Improving Access to Mental Health and Addictions Services
presented at the VCH – Aboriginal Mental Health and Addictions forum

Dr. Rod McCormick
University Of British Columbia
Kanienkehaka (Mohawk)
• Associate professor-Counselling Psychology UBC
• Leader of the Network Environment for Aboriginal Health Research BC and Yukon
• Aboriginal mental health consultant for First Nations and Inuit Health-Health Canada
• Clinical consultant-Intertribal Health Authority
• Clinical Consultant-Indian Residential School Survivors Society
McCormick-Current funded research projects

- Principal Investigator: Network Environments for Aboriginal Health Research-funded by Canadian Institutes of Health research (CIHR)
- Co-Principal Investigator: 2 Suicide Prevention New Emerging team research grants investigating Aboriginal suicide prevention- 1 Provincial and 1 national projects funded by CIHR
- Co-Investigator-National Native Mental Health Research Network-funded by CIHR
- Co-Principal Investigator –International Indigenous Health Research Program-Roots of resilience: Transformations of identity and community in Aboriginal mental health
- Co-Principal Investigator –International Indigenous Health Research Program-Resilient Indigenous Health research: Constructing an International framework
- Co-Investigator -Injury in BC Aboriginal Communities-Funded by Canadian Institutes of Health Research
- Co-Investigator-The impact of Long QT syndrome on First Nations (Genetic counselling research) . Funded by Canadian Institutes of Health Research
Colonization strategies

• Goal: Separate Aboriginal people from all familiar sources of meaning

• Theoretical explanation: (Logotherapy) Viktor Frankl- Jewish psychiatrist who survived the extermination camps of Nazi Germany found that individuals and cultures can survive if they have a strong reason for living (source of meaning eg: spirituality, work, significant relationships, contributing to your culture/community etc)

• As a means to eradicate Aboriginal culture the Canadian Government systematically moved to disconnect aboriginal peoples of this country from all sources of meaning
Strategic disconnection from Sources of Meaning

- **Family**: 125 years of government and church operated residential schools attempted to removed aboriginal children from their parents from age 5-18 in an effort to civilize and Christianize them.

- **Community**: Communities were relocated to “reserves” and often relocated once again whenever the government chose to do so (usually for land grab reasons). Communities have also been split by various means eg: forced replacement of traditional community leadership with elections etc.
Strategic disconnection from Sources of Meaning continued

- **Cultural practices** were often banned or prohibited eg potlatch law, punishment for speaking your language in residential school etc.

- **Connection to nature**: One federal government policy was to relocate aboriginal peoples to urban settings when possible to speed up assimilation.

- **Spirituality**: Spiritual practices were replaced with Christianity. The churches were a welcome partner in this strategy. In some cases spiritual practices were outlawed eg Sun dance ceremony
Colonization-effects

- Over 70% of BC Aboriginal people (on reserve) indicated that alcohol abuse is a problem (the rate of alcohol abuse for Aboriginal people in British Columbia was six times higher than the overall provincial rate: Health Canada, 1995)
- over 60% of BC Aboriginal people (on reserve) indicated that drug abuse is a problem. (Aboriginal Peoples Survey, 1991).
- Over 37% of BC Aboriginal people (on reserve) indicated that family violence is a problem
- 36% of BC Aboriginal people (on reserve) indicated that suicide is a problem (the rate of suicide for Aboriginal people in British Columbia is three times higher than the overall provincial rate: Health Canada, 1995)
- over 35% of BC Aboriginal people (on reserve) indicated that sexual abuse is a problem (Aboriginal Peoples Survey, 1991)
• The rate of external causes of death for Aboriginal people in British Columbia is three times higher than the overall provincial rate (Health Canada, 1995)
• the rate of motor vehicle traffic accidents for Aboriginal people in British Columbia is three times higher than the overall provincial rate (Health Canada, 1995)
• the disability rate for adult Aboriginal people is over twice the rate for non-Aboriginal people in Canada (Aboriginal Peoples Survey, 1991)
• the rate of medically treated diseases for Aboriginal people in British Columbia was five times higher than the overall provincial rate (Health Canada, 1995).
• Incarceration rates are 5x to 20x the non aboriginal rate
SUICIDE

- Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age. (A Statistical Profile on the Health of First Nations in Canada for the Year 2000, Health Canada, 2003)
- First Nations youth commit suicide about five to six times more often than non-Aboriginal youth.
- The suicide rate for First Nations males is 126 per 100,000 compared to 24 per 100,000 for non-Aboriginal males.
- For First Nations females, the suicide rate is 35 per 100,000 compared to only 5 per 100,000 for non-Aboriginal females. (Canadian Institute of Child Health, 2000)
- Suicide rates for Inuit youth are among the highest in the world, at 11 times the national average
That which is healing should lead to:

- Empowerment
- Cleansing
- Balance
- Discipline
- Connection
Based on my current research with aboriginal people in Canada: Resilience = Reconnection

Reconnection to:

• Family
• Community
• Culture
• Nature
• Spirituality
Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP)

• The overall purpose of this gap paper was to explore opportunities for improving the integration of mental health and addictions programming within the National Native Alcohol and Drug Abuse Program (NNADAP). The project was commissioned by Health Canada- First Nations and Inuit Health Branch (FNIHB) and the National Native Alcohol and Drug Abuse Program (NNADAP). The project was approached as an opportunity to identify specific strengths, limitations, and opportunities for providing mental health services, supports, and/or partnerships within NNADAP. Specifically, the objectives of this work were to:
• a. Identify gaps and challenges for providing appropriate mental health services and supports within NNADAP
• b. Highlight existing best practices/promising models, partnerships, and agreements within NNADAP for providing appropriate mental health services and supports
• c. Identify potential partnership opportunities to facilitate additional mental health services and supports between NNADAP and other sectors
• d. Identify from the literature exemplars of best practices/models at systemic, program, and service delivery levels for the provision of appropriate mental health services, supports, and approaches within addiction prevention and treatment services
Sources of data and methodology: literature review and key informant interviews

- Two data sources were utilized to develop this report. The primary data source was a set of key informant interviews to provide their perspectives, expertise and recommendations on how to best approach the integration of mental health services into NNADAP. The second source of data is a set of examples from the literature of approaches, principles and practices to integrating mental health services into addictions programming.
Funding Context

Federal Aboriginal addictions and mental health funding

Addiction Programs: Annual funding

NNADAP – Community-based: 500 communities-30 mill
NNADAP Residential: 50 centres-28 million
Youth Solvent AC Residential: 10 centres-13 million
Tobacco Strategy: 10 million

Total annual addictions funding: 81 million
Mental health and healing annual funding

- Brighter Futures: 50 million
- Building Healthy Communities: 30 million
- NIHB Mental Health: 8 million
- Aboriginal Healing Foundation: 50 million

Total annual funding: 138 million
Provincial funding

• BC Health Budget: 13 billion pa
• BC Provincial funding for mental health and addictions approx 1 billion: Aboriginal allocation???
• VCH budget: 2.8 billion pa, addictions and mental health: 185 million pa,
• BC govt Aboriginal mental health and addictions ???
• Mental Health Commission-Australia
FNIH – rationale for integration of mental health and addictions services

- The following quotes represent the main arguments found in the literature for the integration of addictions and mental health services:
• a. It is already taking place. Collaboration and integration of addiction and mental health services are already taking place in some First Nations and Inuit communities. The integration process is being furthered, but not limited to, communities that have Transfer Agreements with the Federal Government and Healing Centres sponsored by the Aboriginal Healing Foundation (Integration of First Nations and Inuit addiction and mental health services: A discussion paper).
b. Concurrent or Co-occurring Disorders. The most significant movement toward integration of addiction and mental health services pertains to the treatment of a significant population of people who have both addiction and mental health problems. These people have what is called “concurrent disorders” and require treatment for both addiction and mental health problems (Integration of First Nations and Inuit addiction and mental health services: A discussion paper).
• c. Expansion and increased access to mental health services. For First Nations and Inuit people, addiction treatment services are better developed and easier to access within First Nations and Inuit communities than are mental health treatment services. The integration of addiction and mental health services would contribute to the expansion and improvement of mental health treatment services. (Integration of First Nations and Inuit addiction and mental health services: A discussion paper).
• d. Cost effectiveness. To reduce duplication of services, reduce gaps in service and optimize the use of scarce resources, an integrated addiction and mental health service system seems warranted (Integration of First Nations and Inuit addiction and mental health services: A discussion paper).
• The consumer movement. A stronger consumer movement that demands more client-centred, user-friendly services and improved access to information for educated decision-making; A more prominent role for consumer satisfaction as a performance and accountability indicator which, in turn, makes service providers more open to being flexible and adaptable in the treatment and support package they offer. (Canadian Executive Council on Addictions: On the Integration of Mental Health and Substance Use Services and Systems).
Gaps and challenges identified in the literature

• There was a general consensus among witnesses that the current funding levels for mental health services and addiction treatment in First Nations and Inuit communities are inadequate and disproportionate to the burden of illness.

• There is a misdistribution of human resources in this field, which leads to particular concerns in access to necessary services and supports in Canada’s rural and remote regions.

• Mental health and addictions systems are highly fragmented for Aboriginal Communities. Services and supports are provided by different levels of government, different departments and there is limited collaboration.
• There is a critical shortage of adequately trained Aboriginal mental health and addictions professionals. Generally, there is also a lack of culturally appropriate services.

• Two solitudes, two service silos: addictions and mental health services are too frequently separate enterprises pursued by different systems, different people, different cultures, different ideas and different models (professional/medical model vs. self-help/peer support model – cognitive/behavioural vs. twelve step model)
• Addiction and mental health service development: First Nations and Inuit addiction treatment services are better developed than First Nations and Inuit mental health services. Whereas addiction treatment services are provided in First Nations and Inuit communities (on reserves), mental health treatment services are usually provided through NIHB and the provincial mental health services (off reserves).

• Defining the problem: the nature, prevalence and incidence of addiction and mental health problems among First Nations and Inuit people has yet to be studied thoroughly.
• Dominance of addictions or mental health?: it would be very easy to see addictions or mental health dominate the other (because of the greater presence and development of addiction treatment services in First Nations and Inuit communities, addictions is likely to dominate mental health)

• Traditional healers: There is a need to define the roles and to recognize the contributions of traditional healers.

• Clinical consultation and supervision: since services are frequently needed in small, remote communities and provided by paraprofessionals, effective means of providing clinical consultation, advice and supervision need to be developed
• Collaboration with other services and service providers: it is often difficult to develop collaborative working relationships with other services and service providers (e.g. provincial/territorial addiction and mental health services, off-reserve professional personnel funded through NIHB)
Participants identified several issues of concern regarding the current NNADAP mandate: gaps and challenges.

Challenges Identified in Interviews

- There does not seem to be a clear mandate for mental health services within NNADAP.
- There is confusion over the conflicting mandates of existing FNIHB programs such as Brighter Futures and Building Healthy Communities programs.
- There is a lack of collaboration between FNHIB Programs and confusion concerning who provides mental health services and addictions.
• The current mandate creates a barrier with regards to jurisdictional issues by restricting funding/services to on-reserve centres.

• NNADAP was created to address alcohol and drug abuse, not mental health...we will need a new mandate because there is currently no room for the melding of the two.

• NNADAP has not really looked at the mental health piece in a comprehensive way. Mental health and addictions are one and the same, so they should not be separated.
• Just because a First Nations person does not live on-reserve, they do not cease to be First Nations. The policy dealing with non-jurisdiction has to change because 50% of FN now live in urban centres.

• In some of the major centres, the difficulty has arisen from mental health services thinking they are more important than the addictions services, causing a turf war.

• Mental health treatment has been promoted over the last 10-15 years but there is a big fear of losing addictions funding to mental health in the treatment centres’ community.
• It is also really important that addictions not get lost in new movement of combining mental health and addictions. The addictions work is really crucial – there is concern amongst people working in addictions that if the mental health envelope is pushed, already insufficient budgets will get chipped away at even more.
Participants identified several issues of concern regarding NNADAP programming

- The primary theme in participants’ responses was the lack of capacity to providing mental health services and supports. They easily identified examples from their work of the gaps they see in mental health services within their centres. For example, there is a lack of expertise in dealing with complex mental health issues such as grief and loss issues and Post Traumatic Stress Disorder.

- Participants noted the need to have a professional mental health diagnosis before addictions treatment can start in order to better understand the client
• For some mental health issues such as suicide, monitoring may also be necessary to ensure the health and safety of the clients. Again, participants noted that they do not have the ability to monitor clients in these circumstances.
• Participants expressed a lack of ability to provide after care and family supports, particularly when community members have to leave their community to seek treatment.
• Dealing with medications was noted as a reality for many clients, yet NNADAP staff were generally not trained to assist in managing medications. Some centres may even have restrictions on accepting clients if they are on certain medications.
• The remoteness of treatment centres only exacerbates these issues, as supporting services are often not available within geographic reach.
• Transportation for clients to access accompanying services to addictions treatment, particularly primary care, was noted as an issue by several participants.
• Transportation issues were cited as a barrier for external health professionals to access remote areas.
Participants identified issues of concern regarding human resources

• A major challenge related in the capacity for providing mental health services, as well as any future plans for increasing a mental health mandate, is the inability of many centres to hire qualified personnel.

• Participants noted a lack of educated, qualified staff to work in existing programming and noted that this would be an added challenge if the provision of mental health services were added to this workload.

• Serving rural and remote communities is a huge challenge. Many isolated communities are small and cannot attract qualified individuals to provide care.
• What are the criteria for hiring, salary, supervision, case management? What are the training and qualifications for health directors? People are killing themselves and someone has to be accountable.

• Human resources are also an issue at the band level because one person in each community cannot do primary intervention, secondary intervention, treatment and follow up. If we add mental health services officially to NNADAP, there needs to be a budget for training and hiring additional workers.
Participants identified several issues of concern regarding the broader mental health system:

• There are often long waiting lists for mental health services such as detox and assessment. In many cases, services may not even exist for certain populations - particularly around youth. These services are often needed to admit clients to treatment and/or provide information on concurrent disorders that will facilitate client treatment.

• Within the mental health system, participants also noted the lack of Aboriginal mental health professionals, particularly psychiatrists.
• Jurisdictional challenges at several levels were identified as an issue. The federal/provincial jurisdictional issue was noted in that some provincial services are not available for First Nations persons. For example, one participant noted that their client could not afford a physical exam, which was a prerequisite for treatment admission.

• Participants noted the lack of culturally appropriate care in the broader mental health system. Participants noted the need to balance both western medical approaches and traditional healing in NNADAP programming.
Participants identified several issues of concern regarding community

- Creating awareness in communities is essential so that people can recognize mental health issues in others and themselves.
- There is always room to do education around mental health, especially because many people have personal embarrassment or shame around the issue.
- In smaller communities there is a need to ensure the confidentiality of clients seeking mental health services.
- Organizing Elders would provide a huge resource in addition to NNADAP provided mental health services.
Examples of best practices/promising models, partnerships, and agreements within NNADAP

• One promising approach for providing mental health services was by contracting of mental health professionals, such as psychologists and counsellors. In the BC region, for example, 11 of the 12 treatment centres have funding for mental health service providers. In Quebec, some clients are referred to private centres for mental health care.

• Some participants also expressed that mental health is being addressed through the integration with traditional healing approaches. For example, most treatment centres include ceremonies and cultural events as a key component of their work.
Some best practice examples found in NNADAP treatment centres

• White Haven Healing Centre: This centre incorporates western and traditional healing and has an addictions specialist and a psychologist who provides clinical support. They also work to provide a continuum of care including assessment, counselling and after-care.

• Onion Lake First Nation: This community has a treatment centre with 5 crisis teams. They hold inter-agency meetings every week between NNADAP staff and representatives from the local school, police and Brighter Futures program.
• Okanese First Nation: This community approached addictions issues via the hiring of wellness workers. Both a mental health worker and a counsellor act as mentors for these wellness workers.
• Round Lake Treatment Centre: Provides treatment through 2 part-time clinical psychologists and mental health training for staff through videoconferencing and internet facilities.
• Tsow-tun le lum Treatment Centre: A resident Elder is available at the treatment centre 24/7 to provide traditional healing and counselling. A 6 week trauma healing program is offered to clients who complete the 6 week addictions program. Approximately 1/3 of the clients in each program are Corrections Canada clients who provide the centre with an additional source of revenue. The centre partners with the Indian Residential School Support Program who provides the centre with 3 staff positions for community outreach and support of residential school survivors.
Examples of best practices outside of NNADAP

- Aboriginal mental health: There have been many new Aboriginal specific mental health programs and tools developed over the past 10 years. The following examples from British Columbia represent only a few of the many mental health programs developed:
- (Green and McCormick) have developed an aboriginal specific grief and loss support group facilitator guide and training program
• McCormick and France developed an Aboriginal peer support participant manual and facilitator guide.

• The Indian Residential School Survivors Society developed a facilitator’s guide for residential school survivors support groups.
Integration frameworks: A few of the provinces/territories have developed integration frameworks. The following examples from Manitoba and the NWT represent such frameworks/strategies

- **Manitoba:** Addictions Foundation of Manitoba: Co-occurring Disorders Initiative (CODI). CODI has developed clinical training guidelines for co-occurring disorders. There has been a revision of policies and practices across participating mental health and addiction service programs. Across the system, clients are now being screened and assessed for co-occurring disorders and integrated treatment plans are being developed for clients with co-occurring disorders.
North West Territories Mental Health and Addictions Services: Staff and other service providers from mental health and addictions will be integrated into Primary Community Care. Mental health and addictions services will provide a continuum of services that will allow clients to continue living in their community or region. There will be investment in mental health and addictions at the community level where most prevention, outpatient treatment and aftercare should take place. Mental health and addictions services will include a multi-disciplinary team including community and wellness workers, social work, nursing, mental health workers, addictions counsellors, etc. Ongoing development of Integrated Service Delivery Model to address duplication of services and implement best practices.
Examples of potential partnership opportunities

• Partnerships constituted another way in which treatment centres were able to increase the capacity of their current staff. For example, in some treatment centres, NNADAP staff were able to participate in training programs offered through health authorities: risk assessment and processes for referrals to appropriate mental health services.
In Manitoba, there are examples of health authorities working on reserves – showing an example of how jurisdictional issues can be overcome through partnerships.

One participant noted an ongoing collaboration with the local detox centre to facilitate admission into their treatment centre.

Workers from some NNADAP treatment centres and community offices are able to participate in existing training opportunities with their band and/or tribal organizations.
The Canadian Counselling and Psychotherapy Association (CCPA) has indicated an interest in discussing certification of Aboriginal counselors. At present the CCA is the only body that certifies professional counselors at the national level.

The Association of BC First Nations Treatment Programs established an independent society for an Aboriginal addictions worker certification process which thus became known as the First Nations Wellness/Addictions Counsellor Certification Board. The board has partnered with the Nicola Valley Institute of Technology and their Chemical Addictions Counselling Studies Program. This program offers the core skills required for First Nations Wellness Addictions Counsellor Certification, and includes Aboriginal specific content.
• Professional counselling and psychological associations have expressed some interest in providing community service volunteer hours to assist aboriginal community mental health workers with clinical consultation and supervision.
The Mental Wellness Advisory Committee (MWAC) has identified five priority goals within the First Nations and Inuit Mental Wellness Strategic Action Plan

- To support the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit that includes traditional, cultural and mainstream approaches.
- To disseminate and share knowledge about promising traditional, cultural and mainstream approaches to mental wellness.
- To support and recognize the community as its own best resource by acknowledging diverse ways of knowing and by developing community capacity to improve mental wellness.
- To enhance the knowledge, skills, recruitment and retention of a mental wellness and allied services workforce able to provide effective and culturally safe services and supports for First Nations and Inuit.
- To clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal, provincial, territorial and First Nations and Inuit delivered programs and services.
• In recommending the integration of addiction and mental health services, the Integration of Mental Health and Addictions Working Group strongly suggests that the integration processes and operations be guided by major client-related, service provider-related and service-related principles.
• Client Related
  Family and community-centred: family and community are central to service delivery.
• Client-directed: services respond to the needs of clients, families and communities rather than to the needs of the service system.
Service provider related

• Responsiveness
• Strengths-based
• Diversity
• Most vulnerable served
• Traditional healing and indigenous knowledge
• Continuous quality improvement
• Confidentiality
• Service standards
• Accountability
• Continuous professional development
Service related

- Accessibility
- Sustainability
- Partnership
- Evidence-based
- Community control
- Community safety
- Consistency
- Viability
- Adequate resourcing
CONTINUUM OF CARE

• The Integration Mental Health and Addictions Working Group adopted the Holistic Wellness Continuum as the central model for the integration of addiction and mental health

• The major components and sub-components of the Continuum of Care are as follows:
- Prevention and Promotion
- Community and Facility-based Healing
- Supportive Counselling
- Crisis Intervention
- Specialized Healing Services
- Culturally-based Approaches
- Clinical Services
- Facility-based Treatment
- Intensive Services for Complex Needs
- Aftercare and Rehabilitation
- Case Management
Opportunities

- The key to this project was to create an understanding of what was needed to move forward in the integration of mental health services. Guidance provided by both the best practices literature and by experts who were interviewed in this paper described many different routes through which this could be accomplished.
First and foremost, there is a significant need for education and training around mental health for existing staff. Considering the relationship between mental health and addictions, there is a need to ensure an understanding of the impacts of mental health conditions on both addictions aetiology (causes) and recovery. Participants noted that most workers training are in addictions, not mental health and suggested the need for coordinated training approaches and partnerships. In some cases, this is done through participating in existing training opportunities with local health authorities. Joint training linked to paraprofessional credentials is needed to move toward better and more integrated supportive counselling and aftercare services. An InPsych (Indians into Psychology program) could be developed for Canada to address the shortage of Aboriginal psychologists. The United States Indian Health Service funds 5 InPsych programs in 5 different universities across the US in an effort to train/recruit/prepare
Closely related to training is how the human resources requirements for NNADAP can be met. Participants noted the need for a Statement of Qualifications to ensure that appropriate mental health services can be provided. Unfortunately, there appears to be variable hiring criteria between different FNIHB initiatives and a comprehensive, systematic approach was requested. Participants also noted that unique training needs to be developed— one that would incorporate mental health, addictions and cultural knowledge. Clinical services that are able to address both addictions and mental health issues need to be brought into the continuum of care and the case management process are also needed. Competent and culturally appropriate clinical services can build the capacity of paraprofessionals in prevention and promotion, intake, screening and assessment, supportive counselling, aftercare and rehabilitation, by providing training, supervision, and case consultations, and by supporting case management processes.
• From a mandate perspective, in order to move toward a more integrated continuum of services, facility-based treatment centres would need to broaden their mandate to include the treatment of mental health issues, and increase their capacity accordingly.

• Ensuring cultural training is also critical for all staff and contracted professionals and the criteria for counselling, addictions training, assessment, etc all needs to be clear. In summary, a standardization of policies, procedures and programming is needed to ensure a systematic approach to any integration initiative.
• In regards to addressing the **needs of rural and remote communities**, two options were outlined. One is the **development of ‘centralized staff’** and the second is to **build on growing Videoconferencing capabilities**. One community is currently undertaking a pilot project to integrate these capabilities.

• **Supports in the community need to be developed to assist families in providing after care for loved ones.** A **helpline** for communities was suggested as an idea to provide additional support. The example of using **Elders in a residential treatment program** was suggested as a support opportunity. In one treatment centre, an Elder is available 24/7 to provide traditional healing and counselling. Supports also need to be provided to mental health and addictions workers.
• **Funding changes** were also seen as a strategy for improving needed mental health services. For example, participants noted that increasing the rate of pay Health Canada has for psychologists would facilitate contracting out of these services. **Increased funding for NNADAP workers is also critically needed in order to increase opportunities for recruitment and retention.** Increased salaries and supports will also be necessary if higher training requirements are put in place.
• However the integration of mental health services and addiction services is approached, participants noted the need to ensure that addictions funding is not lost. As was stated by the Canadian Executive Council on addictions: Integration efforts need to be adequately resourced and supported since many of the changes that are required are in the realm of organizational and systems culture and, therefore, require sustained efforts and ongoing corrective feedback loops to ensure the goals are being met for people needing services and supports.