strategy - Australia's Integrated Framework 2004-2009*,[27] builds on previous work from 20 years ago (1985), with the more recent version containing workforce development as a priority area for action. Several of Australia's states/territories have followed up with plans that are consistent with the new strategy, with additional priorities specific to their regions. Similar to the NNAPF here in Canada, many have initiated or developed workforce development strategies, most notably the:

- Victoria Alcohol and Other Drugs (AOD) Workforce Development Strategy;
- Western Australian AOD Workforce Development Consultation Report, which includes recommendations; and,
- AERF Workforce Development Research Project, which includes three jurisdictions, New South Wales, Queensland and the Australian Capital Territory.

It is important to note that the Australian Framework is built on the principle of harm minimization (See Glossary), and within this harm reduction approach, eight specific priorities for action are outlined, including the "*Development of the Workforce, Organizations and Systems.*"[28] This priority area recognizes the complex nature of workforce development and the range of strategies needed to address it properly. In addition, the national drug strategy recognizes the value of research in measuring progress, identifying and responding to emerging issues, and strengthening the evidence base relative to workforce development issues. The following excerpt from the Victoria

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[25] Office of Rural Health Policy, US Department of Health and Human Services, *Community Health Worker Certification and Training: A National Survey of Regionally and State-Based Programs*, May 2005, pg. 35.

[26] *Nga Pukenga Ahurea mo Nga Toko Manawa*, Maori Practitioner Competencies for Working with Addictions, Presentation notes, Healing our Spirit Worldwide conference, August 7, 2006.

[27] *The National Drug Strategy - Australia's Integrated Framework 2004-2009*, available at www.nationaldrugstrategy.gov.au

[28] *Workforce Development Policy Document - Alcohol and Other Drugs Council of Australia (ADCA)*, ADCA Policy Positions, Sept 2003, at www.druginfo.nsw.gov.au/treatment/workforce_development

State Workforce Development Strategy is an excellent example of the strategic directions identified by Australia in terms of workforce development:

Strategic Direction 1- Specialist AOD workforce skill development.
- Build the capacity of the specialist alcohol and drug workforce to provide high quality, responsive client services to meet current and anticipated future needs.

Strategic Direction 2 - AOD Workforce Recruitment and retention
- Increase capacity to attract and retain a highly skilled specialist alcohol and drug treatment workforce.

Strategic Direction 3 - Koori AOD workforce development initiatives
- Strengthen the capacity of the Koori AOD workforce to manage and deliver effective and high quality drug and alcohol services and programs to Aboriginal communities.

Strategic Direction 4 - Generalist health and welfare worker skill development in AOD
- Increase capacity to identify and respond to alcohol and drug problems and related harm; and apply evidence-based interventions.

Strategic Direction 5 - Quality AOD treatment services
- Support attainment of quality standards for funded alcohol and drug treatment services and AOD workers.[29]

In support of the above strategies, the *2005-2008 Commonwealth - State Agreement for Skilling Australia's Workforce*[30] sets out the terms and conditions of the Australian government's funding for the new vocational education and training legislation and the new national training system. The Agreement is between the Australian, state and territorial governments and supports the objectives of the National Strategy for Vocational Education and Training 2004-2010. In summary, the goals are:

- To have a highly skilled workforce to support strong performance in the global economy;
- Employers and individuals will be at the center of Vocational Education and Training;
- Communities and regions will be strengthened economically and socially through learning and employment; and,
- ***Indigenous Australians will have skills for viable jobs and their learning culture will be shared.***

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[29] *Victorian Alcohol and Other Drugs Workforce Development Strategy 2004-2006*, pg. 14, as noted at www.health.vic.gov.au/drugservices

[30] *Skilling Australia's Workforce - Commonwealth-State Agreement for Skilling Australia's Workforce. 2005-2008*, at www.nada.org.au/Training/downloads.asp#Publications

On the regulatory side, the Australian technical and vocational system is a competency-based system, supported by the *Commonwealth - State Agreement for Skilling Australia's Workforce,* signed by the Australian, state and territorial governments. Within the agreement, the Australian Qualification Framework (AQF) provides for national guidelines, principles for articulation and credit transfer, a register of authorities empowered by government to accredit qualifications, and lastly, protocols for issuing qualifications and a structure for monitoring implementation of AQF and for advising Ministers, including recommending any changes.

Recruitment and retention are discussed in terms of supporting systems that enhance practice - at the level of the individual, organization and system-wide. For example, at the individual level, there could be support for debriefing and opportunities for training, at the organization level, it could be training to manage change, and at the system level, it could be policies or funding. As well, to ensure both a holistic and culturally appropriate/complementary approach, the National Drug Strategy stresses that there will be linkages between strategies that impact all facets, including the National Supply Reduction Strategy for Illicit Drugs, the National Hepatitis C and National HIV/AIDS Strategies, the National Mental Health Strategy, the National Suicide Prevention Strategy and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan.

In summary, for the NNAPF here in Canada, lessons learned relative to workforce development are similar, and it is interesting to note that Australia has embraced a systems approach in many of the initiatives that they have developed. Their articulation of workforce development in the broader Indigenous world view context is especially gratifying, as it supports the Foundation's approach to alcohol and drug programming design and delivery here in Canada.

Section 4 - Competency Survey Results – Building on What we Know

4.1 Survey Overview and Methodology

In February 2004, the National Native Addictions Partnership Foundation, in collaboration with the Youth Solvent Addiction Committee (YSAC), designed and distributed a survey to measure the formal education and training, as well as self-perceived competency levels of front-line Wellness/Addictions Counsellors working in First Nations communities and treatment centres in Canada. ***A key point for policy makers is that the survey was designed according to the standard competency areas for addictions workers outlined by the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse (IC&RC)[i].*** The survey collected demographic and formal education and training information, as well as self-perceived competency levels from respondents, who were asked to rank their perceived skill level in 14 competency areas. The ranking was based on a no skill, moderate skill, functional and exceptional skill ranking.

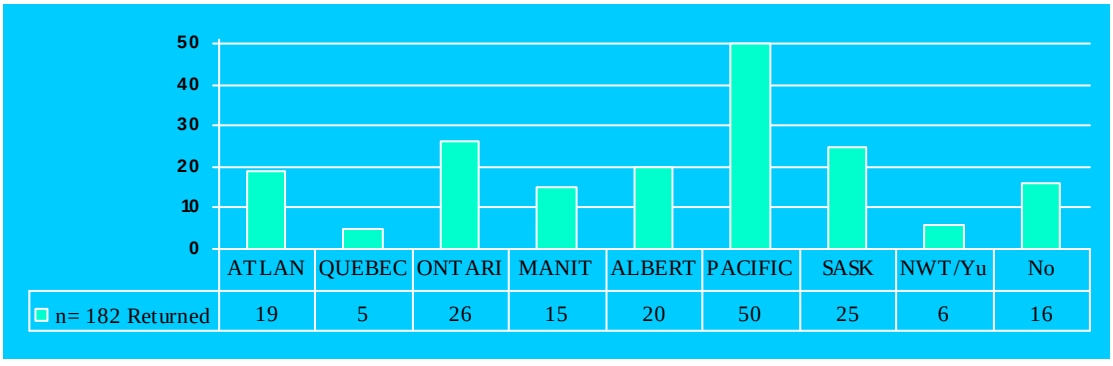
A total of 1,150 surveys were sent by mail or fax to addresses of Wellness/Addictions Counsellors nation-wide. As noted earlier, given the lack of information supports such as a national database, the survey scope intended to provide a baseline of information on the

training needs of this para-professional population, since no other national database captures, or proposes to capture this type of information, for managing and supporting training needs and services for Aboriginal Wellness and Addictions Counsellors.

Whereas accessing a random sample from a national database would have been ideal, the Foundation/YSAC broke new ground in 2004, and surveys were sent directly to treatment centers as well as First Nations community Band offices. A brief introductory letter was included with the survey and requested that of the approximately 1,000+ Wellness and Addictions Counsellors - and other para-professional workers under varying job titles and equivalent job descriptions - complete the survey. The letter noted that the survey could be photocopied as needed, should several workers be employed within the same community or treatment centre. A further 50 surveys were distributed in March, 2004 at the *National Addictions, Mental Health and FASD Training Gathering*, hosted by the National Native Addictions Partnership Foundation. Three focus groups were also held at the Gathering, and the methodology as well as results from these focus groups, are discussed under the competency areas that follow.

In total, 182 responses or 28% of the estimated total number were returned, an excellent sampling for correlation purposes (See Figure 1), and as alluded to above, it is unknown whether the survey sent to First Nation communities was directed to the appropriate recipient(s), whether addictions, wellness and/or mental health workers. Similarly, surveys sent to treatment centers were not addressed to a specific individual, which may have contributed to the response rate. Hence, despite the challenges regarding follow-up, recipient self-identification, the omission of the due date for completion of the survey may have served to maximize survey return – lessons learned for future efforts of the NNAPF!

Figure 1: Survey Respondents by Region



The reader should also note that key findings are reported under each competency area, and although no direct questions of a qualitative nature were asked, all feedback- or comment-type responses were subjected to content analysis for the identification of common themes, and they too are reported in this section. Hence, the only key limitation of this study is the anonymity of those who responded, with the initial survey not having

flagged whether those who responded were representative of the front-line addiction worker, whether communities and/or treatment centres and the mental-health worker field as a whole - a reasonable limitation when interpreting the survey findings. Nevertheless, the returned surveys can be considered a preliminary scan of the wellness, addictions and mental health field, with some very interesting findings produced.

As well, many findings are promising and in contrast to those identified in a telephone scan completed by Health Canada's First Nation and Inuit Health Branch 5 years previous. For example, from the 2004 survey, 83% of respondents reported having an addictions specific certificate or higher (e.g. diploma, degree or PhD), compared with only 40.3% having reported college graduation or higher in 1999 (See Figures 2 and 3).

Figure 2: Education Level 2004 Survey

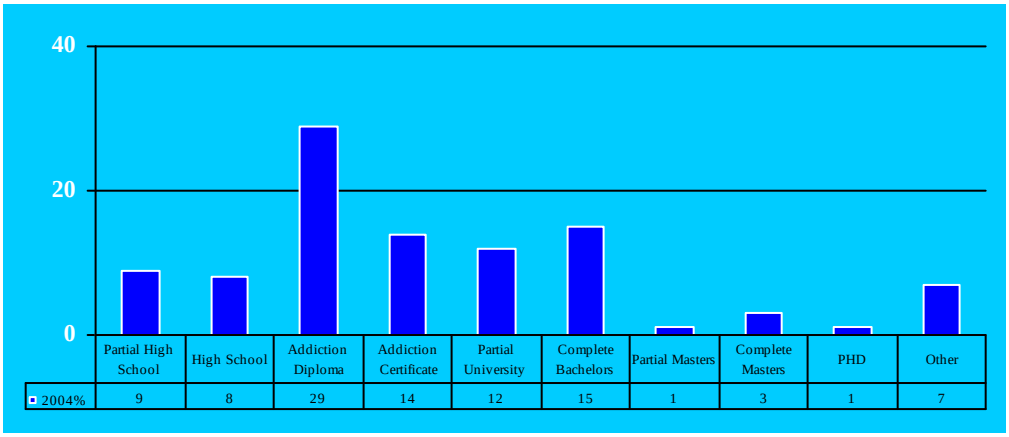
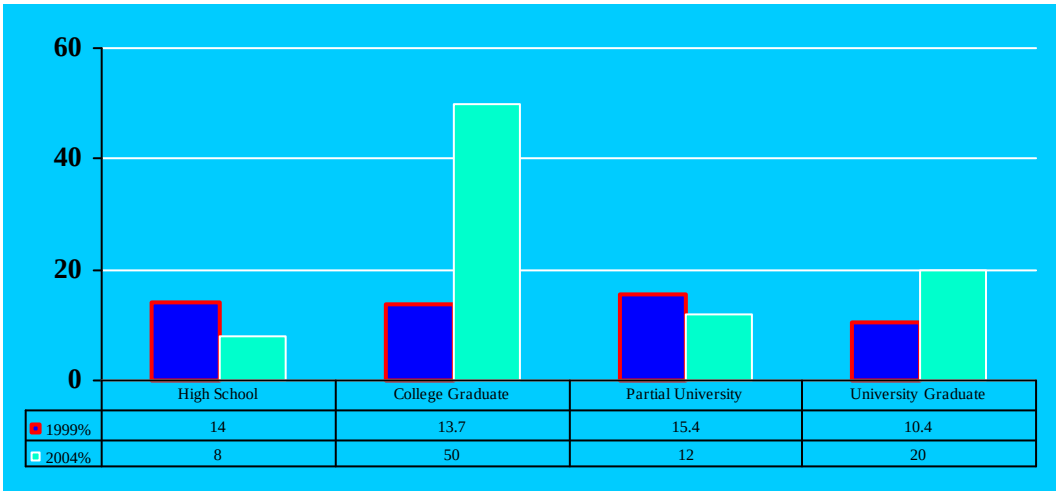


Figure 3: Education Level 1999 Survey



From the survey, we can also observe that 53% of respondents had been in the field for 6 or more years, with 13 years being the average. In comparison, a 1999 national survey showed only 35% of NNADAP workers had been in their positions more than 5 years (See Figure 4). Also worth noting is that the majority (32%) of respondents identified their job-type more so with Community Prevention, followed closely by Inpatient Treatment, and or some combination of the categories (See Figure 5).

Figure 4: Length of Time in the Field

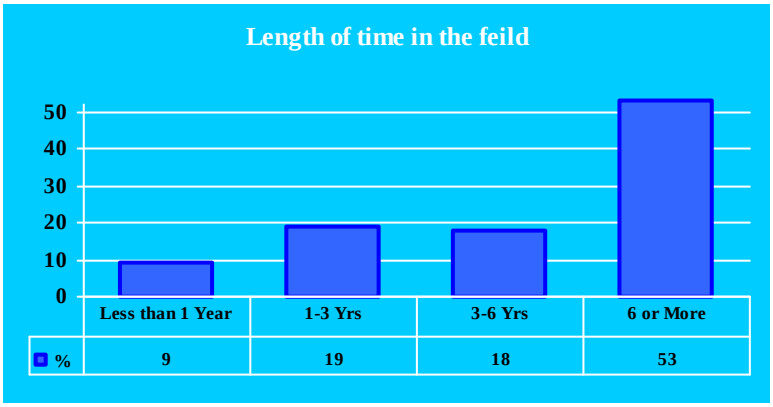
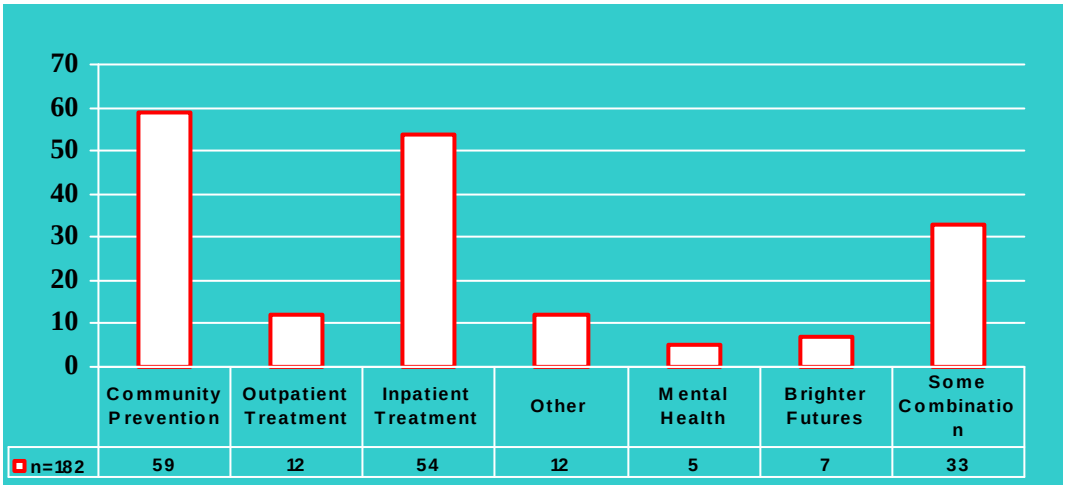


Figure 5: Respondents by Job Type



4.2 Competencies Observations and Analysis[31]

[31] 1. A detailed survey was mailed out to approx. 1200 First Nation organizations across the country; 2. Three focus groups were held during the NNAPF National conference, involving 51 people over 3 days; and 3. A survey of Regional FNIHB and Regional Working Groups was designed and sent out. The combined results of all these activities were used to complete Section 4.2

4.2.1 Addictions Client Screening

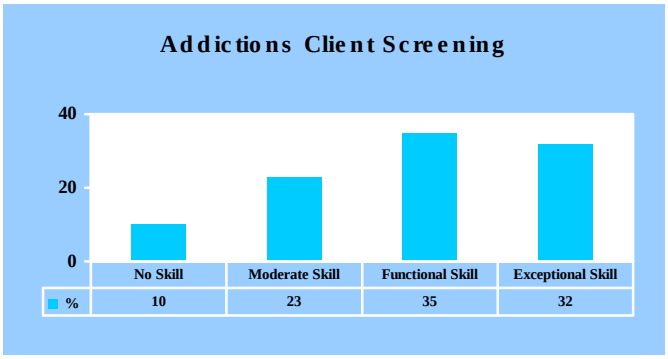
Addictions Client Screening as a competency involves determining the client's eligibility for programs, as well as evaluating psychological, social, and physiological signs and symptoms of alcohol and other drug use and abuse.

From the survey, a whopping 68 % of survey respondents felt they had adequate (Functional/Exceptional) skill in this area, and many identified having taken formalized training in one of the generally accepted addictions screening tools (See Figure 6).

Focus group participants informed the facilitator of the wide variety of screening tools used in their treatment centres, including MAST, DAST, SASSI, PART and PARTY (See Glossary). Some used an unnamed treatment readiness scale that was designed by FNIHB, others the Jelnyk box curve, and a 3 stage assessment that involved 3 increasingly complex interviews was noted by one focus group participant.

Apart from SASSI training and certification, no one was aware of any formal training promoting the use of these tools, except perhaps through the on-the-job training provided by certain employers and/or co worker mentorship activity. Over all, participants expressed that addictions client screening was not a pressing training concern, and many observed that standardizing the tools in use may assist with networking and with 'speaking the same language'.

Figure 6: Addictions Client Screening



4.2.2 Mental Health Screening

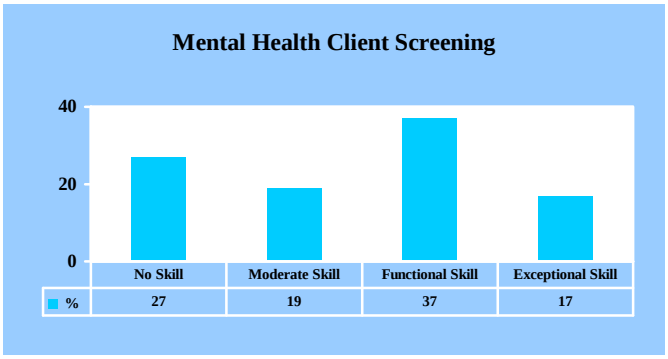
Mental health Screening involves utilizing brief screening instruments and interviewing techniques to assess current level of mental health functioning.

Survey results indicated mental health screening is the highest priority for training, with 46% of respondents indicating they would categorize themselves in the 'no skill' or 'moderate skill' level areas (See Figure 7). Focus group participants articulated that a similar emphasis was required in this area.

Not surprising since the majority of NNAPF-related programs are in the mental health field, given that trauma is the problem, with addiction merely a symptom of the cause. As fore mental health screening instruments, participants indicated the use of CEDI, (See Glossary), including the 'whole person inventory' devised by Nechi. In some cases, SASSI is used to indicate key areas and then workers refer on to adjunct mental health services.

Participants also indicated a range of working relationships with mental health services in their areas. There was also consensus that mental health issues are completely ingrained in what addiction workers do. Some noted that that addictions focused intake screening should routinely screen for mental health difficulties, and should include some practice ideas about dealing with the coexisting conditions in a treatment atmosphere. Given the plethora of brief screening instruments for mental health issues that exist, it will be necessary for NNAPF to consider adopting and promoting a low cost instrument that has been standardized in a specific Aboriginal population, and includes a training component.

Figure 7: Mental Health Screening



4.2.3 Client Intake

Client Intake competency involves completing and assessing the required documents for a client's admission to the program, and obtaining appropriately signed consents from clients and families.

Survey respondents (See Figure 8) indicated a great deal of comfort and competence in the intake area, with 85% having functional or exceptional skills.

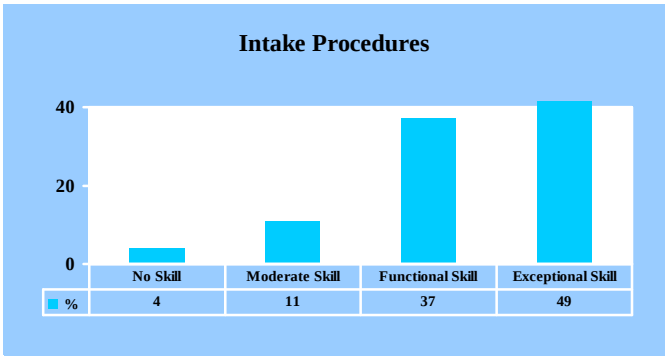
Focus group participants indicated that a wide range of intake procedures were being used. There was also an understanding of the importance of signed confidentiality and consent for services by clients, as well as consent to release information, but these were being utilized only in some areas. The group recognized the need to consider intake as the first stage in effective treatment planning. Participants also recognized that intake information formulates one of the most important pieces of the treatment planning continuum. Participants also acknowledged that from all of the treatment centres and

First Nations represented in the focus groups, there is a lot of valuable information that could be gathered, from research about the histories, drugs of choice of clients, etc.

Saskatchewan Treatment Centre Directors have, for example, amalgamated their referral package into one single form for all Centres provincially, with a view of beginning to collate some regional information to assess clients' profiles, backgrounds and needs, using only aggregate information, and while maintaining all PIPEDA (See Glossary), and respecting OCAP First Nations principles of Ownership, Control, Access and Possession of information, by and for First Nations.[32]

Focus group discussions also noted the gap in policies for delivering intake-related services either within treatment centre facilities or First Nations of policy, and that such absence of policy makes for variant delivery. Focus groups also felt they may need training to deal with the way PIPEDA may suggest required changes in intake procedures. Again, several comments relative to intake noted the valuable information being collected at client intake, and its ability to be utilized to develop a more accurate picture of client demographics/needs.

Figure 8: Client Intake



4.2.4 Client Orientation

Client Orientation refers to a Counsellor's competency to provide an overview to the client of the program by describing the goals and objectives for client care, as well as giving an overview to the client with a thorough description of program rules, and client obligations and rights.

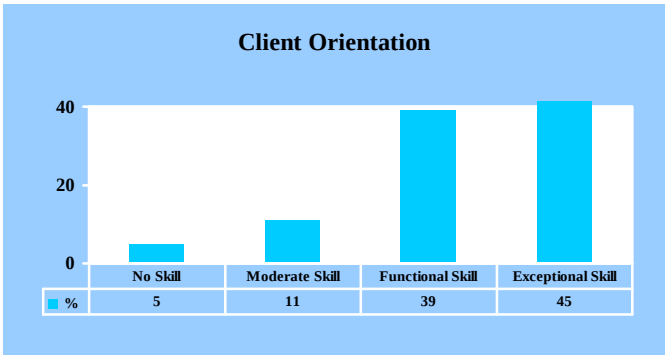
An overwhelming 95% of survey respondents (See Figure 9) felt they were adequately skilled (Functional /Exceptional). Likewise, 85% expressed a similar comfort level during the focus group discussions. Client orientation content was divided into two

[32] "OCAP (Ownership, Control, Access, and Possession) means that First Nations control data collection processes in their communities. First Nations own, protect and control how information is used. Access to First Nations data is important and First Nations determine, under appropriate mandates and protocols, how access can be facilitated and respected…" @ http://www.naho.ca/firstnations/english/ocap_principles.php

categories - that which occurs at the community level and that which occurs in residential treatment. Processes ranged from an ad hoc orientation depending on which counsellor is on shift, to programs that have complete written client orientation packages and formulated policies. Participants recognized that community level orientation pre-residential treatment is an important part of the continuum and that in most cases, if this is well coordinated, it reduces the risk of inappropriate placement.

Focus group members also expressed that a key skill needed would involve training workers to deliver a client orientation that reduces 'the treatment taxi' plan.[33] Participants expressed the desire to have a more comprehensive standardized orientation process, which is still flexible, yet not mechanical. Community-based workers expressed the need to nationally define their "scope of practice," so that they can better explain this to clients and more effectively deliver community based pre treatment, counselling and outpatient-style treatment delivery, before residential treatment is even considered an option.

Figure 9: Client Orientation



4.2.5 Assessment

Assessment as a competency refers to gathering relevant history from clients, including holistic health functioning, alcohol and other drug abuse using appropriate interview techniques. Assessment also involves developing a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments, in order to provide an integrated approach to treatment planning, based on the client's strengths, weaknesses, and identified problems and needs.

There was consensus (See Figure 10) that assessment is covered in some ways in client screening and orientation depending on the tools used. Participants offered information about the use of such tools as holistic assessment, medicine wheel assessment, family functioning assessment, psycho social assessment scales and developmental assessments.

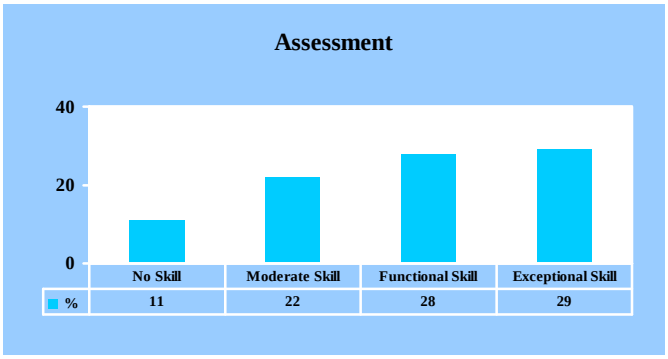
[33] In that community workers sometimes felt historical procedures of having NNADAP workers as 'drivers' to treatment, reduced their effectiveness as first stage counselors, and increased the belief that treatment can only happen away from the community.

Those Counsellors serving adolescents indicated using various comprehensive forms of education assessments e.g. Brigance, WRAT (See Glossary). And Manitoba community-based workers told session facilitators of a Bio- Psycho Social spiritual history tool that was developed and used to match clients to services, and then used again to measure post-treatment change.

There was a general consensus from focus group discussions that assessment is an ongoing process, and an important part of the treatment continuum. Participants expressed interest in moving towards some standardized assessment tools that could be used at the community level, prior to a decision on treatment required, and that from this practice, more client-centered treatment plans could be developed.

Participants also liked the idea of a standardized strength-based assessment, and the development of some policy guidelines around pre-residential assessment and intervention with associated timelines, e.g. four (4) counselling sessions at a community-level, prior to considering a residential referral, etc.).

Figure 10: Assessment



4.2.6 Treatment Planning

> ***Treatment Planning is a key competency, in that it involves identifying and ranking problems based on individual client needs in the written treatment plan, as well as formulating agreed upon immediate and long-term goals using behavioral terms, also recorded in the treatment plan.***

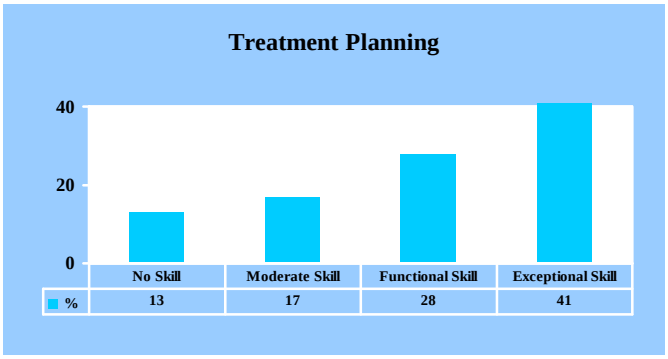
Treatment planning is definitely an area where workers felt they needed to improve their skill, and approximately one third, or 30% felt that their skills in this area were lacking (No Skill/Moderate Skill – See Figure 11). In general, focus groups had different views concerning what events in a treatment episode constituted the term 'treatment planning.' Some felt it happened throughout the process, whereas others described it as a post-residential service item, and something more commonly referred to as aftercare planning. The wide range of definitions speaks to the issue of standardizing treatment planning requirements for monitoring client progress. One participant eloquently defined

treatment planning as, “knowing at the beginning, what the end is going to look like.” Treatment planning processes ranged from the referral form being the only basis for treatment planning, all the way to structured goal-based written treatment plans that are coordinated with the client at 30 day intervals.

In summary, focus group participants indicated several workforce development needs in the area of treatment planning including:

- Training on how to measure indicators of change;
- A mechanism to encourage sharing of treatment plans between community and residential services;
- Assistance with how to build/encourage client responsibility as it relates to treatment planning; and,
- Assistance with defining client rights and responsibilities around treatment plans (e.g. consent signatures, motivation, etc).

Figure 11: Treatment Planning



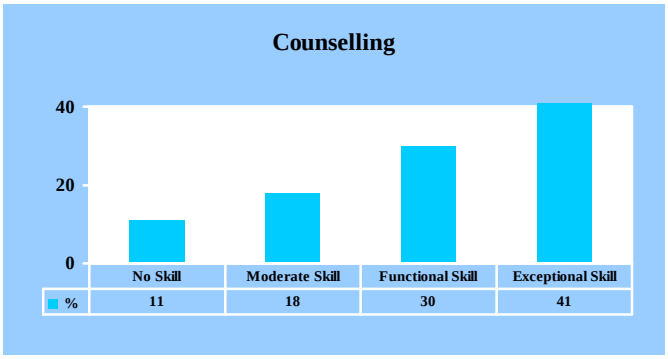
4.2.7 Counselling

> ***Counselling as a competency involves the use of technique(s) to assist the client, group, and/or family in exploring problems and ramifications, and in examining the client’s behavior, attitudes, and/or feelings, if appropriate in the treatment setting.***

In the area of counselling, participants felt they were well versed in a variety of counselling approaches, but that they may not be able to specifically name their counselling orientation when asked. A lot indicated that formal education was not necessarily a predictor of counseling ability, as “even people with degrees are going back to community colleges for more refined community-based counselling skills training.” This observation was also evident in competency-related information drawn from the surveys (See Figure 12). Some referred to the use of solution-focused counselling.

In the area of workforce needs, participants felt there should be some clear policy guidelines about keeping counselling notes, recording counselling hours, and training concerning how to move a client through the various counselling stages, e.g. from the initial 'coffee talk', right through to clients' personal work requirements, an emphasis on the fact that counselling involves more than just listening. Some participants noted that clearer policies around documentation would better meet the counselling needs of clients, and that training on using confrontation in an empathetic way may assist client care. Worth noting is the appreciation of one participant who stressed the importance of remembering that "the greatest counselors are the Elders; we use them regularly and appreciate FNIHB loosening up on policies around using Elders as counsellors."

Figure 12: Counselling



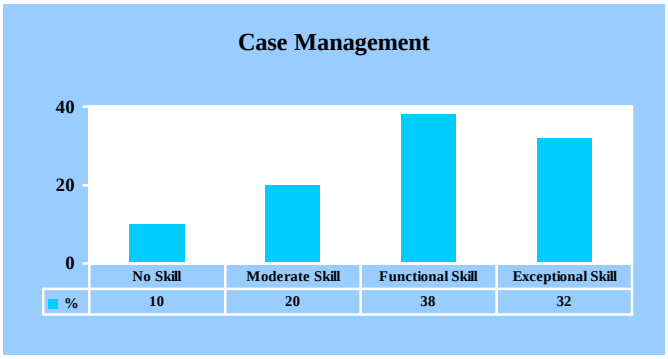
4.2.8 Case Management

Competency in Case Management involves coordinating services for client care, and documenting a clear case plan or case record.

The view of what case management is varied drastically amongst focus group participants, and feedback from one participant defined it as "taking a lead to manage your client's needs." There was a feeling that little is done in case management because everyone is waiting for someone else to be the leader. Case Management seems to be a more onerous task for newer workers who do not have the confidence to assertively advocate for the client (See Figure 13).

There was an understanding that appropriate case management happens when a variety of players are consulted, whether social workers, family, lawyers, counsellors and most importantly, the client. As for training needs specific to case management, participants indicated they would like more information on how to coordinate and set an agenda for a case management meeting. There was a consistent theme regarding lack of policy around case management practices both in community and residential programs.

Figure 13: Case Management



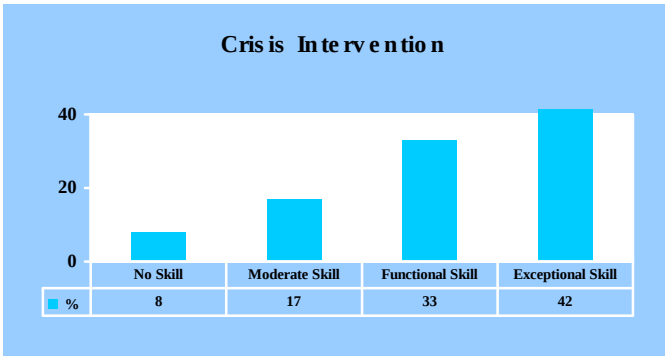
4.2.9 Crisis Intervention

Crisis Intervention competency involves recognizing the elements of the client crisis, and implementing an immediate course of action appropriate to the crisis.

Survey results indicated that 42% rated themselves as having Exceptional Skill (See Figure 14), which mirrored comments from focus groups in that participants felt that crisis intervention was an area in which numerous training models had already been made available to them. In some cases, respondents felt overly trained in this area, which has contributed to an incursion of a crisis-oriented approach rather than prevention-orientated approach in some locations. There was discussion about communities sharing resources around crisis intervention response, as well as a wide range of pre-crisis planning approaches. Everything from "we do what we need to when it happens", to written, practiced and coordinated crisis plans were shared by focus group members.

Survey respondents and focus group participants identified a large number of certified crisis prevention models that had been delivered in their communities, e.g. ASIST, CPI, Mediation Training, PART, PMAB (See Glossary), and several indicated holding certification in more than one model, and several had trainer level themselves or available to them through facilities and Tribal Councils.

Figure 14: Crisis Intervention



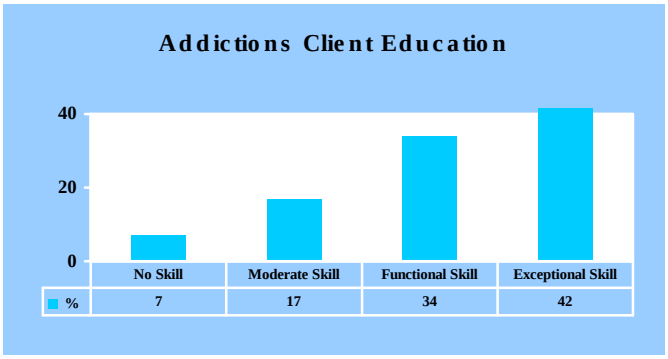
4.2.10 Addictions Client Education

Addictions Client Education refers to the Counsellor's competency in presenting relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes like lecture, group or individual work, including information about available alcohol and other drug services and resources.

A strong majority, 76% of survey participants, again rated their competency as either Functional or Exceptional (See Figure 15), and in general, focus group participants felt they were well versed in providing education to addictions clients, yet many acknowledged most of their ability came from experience rather than formal training in the area. Those who spoke about formal training specifically mentioned the Nechi facilitation skills training module as being helpful. Participants felt they had some adequate resources in this area through utilizing community resources (e.g. nurses), as well as workshops, websites, posters, brochures, videos, books, classroom presentation, and 'canned' prevention education curriculums. Participants also mentioned use of some standard education modules such as DARE, Starting Early AA, Sunburst Communications 9 – 12 set, Canadian 6, Project Charlie, PARTY (Preventing Alcohol Related Trauma in Youth) and NANACOA videos as examples.

There were some comments with regard to providing addictions prevention education in the classroom setting – theory and information delivery is one thing, managing the fallout is another. There was a sense that expanded training may be useful in this area, to learn how to triage clients who present themselves in a prevention session. Participants also exemplified the idea that for education sessions to assist clients with addictions, they have to be address more than just the effects of drug/alcohol e.g. facilitators must also be skilled in grief counselling, budgeting, life skills, etc. As noted by one individual, "In general, addictions clients are about way more than just addictions, its grief, and sexuality."

Figure 15: Addictions Client Education

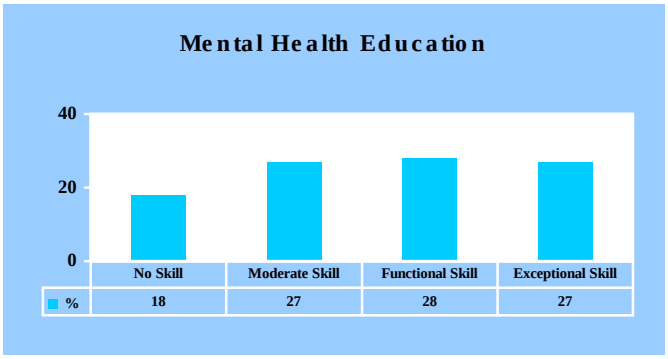


4.2.11 Mental Health Education

Mental Health Education as a competency refers to a Counsellor's ability to conduct presentations on holistic health functioning and mental health disorder prevention, through formal and/or informal processes like lecture, group or individual work.

Mental Health Education scored second highest in priority on the written survey (See Figure 16). While the competency as defined spoke more to education around mental health disorder prevention, both survey respondents and focus group participants felt the competency should be expanded to include competence in delivery addictions sessions to those clients already diagnosed with co-occurring disorders. A few resources were mentioned that workers felt helped address the education needs of mental health clients, including the Sacred Tree curriculum, *I Am Somebody*, courtesy of the Canadian Mental Health Association, as well as Health Canada's release, *Best practices for Clients with Addictions and Mental Health Issues*, authored by Brian Rush.[34] Lastly, participants felt if they had more training in the area of the pharmacology of commonly prescribed mental health drugs, they may be more equipped to tailor existing education sessions to meet the needs of those clients.

Figure 16: Mental Health Education



4.2.12 Referral

Referral as a competency involves identifying the need(s) and/or problem(s) that the agency and/or counselor cannot meet, and where gaps are identified, matching client needs and/or problems to appropriate resources.

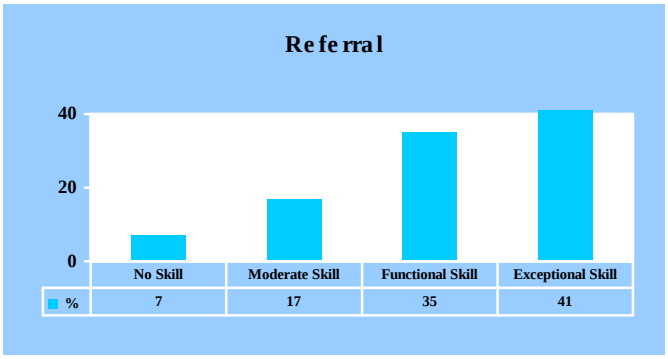
[34] Note: Saskatchewan Treatment Directors (SNAPP) recently brought Brian Rush to speak to program providers about his research and the session served as a "knowledge transfer" which brought broad research concepts down to manageable client centred practice ideas. Initiatives such as SNAPP's would be considered a best practice as part of a workforce development strategy.

Participants recognized that being 'good at' referral depends on being good at assessment and intake matching, and that more standards for clients who can be dealt with at community level versus residential treatment would help. Survey results mirrored the above average competency of workers (See Figure 17).

However, focus group participants also articulated that they needed to become more aware of community resources. Some indicated Tribal Councils have done a good job of cataloging existing resources, but that these types of projects are done on a one-time basis, and not updated regularly to ensure ongoing accuracy. Many indicated relying on Health Canada's Treatment directory, but expressed frustration when an updated version is not published annually. Similar frustration was expressed regarding Federal funding barriers that permit workers from referring to provincial facilities that may be the 'best fit' to meet the client's needs. Specific to training requirements, participants felt the following would be useful:

- Resource Awareness training - delivered by location; and,
- Review of PIPEDA policy and its impacts on referral information.

Figure 17: Referral



4.2.13 Report and Record Keeping

Report and Record Keeping involves preparing reports and relevant records integrating available information to facilitate the continuum of care, while maintaining an ongoing log of information pertaining to the client.

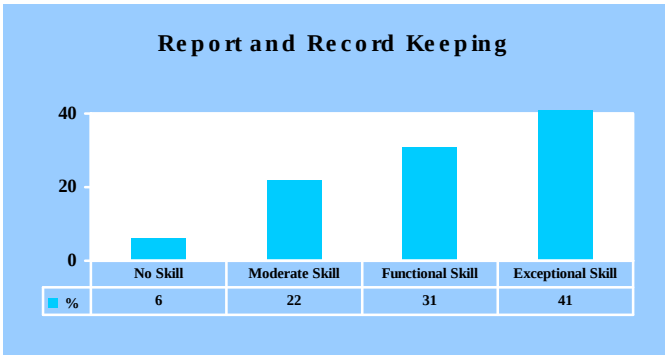
Participants expressed frustration in this area, in that there are no published standards for client record keeping, not even in the area of timelines for destruction. Some treatment centres have individually adopted the seven year timeline as a waiting period for file destruction. Survey results indicated the norm, with more than 70% at the desired comfort level (See Figure 18). Focus group participants understood the importance of getting client consents for services, but felt it has been mostly 'personal preference' which guides what is included in a client file. Many indicated they adopted provincial policies as a way of standardizing their own filing systems. There was frustration expressed regarding form usage, and being advised of a particular form use only after a

FNIHB consultant file audit has taken plan. Likewise, getting consent for services seems to be handled differently in all locations.

Some participants have had formal training through their Tribal Councils as it relates to liability and confidentiality of client records. There is agreement that report and record keeping goes beyond individual client files, and that if there was a standard record keeping training, workers could become better at keeping notes on groups and indicators of client change - including relevancy of file contents, how to do their own internal audits on file contents, as well as how to develop policy about client access to files and such.

As was mentioned in the previous sub-section on referral competency, participants felt PIPEDA had growing implications for Report and Record Keeping on-the-job requirements, and that training in PIPEDA would be not only timely but ethically and legally relevant at this time as well.

Figure 18: Report and Record Keeping



4.2.14 Professional Consultation

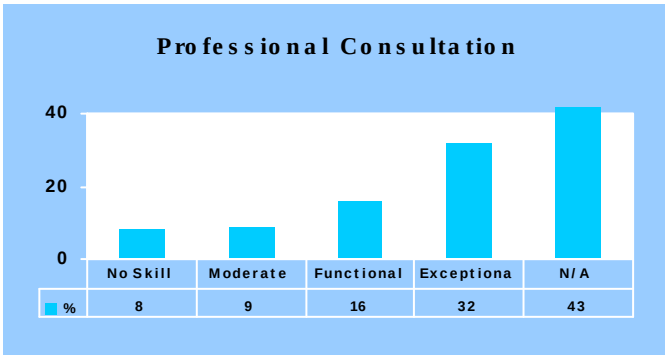
Professional Consultation as a competency refers to a counselor recognizing issues that are beyond his or her knowledge base and/or skill, followed by consulting with appropriate resources to ensure the provision of effective treatment services.

Focus group participants described a range of professional consultation activities including - going to conferences to network and develop a resource base, telephone consultation with peers, colleagues or other professionals. Whereas 43% of survey respondents rated this competency as non-applicable to their work life, only 8% felt they had little to no activity of skill in this area (See Figure 19).

Several participants cited an absence of policies about accessing consultation or funding barriers that discouraged the practice. In general, they felt they needed some clarity regarding which mental health issues are funded under the Brighter Futures Initiative (BFI), as opposed to mental health issues funded through separate contracts under Non-

Insured Health Benefits (NIHB). Some felt that an orientation to these policies in advance of a client emergency would be a valuable training practice. One participant noted that under the Alberta Health Profession Act, the policy for use of services requires contractors to have an updated license before providing their consulting services. Nechi for its part has a policy developed on professional consultation.

Figure 19: Professional Consultation



4.2.15 Clinical Supervision

Clinical Supervision refers to a counsellor having access to competent and qualified supervisors, to meet the certification standards of program and relevant accreditation body.

Although only 32% of the survey respondents reported having some form of clinical supervision as a portion of their work life (See Figure 20), 72% indicated clinical supervision - in some form - is an important part of their professional development (Figure 21). A full understanding of this particular competency is clouded by the fact that the definition of Clinical Supervision is not clear amongst service providers, nor funding agents. Some believe clinical supervision only occurs when a Psychologist oversees the work of Counsellors, others believe it is a hands-on teaching process. One researcher in addictions, David Powell, has synthesized the needs for supervision in the addictions field into a very workable and feasible definition:

> *Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive. This definition results in three main purposes: to nurture the counselor's professional (and, as appropriate, personal) development; to promote the development of specified skills and competencies, so as to bring about measurable outcomes; to raise the level of accountability in counseling services and programs.*[35]

Some work has been done across the country with regard to synthesizing this definition into a meaningful training course for residential treatment workers. The YSAC group has

[35] Powell, D. J. et al., *Clinical Supervision in Alcohol and Drug Abuse Counselling,* 1993, pg. 9.

successfully transformed this definition into a three day practical training course that has been delivered annually for the last three years. The course is one of only two courses in the country to be certified by CCPC, and all participants are credited 24 hours of the thirty required for a clinical supervision designation. The Saskatchewan Institute of Technology has also begun delivering a Clinical Supervision course to the workers in Saskatchewan. As the definitions have some support, clarity and consensus training and certification opportunities will grow.

Figure 20: Clinical Supervision

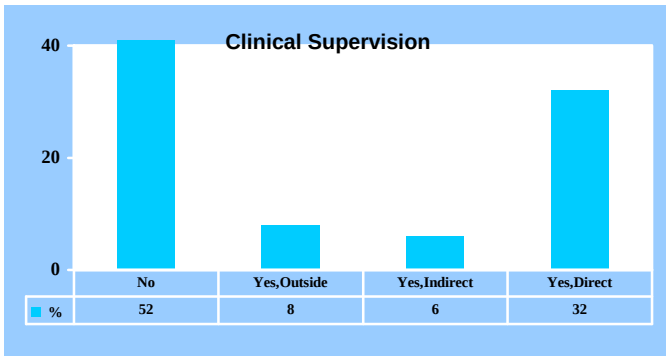
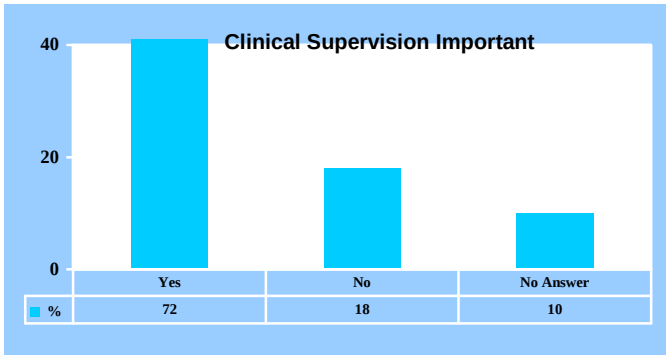


Figure 21: Clinical Supervision Important



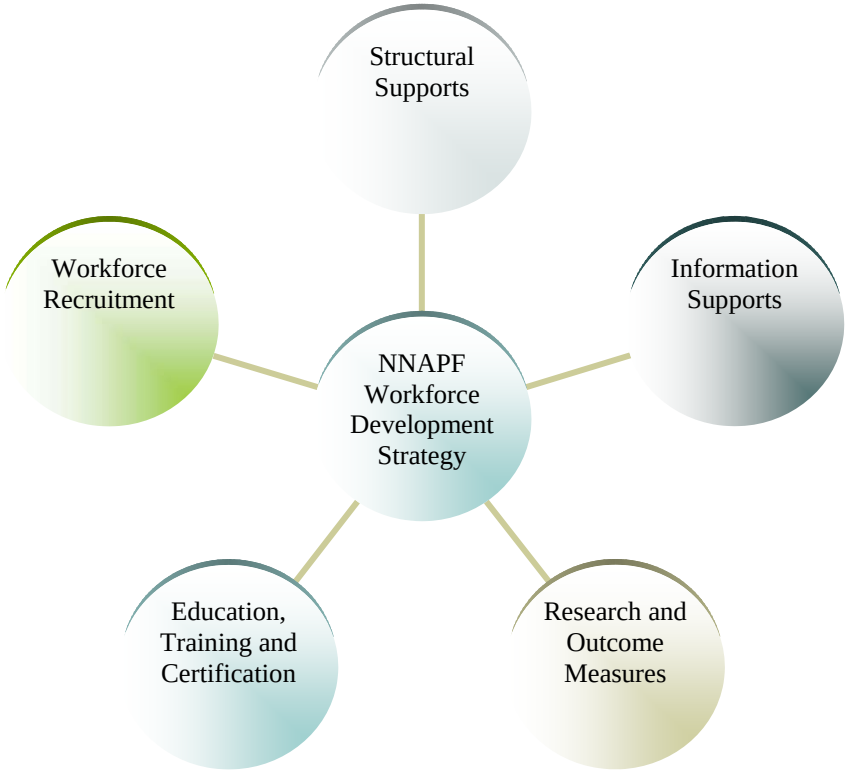
Section 5 – NNAPF Workforce Development Strategy – Maintaining Momentum

Building on what the Foundation knows from the Competency Survey Results presented in the previous section, it is clear that major improvements to the Wellness/Addictions Counsellor workforce have occurred over the last 5 years. These changes have notably included an increase in provincially certified workers, and client needs have led to improvements to addictions specific curriculums offered at various training schools. As well, it has become ever more obvious that while education and certification are necessary parts of a workforce development strategy, in isolation, these elements are not

enough, and the survey/focus group feedback speaks to needs that are training-related but more "systems oriented." In order to continue the momentum of positive change and ensure impact in the area of client outcomes, it is necessary to develop a strategy that goes a lot further than simply offering additional training events.

The definition of workforce development put forth in the NNAPF strategy embraces the idea that all parts of the system be considered including, structural supports for addictions program accreditation and policy development, information supports (through NNAIMS or equivalent, for example), certification incentive policies and recruitment, training, education, as well as mentorship projects. To that end, the following section presents 5 strategic elements specific to the NNAPF's workforce development (See Figure 22), along with specific activities that summarize the future efforts of the Foundation in the years to come.

Figure 22: Five Elements of NNAPF's Workforce Development Strategy



Strategic Element 1: Structural Supports

Aboriginal health human resources reform in Aboriginal communities has faced a number of complex, multi-jurisdictional challenges, which in turn impact health care providers, including Wellness and Addictions Counsellors. Since the 1980's, First Nations and Inuit communities have been undergoing the process of transferring certain responsibilities for managing and delivering health services from Health Canada to Aboriginal communities.

As of 2001, 82% of eligible First Nations and Inuit communities have or are in the process of transferring responsibility.[36]

The Romanow report called for the establishment of a "clear structure and mandate for Aboriginal health partnership to use funding to address the specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers."[37] In essence, Romanow denotes that transferring responsibility from Health Canada to Aboriginal communities has been, for the most part, successful. However, to paraphrase the Commissioner, it has not dealt adequately with capacity building and structural supports within these Aboriginal communities.[38]

And although this variability may impact the short term advancement of structural supports for Wellness and Addictions Counsellors, the work of the NNAPF, its Regional Working Groups and the YSAC speaks to the foundational work that has and continues to take place nation-wide. Hence, key activities that speak to future efforts of the NNAPF relative to structural support elements of workforce development include:

- Continue working with the First Nations and Inuit Health Branch (FNIHB) regionally and nationally to ensure workforce compensation for credentialing;

- Assist with processes that further both facility and program accreditation;

- Develop clear competency assessments for various addiction positions that can be utilized as first level individualized training plan frameworks, to assist with defining appropriate/accurate job descriptions;

- That the renewal of addictions services for Aboriginal Peoples ensures core competencies are developed around cultural practices; and,

- To advocate for national standardized policy development in the areas of client consent, treatment planning and reporting.

Strategic Element 2: Workforce Recruitment

The Foundation's workforce recruitment efforts over the years have attracted, in many regards, a para-professional and professional workforce that has evolved out of both necessity and need. Just as the 1996 *Report of the Royal Commission on Aboriginal Peoples* (RCAP) identified the recruitment and retention of Aboriginal health human resources as essential to ensure the success of new approaches to health and healing,[39] so has the Foundation's recruitment efforts reflected this notion. Likewise, just as the

[36] *Building on Values – The Future of Health Care in Canada*, Honourable Roy Romanow, Commission on the Future of Health Care in Canada, November 2002, pg. 213.
[37] Ibid., pg. 211.
[38] Ibid., pg. 224.
[39] *Report of the Royal Commission on Aboriginal Peoples*, Volume 3, Gathering Strength, pg. 260.

RCAP report stated that "more services, if imposed by outside agencies, will not lead to the desire outcomes,"[40] so has the Foundation exemplified RCAP's approach to improving Aboriginal health, with characteristics of equity, holism, Aboriginal control and diversity within its workforce. Such an approach was espoused as having the power to do what the present health system could not – to focus on whole health and healing.[41] In addition, recommendations for an Aboriginal health and healing strategy, calling for the mobilization of Aboriginal personnel is supported by the rationale that "Aboriginal control of human services is necessary because control over one's situation is a major determinant of health."[42]

To that end, RCAP recommended that governments and educational institutions undertake to train 10,000 Aboriginal people in health, including professional and managerial roles over the next decade.[43] An important element to this recruitment activity was to undertake the collection of data which will support the development of Aboriginal human resources. RCAP acknowledged that the absence to this vital information is an obstacle to human resource planning,[44] and validating this observation is a 2003 poll conducted by the National Aboriginal Health Organization (NAHO), directed to 1,209 First Nations and 801 Métis households in Ontario, Saskatchewan and British Columbia. Worth noting is that 43% of First Nations respondents said they prefer to visit an Aboriginal health care provider to a non-Aboriginal health care provider, while only 29% had no preference.[45]

Hence, findings in this preliminary report supports the notion that Aboriginal peoples, when given the preference, may access services from Aboriginal health service providers more readily, and ultimately, more compliant with health promotion and prevention interventions. It is critical therefore, to examine the recruitment and retention efforts of Aboriginal Wellness/Addictions Counsellors within the broader Indigenous world view, since many Federal and Provincial initiatives have tended to append Aboriginal specific recommendations to mainstream recruitment and retention initiatives.

Key activities that speak to future efforts of the NNAPF relative to the recruitment element of workforce development include:

- Ensuring the Foundation promotes the recognition of workforce recruitment at the national level, to ensure equitable consideration in health human services research, planning and promotion;

- Working to establish a national scholarship in addictions programs, to strategically build upon a workforce of youth who have chosen addictions as a profession at the high school level; and,

[40] Ibid., pg. 293.
[41] Ibid., pg. 229.
[42] Ibid., pg. 232.
[43] Ibid., pg. 265.
[44] Ibid., pg. 267.
[45] *Public Opinion Poll – First Nations Views on their Health and Health Care*, First Nations Centre, National Aboriginal Health Organization, 2003.

- Utilizing NNAPF systems such as the web site as a means to promote minimum qualifications, and assist communities with position postings, interview guidelines, etc.

Strategic Element 3: Education, Training and Certification

The element of education, training and certification speaks to the majority of competency issues identified by both survey and focus group participants. It is also an element where some of the Foundation's greatest strides in workforce development, both nationally and regionally, have and continue to occur. Many of the concerns regarding screening, assessment, planning, etc., are directly impacted by the lack of national standards, and although institutional accreditation of treatment centres has progressed extremely well nation-wide, certification and pay equity of the Wellness and Addictions Counsellor workforce may lag behind their provincial counterparts, despite the anecdotal evidence which would suggest that in many instances, the competency of the Wellness and Addictions Counsellor workforce meets or exceeds that of their provincial counterparts.

Regardless, certification remains an important element of the NNAPF's workforce development strategy, and the Foundation proposes to build upon the success of the NNAPF-BC Regional Pilot Project to spearhead the implementation of a national process to certify Wellness/Addictions Counsellors, with the establishment of a First Nations and Inuit Wellness/Addictions Counsellor Certification Board (FNIWACCB). The ideas and work leading up to this proposal have been in development for many years by numerous dedicated people and organizations.

As noted previously, among a series of recommendations stemming from the *NNADAP Review 1998*, the NNAPF Renewal Framework called for a certification process for both Prevention Counsellors and Treatment Counsellors to be established by NNAPF as part of the larger accreditation process. In response to this need, and the opportunity presented by the development of the First Nations Wellness/Addictions Counsellor Certification Board process in British Columbia, a National Board is moving forward, to oversee certification of all First Nations Wellness/Addictions Counsellors nation-wide.

Funded under the Canadian Drug Strategy through BC's First Nations and Inuit Health Branch office and approved by Ottawa, preliminary information supporting the establishment of a First Nations Wellness/Addiction Counsellor Certification Board (FNWACCB), can be excerpted from the *Standards & Procedures Manual for First Nations Wellness/Addictions Counsellor Certification Board*.[46] In short, the future First Nations Wellness/Addiction Counsellor Certification Board (FNWACCB) proposes to offer national certification to qualified First Nations Wellness and Addictions Counsellors.

The goals of the National Certification Board are:
- to ensure a level of excellence in individual performance;

[46] http://www.firstnationstreatment.org/news.htm

- to establish standards that are relevant to traditional First Nations healing philosophy and which are comparable to and generally accepted in the field; and,

- to gain reciprocity with the National Association of Alcoholism and Drug Abuse Counsellors (NAADAC), the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA), the Canadian Addictions Counsellors Certification Federation (CACCF) and their national board, as well as the Canadian Centre for Substance Abuse (CCSA), and others to be determined by the NNAPF.

Hence, key activities that speak to future efforts of the NNAPF relative to education, training and certification elements of workforce development include:

- Continue working collaboratively with National Certification bodies to streamline certification processes and ensure inclusion of traditional practices in addictions work; and,

- Continue working with individuals or community groups to ensure training opportunities are available that meet the personal training plan needs of service providers.

Strategic Element 4: Information Supports

Information supports, in today's technologically driven society, are only as useful as they are current and applicable to the day-to-day work and training needs of the Wellness and Addictions Counsellor workforce. Whether it be the information requirements to support the ongoing work inputs of Counsellors relative to innovations in drug or treatment therapies, or ensuring that Counsellors have access to training options nation-wide, information supports are only as useful as they can be accessed.

Not surprising, access to information, similar to access to education or knowledge, is in itself a determinant of a Counsellor's professional 'health' so-to-speak, and as noted in Section 4, focus group participants satisfaction relative to information supports were directly related to access. The greater the access, the better informed the workforce. The same can be said with regards to information supports that favour the professional development and certification of Wellness and Addictions Counsellors. Innovations in clinical supervision are taking place with video conferencing for example[47], providing a solid business case to government relative to cost-savings that can support the Foundation's workforce development goals of national certification standards.

Attesting to government intent of the same had been the development and implementation of the National Native Addictions Information Management System (NNAIMS), as well as the pioneer thinking which promised improved access to health care, through so many of the Tele-Health innovations. In addition to improved access to

[47] Courtesy of Marten's & Associates, *Live Video Conferencing, Clinical Supervision, @* www.members.shaw.ca/tonymartens/

information supports to better manage the Federal addictions system, NNAIMS had the potential to include Tele-Training as a feature - a distinct Tele-Health application. Developed as a collaborative effort involving NNAPF, Health Canada and Donna Cona, NNAIMS was an initiative to support addictions Treatment Centres and Community Addictions Specialists (CAS) by providing electronic access to education as well as awareness tools, on-line booking capacity, communication links to all projects and eventually an on-line training venue.

Unfortunately, NNAIMS never lived up to the initial hype that could have seen its use expanded to use tele-training of First Nations and Inuit Wellness/Addictions Counsellors in the 57 First Nations and Inuit Addictions Treatment Centres located throughout Canada. Whereas the function of Treatment Centres has largely settled into its expert provisions of addictions-related counselling and support services (e.g. treatment), these establishments were always considered to have the potential to address the information support and workforce development requirements of First Nations and Inuit Wellness and Addictions Counsellors for two reasons:

1) Treatment Centres remain a focal point for addressing the information requirements of Counselling staff and for fulfilling the clinical supervision requirements of workforce development, not only because of the business of the organization, but because of the availability of a culturally appropriate setting and professional staff; and,

2) The geographic location, national distribution and availability of broad or narrow band connectivity makes Treatment Centres an ideal 'institutional' location that can address a variety of the elements specific to information supports, including support workforce development through tele-training using video-conferencing, for example.

Hence, facilities, connectivity, location, professional staff availability, opportunity to address developmental requirements - all of these variables need to be considered when addressing the information supports and workforce development requirements of First Nations and Inuit Wellness and Addictions Counsellors in remote and rural locations.

A recent development has proved most promising, given tentative confirmation that Health Canada - BC Region, has approved the purchase of video-conferencing equipment for First Nations communities and Treatment Centres (Non-Residential) in British Columbia. To be funded under Health Canada's eHealth initiative, ehealth is "an overarching term used today to describe the application of information and communications technologies in the health sector. A fundamental building block of eHealth is the Electronic Health Record, which allows the sharing of information between care providers across medical disciplines and institutions. Other important uses of eHealth are found in the areas of continuous medical education and public health awareness and education."[48]

Should the capital investment for 'video conferencing' infrastructure, for interested First Nations communities and Treatment Centres in BC materialize, it would represent a raw

[48] Courtesy of Health Canada eHealth at http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/index_e.html

pro-ration of costs, given BC's communities and Treatment Centres represent approximately one third of Canada's total. The biggest hurdle remaining will be to assess the uninformed portions of a national business case, and provide evidence-based intelligence to Federal policy and decision makers on how to best address the technological gap, through an expansion of the initiative on a national scale, spearheaded through the National Native Addictions Partnership Foundation and its Regional Working Groups.

Key activities that speak to future efforts of the NNAPF relative to information support elements of workforce development include:

- Continue working collaboratively with government to identify information support options that best meet the professional development requirements of the Wellness and Addictions Counsellor workforce;

- Continue working collaboratively with research organizations to ensure timely and accurate dissemination of information on emerging drugs, emerging drug trends or best practices within the intervention continuum; and,

- Continue maintaining an up-to-date registry of training options available by region, that is available to field workers, including distance and correspondence delivery.

Strategic Element 5: Research and Client Outcome Work

Research is elemental within any workforce development strategy, not only from the perspective of research to help client outcomes, but also research from the perspective of improving the Foundation's workforce development efforts. As iterated by RCAP, specific to workforce development, there is a paucity of research information regarding the status of Aboriginal human resources workforce in health and social services in Canada.[49] For the most part, government, professional associations and service delivery organizations rarely collect information about the participation of Aboriginal people in the health and healing professions.[50] In fact, mainstream health human resource planners acknowledge the need for more quantitative research in planning and management.[51]

On the positive side, there are several examples of initiatives presently underway, such as the Canadian Institutes of Health Research (CIHR) Institute of Aboriginal Peoples' health (IAPH), which aims to "eliminate disparities between Aboriginal and non-Aboriginal populations"[52] Likewise, the Canadian Health Services Research Foundation (CHSRF) specifically focuses on the health services aspect of the health system, including research

[49] *Report of the Royal Commission on Aboriginal Peoples*, Volume 3, Gathering Strength, pg. 293.
[50] Ibid.
[51] *Assessing Human Resources for Health: What can be learned from labour force surveys?*, Diallo, K. et al., Human Resources for Health, 2003, at http://www.hman-resources-health.com/content/1/1/3
[52] *Improving the Health of Future Generations*, Canada Institutes of Health Research, Institute of Aboriginal Peoples Health, American Journal of Public Health, , Reprint Vol. 92(9), pg. 1396.

associated with personnel requirements. "In addition, the foundation works with these health-system decision makers to support and enhance their use of research evidence when addressing health management and policy challenges."[53]

Likewise, the National Native Addictions Partnership Foundation also firmly believes that First Nations and Inuit Wellness/Addictions Counsellors can best be served through an in-depth research and analysis of the First Nations and Inuit Wellness/Addictions workforce human resource needs. Not unlike other studies undertaken relative to First Nation and Inuit para-professionals such as CHRs[54], the Foundation proposes to capture equitable data to best inform Aboriginal Health Human Resources Inventory work presently underway.[55] The intent of the study would be to provide accurate labour market information relative to the First Nations and Inuit Wellness/Addictions Counsellors sector, while identifying the human resource challenges and issues specific to First Nations and Inuit communities. More specifically, it is the expectation of the survey/study that FNIHB and NNAPF will be able to:

- describe the community care environment and management practices to address both short and longer-term requirements for formal (regulated and non-regulated) service providers and informal and voluntary Wellness and Addictions Counsellors;

- analyze the role informal and voluntary Wellness and Addictions Counsellors play and the barriers they face, specifically, challenges specific to addressing client outcomes, the lack of standardized processes, etc.;

- assess current and forecasted skill development and continuing educational needs and opportunities, specifically as it relates to standards, accreditation and certification, including the need for clinical supervision; and,

- provide for an analysis which considers how the required Wellness/Addictions Counsellors supports under the First Ministers' Accord (FMM Accord), might be delivered in innovative or alternative ways that fit the cultural and traditional needs of First Nations and Inuit communities.

The same can be said in regards to research specific to Client Outcome Services, and again, the work of the Foundation's Youth Solvent Addiction Committee (YSAC) speaks to their efforts and projects, based on the client services reports of each treatment centre. As noted in their report, "often times, the concerns of one centre are identical to the concerns of another. Where national patterns are noticed, YSAC projects take on the 'standardization' approach."[56] Examples of YSAC's past client outcome work include:

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[53] As noted at http://www.chsrf.ca/about/index_e.php
[54] First Nations Community Health Representatives
[55] National Aboriginal Health Organization, *Aboriginal Health Human Resources Inventory Detailed Final Report & Products*, June 30, 2006, pgs. 6-7.
[56] *YSAC Project Report 2003-2004*, pg. 1, @ www.nnapf.org/english/pdf/partners/ysac/ysac_project_report_2004.pdf

Standardized Client Outcome Survey, Data Analysis Guide (developed as part of national research training;

Documented, Standardized, Assessment, and Planning and Implementation Guidelines for organizational program development (Peer Review Process);

The development of a standardized Client Satisfaction Report; and,

The development of a standardized Resiliency Measure Scale, in conjunction with national training.[57]

Hence, key activities that speak to future efforts of the NNAPF relative to research and client outcome elements of workforce development include:

- Ensure workforce development initiatives are best informed by research that takes into consideration the gaps and challenges faced by Wellness and Addictions Counsellors, such as the lack of standards to better inform client outcome work, etc.;

- Support the delivery of training that utilizes research-based interventions and the delivery of promising or best practice strategies; and,

- Work with existing research organizations to design research projects which would support the development of uniform client outcome indicators and standardized reporting mechanisms.

Summary Observations – Direction for the Future

As noted in the Executive Summary, any workforce development strategy is only as good as the organization's capacity to mobilize and draw the elements into a cohesive plan that can be actioned and evaluated. Each Regional Working Group and Advisory Committee of the Foundation, as well as the diversity which resides with the hundreds of front-line workers in treatment centres and First Nations and Inuit communities, serves as an invaluable resource which the Foundation can draw upon to formulate next steps. And to be successful, key activities for each workforce element should reflect each Regional Working Group's best 'workforce development' practice, to ensure that all partners benefit from the transfer of knowledge.

As alluded to throughout this document, the majority of the actionable items are dependent on systems improvements, many of which have been ongoing since the Foundation's efforts began. Others items have emerged over time and since 2004, other key activities will likely spawn as technological advances improve access to education, training and certification.

[57] Ibid.

Challenges yet to face are potential threats from unionized labour, or worse yet, government apathy for the para-profession as a whole. The Federal government's reluctance for equitable national standards in Aboriginal health and human care are well documented, whether dealing with an essential element such as drinking water, or the national certification of Native para-professions such as wellness / addictions counsellors, mental health, dental therapists or midwives for example. To that end, the following synopses of each element is intended to inform the Foundation and policy makers of the more broader concerns or issues, which unless addressed, will continue to impede workforce development progress, at the expense of better addressing the health requirements of First Nations and Inuit.

Specific to structural supports, recommendations from the field would encourage that government work in partnership with the Foundation to advance policy in support of the credentialing, accreditation and standardization of both the job itself, and in support of the core competencies needed to best do the job. Likewise, workforce recruitment again speaks to systems improvements, whether it be the recognition of research concerning the Wellness and Addictions Counsellor workforce to better inform future workforce development activities, or more tangible actionable items such as job placement or scholarship awarding.

Progress relative to Strategic Element 3 has been one of the Foundation's greatest achievements, with improved access to education, training, certification and recognition by the health care system becoming the norm. Information supports have unfortunately, not kept up with expectations, leaving opportunity for improvements yet to be determined, pending federal positioning. And lastly, research in support of both the workforce itself, and to assist the workforce to better do its job – can never occur fast enough. In addition to the community based research workshops taking place at national training symposiums, the NNAPF has embarked on research that is for the community and with community. And with technological advances being outstripped by client demands, the Foundation's future workforce development activities could be better served by research that is practical to improving program and service delivery, relative to client outcomes and workforce needs.

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Appendix A

Position Paper on NNAPF'S National Training and the new Aboriginal Health Human Resources Strategy

OBJECTIVES

NNAPF wishes to ensure that:

- ***the perspectives of its national network of Aboriginal health and addictions specialists and service providers in the professional, paraprofessional and traditional sectors are valued and integrated in the Strategy from the beginning;***
- ***their achievements and expertise are recognized and put to contribution in the ongoing development of the new AHHR Strategy; and,***
- ***Perceived gaps in the new AHHR Strategy are communicated.***

BACKGROUND

NNADAP, a national, federally-funded Addictions program serving Aboriginal Peoples in Canada, was designed to provide treatment, prevention, training and research services as a comprehensive federal strategy.

The program was to provide a balanced professional, paraprofessional and administrative training program to support prevention, maintenance and treatment programs with a cadre of different level positions including advanced and basic level Counsellors. It was anticipated that this component would be carried out by Indian controlled "stations" as well as through contracted arrangements with established institutions.

Independent evaluation and intensive, internal review processes were conducted locally, regionally and nationally, culminating in the *General Review of NNADAP*. This report was completed in 1998 and included 37 recommendations.

The National Native Addictions Partnership Foundation was created as a non profit, non governmental national Aboriginal organization, to implement the Strategic Recommendations of the 1998, General Review of the National Native Alcohol and Drug Abuse Program.

The Foundation is composed of a multi-sectoral network of Aboriginal partners with significant expertise in the field of addictions and their related health and social issues. Its role is to renew the Aboriginal addictions system in order to assist its evolution into a more efficient, culturally-appropriate and relevant program, administered and delivered by trained and experienced Aboriginal Health and Addictions specialists. Details of this AHHR component are contained in its guiding document: *NNADAP Renewal Framework.*

REVISTING AHHR NEEDS, PRIORITIES AND RECOMMENDATIONS

The 1998 general review recognizes that training and accreditation of Aboriginal professionals working in the field of Addictions is a need and a priority. The need for training is articulated in several of its findings, and mirrors the findings of the new 2003 AHHR Strategy:

- There is an inconsistent level of training, particularly for remote or northern communities. Basic training is not related to positions and there isn't a systematic orientation available for new Counsellors to assist them in carrying out functions before basic training is scheduled.
- Advanced Counsellor Training does not occur in an organized fashion in every region. Also when Counsellors do complete advanced training, there is not a process to adjust salaries as an incentive for advancement or for retention.
- Advanced Specialized Training in either addictions or addictions- related topics is not systematically available.
- Community prevention and health promotion needs to be made available or developed to better serve the 60% of the First Nations and Inuit and Inuit population who are 30 years or younger.
- Health Canada in collaboration with First Nations and Inuit representatives should negotiate accreditation with a group such as the Ontario Interventionist Association to utilize the title of Certified Alcoholism Counsellor or to develop a similar accreditation process.
- General Training, such as computer programs, the Internet, financial systems and other similar areas which would benefit NNADAP Counsellors are not systematically available

The Review made several recommendations in support of these findings:

- The possibility of devoting one or more centres to deal with prescription drug abuse and/or to provide training to communities should seriously be considered.
- There should also be recognition and a training strategy developed to assure that NNADAP Counsellors have skills in areas of grief and loss, family violence, sexual abuse, tobacco, gambling, and other areas.
- That Health Canada and First Nations examine means by which Treatment Centre budgets could be increased to provide orientation, training and treatment in grief, loss, cultural programs and in treating other emerging addiction areas such as gambling, prescription drug abuse, etc.
- Additional monies should be made available to residential treatment centres for the purpose of providing their counselling staff training in mental health areas such as victims of sexual abuse, violence, and residential school affects, loss and grief and abandonment issues and general post-trauma processes.
- Health Canada, First Nations and Inuit organizations should negotiate accreditation with groups such as Ontario Interventionist Association to utilize certified alcoholism Counsellor title or develop a similar accreditation process. The program could also consider granting parallel privileges to individuals with certain educational qualifications as well such as Bachelor of Social Work (BSW), Master of Social Work (MSW), psychology, or other fields which would be considered as equivalent.

- Health Canada in collaboration with a steering committee of First Nations and Inuit representatives and representative stakeholders within the various NNADAP Counsellors should develop a new training strategy to enable the communities to respond to the directions contained in this review.
- A second task would be to develop an inventory of courses that may be shared with different jurisdictions. This strategy should include a review of accreditation options and should include development of a strategy to meet the considerations of recognition, targeting of training resources to positions, advance training, and multi-disciplinary training.
- It is recommended that Health Canada and First Nations and Inuit representatives implement the centre of excellence concept to promote communities and treatment centres with recognized strengths and expertise as training and support mechanisms for other communities and treatment centres.
- Discussions should be held with treatment centres to determine feasibility of having treatment centres as service hubs for community Counsellors in such issues as general orientation, training on referral and assessment, information on addictions and other addictions in coordination needs which have been expressed from both treatment centres and the community level.

THE NEW PAN-CANADIAN HEALTH HUMAN RESOURCES STRATEGY

Following the 2003 First Ministers' Health Accord on Health Care Renewal, the Government of Canada has agreed to provide additional health care funding of $17.3 billion over the next three years and $34.8 billion over the next five years. The Accord stated that appropriate planning and management of HHR is key to ensuring that Canadians have access to the health services they need, now and in the future and highlighted the need for a national, comprehensive strategy.

With the collaboration of a Federal/Territorial/Provincial Advisory Committee on Health Delivery and Human Resources (ACHDHR), Health Canada has embarked in the development of a Pan-Canadian Health Human resources Strategy. Funding was approved in August 2004 with a commitment for on-going funding. The strategy will operate for the next 4 years then be evaluated to measure progress.

THE ABORIGINAL HEALTH RESOURCES STRATEGY

In September 2004, First Ministers and Aboriginal Leaders met in Ottawa to discuss joint actions to improve Aboriginal health and adopt measures to address the disparity in health status.

Acknowledging the range and importance of health issues specific to Aboriginal peoples in Canada, the federal government announced a total health funding of 700 million to improve Aboriginal health and adopt measures to address the disparity in health status, including 100 million dedicated to an Aboriginal Health Human Resources initiative.

The stated vision of the Aboriginal Health Human Resources Strategy is to develop and implement a national Health Human Resources Strategy that will meet the needs of Aboriginal People, and respond to the current, new and emerging health services issues and priorities while integrating with the pan-Canadian HHR Strategy.

NNAPF's HHR WORK AND THE NEW AHHR STRATEGY

The well documented, unique and recurrent health issues faced by Aboriginal people highlight the urgent need to achieve and maintain an adequate supply of properly trained and qualified health care providers.

In addition to the recommendations of the NNADAP general review highlighting the training and education needs of Aboriginal Health and addictions Counsellors, the Royal Commission on Aboriginal Peoples estimated in its report that an additional 10 000 trained Aboriginal health Counsellors were required. Studies show that recruitment and retention of Aboriginal personnel, as well as ensuring a culturally safe workforce are serious issues. Aboriginal trends in population growth and epidemiology have exacerbated this need. The principal theme of the AHHR strategy is the education and training of Aboriginal Health Counsellors, to remedy the shortages of key health care providers.

THE VALUE OF COLLECTIVE AND CORPORATE MEMORY

In a previous brief, NNAPF documented the rationale for, and the need to regard the Aboriginal addictions system as an integral part of the health system. The marginalisation of the vast pool of knowledge and skills acquired over many years by the Aboriginal Addictions System through the delivery of a complete continuum of care can be equated to a valuable loss of collective memory.

As illustrated by the findings and recommendations of the NNADAP General Review of 1998, the problems requiring to be solved by the 2003 HHR Strategy are not new. The use of corporate memory to take into account the work that has already been achieved in the areas of HHR by organisations such as NNAPF can only enhance the efficiency and cost-effectiveness of the new AHHR Strategy.

RECOGNITION OF NNAPF WORK IN THE AREA OF PARAPROFESSIONAL TRAINING AND DEVELOPMENT

Through its many collaborative initiatives to bridge the HHR gaps identified in the NNADAP General Review and to implement its recommendations, NNAPF has demonstrated that it is not a marginal organisation working inside the limits of a narrow focus, but that it is a player in the full range of issues at present being explored within the implementation framework of the new AHHR Strategy. There is a perception that the present AHHR is more heavily focused on the training and development of the Health Professional Community.

NNAPF wishes to ensure that the perspectives of its national network of Aboriginal health and addictions specialists and service providers in the paraprofessional sector are valued and integrated in the Strategy from the beginning, and that their achievements and expertise are recognized and put to contribution in the ongoing development of the new AHHR Strategy.

THE GROUND COVERED – NNAPF AND THE THREE (3) AHHR COMPONENTS

In keeping with its intention to underline the ground covered in AHHR, NNAPF has identified several specific areas where it has already spent considerable efforts to advance the goals of the new Strategy in regard to HHR planning, Inter-professional Education, Collaborative Patient-Centered Practice, Recruitment and Retention.

1. HHR PLANNING: Health Canada is working with the provinces, territories, and key stakeholders to determine how best to respond to the call for a more coordinated, pan-Canadian approach to evidence-based HHR planning. This will include enhancing existing capacity for such activities as data collection and forecasting, as well as developing more efficient and effective means of distributing information concerning the optimal supply of health care providers to those concerned.

The National Native Addictions Information Management System (NNAIMS) has been predicted to be, once fully developed, one of the most advanced, coordinated system of its kind in Canada. Developed in a collaborative effort with NNAPF, Health Canada and Donna Cona, the NNAIMS is an initiative to support addictions treatment centres and community addictions specialists (CAS) by providing electronic access to education as well as awareness tools, on-line booking capacity, communication links to all projects and eventually an on-line training venue.

2. INTERPROFESSIONAL EDUCATION FOR COLLABORATIVE PATIENT-CENTERED PRACTICE: The executive summary of Health Canada IECPCP report provides the following definitions:

- **Interprofessional/Interdisciplinary Education :** "occasions when two or more professions learn from and about each other to improve collaboration and the quality of care" (CAIPE, 1997, revised).

- **Collaboration: "**an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided" (Way & Jones, 2000).

- **Collaborative Patient-centred Practice**: "is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines and fosters respect for disciplinary contributions of all professionals" (Health Canada, 2003).

Several of NNAPF's initiatives fulfill the Strategy's definitions of interprofessional education for collaborative patient-centered practice:

NNAPF's First Nations and Inuit and Inuit Community Emergency Response Program

Mirroring the principles and definitions of the Interprofessional education component of the AHHR Strategy, NNAPF, in collaboration with multi-level, multisectoral partners, has developed a unique, community-based, community-oriented and community delivered model for a multi-level crisis intervention program.

This model addresses those group substance abuse patterns that severely threaten the health, safety and even lives of children and youth in First Nations and Inuit communities, and to be managed and delivered by First Nations and Inuit representatives.

The basic functions of NNAPF's First Nations and Inuit Community Emergency Response Program are to provide a highly skilled, mobile intervention and skill transfer capacity. It can be implemented as an initiative reflecting the HHR strategy's interprofessional education goals to:

- Promote the active participation of several health care disciplines and professions.
- Enhance patient, family, and community-centred goals and values.
- Provides mechanisms for continuous communication among health care providers.
- Optimize staff participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all providers can be integrated into.
- Be implementable in rural and northern settings.

Best Practices in Interprofessional Education for Collaborative Patient-Centered Practice

NNAPF can offer a prime example of a practical model for community interdisciplinary collaboration built on the principle of interprofessional education for collaborative patient-centered practice. This initiative is documented in a best practices manual from the Community of Beardy's and Okemasis.

NNAPF National Training Conferences

NNAPF strategic plan calls for Training Institutes and idea exchange Forums to be hosted annually by NNAPF. These institutes not only provide formal Training but serve as venues for the sharing of ideas, consulting and securing input into program renewal Plans. From planning to implementation and evaluation, NNAPF's training conference

promote collaboration and create environments and opportunities for health care providers to learn to work together, to share in problem solving and decision making, to the benefit of patients.

NNAPF successfully hosted several such conferences with stakeholders as well a wide range of paraprofessionals, traditional practitioners and professionals working in major health areas, such as diabetes, HIV/AIDS, suicides, cancers, heart diseases, injuries (drownings, self-mutilation, MVA, violence, FASD, mental health etc.)

Accreditation of Aboriginal Treatment Centres in Canada

One of the new AHHIR aims is to close the gap in the delivery of quality health care through the development of an Aboriginal qualified, culturally safe workforce and to increase the number of opportunities to obtain culturally appropriate, quality health training for the paraprofessional and professional communities in order to respond adequately to the needs of clients.

- NNAPF, in administering an accreditation program focused primarily on Aboriginally-owned and administered Addictions Treatment centres, has contributed major advances in the delivery of high quality treatment and counselling services in the Aboriginal Addictions system.
- NNAPF's accreditation program aims at ensuring quality services through the adoption of national standards. These national standards include the provision of quality service delivery by trained and qualified personnel.
- The ultimate goal is to encourage the evolution of Aboriginal treatment centres towards centres of excellence, able and qualified to provide a wide range of high quality training to the health providers' community.
- An important component of NNAPF accreditation program is therefore focused on the training and qualification of Counsellors involved in the full continuum of care provided by these centres.
- In addition, NNAPF's accreditation initiative is contributing directly to the goals of the AHHR strategy in working directly in the Aboriginal health renewal system, leading to enhanced environment of cultural safety, increased health system efficiency and sustainability through a significant range of training and professional development components.

Some of the global goals of NNAPF's Accreditation initiatives related to the training of Aboriginal health care providers are:

- Help the organization become a learning organization and develop new capacities.
- Develop new education sessions for better support of organisations.
- Recruit and train new surveyors (orientation, observation, mentorship/internship, faculty training).
- Building tools to develop and deliver on-site education sessions comprising five different levels.

3. RECRUITMENT AND RETENTION: There is a growing body of evidence, nationally and globally, documenting serious current and impending imbalances in the supply of health care providers across a wide variety of disciplines. Measures to increase

representation of First Nations, Inuit, Métis, and visible minorities across the spectrum of health care careers in leadership roles, such as clinical care, administration, research, teaching and policy, are required.

There are presently several areas in the AHHR strategy related to paraprofessionals that are perceived as lacking clarity, for example:

- Definition of professional, paraprofessional and traditional service providers in the context of an Aboriginal health care continuum.
- The recognition within an Aboriginal Health Human Resources Strategy, of their place and role, compared to that of western-educated professionals (Aboriginal and non-Aboriginal).
- Protocols that will be established by the AHHR to recognise and credit their alternative qualifications and experience and provide them with access to formal training or education programs.
- The dispositions that will be taken to deal with the present job descriptions, workload, working conditions and salaries of Aboriginal health services providers.

The Aboriginal Wellness and Addictions workforce includes a majority representation of a spectrum of paraprofessionals, with long years of experience and skills acquired through alternative routes, generally some formal qualifications which have been expanded through attendance to a number of informal or semi-formal training sessions. Aboriginal Service providers in the Addictions services often comment that they are the most trained people, if their informal and practical training is taken into account.

These questions have been at the core of NNAPF's work for 4 years. The NNAPF guiding document, the NNADAP *Renewal framework* forms the backbone of its activities.

NNAPF Renewal Framework and Human Resources issues among the addictions workforce

The mission of the National Native Addictions Partnership Foundation (NNAPF) is to advocate, develop, facilitate, and monitor strategies designed to continuously upgrade and enhance the quality of ideas, information, program methodologies, financial allocations and skills of service providers comprising the program.

NNAPF can contribute at least three major initiatives to the Recruitment and retention components of the AHHR: A National Training Needs Survey, A National Training Strategy, and a National Salary survey.

NNAPF National Training Needs survey

NNAPF has begun to work with institutions to facilitate appropriate training that supports a national system of accreditation for addictions Counsellors/coordinators.

NNAPF conducted a needs assement/training survey with addictions and mental health Counsellors. The report on the results of the survey provides an analysis of the skills,

experience, level of education, qualifications and competencies of 182 respondents from First Nations communities and treatment centres across Canada.

Based on the results of this survey, NNAPF then drafted a training strategy, with a focus on national accreditation of Counsellors.

NNAPF National Training Strategy

In its present draft form, this report contains the cumulative findings of a competency survey of front line Counsellors, three worker's focus groups, and regional reports of the state of addictions workforce development within First Nations and Inuit Health Branch.

Based on the results of this survey there is cause to celebrate the last 5 years of training and credentialing efforts by the National Native Partnership Foundation, First Nations and Inuit and Inuit Health Branch and their regional partners.

NNAPF Salary Survey Report

This participant report represents an analysis of nineteen participating organizations for four Treatment Centre positions. The organizations surveyed included 7 Aboriginal Addictions Programs with less than 15 beds; 6 Larger Treatment Facilities with more than 15 beds; 6 Non-Aboriginal Specific Treatment Facilities.

Additional Tools for the Job

An AHHR Strategy which encourages training activities aimed at insuring a sufficient, qualified and a culturally safe workforce also needs to look at the relevant training tools that will be included in the process, in order to increase interest in health careers, both generally and in specific areas of shortage. Based on the needs expressed by its stakeholders and partners, NNAPF has developed some important training tools for services providers in the Health and addictions field, including a reference handbook for Alcohol and Drug Residential Treatment Services, a Risk assessment Manual, a Cerp Program Model, and other fine examples.

References (in order of presentation)

www.nnapf.org/english/projects/national_training/background.shtml

YSAC Project Report 2003-2004, available at
www.nnapf.org/english/pdf/partners/ysac/ysac_project_report_2004.pdf

Report of the Royal Commission of Aboriginal Peoples, *Gathering Strength – Volume 3*.

First Nations and Inuit Health Branch, *National Native Alcohol and Drug Abuse Program General Review*, Final Report, 1998.

Assembly of First Nations, *Public Health for First Nations: A Framework for Improving the Health of our People and Communities*, November 2005.

National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, *Answering the Call*, First Edition, Fall 2005.

Strategic Action Plan for First Nations and Inuit Mental Wellness, First Nations & Inuit Mental Wellness Advisory Committee, June 2006.

EICP Initiative, *Enhancing Interdisciplinary Collaboration in Primary Care in Canada*, April 2005.

Shah, C.P. et al., *Visiting Lectureship on Aboriginal Health: An Educational Initiative at the University of Toronto,* Canadian Journal of Public Health, July-Aug. 1996, Vo. 87(4).

National Aboriginal Health Organization, *Analysis of Aboriginal Health Careers Education and Training Opportunities*, January 2003.

Aboriginal Expert Roundtable on Aboriginal Health Careers, 2003, in NAHO's *Strategic Framework to Increase the Participation of First Nations, Inuit and Métis Peoples in Health Careers*, Dec. 2004.

Minore, B. and Boone, M, (abstract) *Realizing potential: improving interdisciplinary professional/paraprofessional health care teams in Canada's aboriginal communities through education*, Journal of Interprofessional Care, May 2002, Vo. 16(2).

Office of Rural Health Policy, US Department of Health and Human Services, *Community Health Worker Certification and Training: A National Survey of Regionally and State-Based Programs*, May 2005.

Nga Pukenga Ahurea mo Nga Toko Manawa, Maori Practitioner Competencies for Working with Addictions, Presentation notes, Healing our Spirit Worldwide conference, August 7, 2006.

The National Drug Strategy - Australia's Integrated Framework 2004-2009, available at www.nationaldrugstrategy.gov.au

Workforce Development Policy Document - Alcohol and Other Drugs Council of Australia (ADCA), ADCA Policy Positions, Sept 2003, at www.druginfo.nsw.gov.au/treatment/workforce_development

Victorian Alcohol and Other Drugs Workforce Development Strategy 2004-2006, available at www.health.vic.gov.au/drugservices

Skilling Australia's Workforce - Commonwealth-State Agreement for Skilling Australia's Workforce, 2005-2008, available at www.nada.org.au/Training/downloads.asp/Publications

OCAP (Ownership, Control, Access, and Possession) refers to First Nations control data collection processes in their communities. First Nations own, protect and control how information is used. Access to First Nations data is important and First Nations determine, under appropriate mandates and protocols, how access can be facilitated and respected…" at http://www.naho.ca/firstnations/english/ocap_principles.php

Powell, D. J. et al., *Clinical Supervision in Alcohol and Drug Abuse Counselling,* 1993.

Building on Values – The Future of Health Care in Canada, Honourable Roy Romanow, Commission on the Future of Health Care in Canada, November 2002.

Public Opinion Poll – First Nations Views on their Health and Health Care, First Nations Centre, National Aboriginal Health Organization, 2003.

http://www.firstnationstreatment.org/news.htm

Marten's & Associates, *Live Video Conferencing, Clinical Supervision,* as noted at www.members.shaw.ca/tonymartens/

http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/index_e.html

Assessing Human Resources for Health: What can be learned from labour force surveys?, Diallo, K. et al., Human Resources for Health, 2003, at http://www.hman-resources-health.com/content/1/1/3

Improving the Health of Future Generations, Canada Institutes of Health Research, Institute of Aboriginal Peoples Health, American Journal of Public Health, , Reprint Vol. 92(9).

National Aboriginal Health Organization, *Aboriginal Health Human Resources Inventory Detailed Final Report & Products,* June 30, 2006.

Glossary of Terms

ASIST: The ASIST workshop (formerly the Suicide Intervention Workshop) is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. A 2 day course provided by Living Works Institute, and a Trainer level certification is available.

BRIGANCE: Industry standard in personality testing.

CCPC: Canadian Council of Professional Certification

CEDI: Centre for Educational Development and Informatics

CPI: The Nonviolent Crisis Intervention® program, developed by the Crisis Prevention Institute (CPI), not only teaches staff to respond effectively to the warning signs that someone is beginning to lose control, but also addresses how staff can deal with their own stress, anxieties and emotions when confronted with these challenging situations. http://www.crisisprevention.com/

DARE: Drug Abuse Resistant Education

DAST: Drug Abuse Screening Test- Addictions Research Foundation

DEMAND-REDUCTION STRATEGIES: Strategies that seek to reduce the desire for, and preparedness to obtain and use, drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug related harm. (Glossary: AUS National Drug Strategy)

HARM-REDUCTION STRATETIES: Strategies that are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviors such as injecting drug use: they acknowledge that these behaviors occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviors can cause. (Glossary: AUS National Drug Strategy)

HARM MINIMIZATION: The primary principle underpinning the National Drug Strategy. It refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies. Australia's harm-minimization strategy focuses on both licit and illicit drugs. (Glossary: AUS National Drug Strategy)

MAST: The Michigan Alcohol Screening Test was developed as an easily administered and scored 24 item test that can either be administered in written or oral form.

NANACOA: National Association of Native American Children of Alcoholics.

PART: PART® is a two or three day workshop providing a comprehensive and systematic approach to the predicting, understanding and management of aggressive/assaultive behaviour. http://www.mtu-trainingconcepts.com.au/part.htm

PARTY- The P.A.R.T.Y. (Prevent Alcohol and Risk-Related Trauma in Youth) Program is a one-day, in-hospital, injury awareness and prevention program for youth age 16 and older. Developed in 1986 http://www.partyprogram.com/about/index.html

PIPEDA: Personal Information Protection and Electronic Documents Act

PMAB: Prevention and Management of Aggressive Behaviour

PROJECT CHARLIE: A Western Michigan, U.S. program, *Project Charlie* involves community volunteers in combating the causes of chemical dependency

SASSI: The SASSI intends to scale the subtle attributes inherent in the substance abuser by asking questions seemingly unrelated to an addiction problem. The SASSI also is administered in both adolescents and adults, with the adolescent version claiming a reading level of 5th grade. The test has separate scoring for both male and female clients. Audiotape versions have also been developed for those with reading difficulties.

SUPPLY-REDUCTION STRATEGIES: Supply-reduction strategies are designed to disrupt the production and supply of illicit drugs. They may also be used to impose limits on access to, and the availability of, licit drugs - an example is legislation regulating the sale of alcohol and tobacco to people under the age of 18 years. (Glossary: AUS National Drug Strategy)

WORKFORCE DEVELOPMENT: “the broad range of strategies that are used to ensure effective practice,” courtesy of NADA @ www.nada.org.au

WRAT: Wide Range Achievement Test