REGIONAL NNADAP NEEDS ASSESSMENT

First Nations of Quebec

Final Report - June 2009

FIRST NATIONS OF QUEBEC AND LABRADOR
HEALTH AND SOCIAL SERVICES COMMISSION

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Terminology

In order to facilitate the reading of this report, the following acronyms have been used:

AITQ	***Association des intervenants en toxicomanie du Québec*** (Quebec Association of Addiction Workers)
CSSS	***Centre de santé et services sociaux*** (Health and Social Services Centre)
CRPAT	***Centres de réadaptation pour personnes alcooliques et autres toxicomanes*** (Rehabilitation Centres for Alcoholics and Other Substance Users)
FNQLHSSC	**First Nations of Quebec Health and Social Services Commission**
FNIHB	**First Nations and Inuit Health Branch**
FNIH	**First Nations and Inuit Health**
FNRLHS	**First Nations Regional Longitudinal Health Survey**
NNAPF	**National Native Addictions Partnership Foundation**
FQCRPAT	***Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanes*** (Quebec Federation of Rehabilitation Centres for Alcoholics and Other Substance Users)
GRIPMA	***Groupe de recherche et d'interventions psychosociales en milieu autochtone*** (Research and Aboriginal Psychosocial Intervention Group)
MSSSQ	***Ministère de la santé et des services sociaux du Québec*** (Quebec Ministry of Health and Social services)
NNADAP	**National Native Alcohol and Drugs Abuse Program**
SAA	***Secrétariat aux affaires autochtones*** (Native Affairs Secretariat)

BACKGROUND

Purpose of the Process

The main objective of this regional addiction needs assessment process within the context of the National Native Alcohol and Drugs Abuse Program (NNADAP) is to target the needs of individuals who require intervention as well as of those who provide them. The needs are great; therefore an analysis is necessary in order to establish a priority, which will allow for the development of scenarios to reorganize services in a comprehensive and integrated fashion and more people-oriented. Moreover the process aims at developing recommendations to implement an evidence-based continuum of care that will be adapted to the future reality and issues in the field of addictions.

Despite the services currently provided by NNADAP workers, the field of addictions has significantly evolved over the past decades, particularly with regards to the needs of individuals with substance use problems. The clinical profile has become more severe and the service offer has not evolved much; therefore it was deemed necessary to carry out a national reassessment of the program. These new clinical realities raise a definite challenge with regards to the service organization if the latter are to meet the needs of the population in an optimal manner.

The lack of in-depth review of the general variables and those specific to addictions may hinder the implementation of prevention and intervention strategies that are adapted to the clientele and adequately meet their needs with addiction problems. The NNADAP network workers in Quebec have often addressed the necessity to renew their knowledge in the field of addictions among First Nations and Inuit.

The need to expand knowledge goes beyond the clientele profile. It must also lie on the necessity to question the service structure, organization, coordination as well as configuration.

In order to better orientate services and for future related decisions to be evidence-based, this report presents the results of the addiction needs assessment process within the context of NNADAP. The process does not intend to establish the individual needs of First Nations, although each need has been surveyed, except for the Maliseet and the Inuit. It is more of an overall portrait of the regional needs that will be integrated to the national needs.

This report was prepared by the *Groupe de recherche et d'interventions psychosociales en milieu autochtone* (GRIPMA) for the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).

*Overview of the Current Program**

The National Native Alcohol and Drug Abuse Program (NNADAP) is an example of a Health Canada program now largely controlled by First Nations communities and organizations. Since its creation in the 1970s, the program's goal has been to help First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations. NNADAP originated in the mid-1970s as part of a national pilot project to address alcohol and drug abuse. The program was made permanent in 1982.

Program activities fall into three key areas:

Prevention activities, aimed at preventing serious alcohol and other drug abuse problems:

- Public awareness campaigns;
- Public meetings;
- Public speaking;
- Developing content for schools on alcohol and drug abuse;
- School programs;
- News media work;
- Cultural and spiritual events.

Intervention activities, aimed at dealing with existing abuse problems at the earliest possible stage:

- Recreational activities for youths;
- Discussion groups and social programs;
- Aboriginal spiritual and cultural programs.

Aftercare activities, aimed at preventing alcohol and drug abuse problems from reoccurring:

- Counselling;
- Sharing circles;
- Support groups;
- Crisis intervention;
- Support visits;
- Outreach visits;
- Treatment referrals;
- Detoxification referrals;
- Social service referrals;
- Medical service referrals.

**Source: Health Canada website*

Introduction

The NNADAP review had not been done for over a decade now. The rapid evolution of drug use patterns, from the accessibility to various products, to the explosion of certain protection factors and the emergence of new risk factors, has precipitated addicts in states of such fragility and vulnerability that current NNADAP services can no longer meet the needs of the clientele.

Based on the evidence resulting from the research carried out by the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), the data collected in discussion forums and existing data in the Quebec network, there seems to be a consensus that the current NNADAP is too restrictive. If in the past addiction and alcoholism problems motivated the creation of a program, the emergence of other addiction forms just as devastating now implies that an expansion of the program applications has become necessary.

Without necessarily proceeding immediately with a new name for NNADAP, we must however consider that given the rapid evolution of the addiction-related issues, the current program will have to include all forms of addiction: alcohol, drugs, gambling, internet addiction, sex addiction, etc., as a significant public health problem. Consequently, we will use the acronym “NNADAP” in this report to designate the program as it is currently applied and the name “Addiction program” to include all levels of action (prevention, intervention, treatment and post-treatment) that must be considered in a continuum of addiction care and services and based on the needs of the clientele. The time when only alcohol, drug and solvent abuse have triggered an alarm forcing authorities to react is now over. In the current context of our knowledge, it is more appropriate to talk about the addiction phenomenon while being inclusive rather than limiting our review to only a number of addictions.

In the context of the NNADAP needs assessment process, all data collected through inventory and those obtained through interviews with key network stakeholders have been analyzed and merged into several themes presented in this final report.

This report includes four (4) different sections. The first section is divided in two parts: one addresses the biopsychosocial profile of addictions and the second presents the profile of existing addiction services among First Nations and in the Quebec network. This first section essentially deals with the data and current practice inventory that enabled a portrait of the current situation to be made. The second section presents the results and data collected through the NNADAP network workers during the needs assessment. The third section presents the discussion on the results and the fourth section puts forth recommendations that would allow for the implementation of a continuum of care and services that would meet the needs of the network workers and those of the individuals who require assistance.

METHODOLOGY

As previously seen, the main purpose of the current needs assessment process was to collect relevant information on addictions from a general point of view, with regards to the users' profile as well as the services for the Quebec Region. The methodology strategy had therefore to be flexible and adapted.

Literature review

A complete analysis of the material on addictions among First Nations and Inuit was carried out. We also listed all the services offered based on a series of questions that allowed us to collect a maximum amount of information on current services. Since the literature on addictions is vast and scattered, the following rules were applied:

- Look for material that made relevant connections with other environments, such as on the international level or among non-Aboriginals and focused on Canada and Quebec.
- Integrate information obtained on prevention, intervention and postvention activities.

Mixed data collection strategy

We used two data collection strategies with key stakeholders either through structured interviews with a questionnaire or through discussion groups.

Measurement instrument

To assess the needs with key NNADAP stakeholders, a mixed methodology strategy was used. A questionnaire was sent (Appendix 2) to key stakeholders working in the NNADAP network among the First Nations of Quebec. In compliance with the First Nations of Quebec and Labrador Research Protocol, each respondent voluntarily agreed beforehand to the interview process. A total of 48 respondents were interviewed. Once verified all questionnaires were considered valid and entered during data compilation. The themes addressed are mainly the socio-demographic characteristics, prevention, intervention and postvention practices, and the needs according to the respondents. In order to adapt to the content of the approach, we selected a mixed quantitative and qualitative approach.

Administration of the questionnaire

We are aware of the fact that we are using non-probability sampling but given our wish to obtain a variety of viewpoint, we have developed a sampling of respondents whose professional responsibilities may be different but nonetheless related to NNADAP. Consequently we can say that our sampling is representative of all the people directly concerned by the program.

The questionnaires were administered in English and French by the same person. All interviews were carried out by phone after a precise time had been agreed upon with each participant. The questionnaire was sent beforehand to each respondent.

Final sample composition

We initially set our sample at fifty. We did however interview and enter 48 questionnaires. The exact breakdown of subjects is presented in the following tables and graphs in order to understand the sample composition. The following Nations were surveyed (in alphabetical order):

- Abenakis
- Algonquins
- Atikamekw
- Crees
- Hurons-Wendats
- Innus
- Micmacs
- Mohawks
- Naskapis

During data collection, the Inuit were not integrated to the sampling, they were not interviewed during discussion groups and no structured interview questionnaire was administered to them. Moreover, the Inuit are not represented within the FNQLHSSC. As regards the Maliseet Nation, no NNADAP respondent was on duty at the time of the data collection.

Discussion groups

In order to gather the opinion of various stakeholders from other fields, we organized discussion groups. We took advantage of various meetings and forums where stakeholders from various sectors working in First Nations communities were present. We contacted the people in charge of those events and asked if we could request their participants to take part in discussion groups on NNADAP.

Four (4) groups were organized. They included First Nations Health Centre workers, nurses, NNADAP agents, program managers, workers on duty, psycho-educators, people in charge of special education projects, youth workers, and social workers. A total of 40 people were met during these forums, either directly or by videoconference. These forums were facilitated based on a facilitator's guide (Appendix 2) and each participant had to give his/her consent (Appendix 3).

Limits of the process

The main difficulties encountered during the process were mostly related to accessing key stakeholders or, at a lesser level, to the reliability of the interview schedules as planned.

Moreover, only the workers' opinions were collected. NNADAP beneficiaries could not express themselves regarding the nature of needs. We consider that our sampling of workers is significant enough to be representative of their opinions and perspectives but it cannot be extended to the clientele itself.

SECTION 1: INVENTORY – PROFILE OF THE CURRENT SITUATION

PART 1: BIOPSYCHOSOCIAL PROFILE OF ADDICTIONS

REGIONAL PROFILE OF COMMUNITIES

In Quebec, there are a total of 55 First Nations and Inuit communities. The following map illustrates Quebec's geographic extent with the location of each First Nation and Inuit community.

Source: Quebec Aboriginal tourism Corporation (n.d.).

As of December 2008 and based on the data available at the *Secrétariat aux affaires autochtones* (SAA), the First Nations and Inuit population counted 87,251 persons, representing about 1.2% of the province of Quebec's overall population.

Out of the 55 communities in Quebec, 31 (55%) are non-treaty communities and 24 (45%) are treaty communities (FNQLHSSC, 2008).

The 24 treaty communities include Inuit, Cree and Naskapi communities that have signed the James Bay and Northern Quebec Agreement. With this treaty, these Nations have obtained responsibilities such as Education, Health services and Social services. The Government of Quebec was therefore able to develop the territory according to the rules established by the treaty (SAA, 2008). However, the Crees, the Inuit and the Naskapis are still eligible to NNADAP. The non-treaty communities are under the Indian Act and are eligible to NNADAP.

Since the First Nations and Inuit communities of Quebec are distributed over a wide territory, their individual level of geographic isolation varies. Here are Health Canada's definitions of the various isolation levels:

Isolated	Flights, good telephone services, no road access
Semi-isolated	Road access greater than 90 km to physician services
Non-isolated	Road access less than 90 km to physician services

Based on these definitions, there are 28 isolated communities, 6 semi-isolated communities and 21 non-isolated communities. It is important to note that all Inuit communities are isolated.

PREVALENCE OF DRUG USE METHODS AND PATTERNS

The following section deals with the prevalence of high-risk drug use methods as well as patterns among the First Nations of Quebec.

IN FIRST NATIONS COMMUNITIES

The results of the First Nations and Inuit Regional Longitudinal Health Survey (FNIRLHS), published in 2002, show that more than two teenagers out of five (44.2%) used drugs or volatile substances during the 12 months preceding the survey. Among the 12-14 age group, 27.1% used drugs versus 58.4% in the 15-17 age group. Marijuana is the drug most used by teenagers. The vast majority of teenagers who used drugs (92.1%) used marijuana. Regarding alcohol, the survey shows that consumption considerably increases during adolescence among the First Nations and Inuit. While a third of the 12- to 14-year-olds drank beer, wine, spirits or alcoholic beverages in the 12 months preceding the survey, it was the case for three-quarters of 15- to 17-year-olds (75.9%).

The FNIRLHS shows that one adult out of five living in a First Nation community in Quebec drinks at least five glasses or more of alcohol per day. Also, more than 36.2% of First Nations members indicated that they used drugs in the 12 months preceding the survey. Moreover, 40.5% of men reported using drugs, versus 32.1% of women. In the overall population, 26.6% used marijuana, 11.0% used cocaine, crack or freebase, 8.6% used codeine, morphine or opiates, and 4.6% used PCP or angel dust. Finally, 10.2% of adults have previously received treatment for drug or volatile substance abuse.

The FNIRLHS shows that 18- to 34-year-olds are the most important drug or volatile substance users. More than 54.8% of 18- to 34-year-olds used drugs and/or volatile substances in the 12 months preceding the survey, versus 24.6% of 35- to 54-year-olds and 17.6% of adults 55 and older. We also note that the proportion of users seems higher in medium and large communities. However, it is possible that

a number of adults in small communities have not declared their drug use because of the proximity between people or because of concerns about the confidentiality.

Regarding people aged 55 and over (Elders), more than half (57.3%) reported they had consumed alcohol during the 12 months preceding the survey. As for drug consumption, we estimate that 17.6% of Elders take drugs. However, the survey shows that 97.6% of them indicated they have never been treated for drug abuse and 98.3% have never been treated for solvent abuse.

The survey shows that the substances most used in communities are alcohol and marijuana. We may therefore conclude that the consumption methods used represent low health risks as opposed to the use of injection drugs.

FIRST NATIONS LIVING OFF RESERVE IN URBAN CENTRES

The results of the FNIRLHS for individuals living off reserve show that almost two-thirds of respondents drank alcohol in the 12 months preceding the survey and over one-quarter of them drank more than once a week. Furthermore, 57.1% of adolescents used drugs in the 12 months preceding the survey and smoked marijuana as well. Among marijuana users, 20.0% used it two to three times a week, while 17.1% of them used it every day.

Concerning the use of alcohol, 80.8% of adults drank beer, wine, spirits and other alcoholic beverages in the 12 months preceding the survey. Among them, 39.2% drank at least two or three times a week. One-quarter of respondents have been treated for alcohol abuse.

The study reveals that 57.8% of respondents used at least one non-prescription drug in the 12 months preceding the survey (excluding marijuana and chewing tobacco), which represents a proportion slightly inferior to that observed in the communities (62.3%).

The number of users declines significantly with age, dropping from 74.2% among 18-to 34-year-olds to 46.8% among 35-to 54-year-olds, to 13.0%* among adults aged 55 and over. The proportion is also much higher in Montreal (71.7%) than in Quebec City or Val-d'Or (fewer than half of all respondents). Nevertheless, while one in five adults in Montreal and Quebec City has been treated for drug abuse, it rises to more than one in four adults in Val-d'Or.

The study also reveals that 51.3% of respondents used marijuana in the 12 months preceding the survey. This is double the rate of what is observed in the communities. Among the adults who have used drugs, 65.1% used marijuana in Montreal and 38.7% in Quebec City. Finally, 55.5% of adults who used marijuana smoked two to three times a week, representing a proportion similar to that observed in the communities (50.8%). Nearly one adult in five (16.9%) used cocaine, crack or freebase in the 12 months preceding the survey.

The main difference between men and women concerns cocaine: nearly one man in four uses cocaine, versus less than one woman in seven. Only a few respondents in Montreal used heroin or inhaled glue, gas or paint. More Montreal residents also used ecstasy, LSD and codeine. Finally, although less than one in five adults has received treatment for drug abuse, this number is nearly doubled for adults living in the communities.

PREVALENCE OF ADDICTIONS AND COMORBIDITY

Comorbidity, or dual diagnosis, is defined by the World Health Organisation (WHO) as the 'co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder' (WHO, 1995). According to the United Nations Office on Drugs and Crime (UNODC), a person with dual diagnosis is a 'person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric, e.g. mood disorder, schizophrenia' (UNODCCP, 2000). In other words, comorbidity in this context refers to the temporal coexistence of two or more psychiatric or personality disorders, one of which is substance abuse problem.

According to the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey carried out by the FNQLHSSC in 2008, certain factors in a person's life facilitate the transition towards problematic use. However most of these agents, known as risk factors, are not specific to psychoactive substance abuse, but rather associated to the development of a series of deviant or problematic behaviours (for ex. perpetration of crimes, unsafe sex, impaired driving…), including abusive consumption. These risk factors are different in nature: biological factors, family factors, social factors and other personal factors. Consequently biological factors may therefore explain the comorbidity among subjects abusing substances.

The FNQLHSSC survey (2008) indicates that a number of mental illnesses, transmitted genetically, may also explain drug abuse for several individuals, notably those with schizophrenia and bipolar disorders (Brochu, 2006; Ripple and Luthar, 1996; Cadoret, Troughton, O'Gorman, and Heywood, 1986). People with mental illnesses, or those with certain personality traits (border, histrionic or passive-aggressive), are effectively more at risk of developing drug abuse problems than the general population (Cuffel, 1996; Nace, Davis and Gaspari, 1991; Regier and al., 1990).

First Nations respondents in this survey indicated they showed significant signs of disorders generally associated with biological factors. Indeed, over one-third (35%) of respondents experienced depression for more than 2 weeks in the 30 days prior to their admission to a treatment centre and 73% indicated such depression episodes in their lifetime. Results also indicate that 42% of respondents have experienced anxiety and stress for more than 2 weeks in the 30 days prior to their admission to a treatment centre, and 70% in their lifetime. Almost one quarter of respondents had problems controlling violent behaviour for more than 2 weeks in the 30 days prior to their admission to a treatment centre and 57% reported such problems in their lifetime. Such problems also impact the request for services since 62% of respondents reported they had consulted a professional for psychological disorders in their lifetime.

Moreover, based on the results of the First Nations and Inuit Regional Longitudinal Health Survey (FNIRLHS), carried out in 2002, a high number of First Nations teenagers living in communities show mental health disorders. The data show that many of them have had suicidal thoughts at one point in their life (46.5% of girls and 23.6% of boys) and/or have felt depressed for more than two weeks in the 12 months preceding the survey (39.3% of teenagers).

The FNIRLHS demonstrated that there seems to be a link between emotional and/or mental health and drug use. As such, 50.4% of adults who previously considered suicide and 55.1% of adults who attempted suicide used drugs and/or volatile substances in the 12 months preceding the survey.

The FNIRLHS has also demonstrated that 47.5% of community members who have indicated a low level of physical, mental, emotional and spiritual balance also indicated they used drugs and/or volatile substances. Finally, young adults surveyed are the ones who indicate the most alcohol, medication and drug abuse, as well as verbal or psychological abuse problems.

According to the workers from the treatment program for adults who were surveyed within the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations" survey*, workers experience the same problems as the people surveyed. Among the problems encountered, 78% of the workers mentioned suicidal thoughts, 75% psychological or mental health problems, 75% experienced depression or felt depressed, 72% psychological and individual problems such as loneliness and isolation and 23% of respondents perceive that adults who have been treated live with a person with compulsive gambling issues. Also, according to the workers from treatment programs for teenagers surveyed, the problems most often encountered are psychological and mental health problems, experiencing depression or feeling depressed for 79% of respondents, while 73.5% of respondents indicated violence and aggressive behaviour problems and 68.5% indicated suicidal thoughts.

The results of the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey confirm the idea that youths start using substances at an early age. Inhalants are among the substances used at an early age. One-third of respondents started using inhalants at the age of 10 or younger and 58% between ages 11 and 15. Alcohol and marijuana are also used at an early age compared to amphetamines, cocaine, heroin and medication. First use generally occurred (about 60%) in the 11-15 age group and slightly more than 20% reported first using alcohol at the age of 10 or younger.

The age of onset of problematic substance use varies depending on the substance. For example, more than 80% of respondents with inhalant abuse problems declared their substance use became problematic when they were 11 to 15 years of age. Use of amphetamines tends to become problematic in the 16-20 and 21-25 age ranges. It is also the case for the use of cocaine and hallucinogens.

For about 50% of substance users with alcohol abuse problems, onset of problem drinking occurred between ages 16 and 20. For slightly over 25% of substance users, the use of medication became problematic between ages 21 and 25. Onset of problematic marijuana use mostly occurred in the 11-15 and 16-20 age ranges.

RISK FACTORS AND POSSIBLE CONSEQUENCES OF ADDICTIONS

In terms of consequences, the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey illustrates the impacts of addictions on individuals.

Parents are the first major socialization institution in the life of a child. This explains why the absence of a parent (usually the father) or disengaged parenting (accompanied by a feeling of rejection) generates major difficulties in the social integration process, which in turn considerably increases the risks for a child of developing drug abuse problems over time (Brochu, 2006).

The parents' influence may also be more direct. Several authors refer to the imitation phenomenon, also called inter-generational addiction process, when at least one family member uses substances. Through consumption, this parent seems to transmit a positive attitude towards drugs, which constitutes a form of approval towards their use (Brunelle, Cousineau and Brochu, 2002; Brook, Brook, De La Rosa, Whiteman, Johnson and Montoya, 2001; Cormier, Brochu and Bergevin, 1991; Hammersely, Marsland and Reid, 2003). As such, children who grow up in an environment where drug use is frequent and problematic, come to consider it as normal and are more at risk of developing drug use problems themselves.

Finally, a family environment at risk, characterized by inadequate parental supervision, disengaging from

parental responsibilities, violence and use of psychoactive substances, is a risk factor that fosters alcohol and drug abuse among adolescents.

According to the workers from the addiction treatment programs for adults who were surveyed, family problems are a major area of concern. They rank 1st and 2nd among adults in the elements reported by workers (family problems and difficult family and personal relationships; cumulative percentage of 97%) and child negligence (cumulative percentage of 90.5%). Violent and aggressive behaviour problems appear at the 4th rank (cumulative percentage of 84.5%). In the overall population, woman abuse and family violence are the 5th problem most recurrent in communities. 12.5% of respondents find it very much present, 50% very present and 34.4% somewhat present.

According to workers who deal with teenagers, two problems are especially recurrent. Almost two-thirds of respondents (63.5%), all or several of their teenager clients experience difficult or unhealthy family or personal relationships. Moreover, according to almost half (42%) of the respondents, most teenagers in their charge suffer from parental negligence.

Close behind family, school rapidly becomes the second socialization environment in the life of a child. School also plays an important role in the transmission of accepted social values. But a poor academic integration may seriously jeopardize the adhesion to those values and thus increase the youth's susceptibility to adopt problematic behaviours such as drug abuse (Bryant, Schulenberg, O'Malley, Bachman, and Johnston, 2002; Grapendaal, Leuw and Nelen, 1995; Normand and Brochu, 1993). The use of psychotropics is seen here as the development of an alternative outside the school frame that is meant to fill the gap left by a poor integration to school. The transition between primary school and secondary school is often a determining factor in the onset of deviant behaviours. This transition is particularly difficult for youths who have never developed any real and significant attachment with school or learning (Brochu, 2006). It is therefore appropriate to intervene with children experiencing adaptation disorders before they enter secondary school in order to prevent the onset of problems related to drug use.

Respondents also considered school drop-out as being an issue not to be neglected, as the results of the survey have shown. School drop-out ranks 6th, and 9.4% of respondents consider it to be very much present, 53.1% very present, and 28.1% somewhat present. Teenagers also experience problems with school drop-out according to workers since it ranks 3rd. School drop-out also contributes in maintaining the respondents' socioeconomic and socioprofessional problems and increasing their vulnerability to addiction problems.

While family plays a lesser role in the socialization process of a child who goes to school, peers represent a major risk factor when it comes to drug abuse (Brochu, 2006; Claes, 2003; Wasserman and al., 2003). The group of friends then becomes an influential source of values that reinforces the development of deviant behaviours. It fosters the first experiments with psychotropics and then becomes a practical source of supply. Teenagers most prone to be tempted by a deviant group of friends are those experiencing family and school issues, who do not have much hope for the future and who experience rejection by the adults in their environment (Brochu, 2006). In this type of situation, the group of friends fills the gaps left by family or school (Hotton and Haans, 2003). Therefore, adhering to a group of deviant peers, adopting their values and being exposed to pressure on their part constitute factors that foster the youth's evolution towards abusive drug use (Brunelle, Cousineau, Brochu, 2002; Bryant and al., 2002; Curran, White, Hansell, 2000; De Witt, Silverman, Goodstadt and Stoduto, 1995; Farrington, 2003; Grapendaal, Leuw and Nelen, 1995).

In his book on the relation between drug use and crime, Brochu (2006) notes that the risk factors usually associated with psychotropic drug abuse have also been found to induce the perpetration of crime. Several similarities found among a significant proportion of drug users would imply that violence and other forms of criminal acts are present in the behaviours of drug abusers. This phenomenon is generally described as general deviance syndrome (Brochu, 2006). A fair proportion of respondents in the FNQLHSSC's 2008 survey had to deal with the justice system. As such, 86 respondents indicated they had been incarcerated: 38% only once, 29% twice and 13% more than 5 times.

Several authors link drug use and perpetration of crime (Brochu, 2006; Germain, Brochu, Bergeron, Landry and Schneeberger, 2001; Schneeberger and Brochu, 2000). While some users commit crimes under the influence (effects of the substance), others will commit crime to obtain substances (intense need for the substance) (Brochu, 2006). The high cost of drugs will also push many drug users to make a move in order to finance their consumption (Brochu, 1997a). The abuse of psychoactive substances and the addiction then become proximate causes for criminal behaviour and second offences (Canadian Centre on Substance Abuse, 2004). In other terms, for several addicts, their drug use is the cause of the crimes they commit.

For example, particularly in the case of the Aboriginal population, Mercier, Rivard, Guyon and Landry (2002) demonstrate in their last report that, for the year 2000/01, 70 to 80% of all criminal offences in the Ungava Bay were committed under the influence of legal (mainly alcohol) or illegal drugs. These results were obtained following consultation of the crime files by the Attorney General in function at the time of the survey. However, the police would probably rather estimate that to be 90% of all crimes, considering the cases that never make it to court. However, these stakeholders are unable to determine whether these crimes were committed because of the craving or because they were committed under the influence.

Based on the data from the Correctional Service of Canada, Aboriginals are still overrepresented in federal correctional facilities: they represent 2.8% of the Canadian population, but constitute over 18% of the federal inmate population. Moreover, most crimes perpetrated by young Aboriginals are generally committed under the influence of alcohol, inhalants or drugs, while a minority of those crimes would be committed while sober. Finally, it seems that alcohol plays a major role in the life of Aboriginals incarcerated in Canadian prisons (Mercier, Rivard, Guyon and Landry, 2002).

Therefore, the previous description of risk factors shows that drug abuse usually results from a series of negative elements in the life of an individual. The complexity of these factors, which are interrelated, highlights the importance of implementing prevention and treatment programs capable of intervening not only on drug use problems, but also on environmental factors that may contribute to substance abuse, such as family dysfunction, associating with deviant peers, the lack of perspectives for the future, the perpetration of crime or poverty. Furthermore, knowing that early drug use is a key factor in predicting drug abuse among teenagers, it would appear relevant to provide prevention programs adapted for the younger ones.

In terms of harm reduction and according to the National Native Addictions Partnership Foundation (NNAPF, 2007), Aboriginals were affected in a disproportionate way by substance use-related harm and are overrepresented in some urban disadvantaged populations, in sex trade, and in prison. Inhaling substances has been recognized as a major problem in Aboriginal populations.

The risk of intergenerational transmission caused by social integration difficulties, school drop-out, the adoption of problematic behaviours, violence, delinquency, crimes (general deviance syndrome) appears

as part of the consequences of addictions. The abusive use of psychoactive substances, as previously seen, usually comes with several problems and social issues. These issues usually undermine community life, and sometimes even lead to apprehensions by the criminal justice system. Moreover, the gambling addiction problem in Aboriginal communities constitutes a complex issue. Gambling is usually seen as a "replacement addiction" for ex-addicts who are now clean; NNADAP workers dealing with gambling issues often express their frustration towards the increasing access of their former alcoholic clients to games of chance (NNAPF, 2005).

In terms of consequences on service needs, addictions require special attention according to the respondents of the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey. There is an increase of psychological distress among adult users. Mental health prevention activities lack for 53% of respondents. Workers also indicate they lack training on mental health and more specifically on schizophrenia. Suicide itself is a delicate issue for workers who experience a lot of stress towards this issue, and feel they lack training according to NNADAP agents.

Solving addiction-related issues is not simple. The historical severity of the challenge when it comes to Aboriginal communities is well illustrated in "Answering the Call", which is the document of the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Substances in Canada. In "Answering the Call" it is considered essential to address the fundamental causes of problematic substance use in Aboriginal communities. Access must also be given to treatment in a holistic approach, which recognizes the commitment of the person but also of the community as a whole. The training and capacity building of First Nations, Inuit and Metis, as well as the self-sufficiency of Aboriginal peoples are significant components to provide them with the means to develop and implement strategies adapted to their culture in order to achieve long-term sustainable progress.

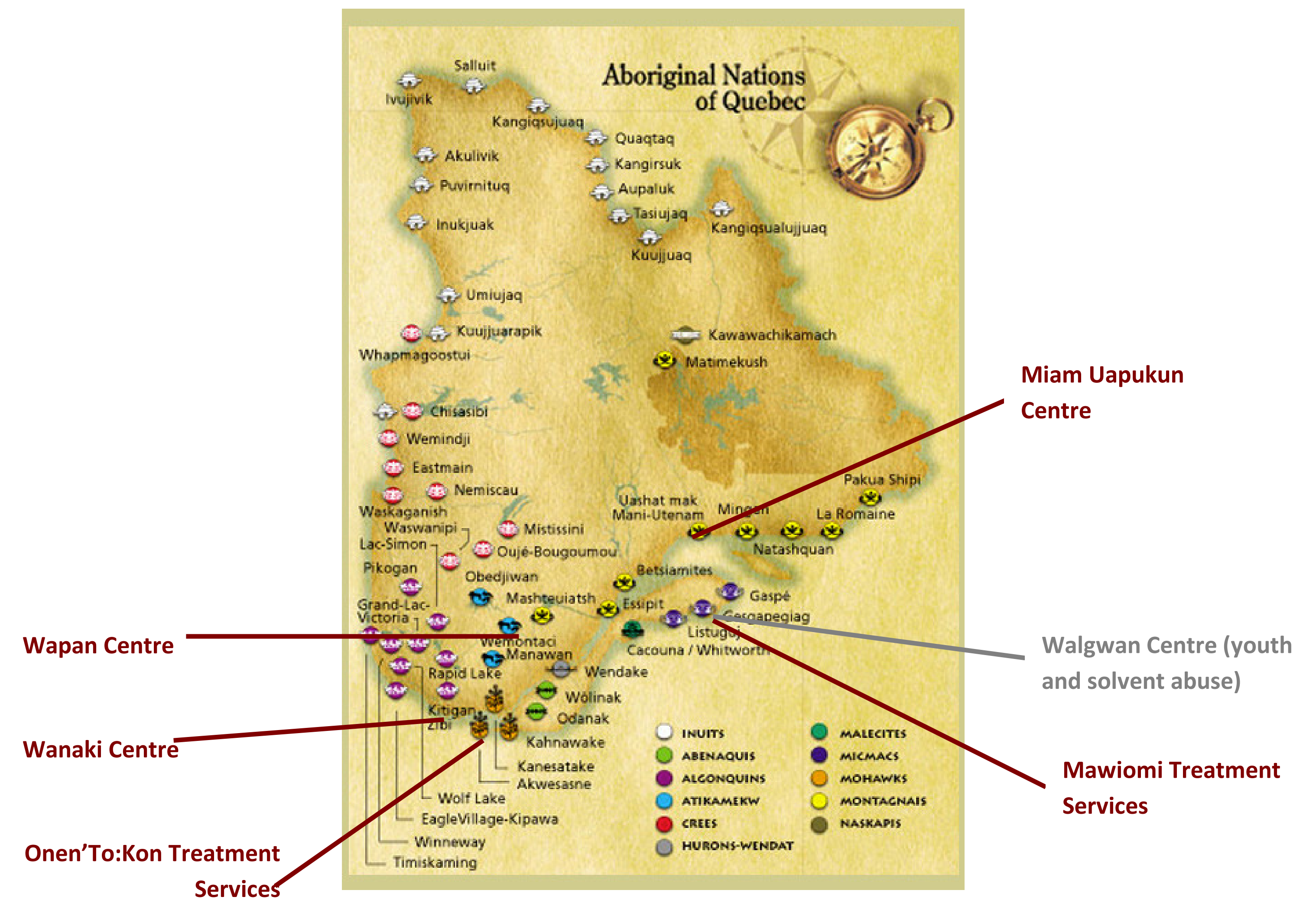
PART 2: PROFILE OF ADDICTION PREVENTION, INTERVENTION AND POSTVENTION SERVICES

SERVICE PROFILE

AMONG QUEBEC FIRST NATIONS

The NNADAP aims prevention, intervention and post-observation. Each First Nation community employs a NNADAP agent who works at improving the wellbeing of the individuals in the community through various activities described in the previous chapter "Overview of the current program". It is to be noted that in Quebec, most health programs, such as NNADAP, are transferred to First Nations communities.

In addition to employing agents in the communities, NNADAP provides funding to treatment centres where individuals may undertake a residential rehabilitation program. The map below illustrates the location of all NNADAP treatment centres in the First Nations of Quebec:



Source: Quebec Aboriginal tourism Corporation (n.d.).

The five (5) NNADAP treatment centres are intended for adults over 18 years of age, apart from a few exceptions when services may be provided to individuals aged 17 with the consent of the parental authority holder. The Walgwan Centre is the only rehabilitation centre that offers services to youth aged

between 12 and 17 using solvents and other substances.

Profile of each NNADAP Treatment Centre in Quebec:

Centre	Target clientele	Length of the residential program	Language	Special services	Number of beds
Wapan	Adults, 4 Nations	3 weeks	French	Intake screening; dual addiction; walk-in crisis/crisis intervention; follow-up/aftercare; outpatient (limited)	12
Wanaki	Adults, First Nations and Inuit	5 weeks	English and French (in alternating cycles)	Intake screening; dual addiction; follow-up/aftercare; interpretation services; outpatient (limited)	12
Onen'To:Kon	Adults, First Nations and Inuit	6 weeks	English	Intake screening; dual addiction; walk-in crisis / crisis intervention; follow-up/aftercare; interpretation services; outpatient (2 offices)	16
Mawiomi	Adults, First Nations and Inuit	5 weeks	English	Intake screening; dual addiction; follow-up/aftercare; outpatient; interpretation services	7
Miam Uapukun	Adults, First Nations and Inuit	3 weeks	Innu and French	Intake screening; dual addiction; follow-up/aftercare; walk-in crisis /crisis intervention	12
Walgwan	First Nations and Inuit youth aged between 12 and 17	Maximum of 6 months (possibility of extension)	English and French	Intake screening; dual addiction; outreach services; day client (non residential); follow-up/aftercare	12

Most NNADAP-funded treatment centres in Quebec have undertaken a process with Accreditation Canada for the recognition of their achievements in recognized quality standards.

It is to be noted that there are no NNADAP-funded family treatment centres, centres with day programs or outpatient services in Quebec, in opposition to other regions in Canada.

As to the follow-up, and although the post-treatment follow-up is desirable, the results of the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey indicate that the respondents perceive a lack at that level. It is reasonable to believe that there is a gap between the quantity of post-treatment follow-up services and the needs of individuals dealing with addiction problems. Finally, the results of the survey have shown that a majority of respondents (53%), believed that post-treatment services were not well adapted and lacked efficiency. Several respondents also indicated clientele follow-up as a major problem in their work.

In terms of intake, requests for a treatment are usually carried out through a referral agent (NNADAP

agent or other person). However some centres accept requests from individuals who send their own request. Each centre has its own intake procedure and forms that are approved by a board of directors. As such, a client may prefer or “select” a centre over another one. Intake requirements also vary from one centre to another and the language in which services are provided may affect a centre’s waiting list. The transportation procedures, approaches, the type of clientele admitted and the activities also vary from one centre to another. Although Treatment Centre Directors work jointly to discuss and exchange on common issues, each centre still operates individually. The current situation leads to the conclusion that there are major gaps in terms of services, which may even result in service overlap. For example, if the Miam Uapukun Centre offers an Innu language program while the Wanaki Centre offers a program in English, the Wapan Centre remains the only one to offer the program in French for a given period of time. It goes without saying that Treatment Centre Directors try not to create service gaps, but this operation turns out to be major logistical gymnastics that does not solve the problem.

IN QUEBEC (Organization of provincials services)

Regarding the services and programs in Quebec, the overall objective of the *Dependencies* program is to prevent, reduce, and treat dependency problems by broadening the range of drug addiction and pathological gambling services and ensuring the provision of these services throughout the Quebec territory.

Frontline services

The Health and Social Services Centres (CSSS) are responsible for the access to frontline services. As such, they receive the various clienteles, carry out case screening, outpatient detoxification and early interventions. They ensure methadone maintenance services, refer persons whose screening indicates results of abuse or addiction towards rehabilitation centres for alcoholics and other substances users (*centres de réadaptation pour personnes alcooliques et autres toxicomanes* - CRPAT) for specialized evaluations and provide support to their entourage and community.

Specialized services

As second line, CRPATs provide specialized services to people with addictions. With a solid expertise in intervention, CRPATs evaluate the level of abuse or dependency of each person and refer him/her towards the proper specialized services. They also play a significant role in the support, training and expertise with various partners in order to contribute to the consultation on addictions in each region.

Organizations recognized by the ministère de la Santé et des Services sociaux

Moreover, in order to ensure that the environment provided to these persons is safe on the physical, psychological and mental levels, the *ministère de la Santé et des Services sociaux* proposes a voluntary certification program to private and community organizations intervening in the field of addictions and providing accommodation. Organizations that have achieved the *ministère*’s certification have enrolled in a continuing quality improvement and research for excellence process in the interest of their clients.

Other resources

The MSSSQ has developed several resources on addictions and resources associated with addiction-related problems, such as a directory of addiction resources intended for any person likely to refer individuals with an addiction problem and allow for the referral of persons experiencing problems towards a specialized resource. It provides public resources offering treatment services, private or community organizations intervening in the field of addictions and providing accommodation certified by the *ministère de la Santé et des Services sociaux* and the organizations funded by the *ministère de la Santé et des Services sociaux* and dealing with gambling.

For each health region of Quebec there is:

- A detailed list of each resource
- The nature of the services offered
- The services available in English or in another language

This list does not prejudice the quality of the services offered by the private or community organizations intervening in the field of addictions and providing accommodation that do not appear in the directory. The directory is available online at:
http://dependances.gouv.qc.ca/index.php?repertoire_des_ressources_dependance (in French only)

Private and community organizations

In Quebec, there is a variety of private and community resources and services distributed throughout the province. For example, the *Fédération des centres communautaires d'intervention en dépendance* (formerly FOBAST) gathers, guides and coordinates the efforts of voluntary and community organizations who share its philosophy regarding prevention of addictions and the assistance it wishes to provide to addicts who are determined to enter rehabilitation. To consult their website: http://www.fccid.qc.ca

There is also an association of addiction workers (*Association des intervenants en toxicomanie*, AITQ- http://www.aitq.com, in French only) whose mission is to:

- Gather professional and voluntary interveners who work in the field of addictions and excessive gambling.
- Foster the involvement of the community in the prevention and treatment of addictions and excessive gambling.
- Foster exchanges between the various interveners in the field of addictions and excessive gambling.
- Foster the learning of new knowledge in the field of addictions and excessive gambling.
- Produce documents and tools for addictions and excessive gambling interveners and clientele.
- Raise awareness in the community on the use and abuse of alcohol and other psychotropic substances.

Many organizations of interest contribute to a greater awareness by providing publications on the issue of addictions in Quebec. More information on the subject is available on their website.

- *Centre Québécois de documentation en toxicomanie (CQDT)* (in French only)
  http://www.centredollardcormier.qc.ca

- Addiction Prevention Centre
  http://www.cqld.ca/cqld_en/cqld.0.a.php
- *Drogues, santé et société* (in French only)
  http://www.drogues-sante-societe.ca
- *Fédération québécoise des centres de réadaptation pour personnes alcooliques et autres toxicomanies* (in French only)
  http://fqcrpat.org
- Gambling; Help and Referral
  http://www.jeu-aidereference.qc.ca/www/homepage_en.asp
- Joueurs anonyms (in French only)
  http://www.ja-quebec.com
- Parlons Drogues (in English)
  http://www.parlonsdrogue.com/en/accueil/index.php
- Recherche et Intervention sur les Substances psychoactives-Québec (RISQ) & Collectif en Intervention et Recherche sur les Aspects SocioSanitaires de laToxicomanie (CIRASST) (in French only)
  http://www.risq-cirasst.umontreal.ca
- Toxquébec.com (in French only)
  http://www.toxquebec.com

In light of the data collected within the context of this inventory, it appears that the Quebec network of addiction services is organized as a continuum of care and based on the needs of the person. In the First Nations network, the service offer is relatively consistent and more oriented towards assisting all the individuals from communities with substance use problems regardless of specific problems.

It is obvious that demographics justify a more diversified service offer such as it exists in the Quebec network. However, this does not dispose of the need for First Nations to draw inspiration from the Quebec model regarding the diversification and organization of services.

SECTION 2: RESULTS OF THE NEEDS ASSESSMENT

PART 1: RESULTS OF THE STRUCTURED INTERVIEWS WITH QUESTIONNAIRE

With a questionnaire sent beforehand to respondents, the structured interviews were carried out between March 27 and April 22, 2009, and lasted 24 minutes each on average. There were 48 respondents: 29 women (60%) and 19 men (40%); their average age was 47 and 85% of them were members of a First Nation. All the respondents agreed verbally to the phone interview.

Note: *Since the preferred method for structured interviews was to let the respondents express themselves freely on specific questions, the information was organized into themes in order to facilitate the reading and organization of results.*

HIGHLIGHTS

- 85% of respondents are members of a First Nation.
- 100% of respondents are closely associated to NNADAP.
- 54% of respondents bear the title of NNADAP agent and work in communities and 40% of respondents work directly with NNADAP either as worker, clinical supervisor or program manager.
- Relapse prevention activities are the ones preferred by respondents on a priority basis (46% of respondents).
- The lack of financial resources is the chief obstacle to the implementation of prevention strategies (75% of respondents).
- 54% of respondents indicated that prevention activities as they are currently carried out in their environment are not efficient.
- Concerning intervention tools, 96% of respondents indicated that practices and strategies to improve the treatment of addictions of the people who have relapsed would be useful for them.
- 33% of respondents identified the counselling for addict clientele training program as the preferred intervention tool.
- 71% of respondents deem that the centres as they are currently organized do not meet the needs of the addict clientele.
- A vast majority of 98% of respondents indicated they agreed that the centre for teenagers should also be able to provide family services and that a greater number of rehabilitation services and options for teenagers should exist.
- With regards to treatment centres, 46% of respondents preferred the fact that a centre should offer detoxification and crisis intervention services.
- The 12-step AA approach in treatment centres is preferred by 29% of respondents, followed by the cultural, traditional and spiritual approach at 25%.
- The post-treatment follow-up protocol with a detailed intervention plan for each person remains the preferred tool of a majority of respondents (60%) when it comes to post-treatment.

Sociodemographic aspects

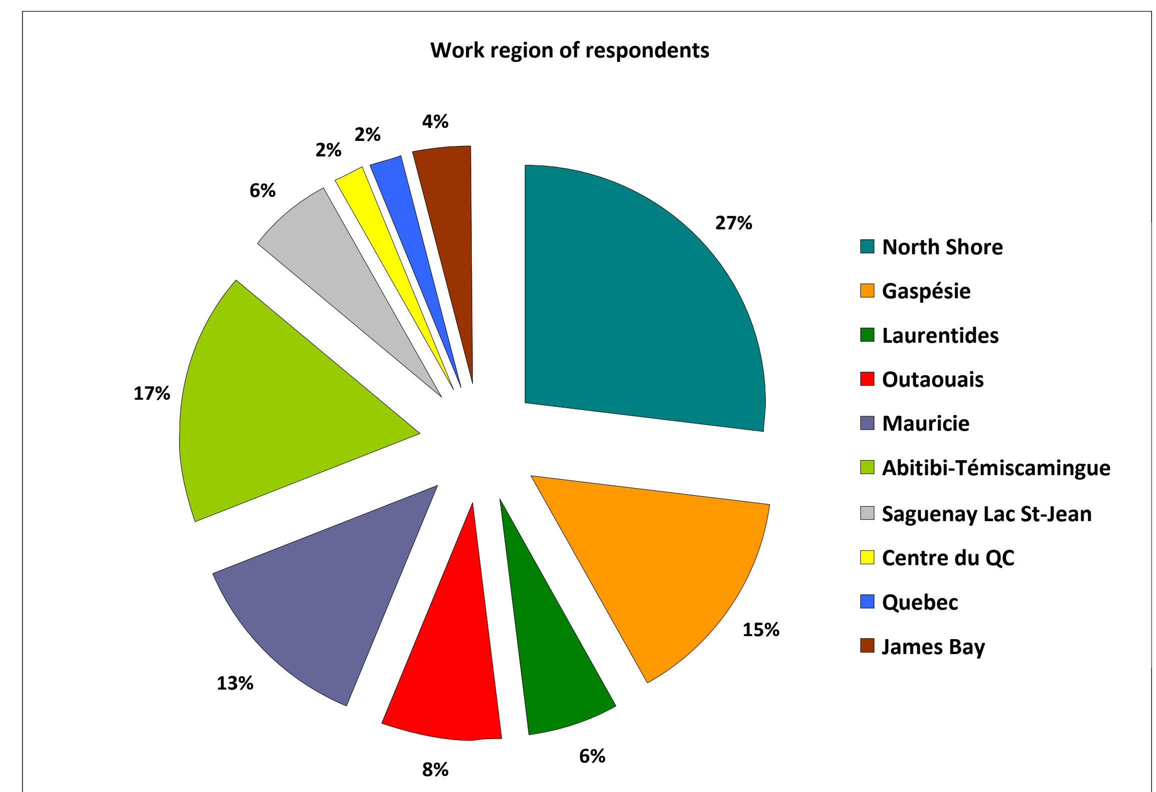
Distribution of respondents according to the language they use on a daily basis

The respondents' language used on daily basis is distributed as follows:

- 38% Aboriginal language.
- 31% English.
- 31% French.

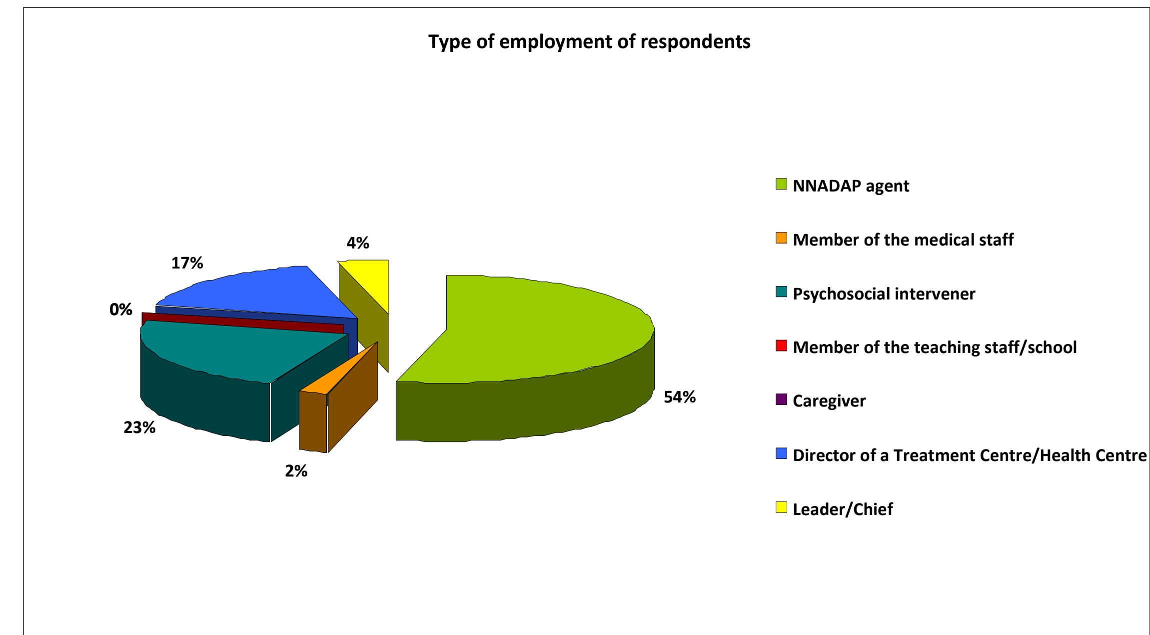
Distribution of geographic locations where respondents work

The following graph shows the distribution of respondents according to the region where they work. The North Shore (including the Lower North Shore) is represented by 27% of respondents, while Abitibi-Témiscamingue is represented by 17% of respondents.



Distribution of respondents according to their occupation

The following graph illustrates the distribution of respondents according to their type of employment. A majority of respondents are NNADAP agents (54%), whereas 23% psychosocial interveners who work in the field of addictions. Moreover 19% of respondents identified themselves as being directly involved with NNADAP either as Director of a Treatment Centre or a Heath Centre or as Chief in a community in charge of NNADAP. As such, 98% of respondents are directly related to NNADAP.



When questioned on the number of years of work in their current job, 58% of respondents indicated they had been in duty for more than five years, 15% for two to five years, 10% for one to two years and 17% for less than a year.

Years of experience in a field related to alcohol and drug abuse prevention or treatment

Before being in their current occupation, 50% of respondents indicated they had worked in a field related to alcohol and drug abuse prevention or treatment for more than five years, 13% between two to five years, 6% between one to two years and 33% for less than a year.

PREVENTION COMPONENT

Easiest types of prevention activities to apply

Respondents identified types of activities that were easy to organize or to implement in their environment. The activities to identify were the following:

a) Activities that will allow youth to learn about various drugs and their effects.

b) Activities that will allow youth to learn practical techniques and adequate attitudes to resist using drugs.

c) Prevention activities for the whole population that would be structured and spread across the year.

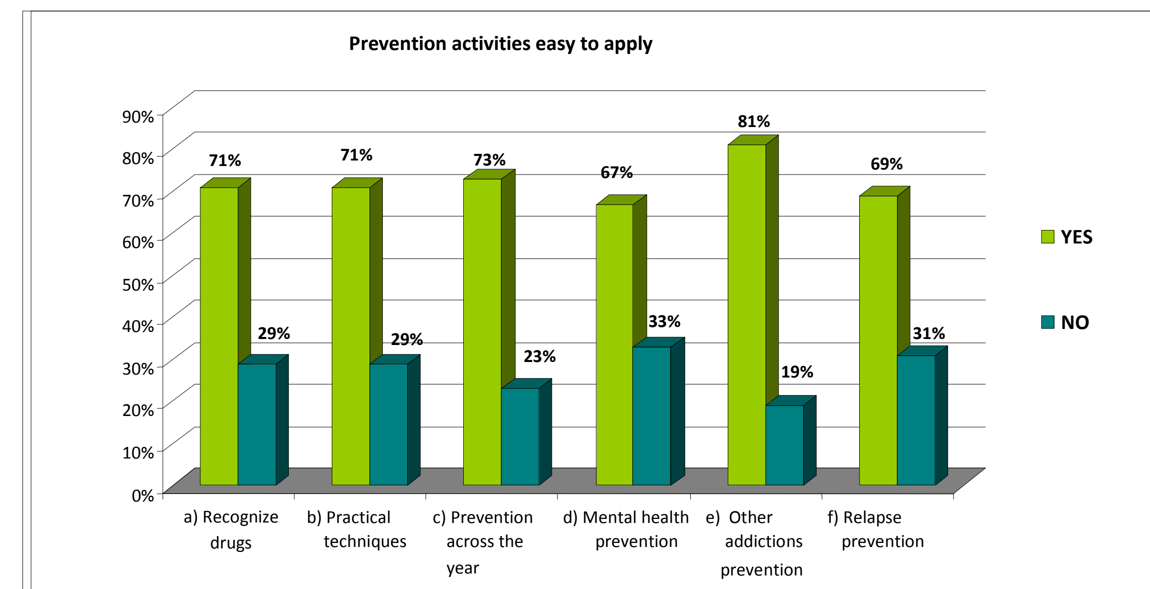
d) Prevention activities related to drugs but also to mental health prevention.

e) Prevention activities related to drugs but also to the prevention of other forms of addictions, such as gambling.

f) Relapse prevention activities that can be offered to those having received care in treatment centres or individual counselling.

Results show that 81% of respondents indicated that the easiest prevention activities to apply in their environment are the prevention activities related to drugs but also to the prevention of other forms of addictions such as gambling. In contrast, 33% of respondents indicated that the most difficult prevention activities to apply are the prevention activities related to drugs but also to mental health prevention.

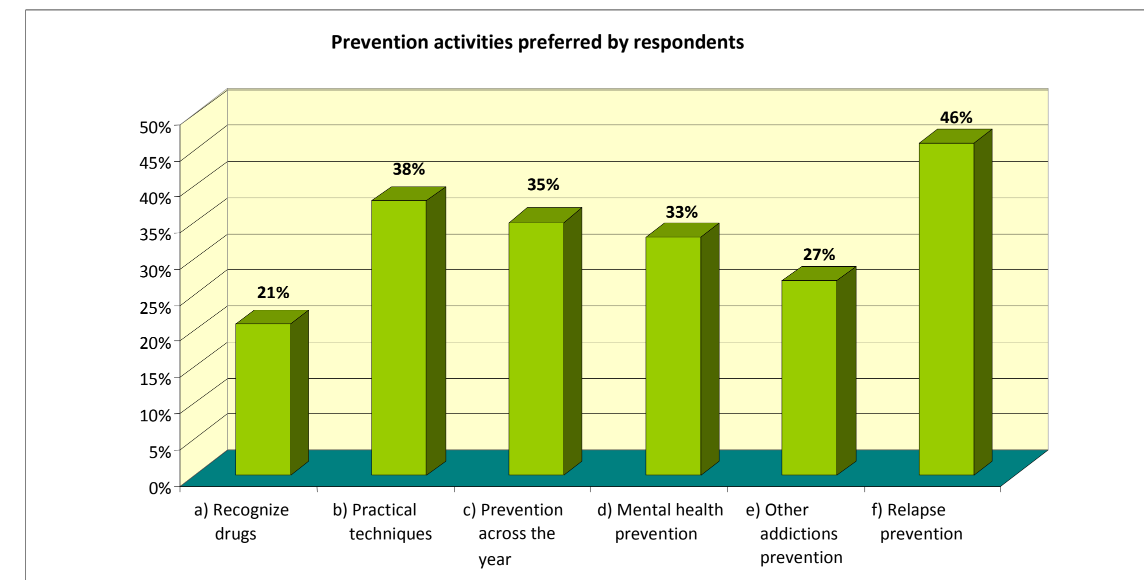
The following graph illustrates the respondents' opinion concerning each type of prevention activity:



Selection of priority prevention activities

Respondents were asked to prioritize two prevention activities among the activities previously proposed. Relapse prevention activities that can be offered to those having received care in treatment centres or individual counselling were preferred by 46% of respondents. The second choice was the activities that will allow youth to learn practical techniques and adequate attitudes to resist using drugs. The results show that the easiest and more difficult activities to apply are not those preferred by respondents.

Distribution of the respondents' preferred choices:



When questioned on other prevention activities that would be easy to apply in their environment, respondents mentioned the following activities:

Activities targeting youth

- Have the youth at risk and other youths visit the treatment centre.
- Youth Council.
- Entertainment activities to keep youth from using substances.
- Activities in schools.
- The community organizes intergenerational meetings between youth and Elders and it works.
- Activities in the forest with youth.
- Workshops in schools and Aboriginal resource persons in schools.
- Educational school program.
- Youth Centre: activities and addictions camp.
- Youth Health Committee.
- Activities targeting youth.
- Activities at the Youth Centre (sub-groups).
- Ask people who have graduated from the treatment centre to share their experience with the

youth in school as role models.
- Youth groups and let the youth organize prevention activities.

Activities targeting parents

- Workshops on the development of children, on the art of being a parent and on a healthy lifestyle.
- Program aimed at developing parental skills.

Cultural/natural environment activities

- Cultural and traditional activities.
- Intervention in a natural environment.
- Activities in the forest with group themes, weekend healing.
- Traditional activities with sweat lodge ceremonies.
- Activities in the forest (hunting and fishing).
- Activities outside without the people knowing it is a prevention activity.
- Activities directly related to culture; more people will get involved.
- Adventure activities and traditional Cree activity.

Relapse prevention activities

- Ambulatory therapies, counsellors visit communities (for ex. for relapse prevention).
- AA meetings.
- Community project to acknowledge people who stopped alcohol and drug abuse (November 25 each year).
- More meetings of former clients who have gone through therapy, on a weekly basis, to support them in their progress.

Theme activities

- Walks for the fight against drugs.
- Theme workshops on self-esteem, we develop the “how to live without using”.
- Healing and sharing activities for people in substance-use prevention.
- Activities towards a better life and sobriety oriented towards life promotion.
- Bi-monthly workshops for the population.
- Theatre play.
- Occupational activities to foster harm reduction.
- Personal growth activities.
- Weekend workshops with an external resource from the Centre Attitude in St. Jérôme.
- Open-line radio show with a suggestion box to allow people to choose the subjects.
- Community fundraising activities.
- Radio show.
- “Impaired driving” awareness campaign.

Other activities

- ❖ Prevention activities undertaken by the local treatment centre through the service continuum implemented.
- ❖ Sharing circles.
- ❖ Consumption-free social activities.
- ❖ Social workers training.
- ❖ Leisure activities.
- ❖ Promotion of careers in the social field.

Constraints or barriers that can hinder the implementation of prevention strategies in the community/organization

Respondents had to identify, in the following list, the elements that constitute constraints or barriers to the implementation of prevention strategies in their environment:

a) The lack of financial resources.

b) The lack of human resources.

c) The lack of knowledge concerning what can be done to prevent addiction among youth.

d) The lack of knowledge concerning what can be done to prevent addiction among the population in general.

e) The workers' lack of training to carry out prevention.

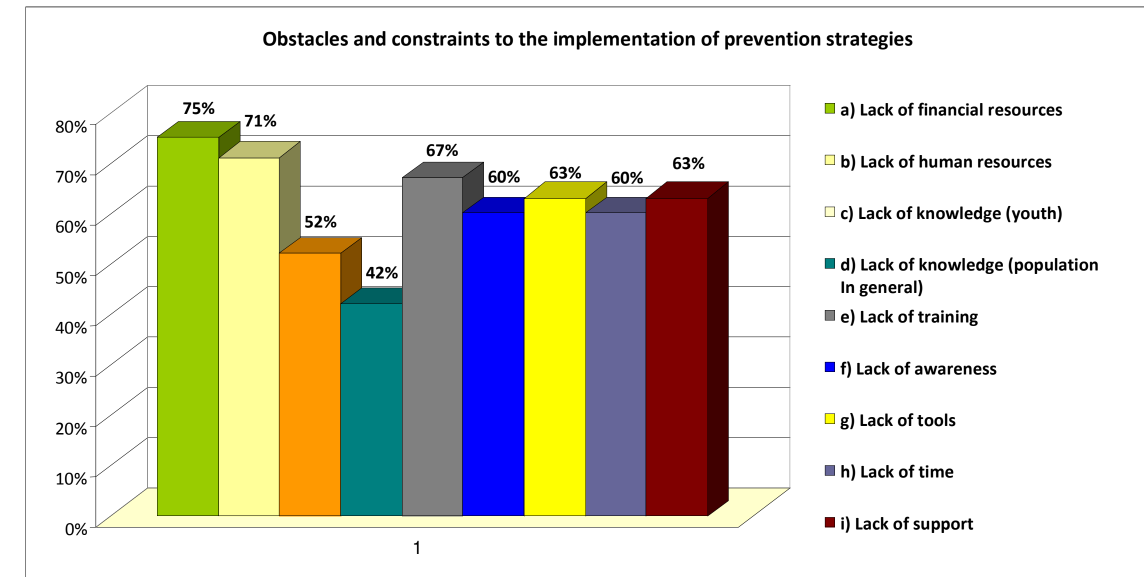
f) The lack of awareness in the community/environment regarding the importance of carrying out addiction prevention.

g) The lack of tools to carry out prevention on a regular and ongoing basis.

h) The lack of time to carry out prevention because most of the time is spent "putting out fires".

i) The absence or lack of support from the community or organization leadership.

Results show that 75% of respondents identified the lack of financial resources as the most often reported barrier, followed by the lack of human resources (71%) and the workers' lack of training to carry out prevention (67%). The lack of knowledge on what can be done to prevent addiction among the population in general remains the barrier least often reported (46%). The distribution of the barriers and constraints expressed by all the respondents follows.



Other constraints or barriers that can hinder the implementation of prevention strategies in the environment

Respondents could indicate other barriers to the implementation of prevention strategies in their environment. The respondents' answers follows:

Barriers related to communication and structure problems

- Lack of communication between the team members and frontline workers.
- Services don't work together (police, school, etc.). Nobody is on the same level and rules must be fair.
- We wanted to bring all the community organizations together to do prevention but it did not happen because the political level got involved.
- Community structure too heavy: projects wither away.
- Lack of collaboration of the other sectors in the community.
- Money earmarked for prevention is not used accordingly in the community.
- Lack of structure; it has to be a grassroots movement.
- The Youth Centre was closed.

Barriers related to the lack of participation of the people in the community/environment

- The population is hard to access and there is a lack of mobilization. People abandon halfway.
- Lack of participation of the community members.
- Low participation rate in prevention activities.
- The population's participation is deficient.
- Those we target don't participate.

Barriers related to authorities in the community/environment

- The lack of information provided to the leaders. There was a carnival in the community and there were a lot of games similar to pathological gambling. It would have been important to advertise in order to raise awareness among people.
- Lack of support from the community especially when we need to address youth.

- Lack of intervention from the police.
- The community does not carry out any prevention because there is no leadership.
- Council members sell drugs. We ask workers to perform miracles while leaders themselves sell illegal products. They are the first to complain when someone overdoses.

Barriers related to the attitude of the members in the community/environment

- People don't want to address their problems.
- The attitude, the normalization of substance use in the community, attitudes must change significantly. The worst problem is the normalization of marijuana use.
- People don't see any problem; they still drink.
- Some parents and community members don't want their children to know about drugs so they won't think about them. Some people have closed minds. Not everybody, but some people don't want us to put that in their children's head.
- Traditional and cultural practices: it is hard to convince people it really works.
- The youth won't participate if the worker is not aboriginal.
- Normalization of behaviours, acceptance of non acceptable behaviours (for ex. use drugs at an early age).
- Community members are scared of being judged.
- Accessibility of drugs for the youth.
- Nobody talks about it; there is a lot of denial.
- There are no role models in the community.
- People abandon easily and they don't help each other.
- There are a lot of obstacles for people. They cannot succeed because they don't know what to do.

Barriers related to the lack of resources

- Treatment centres have no money to do prevention.
- The treatment centre has no resources in prevention. When the person is following a treatment, it is an emergency situation. There should be additional human and financial resources to do prevention and it would need more time.
- The treatment centre can only act on relapse prevention but prevention is not part of its mandate.
- Lack of external resources and material adapted to the various age groups (booklets, etc.) It is difficult to do prevention in schools.
- There are only 2 NNADAP agents for a population of 4000 people. There is a terrible lack of resources even though we are trained on addictions. Not everybody knows addictions. We bear the weight of the task. There is a lack of addiction-specialized resources.
- The lack of interveners to work with youths and adolescents.
- Lack of prevention programs at school.
- The language.
- More material (posters, flyers, newsletter).
- Lack of prevention counsellors.
- Limited space to carry out prevention activities. We must pay to reserve spaces and it's expensive.
- We don't have NNADAP in the community although we should have it.

Barriers related to the lack of knowledge

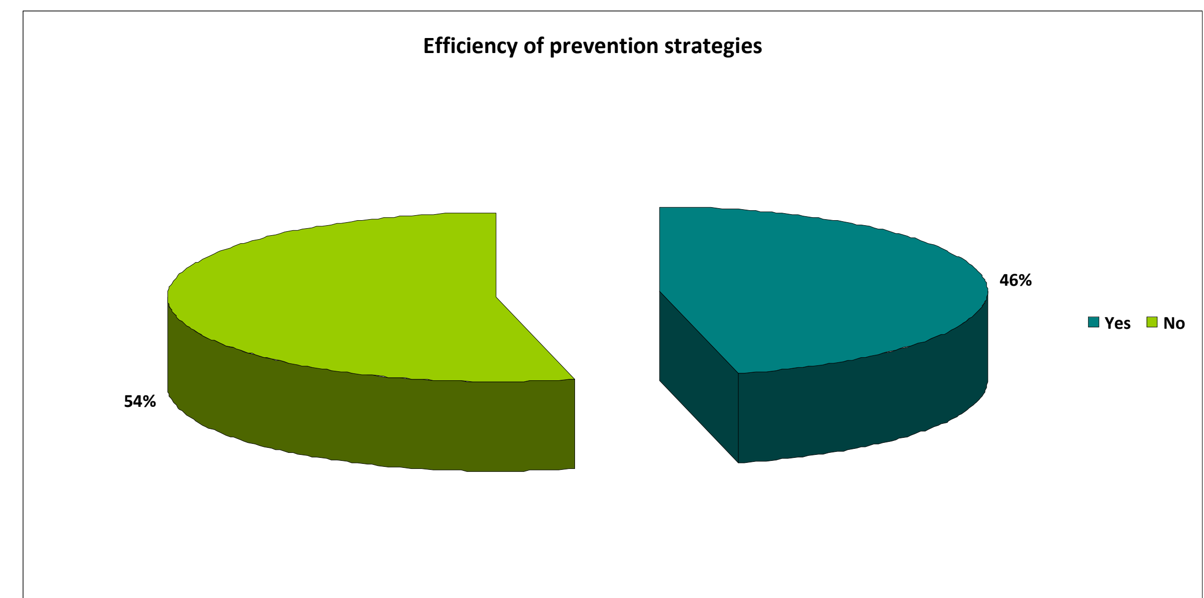
- Communication skills are necessary to do prevention and it cannot be learned at school. It's a major obstacle. It's not given to everybody to be able to talk in front of a group. Group facilitation training would be necessary.
- The lack of knowledge regarding the holistic and traditional approach.

Barriers related to the lack of time

- Lack of time on the school schedule.
- The lack of time constitutes a major barrier.
- Lack of time.

Efficiency of the prevention strategies currently carried out

Respondents were questioned on whether prevention activities such as those currently carried out are efficient (i.e. do they foster drug use reduction, raise awareness among youth and the population on the adverse effects of substance use, etc.). 54% of respondents answered negatively and 46% positively.



Among the respondents having responded negatively, we provide you with the suggestions they made in order to increase the efficiency of prevention strategies:

In terms of communication and networking

- More advertisement.
- More networking between communities and sectors.
- There is no follow-up and it needs to be focused on youth.
- There needs to be more partnerships in order to do more prevention in schools, for example. Meetings need to be held to create partnerships and see who can do what.
- People need to be informed of the situation, they need to ask for services and take position.
- Greater public outreach and more than once a year.
- We need to consult youth and ask for their opinion.
- More networking between services and community programs (police, Council, etc.).
- Men need to be with men, women with women, and youth with youth. People feel more comfortable that way. Youth feel misunderstood when in the presence of adults.

- Ask people what they want (nobody does that).
- Prevention plan adapted to the needs of First Nations.

In terms of approach, structure, management and service delivery

- There must be a comprehensive approach and a continuum of care, prevention, intervention, postvention and reinsertion. There must be a structure.
- There must be a coordinator, a follow-up and the people's will.
- There seems to be no prevention activities in the community. Another organization should manage the funds.
- Treatment centres don't have the mandate to carry out prevention.
- Prevention and follow-up services: involve the family in the referral process because the client receives better support with his family.
- Workers should do more prevention activities in the community because it is not done. Clients should be supported in the healing process, organize follow-up activities with the family, organize more workshops and prevention activities organized with the collaboration of the Treatment Centre.
- Prevention, treatment and post-treatment: those are the 3 components of NNADAP, and the post-treatment is almost non-existent while treatment and prevention are separated.
- A harm-reduction approach could be implemented.
- There needs to be support. There needs to be an appropriate community structure. We need to bring other specialist to work with NNADAP and have a work team.
- Someone needs to be designated in the community to ensure stability.
- There is a lack of planning and reflection; there are occasional activities, we should work on this and develop an action plan.
- With the community health plan we evaluate the impact of the prevention strategies. Every time we administer a questionnaire at the beginning of the activity and again at the end of the activity; it provides an indication of the impact.
- We should foster accompaniment, communication and prevention.
- There needs to be intervention with the family but it is difficult when both parents are users of multiple drugs.
- Prevention activities must be part of a harm reduction approach.
- Based on recent studies, realistic prevention strategies must be proposed, and we must develop a regional vision but activities must be led by communities.
- We must reach out to youth in order for them to trust us.
- Target clienteles (youth at school, adults, youth at the youth centre).

In terms of attitudes

- Those who do prevention should be role models in the community and do more activities.
- Provide clients with tools so they make enlightened choices.
- The more adults will take charge of themselves, the more youth will follow.
- We should be meeting all the youths; they have a lot of influence over each other. Youths aged 9-10 use drugs.
- If the strategies are not efficient they should be focused on the youth and not on drugs.

In terms of gaining knowledge

- Training activities to make youth more independent and educate them about drugs. Provide youth with certified training in order for them to know about the various drugs and feel more

self-confident.
- ❖ There needs to be more training on how to talk to youth.
- ❖ Training on new drugs is necessary.
- ❖ Focus more on FASD and gambling.
- ❖ The development of parental skills is necessary.
- ❖ Relapse prevention tools.
- ❖ Information on harm reduction.
- ❖ Focus more on cultural activities to promote pride and cultural values.
- ❖ The NNADAP agent is not qualified and there is no prevention. Have qualified people and ensure greater community outreach works.

In terms of regulation and compliance with the laws

- ❖ Nobody cares about looking for the drug dealers at the moment.
- ❖ People are scared of denouncing drug dealers. We are told to mind our own business.
- ❖ Both convenience stores promote alcohol: there were pallets of beer and it was as though alcohol use and accessibility were encouraged.
- ❖ All the youth seem to be smoking at school. There needs to be a reduction of the numbers of smokers, incidents related to alcohol abuse need to be reduced. Alcohol abuse is often followed by fights.

INTERVENTION COMPONENT

Types of tools or programs that would be most useful to intervene with people requesting help for their substance use problems

Respondents were asked to express themselves on the types of tools or programs that would be most useful to intervene with people requesting help for their substance use problems. Respondents had to answer positively or negatively regarding the following types of tools or programs:

a) An interview guide in which the person’s motivation to undertake a process would be measured.

b) A guide to evaluate the person in order to refer him/her to the appropriate resources based on his/her condition.

c) A coaching and clinical supervision program (series of measures applied according to guidelines).

d) A training program on counselling with an addiction clientele.

e) A continuum of care and services for addictions (client’s path from the beginning to the end of a rehabilitation process).

f) Practices and strategies to improve the treatment of addictions for individuals who have relapsed.

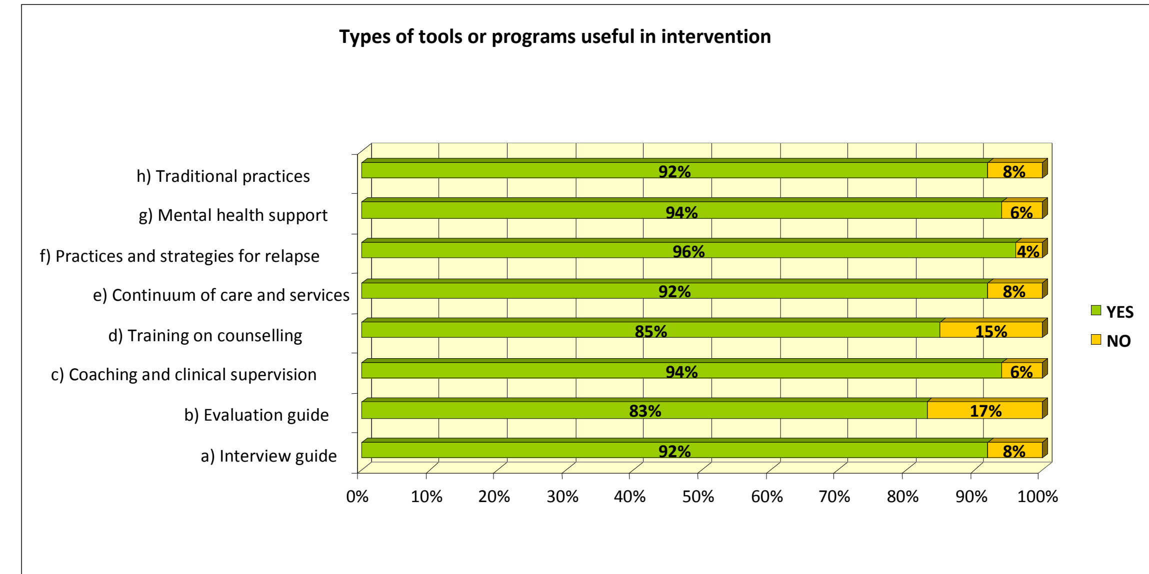
g) Mental health support.

h) Traditional practices related to the culture.

Concerning the practices and strategies to improve the treatment of addictions for individuals who have relapsed, 96% of respondents indicated they agreed, followed *ex aequo* by mental heath support (94%) and a coaching and clinical supervision program (94%). Traditional practices related to the culture and an

interview guide in which the person's motivation to undertake a process would be measured also constitute a choice indicated by 92% of respondents.

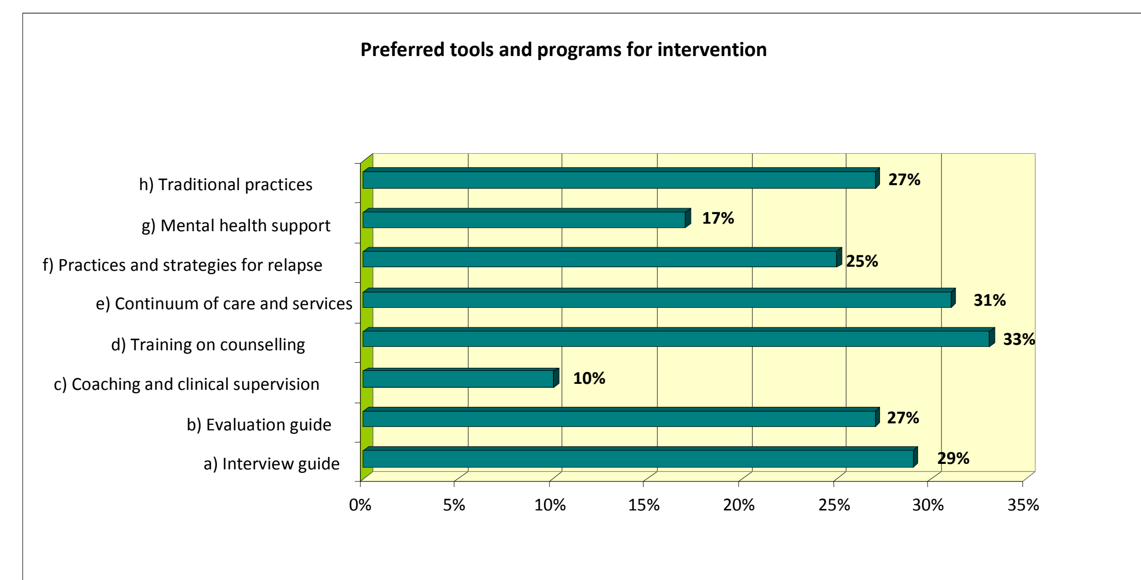
The following graph illustrates all the choices:



Preferred tools or programs for intervention

Among the tools and programs proposed, respondents were asked to select two programs or tools they preferred for intervention with clients. A training program on counselling with an addiction clientele arrives first with 33% of respondents, followed by a continuum of care and services for addictions for 31% of respondents. The coaching and clinical supervision service arrives last with 10%.

Distribution of the respondents' choices:



Other tools or programs important to develop

In addition to the list of tools and programs previously proposed, respondents suggested other tools and programs that would be important to develop:

Related to the approaches, structures and service delivery

- A Treatment Centre for youth aged 12 to 17 in the North Shore region.
- A comprehensive approach that would address all of a person's dimensions (balance). We need to work on the dimensions of the person in addition to working with cultural concepts.
- We must establish partnerships and exchange with all collaborators, set objectives and evaluate them, and then distribute everybody's roles and responsibilities in a continuum.
- Develop a "research" component.
- A good follow-up intervener in the community to prevent relapse (more focus on the post-treatment follow-up).
- There must be detoxification services.
- There must be services for people who are exhausted, respite services for single mothers who use drugs (crisis or respite centre).
- An intervention emergency line.
- Elders to give advice.
- The health centre has a prevention mandate and workers often go beyond that mandate. Mandates need to be reviewed and adapted to today's reality. We are limited by our restrictive mandates.
- Protocols for the referral of mental health cases depending on the services available in the region.
- Family services.
- Structured prevention of relapse.
- The roles of NNADAP and intervention must be developed. Intervention comes before treatment. There are so many gaps in the process. There is a flagrant lack of detoxification services. We don't know what to do with these clients. Waiting lists are very long.
- Group support (AA and NA) and sharing circles.

Related to the workers' evaluation methods and tools

- A standardized evaluation tool.
- The interview guide must include all the treatment centres and the guide should be the same for all centres and NNADAP agents.
- Tools to help people learn how to practice sound financial management and pay their bills.
- A complete work kit is necessary because it ensures we all use the same "vocabulary" and tools.
- Tools to work on relapse prevention.
- Presentation tools (such as Power Point), we need tools to work.
- There needs to be an evaluation tool for detoxification.
- A directory of treatment centres classified by the treatment of various problems.
- A website with information, guides, etc. Not just links; a website developed for First Nations interveners.
- Standardize admission request forms for NNADAP treatment centres.
- Tools to detect high-risk situations (suicide) and the associated protocols.

- ❖ Tools to detect mental health cases.
- ❖ Post-treatment follow-up tools.

Related to gaining knowledge

- ❖ Offer training on intervention.
- ❖ More traditional programs to keep people busy. Ways of showing people there are other leisure activities and enable them to explore their talents. Many clients are talented (woodworking for example) and we need to involve them and teach them how to use them.
- ❖ Training on Bill P-38. As frontline workers, we need a frontline worker who manages cases. Training should be mandatory.
- ❖ Community outreach on a more continuing basis.
- ❖ Training on addictions to intervene with youth in a school environment, how to approach them.
- ❖ The know-how-to-be and social skills: we must be able to establish a relation of trust with clients. Agents often give clients a lecture; there are listening techniques to be learned, techniques to question people. NNADAP agents need to learn them.
- ❖ It would be very important to develop the traditional and holistic approach. With the number of clients we have, we do the approach in a natural environment. The NNADAP agent developed a program that really works and trained another community. The lack of time prevents the training from being given elsewhere.
- ❖ Program on the development and maintenance of parental skills; we need to go to the root to prevent abuse and deficiencies.
- ❖ Work on motivation with teenagers.
- ❖ Certification for NNADAP agents.

NETWORK OF REHABILITATION/TREATMENT CENTRES

Types of intervention in rehabilitation/treatment centres that should be developed to meet the addiction clientele's current needs

Respondents were asked to express themselves on the types of intervention in rehabilitation/treatment centres that should be developed to meet the addiction clientele's current needs. Respondents had to answer positively or negatively regarding the following types of intervention:

a) The centres as they are currently organized meet the needs of the addiction population.

b) A centre should offer detoxification and crisis intervention services.

c) A centre should offer specialized services for individuals with addictions who also have mental health problems.

d) A centre should offer specialized services for individuals with addictions who also have other addictions such as gambling.

e) A centre should always accept admission requests (i.e. without any fixed admission dates, the client could be integrated to the treatment as soon as the admission request is accepted).

f) A centre should be designated to offer specialized services to court referrals.

g) The centre for teenagers should also be able to offer family services.

h) A greater number of rehabilitation services and options for teenagers.

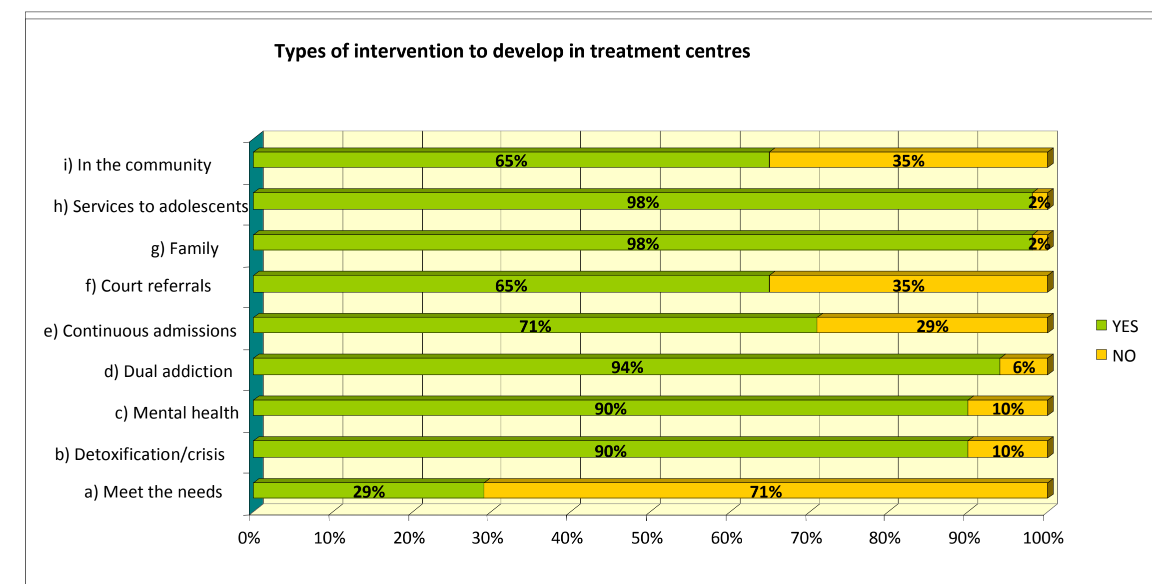
i) A Treatment Centre located in the community.

In light of the data collected, it is obvious that the centres as they are currently organized do not meet the needs of the addiction clientele since 71% of respondents were of that opinion.

Furthermore, a strong majority of 98% of respondents indicated they agreed with the fact that the centre for teenagers should also be able to offer family services and that there should be a greater number of rehabilitation services and options for teenagers.

A strong majority of respondents also indicated that a centre should offer specialized services for individuals with addictions who also have other addictions, such as gambling (94%); that a centre should offer detoxification and crisis intervention services (90%) and; that a centre should offer specialized services for individuals with addictions who also have mental health problems (90%).

The following graph illustrates the respondents' opinion concerning the types of intervention to develop in treatment centres:



Preferred types of intervention in treatment centres

Among the types of intervention proposed, respondents were asked to select two types of intervention they would prefer, which could be offered by the treatment centres network.

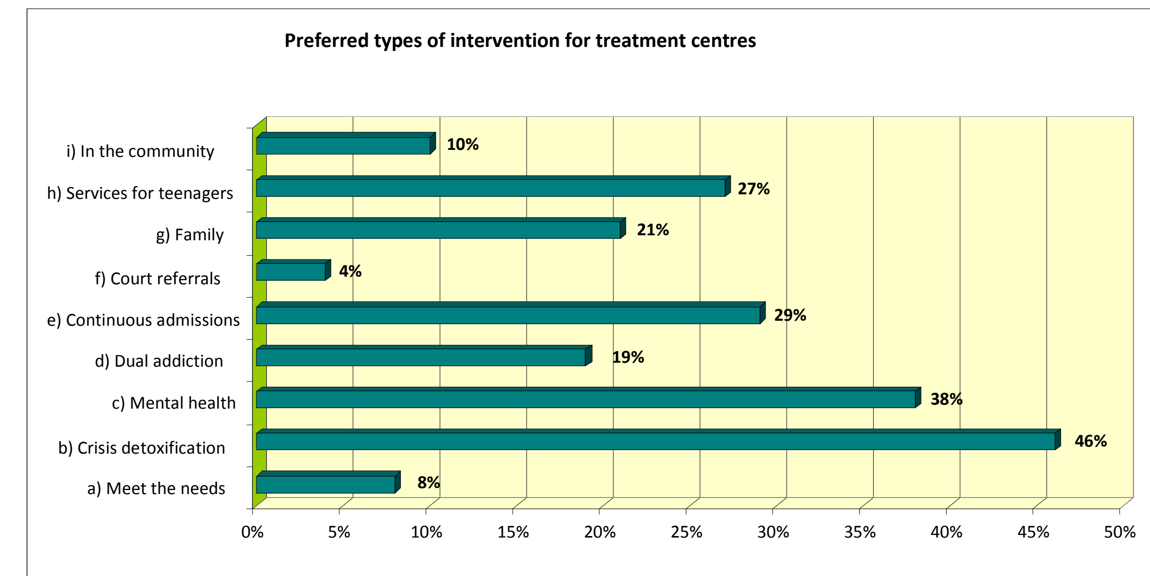
46% of respondents preferred that a centre should offer detoxification and crisis intervention services. Secondly, 38% of respondents preferred that a centre should offer specialized services for individuals

with addictions who also have mental health problems.

Two types of intervention receive very little support from respondents: a centre should be designated to offer specialized services to court referrals (4%) and a Treatment Centre located in the community (10%). Once again respondents did not support the fact that treatment centres meet the needs of the current clientele since only 8% of respondents preferred that statement.

The results clearly show that mental health, detoxification and continuous admission services are preferred compared to the statements to the effect that the centre for teenagers should also be able to offer family services and that a greater number of rehabilitation services and options for teenagers should exist. Although at the previous question it was clear that those two types of intervention were deemed useful by 98% of respondents, they do not seem to be priorities when the time comes to choose.

Distribution of the respondents' choices:



Winning conditions of a program fostering healing

Programs currently promote the 12-step AA approach, others are based on culture, while others advocate a biopsychosocial comprehensive approach. Respondents were asked to express themselves on the conditions they consider to be winning conditions for a program that fosters healing. Their recommendations follow:

Conditions related to the client's environment

- Couples' therapies and family counselling.
- Add a family component that incorporates culture.
- First and foremost we need to know the person's needs.
- The approaches are diversified but families need to be included. Families are not prepared.
- Therapies should also include outgoings; people don't get out and the return to everyday life is difficult.
- We need to address parental skills.

Conditions related to approaches recommended in treatment centres

- Combine the AA approach with cultural approach (3x).
- Programs need to be evaluated and the addiction severity index ASI is the best efficiency measurement but the ASI should be adapted to the communities and include the spiritual and cultural aspect.
- Holistic approach that integrates culture and traditional aspects.
- In the Quebec region, 3 treatment centres promote the AA approach but it would be better to adopt a holistic approach.
- Comprehensive and holistic approach, an approach that offers continuous training (new addictions new techniques and practices).
- The 3 integrated approaches are winning approaches.
- The 12 steps with a holistic and cultural approach; we must combine both approaches.
- Go into the natural environment, do therapies in the forest.
- The cultural approach is good for all clients.
- Cultural approach for high risk youth.
- Most people consider the cultural approach.
- Program focused on the reinforcement of the identity with sweat lodge, holistic approach (comprehensive), approach based on the circle.
- All approaches are important and must be integrated.
- Include spirituality and more cultural activities.
- Culture is irrelevant but spirituality is important.
- Focus more on Aboriginal values.
- We must include traditional culture and be closer to the Aboriginal reality. People may find it difficult to share their experience in an environment that is too different.
- A program that integrates spiritual life, with religious prayers (rosary) and incorporate nature (forest).
- Based on experience, there is a flagrant need to renew with our Aboriginal identity and the centres do not focus on that very much. We must focus on a holistic approach and a centre should offer that exclusively (without AA and other resources). We must address the 4 dimensions of life and return to Aboriginal sources.
- The Innu language and traditional medicine.
- The 12 steps and culture and spirituality.
- We must balance the various approaches. AAs have saved the most alcoholics throughout the word and we cannot deny culture's role in healing.
- The three approaches combined and it all depends on the person.
- Multidisciplinary approach based on the client's profile.
- We must adopt a holistic approach.
- AA lifestyle and get involved actively.
- Culture and spirituality must be included.
- Biopsychosocial approach integrating culture and spirituality.
- Comprehensive biopsychosocial and spiritual approach.
- 12 steps and psychosocial approach.
- Approach must be based on the client's needs. Clients must be able to choose the approach.
- Based on the clients needs; we do not want to impose our beliefs on someone else.
- Culture must be included.

Conditions related to the structure of treatment services

- Have complete services that incorporate all the dimensions of a person (physical, mental, etc.) and see rehabilitation as an ongoing process, we need to improve the person's conditions and a continuum of care is necessary to do that. But we need to meet and share the tasks.
- A longer-term treatment would be beneficial. In five weeks we can only scratch the surface.
- Opiates are not addressed. Several youth are dependent on painkillers and treatment centres do not focus on prescription drug abuse. Six to 9 months are necessary to cleanse the body; it requires a long-term treatment centre.
- There is only one Centre for youth and there should be one for young adults aged 18 to 30.
- Offer AA meetings in the community.
- Treatment centres are afraid of the clientele; if we add too many specifics, it's as if the Centres resist admitting certain clients.
- The Centres are restrictive and often there are no places available, workers are exhausted in the Centres.
- Treatment centres with units (eaters, gambling, drugs, alcohol, anger management) like the Graham Bell Hospital in Tampa. They have traditional teachings.
- We need role models who have stopped using substances.
- Focus on post-treatment care, AA groups and individualized support.
- Offer a social reinsertion service.
- The mental health component is necessary. We need to evaluate these cases and ensure a psychological follow-up.
- Program that fosters social reinsertion, ensure post-treatment follow-up.
- Work on personal difficulties such as pathological gambling, it is a major problem for us.
- A therapy centre for youth (the one for non-Aboriginals closed down).
- Multi-service approach instead of working in a vertical approach.

Conditions related to the preparation of clients prior to treatment

- We need to have a long-term vision. The lack of follow-up of a client often causes the client to relapse. Some people have extreme violent behaviour problems and we need to be able to evaluate them well to refer them well.
- Detoxification must be included.
- The person's motivation must be worked on (motivational approach), workers need to possess counselling techniques and the approach needs to correspond to the clients values.
- Prioritize the people who have gone through detoxification before entering therapy.
- We need to foster detoxification before entering therapy.

Availability of approaches in treatment centres

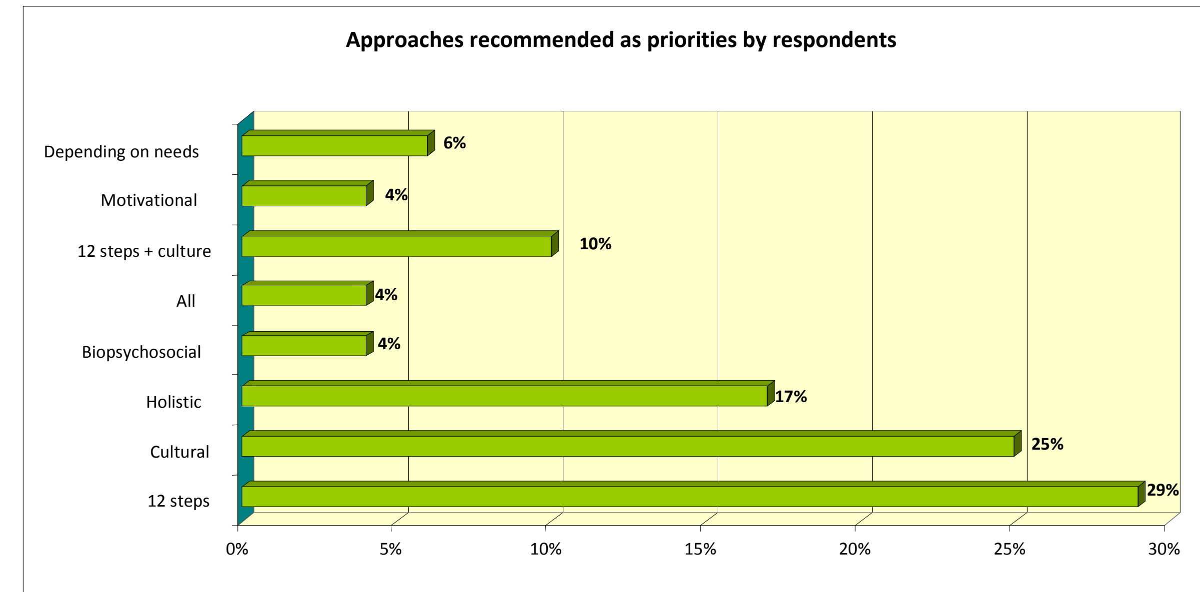
When questioned to know whether there should be a variety of approaches available (AA, cultural, spiritual) in the network to satisfy the needs of the clients admitted in the Treatment Centre, 100% of respondents answered positively.

Approaches recommended as priorities by respondents

Respondents had to indicate the approach they recommended as priorities in treatment centres. The 12-step AA approach arrives first with 29%, followed by the cultural, traditional and spiritual approach with 25% of respondents and by the comprehensive and holistic approach with 17%. The biopsychosocial

approach and the motivational approach received little support since only 4% of respondents preferred these approaches respectively.

The following graph illustrates the distribution of the approaches recommended by respondents for treatment centres:



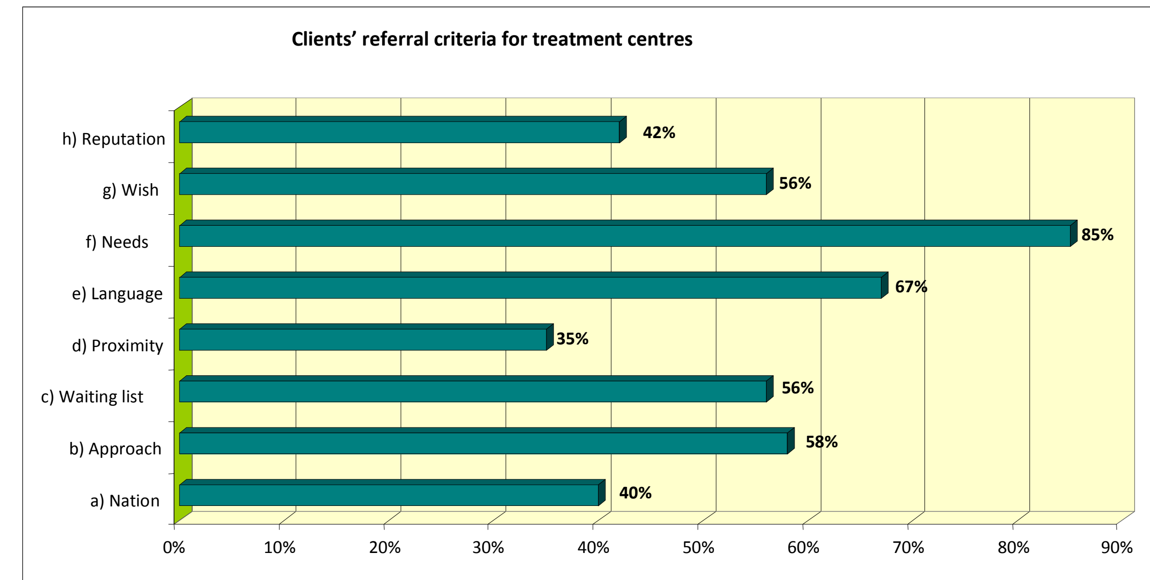
Referral criteria in treatment centres

Respondents were questioned about their clients' referral criteria for rehabilitation/treatment centres (many choices could apply). The list of criteria on which respondents could express themselves is as follows:

a) Based on the Nation of clients targeted by a centre.
b) Based on a centre's approach prioritized by a client.
c) Based on the centre with the shortest waiting list.
d) Based on the nearest located centre.
e) Based on the client's mother language.
f) Based on the client's needs.
g) Based on the client's wish.
h) Based on the centre's reputation.

A majority of respondents (85%) refer clients to a Treatment Centre based on their needs. However a criterion such as the client's mother language is a referral criteria for 67% of respondents, followed by the approach prioritized by the client (58%), the client's wish (56%) and the shortest waiting list (56%).

The distribution of the criteria is as follows:



Many respondents mentioned other criteria:

- Client's detoxification level.
- Number of prescription drugs taken by the client.
- The quality of a centre's services.
- The follow-up offered by a centre.
- The promotion of the 12-step approach.
- Based on the quality of the preparation before the treatment (motivation, client's needs, reasons for the treatment, etc.)
- Based on the client's family status (single parent).
- A centre's accreditation.
- If the centre ensures post-treatment follow-up.
- If the former clients are satisfied.
- The rapidity of a centre's response.
- Based on the length of the treatment.
- Based on the client's state of emergency.
- Based on the services offered in the community.
- Based on the client's personal progress.

POST-TREATMENT FOLLOW-UP

Types of tools or programs that would be most useful to intervene in post-treatment follow-up of people who have participated in a therapy program

Respondents were asked to express themselves on the types of tools or programs that would be most useful to intervene in post-treatment follow-up of people who have participated in a therapy program. The list of tools or programs they had to choose from is as follows:

a) A post-treatment follow-up protocol with a detailed intervention plan for each person.

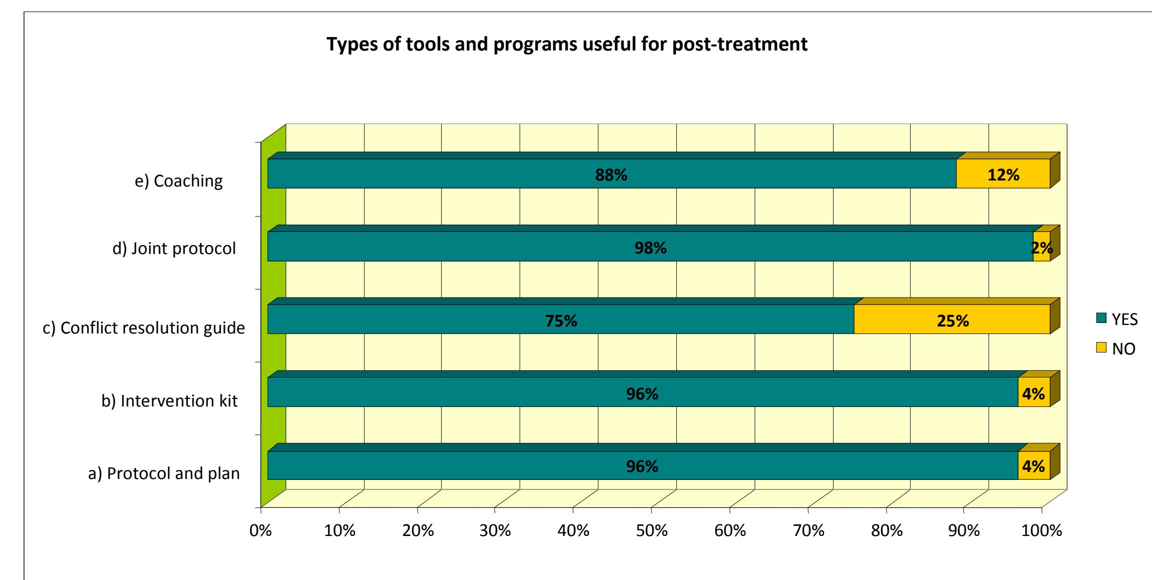
b) A post-treatment follow-up kit including several themes that could be addressed such as relapse prevention and anger management.

c) An intervention guide on conflict resolution.

d) A joint follow-up protocol with the centre where the client completed the treatment.

e) A coaching and clinical supervision service.

A joint follow-up protocol with the centre where the client completed the treatment is a tool that would be useful for 98% of respondents. A post-treatment follow-up protocol with a detailed intervention plan for each person and a post-treatment follow-up kit including several themes that could be addressed such as relapse prevention and anger management were respectively chosen by 96% of respondents. An intervention guide on conflict resolution remains the tool least chosen but 75% of respondents indicated it was a tool that could be useful. The following graph illustrates what the respondents expressed concerning post-treatment tools:

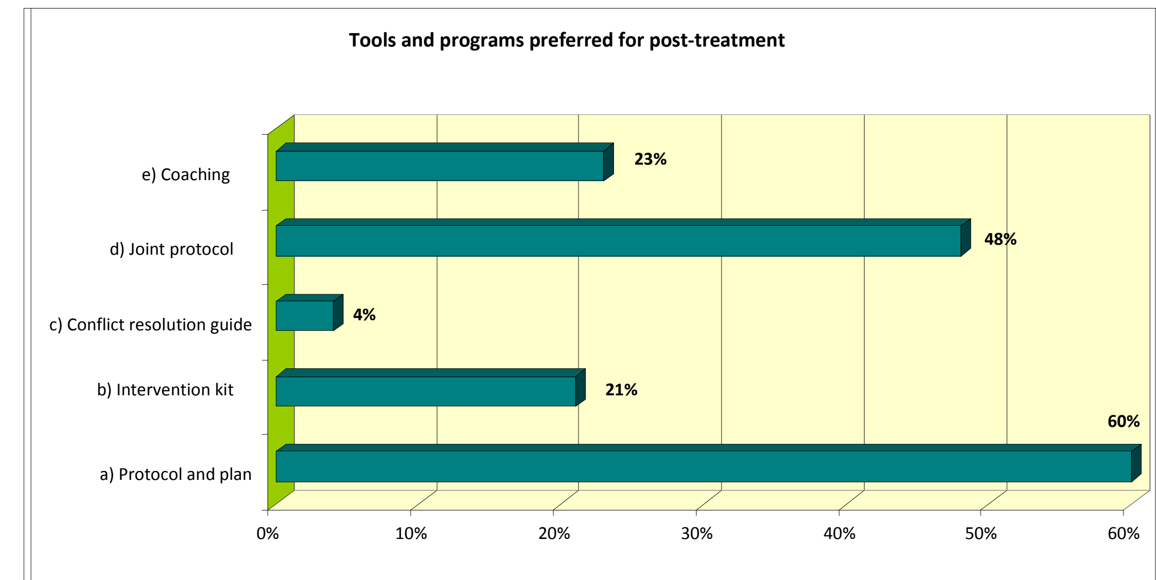


Tools or programs privileged for post-treatment

Among the tools and programs proposed respondents were asked to select two types of tools or programs they privilege and which could be offered by the Treatment Centre network.

The post-treatment follow-up protocol with a detailed intervention plan for each person remains the tools preferred by a majority of respondents (60%). In second place, 48% of respondents preferred the joint follow-up protocol with the centre where the client completed the treatment. The guide on conflict resolution is preferred by only 4% of respondents.

Distribution of the respondents' choices:



Other tools or programs important to develop for post-treatment

In addition to the list of tools and programs previously proposed, respondents suggested other tools and programs that would be important to develop for post-treatment:

Related to networking and partnerships

- We need to encourage voluntary work.
- Ideally we need to meet and develop partnerships. All the tools are useful, but we need to really work jointly, sign agreements and distribute tasks. The treatment centre develops follow-up plans but we don't know if the follow-up is done. We need to know how to work together in order for it to work better. We need to be open with the other person, know the components and share tasks (behaviour, physical cultural, spiritual, training employment, etc.) There is no exchange of ideas at the moment.

Related to the service structure

- We need to set ourselves objectives and evaluate whether we can achieve them.
- A post-treatment follow-up worker in each community.
- A greater number of support groups and relapse prevention activities in the community.
- Focus on youth.
- We need to adopt a cultural approach with specific themes related to addictions.
- Youth ASI program (and adult).
- Program in natural environment.

- "Grief and Loss" program: many losses are not resolved and we need to offer short-term treatments (weekend) on specific themes.
- We should not wait to be in a crisis, we need long-term work plans.
- Treatment centres could offer post-treatment support since the clients have developed ties with the workers in the centres. We know the clients in the communities and sometimes they are afraid to talk about their problems with community workers. However ideally we would have people from other communities like the workers in the treatment centres.
- Post-therapy in natural environment with holistic approach.
- A post-treatment resource centre.
- Social reinsertion program after the treatment.
- Work in teams with the community's various sectors (employment, training).
- More financial resources for activities in the forest.
- Structured relapse prevention program and ensure its application.
- Harm reduction approach.

Related to knowledge acquisition

- If the NNADAP worker did not use substances himself, it would help. NNADAP should set criteria and people who sell or use drugs should not be hired.
- Provide training on post-treatment to NNADAP workers.
- Training on conflict resolution.
- Training on relapse prevention.
- Training on post-treatment follow-up for all NNADAP workers.

Related to the client's environment

- It would be great to have a support system. There is nothing when the client returns home. We need measures to keep people on the right path.
- Family assistance.
- Improvement at the family level (post-treatment).
- Family program to help the family when the client returns home.
- Environmental factors influence relapse. We need more support groups and their meetings need to be on a regular basis. The client needs to be integrated to a support group.
- We need to involve people who have been sober for many years, we need more resources for them on weekends.
- A support group so the client can hang around people who are sober.
- Follow-up with the family and the spouse during the treatment.
- Traditional teachings to help people after their treatment.

Related to the interveners' work tools

- Material for post-treatment, the respondent has been a NNADAP agent for 14 years and nothing has changed.
- Guide on family conflict resolution.
- Concrete tools for relapse prevention (documents, etc.).
- Youth program with biopsychosocial approach.

SUGGESTIONS TO IMPROVE THE SERVICES OF THE NNADAP PROGRAM

Respondents were asked to suggest elements that could improve the services of the NNADAP program. The methodology allowed the respondents to express themselves freely but in order to facilitate the reading of the results, the information has been organized in themes.

Please note that the answers cited herein were drawn from the written transcriptions of the structured interviews.

Service structure

- There needs to be an information and promotion service.
- We need a facility with tools allowing people to be self-sufficient and resourceful so they can manage on their own.
- There must be a continuum of services.
- A detoxification service is required because some people enter therapy still under the influence.
- There must be centres for teenagers, families, adults and court referrals.
- There must be social reinsertion services.
- There must be an outpatient follow-up service over many years in order to really help the client to become self-sufficient.
- Detoxification services are required.
- NNADAP should not be a test for accreditation. Our work is to treat and heal.
- A detoxification centre with 5 beds in the Montreal region.
- We need to develop post-treatment follow-up services, it is urgent.
- Treatment centres must reach appropriate occupancy rates. A greater number of centres would not help centres maintain and comply with this requirement.
- Detoxification and mental health services must be implemented.
- There must be more post-therapy follow-up.
- Treatment centres must have more beds.
- There should be a crisis centre and shelter for men only as we do not know where to refer them.
- There must be a specialized centre for gay clients. They need specialized care. When a gay person goes to a general treatment centre, his concerns are not taken into account.
- Treatment centres should not admit people with bipolar disorders. Mental heath services are required.
- The staff in treatment centres should be specialized in mental health.
- A long-term treatment centre is required.
- Booster treatment sessions to reenergize former clients.
- There must be group activities and post-treatment activities.
- Take into account the client’s reality, it is not just alcohol, there is a lot of comorbidity and mental health cases.
- Objectives must be realistic.
- Transition centre for detoxification: it can remedy crisis situations.
- A detoxification centre is required.
- More treatment centres recognized by Health Canada, people would like to go elsewhere than in NNADAP centres. We are very limited in the choice of treatment centres.

- Strategies must be realistic.
- Means to refer court referrals to treatment centres: at the moment, NNADAP centres seldom accept them.
- The Cree people must leave the community and it is as if entering a residential school because treatment centres are too “institutionalized”. Crees must have a treatment centre.
- Conflict with NNADAP: NNADAP is a federal program and the Cree Health Council wants to keep the program. It should demonstrate some courage and decentralize the program because it instigates a lot of negative comments from Cree communities.
- Reduce treatment centres’ waiting lists, it is discouraging for clients.

Research and evaluation

- Pursue validation process of the situation concerning addictions (validation and update of statistical data).
- An organization should focus on research.
- Statistical evaluations (we want to be aware of our strengths and weaknesses), we need to know which of our services to improve.

Human resources

- A standardized job description for all NNADAP agents.
- Have an additional regional representative at the FNQLHSSC: with all the territory to cover, notably Crees and Algonquins, one person is not enough.
- More resources available on the community.
- Outreach worker.
- We have a turnover problem, we have 2 workers for 4000 people and one treatment centre. We have to send clients where there are some openings and this is not an ideal situation.
- A worker for the youth and another worker for mothers and young girls are definitely required. One worker is not enough, human resources must be doubled. We have no workers for men and fathers.
- Is there really a NNADAP program? Someone should tell us what our chief role is, should we do prevention or counselling?
- We need nurses and doctors. We need a complete care structure, that would be ideal.
- We need NNADAP agents of both genders in the communities, because some clients are embarrassed to confide in a woman and vice versa. Men, and especially youth, are embarrassed to consult a woman and talk about their problems.
- We need to fight against the adverse effect of staff turnover.
- Workers specialized in mental health.
- Network team.
- Addictions multidisciplinary teams (doctor, psychologist).
- Workers should do more frequent follow-ups, more than once a month.
- We absolutely need additional staff: with only one NNADAP worker, it is impossible to provide services.
- We need prevention and post-treatment follow-up interveners.
- We need more support groups to help clients. Workers would feel less isolated and clients would not depend on only one worker.

- More addiction workers (prevention, intervention in schools).

Networking and communication

- We have quarterly NNADAP meetings for the Algonquin Nation. It allows us to expand our networking and share our ideas and discuss. It would be useful for other Nations to do the same.
- Better communication between the communities and the treatment centres.
- Exchange more with the people in charge of the program at Health Canada and have them visit the communities so we can take the time to get to know each other.
- Establish a regional strategy with our partners and have the communities adhere to it.
- Ensure that the regional strategy can be adapted to each community.
- Better networking between communities.

Knowledge acquisition

- Training should be mandatory, among other things, workers in treatment centres and NNADAP agents should be certified.
- More training for NNADAP agents. Many clients consult and the agent is not prepared.
- NNADAP agents should have a better knowledge of treatment programs.
- Training on all the aspects of addictions.
- Accredited training to obtain the university addictions diploma or certificate for all agents.
- Train NNADAP agents so they can work with youth.
- Remain updated on new drugs.
- NNADAP agents have no mental heath training and they should.
- The NNADAP network should have trained interveners. The receptionist should not pose as the intervener.
- We need to have some training on how to keep files, it has never been done before and it would be very important.
- Invite traditional healers and have the opportunity to have them to stay around so we can have some training with them.
- Better training on client evaluation for NNADAP agents.
- Mentoring program to support workers in other communities (upon request) for example, assist with the development of the community health plan. People with experience can offer that service.
- Training on counselling for all interveners.
- We must have the same concerns for training and staff support.
- Human relations training.
- All NNADAP agents should have a degree.
- All NNADAP agents should have the same training.
- Training for interveners.

Involvement of authorities

- Politicians must get involved and support people in their process to become more responsible.
- Ensure strategies are taken in charge by the communities’ leadership.

Tools and measures to facilitate the interveners' work

- Evaluation tools must be standardized and we all need the same data: we need access to a database.
- There must be a website of all services.
- The clients must be appropriately evaluated to be appropriately referred.
- Interveners receive very little support from NNADAP agents in terms of admission. NNADAP agents in isolated regions experience difficulties and receive no support. We need to organize meetings and provide them with opportunities to network.
- Orientation for new NNADAP agents.
- Have offices with a certain level of intimacy; currently we share our offices and it does not foster confidentiality when the other agent receives clients.
- We need to develop a toolbox based on age groups.
- We need to coach new NNADAP agents.
- We need to have tools on the various types of addictions and other themes and expand on themes, such as self-esteem.
- There needs to be a healing program for NNADAP agents, we need preventive leave.
- Filing tools, archiving system.
- Clinical evaluation computer program.
- There must be healing resources on a regular basis for NNADAP agents, they are isolated and work alone.
- We need defined work tools.
- More prevention material.
- Hold regular meetings (once a year) for NNADAP agents.
- Healing resources for NNADAP agents.
- Develop a flyer or newsletter for the NNADAP network.
- Standardize work tools across Quebec.
- A lot of interveners still have difficulties, we need to provide healing resources and go through the healing process ourselves prior to working as an intervener. We need to help them solve what remains to be solved.
- Offer psychological support to interveners.
- We need to develop more tools for communities.
- NNADAP agents need to go through weeks of healing.
- Weekend healing resources (e.g.: 4th and 5th steps, on mourning). We have no supporting resources in our region.
- More material and tools, there does not seem to be any funding for these. Learning tools are very expensive and we cannot buy them. We feel limited in isolated regions because there are no resources.
- Retreat lodges for addictions workers.
- A regional resource centre to order material (flyers, videos, booklets, etc.)
- Healing resources for interveners.

Youth

- More prevention activities for youth.
- There needs to be specialized centres (youth). It needs to be accessible on a short-term basis for

youth in treatment centres, but currently there is only one centre that offers long-term stays.

- The main concern is that there are very little services for youth.
- Youth NNADAP worker.
- We need interveners to work with teenagers. NNADAP agents are trained to work with adults but half the population is composed of teenagers. We conduct substance use studies in the communities. Drug use among youths is ever increasing. We have nothing to offer them in terms of services.
- Day centre for teenagers.

Financial resources

- All the amounts that are provided to NNADAP services should go to NNADAP. Some Band Councils take the amounts earmarked for NNADAP, which means services need to be cut. We therefore need to ensure that services are offered according to the means allocated to NNADAP.
- We must ensure that all treatment centres receive the same core funding (equity on the allocation of resources).
- Have the means to review programs based on the new addictions.
- Develop a salary scale to encourage NNADAP workers to keep their position.
- Increase salaries since NNADAP agents are underpaid.
- There are no resources to allow family members to attend graduation ceremonies in treatment centres. We do not have the means to organize meetings in isolated regions.

Approaches

- We need to respect people's values in addition to their needs.
- Treatment centres must offer services through collaboration, not competition.
- Try to involve the whole community in the drug and alcohol issues; NNADAP is not the only one responsible.
- A centre cannot address several addictions at once.
- More cultural components.
- The whole intervention process must always focus on identity and culture.
- We need to provide training on the holistic approach with the medicine wheel.
- We need to adapt work tools to the culture, everybody works in silos at the moment.
- We need to help people become more responsible because clients often rely on others to do their work. The NNADAP system does not foster a greater responsibility for the client because we do everything for them (admission request for treatment centre, etc.).
- Include families.
- We need couple therapies. Couples follow treatment separately.
- Change the name "NNADAP".

PART 2: RESULTS OF DISCUSSION GROUPS

Four (4) forums were organized, which gathered about forty interveners from First Nations Health Centres, nurses, NNADAP agents, program managers, interveners on duty, psycho-educators, special education project managers, youth workers and social services workers. With the help of a facilitator's guide, interveners were asked to express themselves on the strengths and weaknesses of NNADAP, the efficiency and relevancy of the program, the specific needs of NNADAP agents, their perception of the clientele's satisfaction regarding the existing services within the context of the program and on the potential reconfiguration of the NNADAP network in terms of prevention, intervention, treatment as well as post-treatment follow-up.

From the outset, the participants in the discussion groups chiefly criticized the fact that NNADAP is not able to meet the current range of needs because of the emergence of new drugs and new addictions. In this sense, NNADAP is a stagnant program that does not allow the resources in place to evolve with the problems emerging in their communities and their environment.

The participants in discussion groups also commented on the lack of efficient prevention strategies, which can be explained by the very high level of expectations from NNADAP agents: the population expects them to do as much prevention and intervention as post-treatment follow-up. Although one of the NNADAP's strengths is that the agents in the communities know their clientele, these expectations are impossible to meet because of the lack of resources and training, which leads to the NNADAP agent "putting out fires" instead of acting upstream of problems based on defined strategies.

Regarding the lack of resources, the participants in the discussion groups explained this priority requirement by indicating that it results in consequences that do not permit to meet the needs of the clientele. Moreover, the lack of resources, be it financial or human, only aggravates a situation that cannot be tolerated any longer. In general, NNADAP agents are exhausted and poorly paid, which results in a cycle where the approach is not oriented towards the client but rather at the mercy of existing services. So resources must be increased, as well as the opportunities for resourcing and networking between the program interveners.

Participants often reiterated the fact that treatment centres are not really adapted to today's reality and as such, they do not meet the needs in general anymore. They also criticized the lack of specialized treatment services, such as detoxification and mental health treatment. Participants also often repeated that intervention training is a major gap in NNADAP, especially to offer support in the community following a residential treatment.

Participants also highlighted significant gaps with regards to family services and, consequently, the need for a continuum of care that allows acting on youth-related environmental factors that cannot be ignored in light of the data on substance use among that clientele.

Finally, participants in discussion groups concluded that NNADAP is outdated and does not meet today's reality in the communities. As with respondents to structured interviews, a majority expressed the need for a continuum of care that allows the clientele to have post-treatment follow-up in order to prevent relapse and take advantage of a support network. To this effect, participants also concluded that the need for an individualized follow-up that could be integrated in a continuum of care and through support offered in the community is an avenue which needs to be developed.

Comments of the researcher on the results of the discussion groups

The credibility of the results obtained through the discussion forums is always increased when the writer brings forth elements of discordance expressed by participants in the discussion forums. In the current process, as in all the processes we are involved in, we have attempted to isolate from all the comments, certain opinions that could have been contrary to the general consensus obtained in the survey results as well as in the discussion forums. After analysis of the written transcriptions, we were not able to identify specific clashing opinions.

PART 3: GENERAL DISCUSSION

Many subjects were addressed in the context of the inventory, interviews or discussion forums. In order to facilitate the analysis of the results, we have merged all the data into three general themes. Based on the information collected within the context of the current process, we developed the following general discussion based on the elements we deemed most relevant.

THEME 1: In terms of prevention

Scientific literature suggests that primary prevention programs, i.e. programs that chiefly target youth who do not use any substances in order to prevent them from being initiated to the use of psychotropics of all kinds (Gates, McCambridge, Smith and Foxcroft, 2006) are directly oriented towards the reduction of the incidence (emergence of new substance users) or the prevalence (proportion of substance users in a given population, including former and new cases) of substances use and its consequences. These strategies and programs are aimed at improving knowledge, attitudes and adequate behaviours related to drug use (Foxcroft, Ireland, and Lowe, 2002).

The results of the structured interviews show however that 81% of respondents indicated that prevention activities that are the easiest to apply in their environment are the prevention activities associated to drugs. Nonetheless, 54% of respondents indicated that prevention activities, as they are currently carried out, are not efficient. This perception is also corroborated by the comments obtained during the discussion forums. Many participants reported that prevention strategies are often aimed at providing information on the risks and consequences related to the use of certain drugs while the public targeted by these activities is already aware of these facts.

It is recognized that the majority of community prevention programs are primary prevention programs that target non-users, while the majority of the targeted public are people who are already using drugs. The "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey clearly shows that the use of psychotropics becomes problematic at an early age among First Nations. First use generally occurred (about 60%) in the 11-15 age group and slightly more than 20% reported first using alcohol at the age of 10 or younger. Consequently, the prevention programs' efficiency is reduced because they are not adapted according to the level of prevention required for identified risk factors that characterize each target clientele.

Regarding the barriers to the implementation of prevention strategies, the lack of human resources was identified by 71% of respondents and the lack of training of interveners to carry out prevention by 67% of respondents. Moreover, 63% of respondents indicated that the lack of support represents a barrier. The participants in the discussion groups explained this priority requirement by explaining that one of NNADAP's major gaps is the lack of resources and the low priority it seems to be given. Furthermore, many participants noted that NNADAP agents intervene in all sorts of situations and the expectations towards them are too high given their responsibilities exceeding by far the program's objectives.

In the current context where consumption, as seen previously, starts at an early age among First Nations, prevention programs will have to be modified. Nowadays, we do not foster change when we limit ourselves to transmitting plain information on drug use-associated risks to youth who already use drugs. It is recognized in the literature that prevention programs that focus on the skills and the social and psychosocial factors predominant in the onset of drug use (risk factors) generally have a more positive impact regarding the teenagers' knowledge on psychotropic drugs. This type of program also has more

impact on the decision process that leads to the use of drugs, self-esteem and resisting peer pressure. All these impacts significantly reduce the incidence of both soft drug use (cannabis) and hard drug use among school children (Faggiano and al., 2008). These types of programs work well because they reposition the youths' perceptions regarding drugs and they teach them strategies on how to refuse drug use despite peer pressure. Role plays, feedback, problem resolution strategies and positive behaviourial reinforcement are all efficient ingredients that are part of the prevention programs' success (Tobler and al., 2000). If we persist in transmitting only information on drugs without contributing to the development of assertiveness skills, we will never reach the expected outcomes.

THEME 2: In terms of treatment

A proportion of 46% of respondents preferred that at least one rehabilitation centre should offer detoxification and crisis intervention services. In second place, 38% of respondents preferred that a centre should offer specialized services to individuals with addiction who also have mental health disorders. On their part, participants in discussion groups criticized the lack of specialized treatments, notably in terms of detoxification, mental health and assistance to individuals with all sorts of addictions.

Respondents did not give much support to the fact that treatment centres meet the needs of the current clientele, since only 8% of respondents preferred this statement. As did the respondents to structured interviews, participants in discussion groups repeatedly noted that treatment centres are not appropriately adapted to today's realities and as such, they no longer meet the needs of the clientele. This opinion is also shared by 71% of respondents in our survey.

Furthermore, since the prevalence of addictions and comorbidity seems high among First Nations, the current prevention, intervention and postvention services do not necessarily allow us to address the cooccurence of problems.

A study carried out with addictions treatment workers (clinical and non clinical staff) and Quebecois users led to the identification of elements that are essential to the efficiency of treatment programs (Landry, Mercier, Kishchuk and Caron, 1997). A total of six dimensions emerged as priorities regarding the quality of treatments and are therefore, according to the workers, active success ingredients. In other words, a good treatment should include the following components: 1) the improvement level of the health, wellbeing and life quality of users; 2) the competence of staff members when hired and currently working; 3) the link between the user's needs and the objectives of the intervention plan; 4) the quality of the user-worker relationship; 5) the respect of confidentiality regarding the user's data, and 6) the service efficiency, i.e., the means implemented to resolve the drug abuse problems.

There are no magical recipes: treatments are not efficient for all individuals. It is important to offer the user a treatment that will correspond to his/her actual needs since a treatment that exceeds the needs of a participant may reduce the treatment's effectiveness. It is also important to insist on persistence during the treatment since it guarantees better results (Pearce and Holbrook, 2002).

Currently, the configuration of treatment services is more organized around the geographical location of the communities and on their Nation. If this service organization was satisfactory in the past, it seems it can no longer claim it or do as if it met the needs of the population.

Regarding the youth clientele, a majority of respondents (96%) indicated that the availability of services was disproportionately low and that the range of services should be expanded to include families. Participants in discussion groups also noted important gaps in this area. We have to report here that many interveners we met indicated they were in favour of the creation of another youth centre that

should be located in a much more central region than where the only youth centre is currently located.

THEME 3: In terms of intervention and post-treatment follow-up

The post-treatment follow-up protocol including a detailed intervention plan for each person remains the tool preferred by a majority of respondents (60%). Participants in discussion groups also expressed the need for a personalized follow-up that can be implemented in a continuum of care through the support offered in a community. Moreover, the "*Alcohol, drugs and inhalants - Profile of substance users and use patterns among Quebec First Nations"* survey clearly indicated the presence of gaps with regards to follow-ups. This reality contributes among others, to the risk of relapse and the current service organization does not foster the best possible comprehensive approach to ensure the preparation and adequate and continuous follow-up of the client. It seems that the quantity of post-treatment follow-up services still does not correspond to the needs of the individuals with addiction problems. The results of that survey indicated that a majority of respondents (53%) thought that post-treatment services were not appropriately adapted and lacked effectiveness. Many respondents mentioned client follow-up as a major difficulty in their job.

Several authors insist on the importance of the follow-up following treatment to increase the intervention's effectiveness and hence, positive results (Perry, Coulton, Glanville, Godfrey, Lunn, McDougall and Neale, 2006; Welsh and Zajac, 2004; Hiller, Knight, Dwayne and Simpson, 1999). Several studies indicate a better success rate when the therapeutic community is combined with community support (Welsh and Zajac, 2004). Persons who were institutionalized, such as drug users, need supervision and assistance to reintegrate society. This transition period is used to develop social support that includes non deviant peers (Hiller, Knight, Dwayne and Simpson, 1999). In most cases follow-up will cover an average of three months (Welsh and Zajac, 2004; National Institute of Justice, 1995).

Yet, despite the importance given to post-treatment interventions, there seems to be a consensus regarding the lack of structured follow-up in the community for individuals who have or have not been in a rehabilitation centre. It is certainly not a question of lack of good will but could rather be attributed to the lack of knowledge and tools to ensure follow-ups prior to or following treatment and to the NNADAP agents' work overload. Furthermore, 96% of respondents indicated that follow-up strategies are important. In light of the data collected, it seems that community activities associated to relapse prevention remain a consistent priority requirement for 46% of respondents. Training on addiction clientele counselling is also considered a significant element. As far as priority requirements are concerned, the training program on addiction clientele counselling ranks first with 33% of respondents. Participants in discussion groups repeatedly noted that intervention training is one of NNADAP's major gaps, in particular in providing support in the community either prior to or following a residential treatment. The development of a continuum of care which would allow the clientele to receive follow-up prior to and following treatment is much favoured so as to prevent relapse and take advantage of a support network.

However, one thing is constant and for certain. Whatever strategies are put forth with the addiction clientele, perseverance during the treatment and learning retention most often depend on the person's motivation. To this effect, Bergeron, Landry, Brochu and Cournoyer (1997) note that a person's intent to get involved in his/her individual therapy plays a determining role in perseverance during treatment. This being said, it seems that the role of the drug user himself/herself considerably influences the success or failure of the program. In other words, the client's involvement usually determines his/her perseverance during the treatment. Also, those who perceive themselves as less involved are more prone to abandon and are therefore more vulnerable to relapse.

How to support these individuals and how to help them face resistance to change are essential elements to consider. To better understand the person, one must not only equip interveners with pre- and post-treatment follow-up strategies but also with means to understand the person. If the person is supported by services that adequately meet his/her specific needs, his/her motivation will be increased. To achieve this, one must become fully aware of the importance of the clinical evaluation and be able afterwards to propose a service offer that is diversified and adapted to the person's needs.

We are however obliged to recognize today that very few of these conditions are found within the NNADAP network.

Recommendations

Several data support the conclusion that the services currently offered exclusively to First Nations do not meet the needs of the First Nations clientele regarding addictions. The six (6) treatment centres funded by NNADAP combined to the fact that only one NNADAP agent per community is hired (even though some of these communities have the budget for two resources) do not seem to be enough to meet the growing needs. Results of the surveys conducted with the First Nations of Quebec have shown that the services do not seem suitable on the grounds of many factors. Whether treatment service offers are not sufficiently diversified, or because NNADAP agents have too many responsibilities and not enough means, or whether the increased complexity of the clientele has considerably modified the clinical profile or the program is not sufficiently inclusive in terms of problems to address, everyone agrees on the necessity to rethink NNADAP.

Several elements may be taken into account to develop efficient programs and services. However, as noted by Gendreau and Ross (1987), the actual issue does not concern which type of treatment works best but rather what is the best treatment for a given individual, at different points in time of his/her substance use. Furthermore, since drug use patterns appear at a rather early age among First Nations, it would be relevant to undertake a continuum of care and services that includes the individual, the family and the community. The greater the service diversity, the more we will be able to offer a care program that is appropriate for the individual's needs.

The following recommendations, based on evidence, would allow for the implementation of services that take into account individual but also collective needs regarding prevention.

It is clear that whatever strategies are proposed, we must keep in mind that the addiction phenomenon is often the symptom of a disorder that is as varied as complex. The number of risk and protection factors associated to addictions is so great that it would be pretentious to believe that our recommendations alone will allow for the problem to be solved. However, we trust they will foster change in order for the First Nations communities and members to obtain the services best adapted to today's reality.

In order to facilitate the reader's comprehension, we have structured the recommendations based on the groups of individuals or the organizations they are specifically intended for. Respondents to structured interviews and participants in discussion groups have issued their comments and recommendations to specific groups. In terms of prevention, we have issued specific recommendations since we consider it to be an area which addresses individuals of all ages and in that sense, the activities must be specified according to the problems addressed per age group. We have also developed three recommendations for scenarios that aim at reconfiguring services and included them into a diagram to illustrate their function, advantages and disadvantages. Since the literature and evidence indicate we should put the individual at the center of our concerns in terms of addictions, our recommendations could not be divided into stages of an individual progress but rather into the actions and responsibilities to be implemented by the organizations and groups of people offering care and services to the clientele.

PREVENTION

As confirmed by the statistics on the prevalence of drug use among youth (Chevalier and Lemoine, 2001), adolescence appears to be the period of life when youth is most at risk of using drugs. Furthermore, the persistence of drug use towards the end of that critical period plays an important role in the prediction of drug and alcohol abuse among adults. These findings highlight the importance of intervening early on the use of psychotropic drugs during the adolescence in order to prevent drug use problems. These interventions will be effective on the long term provided they succeed in stopping drug use before the ages of 18 to 21 (Brochu, 2006). Generally, prevention programs may be universal and target the population as a whole or be specific and intended for groups that are particularly at risk or for those who present specific characteristics (Gates, McCambridge, Smith and Foxcroft, 2006).

In Quebec, there are three levels of prevention. First, there are programs that specifically target youth who do not use any substances so as to prevent them from being initiated to the use of psychotropics of any kind (Gates, McCambridge, Smith and Foxcroft, 2006). These services, called primary prevention programs, are directly oriented towards the reduction of the incidence (emergence of new substance users) or the prevalence (proportion of substance users in a given population, including former and new cases) of substances use and its consequences. These strategies and programs are aimed at improving the knowledge, attitudes and adequate behaviours related to drug use (Foxcroft, Ireland, and Lowe, 2002). Secondly, other programs are intended for substance users groups so as to minimize as much as possible the consequences generated by their drug use patterns (Gates, McCambridge, Smith and Foxcroft, 2006). They act notably on the identification of these individuals, their referral to appropriate services and the treatment of this clientele with rather recent drug-related disorders. The goal of secondary prevention is to intervene on the problem before it further develops and becomes too serious. Finally if both other types of programs have failed, tertiary prevention deals with the treatments of drug abusers (Foxcroft, Ireland and Lowe, 2002). In a nutshell, primary prevention differs from both other types because it intervenes with the population as a whole, a population that is not necessarily at risk of developing addiction problems, while the secondary and tertiary prevention deal with an individual clientele already involved in some form of substance use (Foxcroft, Ireland and Lowe, 2002).

The prevention programs most in use in North America are based on the DARE model (Drug Abuse Resistance Education), intended for school children. Presented by police officers, it pursues the objective to inform students on the various psychotropic drugs and on peer pressure related to drug use. Several studies show that children have a better knowledge of drugs after the program. However, according to the findings of major research work carried out by West and O'Neal (2004), becoming aware of this information would not be sufficient to really improve long-term drug use among teenagers. This being said, despite its popularity, the DARE prevention program would be rather inefficient. These results tend to let us believe that the programs that interest decision-makers are not necessarily the most efficient ones in terms of prevention (Brochu, 2007). Thus, the most performing programs should not only inform students on the various drugs available but should also teach them practical techniques and adequate attitudes to resist these products. To use Brochu's words (2007), not only must one know it is preferable to say no to drugs, but one must also know how to do so.

Prevention programs that focus on the skills and the social and psychosocial factors predominant in the onset of drug use (risk factors) generally have a more positive impact regarding the teenagers' knowledge on psychotropic drugs, the decision process related to drug use, self-esteem and resisting peer pressure. These impacts all significantly reduce the incidence of both soft drug use (cannabis) and hard drug use among school children (Faggiano and al., 2008). These types of programs do well because they reposition the youths' perceptions regarding drugs and they teach strategies to turn down drug use

despite peer pressure. Role plays, feedback, problem resolution strategies and positive reinforcement of aimed behaviours are all efficient ingredients that are part of the prevention programs' success (Tobler and al., 2000).

At this point, we should also be keep in mind that risk factors associated to drug use are also associated to a wide range of deviant behaviours. In other words, the use of psychotropic drugs rarely comes alone. Now, given the wide spectrum targeted, programs that aim at preventing drug abuse seem to be just as effective to prevent school drop-out and other behaviours at risk (Wilson, Gottfredson and Najaka, 2001).

Recommendations

1. It is recommended to Health Canada to provide funding for an additional resource devoted exclusively to prevention and outreach in each community.
2. A comprehensive prevention kit that can be adapted to the reality of each community and fosters the promotion of cultural identity should be developed. The development of this kit should be funded by Health Canada and designed by the FNQLHSSC based on the following target groups and prevention focuses:

Target groups	**Prevention focuses**
Families	Parental skills development programs.
2nd cycle Primary school	Programs developed based on prevention regarding information on drugs and including training on adequate attitudes to resist drugs.
Ages 12-17 Non-users	Prevention programs addressing knowledge of addictions and focusing on social and psychosocial skills and factors (self-esteem, self-assertiveness, school drop-out, conflict resolution, personal communication, resistance to peer pressure, etc.).
Ages 12-17 Users	Secondary prevention programs to intervene on the problem before it becomes too serious. Prevention in the environment where youth use drugs (outreach). Harm reduction approach. Prevention programs addressing knowledge of addictions and focusing on social and psychosocial skills and factors (self-esteem, self-assertiveness, conflict resolution, personal communication, resistance to peer pressure, parental skills, etc.).
Adults	Prevention programs addressing knowledge of addictions and focusing on social and psychosocial skills and factors (self-esteem, self-assertiveness, conflict resolution, personal communication, resistance to peer pressure, parental skills, etc.). Prevention in the environment where individuals use drugs (outreach). Create a prevention program specifically based on comorbidity (addictions and mental health disorders).

3. All prevention activities should be carried out year-round and not only occasionally. It is also

recommended that the prevention worker should develop a yearly schedule of prevention activities.
4. It is recommended that the prevention worker should coordinate addiction prevention activities in the community and in the environment, while ensuring the availability of prevention in all activity sectors of the community: daycare centre, schools, nurses, police services, Band Council, etc.
5. It is recommended that the FNQLHSSC should foster the merging of prevention work tools in order for them to be easily accessed by all addictions prevention agents.
6. It is recommended that each treatment centre should include in its therapy program a component specific to relapse prevention.
7. It is recommended that Health Canada, in collaboration with the FNQLHSSC, should develop training on the prevention kit intended for community addictions prevention agents.
8. It is recommended that Health Canada should evaluate the impacts of all prevention activities generated by the kit.

INTERVENTION, TREATMENT AND POST-TREATMENT FOLLOW-UP

Studies conducted on the issue of addictions intervention are numerous. However, beyond the content and the nature of the intervention, perseverance during the treatment seems to be associated to its success. The significant proportion of drug users quitting before the end of the treatments casts doubt on their efficiency. This finding is however somewhat toned down by Bergeron, Landry, Brochu and Cournoyer (1997). First, these researchers note that a person’s intent to get involved in his/her individual therapy plays a determining role in perseverance during treatment. This being said, it seems that the role of the drug user himself/herself considerably influences the success or the failure of the program. In other words, the client’s involvement usually determines his/her perseverance during treatment. Now, those who perceive themselves as less involved are more prone to abandon, therefore more vulnerable to relapse.

Let us keep in mind that a study conducted with addictions treatment workers (clinical and non clinical staff) and Quebecois users led to the identification of elements that are essential to the efficiency of treatment programs (Landry, Mercier, Kishchuk and Caron, 1997). A total of six dimensions emerged as priorities regarding the quality of treatments and are therefore, according to the workers, active success ingredients. In other words, a good treatment should include the following components: 1) the improvement level of the health, wellbeing and life quality of users; 2) the competence of staff members when hired and currently working; 3) the link between the user’s needs and the objectives of the intervention plan; 4) the quality of the user-worker relationship; 5) the respect of the confidentiality regarding the user’s data, and 6) the service efficiency, i.e., the means implemented to resolve the drug abuse problems

Efficient treatments

It is essential here to state existing evidence regarding the composition of an efficient addictions treatment prior to putting forth intervention, treatment and post-treatment follow-up avenues that are connected and inseparable when considered within the perspective of a continuum of care.

All treatments have the potential to reduce drug use at different levels. However, a systematic literature review indicates almost unanimous support to therapeutic communities (TC), particularly when it comes to court referrals (Mitchell, Wilson and Mackenzie, 2005; Perry, Coulton, Glanville, Godfrey, Lunn,

McDougall and Neale (2006). TCs are among the most popular programs in the USA regarding the treatment of court referrals for drugs (Hiller, Knight, Dwayne and Simpson, 1999). These programs are individually tailored according to each participant, depending on his/her level of addiction and progression rate within the TC (National Institute of Justice, 1995). They are usually reserved for chronic abusers (Lurigio, 2000).

Therapeutic communities take place in residences without any type of drug or alcohol use and are based on a hierarchy treatment model within which each level achieved represents an improvement of the client's personal and social responsibilities. Peer influence is used to facilitate the assimilation of social standards and the development of positive social skills. These treatments are different from others in that they use the "community" as the key change agent. The community includes the interveners and those following the treatment. However, the individual responsibility regarding the success or failure of the treatment remains essentially within the therapeutic communities since each individual is the person chiefly responsible for the change process.

People referred in these communities usually have multiple drug abuse problems (including alcohol), mental health disorders, inadequate social and family support and are often involved in the justice system (Smith, Gates and Foxcroft, 2005). These characteristics also being present among the Aboriginal population, one could think that this type of treatment could be adapted to this clientele. Furthermore, the heterogeneousness of the problems surrounding drug abuse reinforces the necessity to carry out rigorous evaluations on the following aspects: psychiatric, psychological, emotional, social, family, nutritional, legal and vocational (Pearce and Holbrook, 2002). In addition to these elements, other authors mention demographic characteristics, substance use history, past treatment experiences, belief in the treatment's efficiency and the desire to enter into a program (Lurigio, 2000; Marshall and Hser, 2001). This being said, several authors indicate that the programs demonstrating the best success rates are the ones that correctly select potential candidates (Day and Howells, 2002; Grifith and coll., 1999; Farabee and coll. 1999).

These intensive and very structured treatments are designed on a long-term basis (Lurigio, 2000) and include daily activities (Welsh and coll., 2004). They chiefly target a change in the participant's lifestyle, including abstinence, the elimination of antisocial behaviours and the development of prosocial values and attitudes (Lurigio, 2000; Welsh and coll., 2004).

A major part of the staff includes former community participants in the program who have graduated and act as counsellors (Lurigio, 2000). Their presence is important since they are role models for other clients (National Institute of Justice, 1995).

Some therapeutic communities even open up to families and close ones by taking in spouses, children and other members of the participant's family in order to offer them maximum support in their change process (National Institute of Justice, 1995).

Several authors insist on the importance of the follow-up following treatment to increase the intervention's effectiveness and positive results (Perry, Coulton, Glanville, Godfrey, Lunn, McDougall and Neale, 2006; Welsh and Zajac, 2004; Hiller, Knight, Dwayne and Simpson, 1999). Several studies indicate a better success rate when the TC is combined with community support (Welsh and Zajac, 2004). Persons who were institutionalized, such as drug users, need supervision and assistance to reintegrate society. This transition period is used to develop social support that includes non deviant peers (Hiller, Knight, Dwayne and Simpson, 1999). In most cases follow-up will cover an average of three months (Welsh and Zajac, 2004; National Institute of Justice, 1995

Since follow-up is not mandatory, residents who decide not to take advantage of this opportunity are invited to keep close ties with the TC. They are encouraged to join a sponsoring group or a sponsor by telephone or a community support group, such as Alcoholics Anonymous or Narcotics Anonymous (National Institute of Justice, 1995).

The efficiency of treatment centres is therefore directly related to the time spent in treatment, particularly regarding recidivism (Wexler, Falkin and Lipton, 1990). The National Institute of Justice (1995) indicates that a minimum of ten to twelve months is required to witness the first changes in the behaviour of drug users. Once this period is completed, the treatment itself becomes more efficient than the absence of intervention. While the success of the program depends almost essentially on persistence during treatment, efforts should be invested in the clients' motivation (Mitchell, Wilson and Mackenzie, 2005; Brochu, Bergeron, Landry, Germain and Schneeberger, 2002).

As mentioned earlier, interventions in the field of addictions are numerous, confusion therefore can easily arise. Meta-analysis represents a technique of literature review of previous studies, consisting in gathering the results from several comparable and relevant studies on a specific subject, to unravel the maze. The studies conducted on addiction treatments by Pearce and Holbrook (2002) and Welsh and Zajac (2004) are among the most interesting. The results of this meta-analysis also point in the same direction and clearly indicate that therapeutic communities stand apart from other forms of treatment in terms of drug abuse reduction and recidivism, particularly for individuals with severe disorders. They also emphasize that these results are even more conclusive when the TC is backed by a follow-up in the community (see also Perry and al., 2006). Furthermore, Welsh and Zajac (2004) indicate that TCs are the most consistent programs with regards to the client/intervener ratio. For instance, they found a 9:1 to 16:1 ratio for TCs; a 5:1 to 64:1 ratio for educational programs; and a 7:1 to 60:1 ratio for outpatient programs. Another one of their advantages is that they require a minimum of resources and promote the interconnection of community members with such problems.

In their article, Pearce and Holbrook (2002) do not however offer any magic recipes: treatments are not all efficient for the same individuals. They underline the importance of offering the user a treatment that will correspond to his/her actual needs since a treatment that exceeds the needs of a participant may reduce the treatment's effectiveness. They also insist on the importance of persistence during treatment since it guarantees better results (Pearce and Holbrook, 2002).

Finally, in light of the studies listed in this report, a number of conditions may considerably increase the chances of success of a treatment. Here are a few that could contribute in improving addictions programs:

1) Set aside intensive treatments for users with severe problems: a rigorous evaluation should be carried out with all drug and alcohol users. It should be based on the client's needs as well as on the severity of their problems in order to direct them towards the most efficient treatment. It is recognized that a treatment that is too intensive may harm a person with light substance use problems (Brochu and coll., 2002). This opens the way to the development of a variety of services that will meet the range of needs of drug abusers (Germain and coll., 2001).

2) Train qualified interveners: recruiting qualified and experienced personnel may prove to be difficult but it is nevertheless essential. Several interveners who have demonstrated their skills in a community program may not necessarily perform as well in a therapeutic community. A lack of knowledge of the clientele may hinder the therapeutic bond, which remains a most significant element in the treatment's success and forces therapists to adjust their intervention style in response to the situation (Farabee and

coll., 1999). Training manuals should be developed, not only on the intervention mode but also on the clientele.

3) Standardize evaluation and training tools: while both previous elements seem essential to the treatment's success, they do need to be based on adequate tools. First, a rigorous evaluation of substances users, especially their biopsychosocial profile and their needs, is essential in order to refer them to an adequate treatment (Germain and coll., 2001). The failure of a treatment often results from a mismatch between clients and therapy conditions (Lurigio, 2000). Good evaluation tools would therefore keep the most intensive and structured treatments for users with really high needs. Secondly, it is essential to preserve a treatment's integrity to guarantee its success (Lurigio, 2000). A well-trained and experienced staff will implement the protocol correctly thus maintaining the treatment's integrity. It is therefore recommended to standardize the evaluation tools and training manuals so as to standardize practices.

4) Match services adequately: it is in the addiction program interveners' best interest to work jointly with the community organizations in order to meet as many as possible of the users' needs after their treatment. A better coordination between treatment centres and community programs would be indicated (Germain and coll., 2001; Lurigio, 2000; Wexler and coll., 1990).

5) Offer follow-up in the community: a continuity of services in the community as the next step following the end of the treatment is required to optimize the chances of success (Mackenzie, 2000; Pearce and Holbrook, 2002 ; Perry, Coulton, Glanville, Godfrey, Lunn, McDougall and Neale, 2006). This opportunity ensures the transition between the treatment centre and the community and improves the client's long-term social rehabilitation (Lurigio, 2000). Furthermore, creating such collaboration between the interveners and the community organizations may facilitate the follow-up offer.

6) Evaluate addiction programs intended for drug users: the program evaluation should be carried out by experts that are not the interveners offering the treatment. The implementation details, general impacts and the training of interveners should be evaluated on a more frequent basis in order to improve services and preserve their integrity (Lurigio, 2000). Assigning program evaluations to qualified researchers would allow minimizing sampling bias and methodology errors, ensuring the comparison of treatments and improving the programs (Farabee and coll., 1999). Moreover, these evaluations should assign participants randomly and include a control group to arrive at a decision regarding the efficiency of the treatments and the typical client selection criteria, such as the type of drugs, drug use frequency, retention in treatment criminal activities, etc. (Farabee and coll., 1999).

Finally, to use the words of Gendreau and Ross (1987), the actual question is not about which type of treatment works best but rather what is the best treatment for a given individual, at different points in time of his/her substance use.

In order to facilitate the reader's comprehension of the recommendations in terms of intervention, treatment and post-treatment follow-up, the following recommendations have been developed according to the organization or group of individuals for whom they are intended.

General recommendations to Health Canada

It is recommended to Health Canada:

1. To show some flexibility in adapting its programs to the new realities experienced in First Nations communities. These realities leave us no other choice but to recommend to Health Canada to expand its understanding of addiction problems beyond the definitions already agreed upon, particularly regarding alcohol and drugs, in order to include other forms of addiction that are as destructive as those previously identified.
2. To expand not only its comprehension of the phenomenon but also its vision of the required services deployment. Consequently, it is recommended that for the Quebec region the name NNADAP be changed for a program title that will illustrate the "addiction" aspect in all the strategies put forth.
3. To redefine the role of NNADAP agents, to modify their title and their tasks and to adapt them to the current realities.
4. With the FNQLHSSC's support, to raise awareness among the communities' political and administrative authorities regarding the role that NNADAP agents should be playing in order to avoid that they be assigned tasks that largely exceed their mandate, their capacity and their expertise, as it is currently the case.
5. Make the required financial resources available to communities in order for them to hire an additional resource whose mandate will essentially be to do prevention in the community.
6. To maintain the funding required to pursue the youth intervention training program delivered by the *Université du Québec à Chicoutimi* and to make this training available for all addiction workers in the communities.
7. It is recommended to Heath Canada to develop, in collaboration with the FNQLHSSC, a 5-year training plan that includes training on the following subjects: work planning/efficient time management, group facilitation, continued training on addictions (new drugs), new prevention and intervention approaches, individual and group counselling, mental health, accompaniment and post-treatment follow-up.
8. From a staff-retention perspective, to prioritize the addiction workers' salary upgrade in order to make the pay competitive compared to similar level positions.
9. To make funding available to allow addiction workers to have access to healing retreats on an annual basis.
10. To make funding available to implement professional coaching and clinical supervision services for addiction workers.
11. To fund the implementation of detoxification services within the context of a continuum of care. Excluding this step in the service reconfiguration would jeopardize subsequent interventions and would maintain the status quo of services as they are currently delivered.
12. From a continuum of care perspective, to support, through additional human and financial resources, if required, the necessity to carry out a reconfiguration of the service offer delivered by treatment centres in order to ensure it corresponds to the current reality and meets the needs that result from it.

General recommendations to the communities' political and administrative authorities

It is recommended to the communities' political and administrative authorities:

1. To integrate the addiction phenomenon to their action priorities so it can be recognized as a major public health issue.

2. To show rigour in the respect of the amounts of money allocated in order to avoid that the funds dedicated to addiction issues be misappropriated in the interest of other sectors in the community.
3. To be respectful of the roles and responsibilities assigned to addiction workers in order to avoid a work overload that exceeds their mandate.
4. To ensure that a specific protocol that exclusively concerns patients who must leave the community to pursue a treatment be developed and implemented.
5. To provide the necessary support to the public security sector in order to fight against the accessibility and sale of illegal drugs.
6. To show leadership in the mobilization of all the community activity sectors in order to fight against addictions in an efficient and joint manner.

General recommendations to the FNQLHSSC

It is recommended to the FNQLHSSC:

1. To pursue networking efforts among addiction workers in order to strengthen the network among First Nations.
2. To develop partnerships with the Quebec heath and social services network in order to promote First Nations' access to the existing services in the Quebec addiction network.
3. To establish knowledge transfer agreements with the Quebec network and notably with the Addiction Prevention Centre and other related organizations.
4. It is recommended to develop a database tool that includes a regular update of clinical information on addictions accessible to the whole network.
5. To pursue efforts invested in the last past years in terms of research on addiction-related issues.
6. To support any process deemed appropriate aimed at reconfiguring the network's service offer, including the implementation of training or specialized services.

General recommendations to addiction workers

It is recommended to addiction workers:

1. To show some flexibility and adaptation in the work methods modifications required by the rapid evolution of addiction-related problems over the last years.
2. To seize all opportunities to improve their knowledge and professional skills in order to increase the efficiency of their interventions with the clientele.
3. To develop jointly, with all the sectors concerned in the community, a work plan that will include prevention activities to be carried out over a 12-month period.

General recommendations to treatment centres

It is recommended to treatment centres:

1. To show some flexibility and adaptation in the changes required for diversifying the service offer that must take into account the clientele's new clinical needs.
2. To diversify their service offer, while taking into account the clientele's new clinical needs.
3. To develop a more regional vision for the services they intend to offer to the population.
4. That each treatment centre may define a field of expertise within which it will operate from a

regional perspective that meets the needs of the clientele.

5. To pursue their consultation and collaboration efforts among them in order to avoid overlapping of services.
6. To pursue the development of professional relations with addiction workers in a continuing effort of information exchange and collaboration in order to offer the best possible services to the clientele.

Recommendations for service reconfiguration scenarios

Apart from the recommendations previously stated, it appears essential that scenarios aimed more specifically at diversifying the service offer should be proposed. These scenarios were developed while taking into account all the data collected through this process. They are essentially aimed at filling the gaps in the support to be provided to the clientele within the context of a continuum of care, from detoxification to client care in their environment, in the case of addictions.

In terms of intervention, several scenarios are worth considering since it has been demonstrated that the current service organization no longer corresponds to the needs of the clientele.

First, two major barriers stand in the way of intervention: the geographical factor and the language. The First Nation communities of Quebec are spread over a vast territory that includes isolated and semi-isolated regions for which outpatient services are hard to access. Moreover, one of the barriers to service access is the diversity of the languages used on a daily basis by First Nation members in Quebec. These two barriers combined represent significant challenges in terms of organization, access, and addictions services delivery and continuity.

However, we believe that we now have an opportunity to develop a continuum of care and services that may well expand into the future. We have therefore built these scenarios within a perspective where the individual is at the centre of our concerns. We consider most of these scenarios to be configured in such a way as to be easily adapted to the evolution of addiction-related problems and to subsequent practices that will arise from them.

These scenarios have the advantage to allow for the integration of cultural, traditional and spiritual components specific to First Nations. It is important to specify that what is known as “cultural and spiritual approach” and “holistic approach” are not strictly speaking clinical treatment approaches. Rather these approaches are components that complete a clinical treatment process and allow for the reinforcement of the cultural identity, while taking into account First Nations characteristics. These approaches can translate into activities such as sweat lodge sessions, the making of handicrafts or the participation of Elders for the spiritual accompaniment of individuals within the context of activities supporting the therapy.

However, it goes without saying that the operationalization and feasibility of these scenarios will require more in-depth review to determine the ins and outs they involve. Consequently, we were not able to predict the exceptions and limitations for each scenario.

The objective we pursue by putting forth service reconfiguration scenarios is to reflect the concerns and needs identified and reported several times in the context of the current NNADAP evaluation. Not only have we been guided by this data, but we have also taken into account the scientific literature and the integrated service offer model that exists in the Quebec network.

In order to facilitate the comprehension of the scenarios, we described them first, and then used

diagrams to illustrate the configuration of care and services. We also briefly indicated what we considered to be advantages and disadvantages for each scenario.

Scenario 1: Implementation of an organization of services integrated into a continuum of care from detoxification to post-treatment follow-up

The scenario involves a complete service reorganization and includes the conversion of an existing treatment centre into a centre specialized in evaluation, detoxification, referral and post-treatment follow-up ("hub centre"). This scenario would require redefining the agents' tasks and responsibilities in the communities, professionalizing the interveners in treatment centres and promoting dialogue among treatment centre managers. Ultimately, this scenario is aimed at securing all services into an integrated and organizational structure of services based on the client's request, referral, evaluation, detoxification, treatment and post-treatment follow-up. It is actually a true continuum of care within a comprehensive and holistic perspective that allows meeting as adequately as possible the individual and specific needs of each person requiring an intervention. This intervention approach is oriented towards the client and no longer exclusively on the common problem shared by those who must go into a treatment centre for their alcoholism and addiction problems. In light of the data collected, there seems to be a consensus on the fact that the best way to meet the clientele's needs is to implement a continuum of care, as presented in this scenario. Moreover, we are of the opinion that this scenario represents a true offer of services that are diversified, specialized and oriented towards the needs of the person.

Description of the scenario

This scenario allows the worker to be relieved of any intervention work so to speak in order to devote himself/herself almost exclusively to addiction prevention. As such, the addiction prevention agent receives any person asking for help and refers him/her to the "hub centre", except for clients who only request support in the community. In the latter case, a clinical team associated to the hub centre is available to supervise the prevention agent and prepare with him, if required, a follow-up service plan in the community.

The intervention role, which also includes the evaluation, is then ensured by professionals associated to the specialized centre ("hub" centre) located in a geographically-centralized region and who receives all the clients referred by the community prevention agent. The "hub" centre is also a crisis centre that offers stabilization services. Based on recognized evaluation tools, the staff at the hub centre carries out an evaluation of all the factors contributing to the emergence and maintenance of the addiction problems of the individuals it receives in person. Following this evaluation, the hub centre determines the appropriate orientations in the perspective of a continuum of care that optimizes the intervention's efficiency. This continuum necessarily involves:

- That detoxification services be ensured by the hub centre for individuals who do not require intensive medical supervision but who need detoxification.
- That current treatment centres become specialized based on a new configuration of the service offer that takes into account the main evolutions of the addiction phenomenon over the last decades. This configuration proposes a continuum of care that could take the following form and that will have to respect English-speaking as well as French-speaking individuals, and to which it will be possible to integrate cultural components:

ADULTS

- ❖ A centre ensuring long-term intervention for adults requiring a heavier intervention, with admissions on a continuous basis and based on the therapeutic community model.
- ❖ A specialized addiction and mental health centre.
- ❖ A centre specialized in the treatment of alcoholism, addiction and other forms of dependencies.
- ❖ A centre for individuals whose treatment does not require a specialization field (such as the current centres).

YOUTH

- ❖ A specialized centre for youth aged 12-17 with mid- and long-term interventions. The centre should also include a family intervention service component. This centre is the equivalent of the hub centre but is focused on the clientele aged 12-17 insofar as it ensures detoxification, evaluation and treatment. This centre also has the mandate to ensure the coordination of the child and family support with the social services of the resident's community of origin.

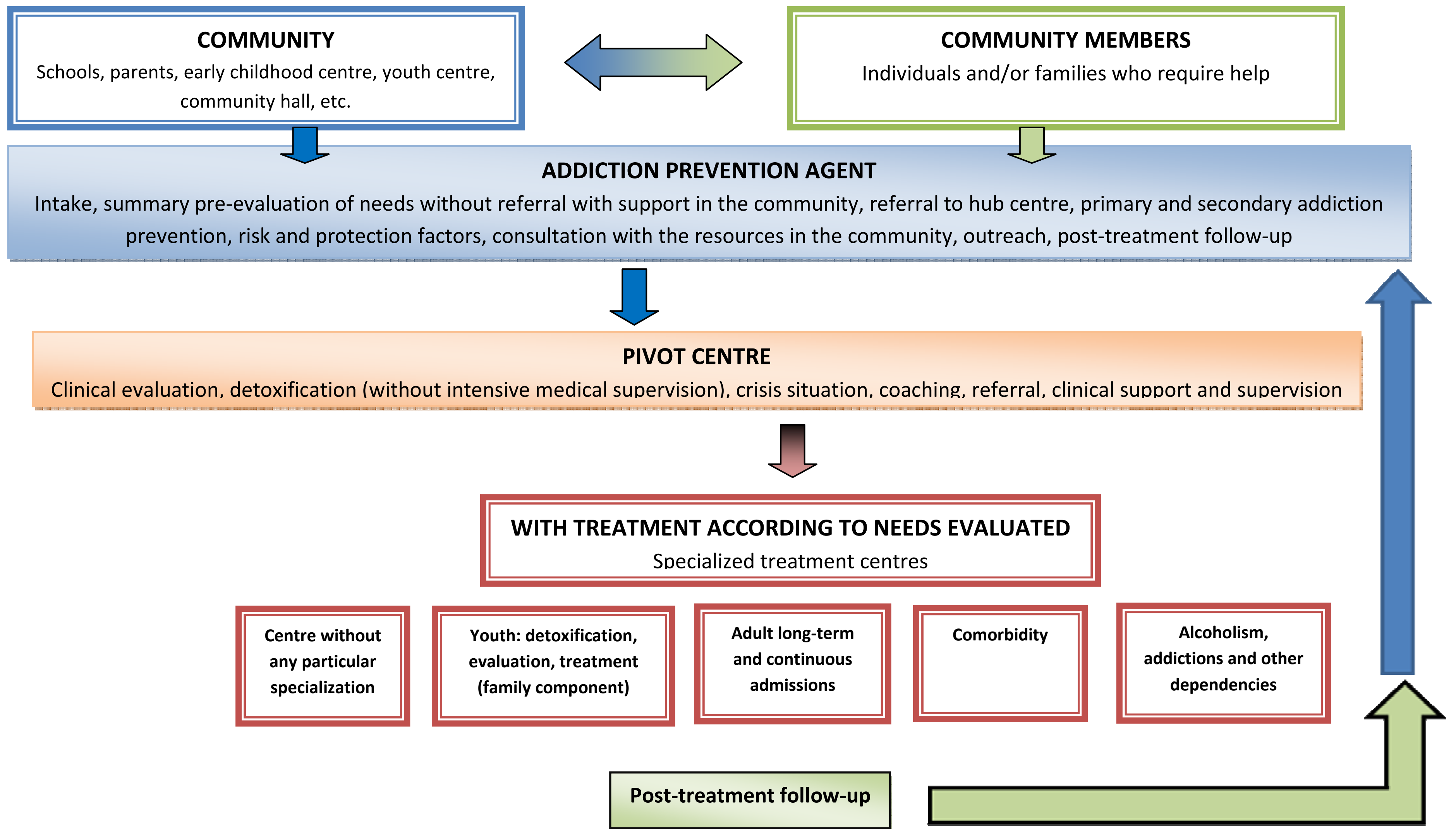
The hub centre also coordinates the post-treatment follow-up of all the individuals it has evaluated, after the treatment centre's clinical staff has prepared an intervention and post-treatment service plan. The measures included in the intervention plan are coordinated by the hub centre, carried out in the community by the prevention agent, but supervised clinically by the hub centre's staff. To that effect, the hub centre is equipped with standardized evaluation, referral and follow-up tools. Post-treatment follow-ups will be implemented according to a protocol that defines the follow-up stages to ensure with the clientele and according to the roles and responsibilities of the hub centre's clinical staff and addiction prevention agent.

It is important however to present a summary of this scenario's advantages and disadvantages:

Advantages	Disadvantages
• Standardized clinical evaluation • Evaluation by qualified professional resources • Allows an addiction prevention agent to focus on prevention and post-treatment follow-up in collaboration with the hub centre • Allows access to detoxification • Allows for the identification of the most adequate treatment for an individual based on his/her needs while focusing a continuum of services • Allows a more efficient post-treatment follow-up • Reduce the pressure of the treatment centre in terms of post-treatment	• A lot of travelling • This scenario involves the conversion of an existing centre into a hub centre • Major changes in the service delivery (potential resistance to change in the treatment centres and communities) • The interveners in treatment centres will need to receive training to practice in their field of expertise • Difficulties to recruit specialized staff among First Nations

• Provides prevention agents with clinical coaching • Adaptability to future problems and practices • Ensures a greater variety of the service offer within a continuum of care perspective • Allows for a more adequate coordination of child and family support	

Diagram for scenario 1



Scenario 2: Implementation of a diversified service offer based on the needs of individuals with an evaluation in the community

As with scenario 1, this scenario proposes a diversified service offer through the specialiation of the current treatment centres. However, it has the disadvantage of weakening the client's follow-up and supervision due to the lack of rigorous follow-up while being supervised by a single structure as in scenario 1.

Description of the scenario

This scenario involves that an intervener in the community becomes exclusively dedicated to the intake, referral, evaluation and support of individuals who require help for an addiction problem. It also involves that another intervener becomes exclusively dedicated to prevention. This scenario involves a standardization of the tools to evaluate the needs of an individual as well as the admission forms in treatment centres. To prevent each treatment centre from allocating a resource for the coaching and clinical supervision of the community agents, this scenario also involves that the FNQLHSSC takes charge the coaching and clinical supervision services in support of the interveners responsible for the evaluation and post-treatment follow-up.

An intervener in the community carries out the clinical evaluation of the individuals' needs and, if required, refers them to a specialized treatment centre according to their needs. The treatment centres each have a specific field of expertise that correspond to all the priority needs reported by the NNADAP needs assessment. The following configuration proposes that treatment centres reorganize their services and respect English-speaking as well as French-speaking individuals, and that cultural approaches may be integrated to them:

ADULTS

- ❖ A centre ensuring detoxification and crisis situation services.
- ❖ A centre ensuring long-term intervention for adults who need a heavier intervention, with admissions on a continuous basis and based on the therapeutic community model.
- ❖ A specialized addiction and mental health disorder centre.
- ❖ A centre specialized in the treatment of alcoholism, addictions and other forms of dependencies.
- ❖ A centre for individuals whose treatment does not require a field of specialization (as in the current centres).

YOUTH

- ❖ A specialized centre for youth aged 12-17 with mid- and long-term interventions. The centre should also include a family intervention service component. This centre is the equivalent of the hub centre but is focused on the clientele aged 12-17 insofar as it ensures detoxification, evaluation and treatment. This centre also has the mandate to ensure the coordination of the child and family support with the social services of the resident's community of origin

In this scenario, the treatment centre's clinical staff prepares the intervention and post-treatment follow-up service plan of clients, whose follow-up is ensured by the intervener in the community under the supervision of the FNQLHSSC.

Advantages	Disadvantages
• Standardized evaluation • Single admission form for treatment centres • Requires very few investments in terms of infrastructures • Specialized clinical treatment services based on needs expressed • Creation of a long-term care centre • Detoxification and crisis intervention services • Increased efficiency of the treatment because it corresponds better to the individuals' specific needs • An intervener is dedicated exclusively to prevention • An intervener is dedicated exclusively to the intake, evaluation, referral and follow-up of individuals who require help • Coaching and support services to interveners responsible for the evaluation and post-treatment follow-up • Additional human resource in the community	• Major changes in service delivery (potential resistance to change in treatment centres) • Potential lack of qualified human resources in treatment centres and in some communities • High training requirements • Weakened client follow-up

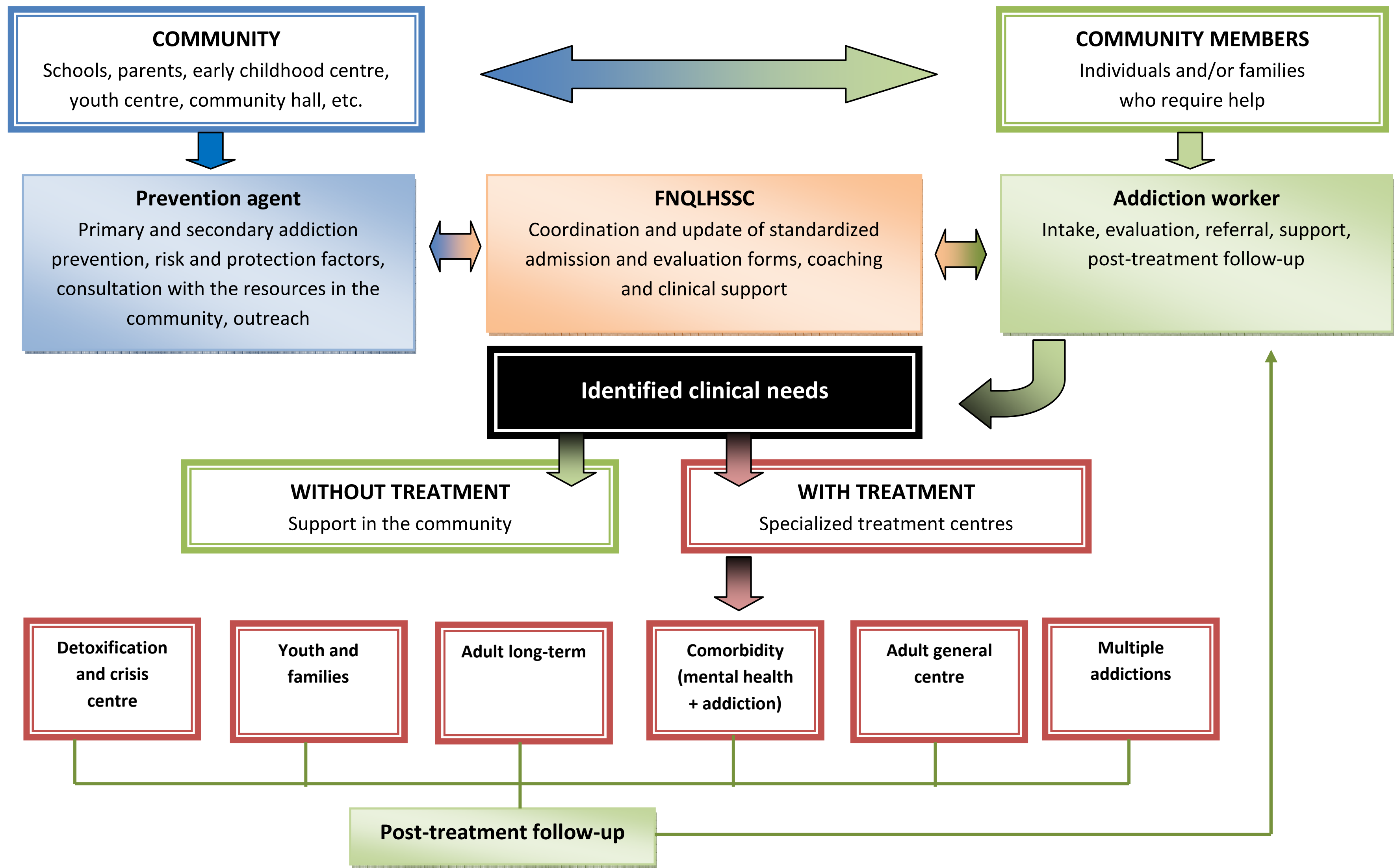


Diagram of scenario 2
COMMUNITY
Schools, parents, early childhood centre, youth centre, community hall, etc.
COMMUNITY MEMBERS
Individuals and/or families who require help
Prevention agent
Primary and secondary addiction prevention, risk and protection factors, consultation with the resources in the community, outreach
FNQLHSSC
Coordination and update of standardized admission and evaluation forms, coaching and clinical support
Addiction worker
Intake, evaluation, referral, support, post-treatment follow-up
Identified clinical needs
WITHOUT TREATMENT
Support in the community
WITH TREATMENT
Specialized treatment centres
Detoxification and crisis centre
Youth and families
Adult long-term
Comorbidity (mental health + addiction)
Adult general centre
Multiple addictions
Post-treatment follow-up

Scenario 3: Through various treatment avenues, intake and referral in the community

In this scenario the client's clinical needs are not taken into account, but rather the objective of the client.

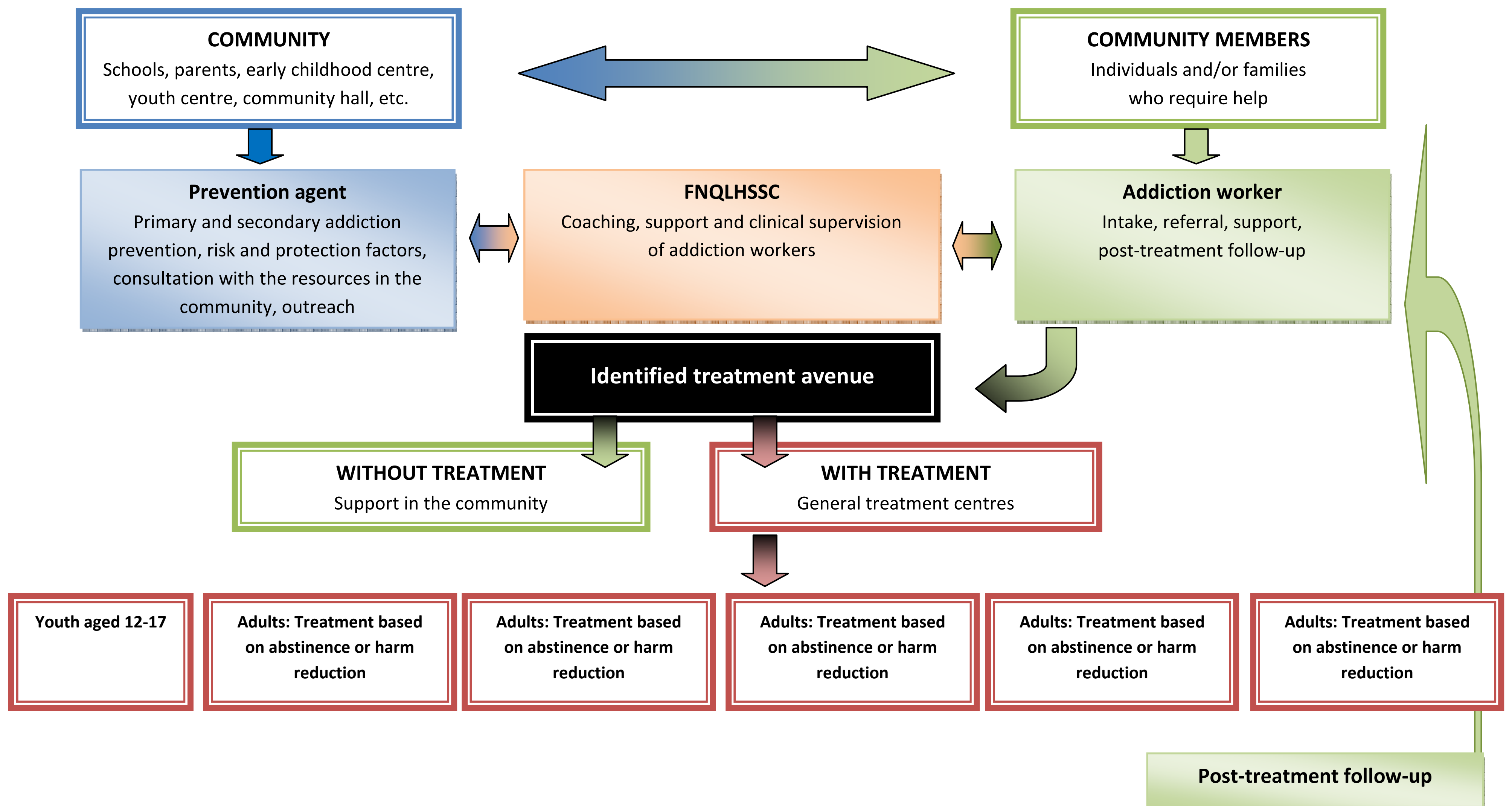
Description of the scenario

This scenario involves that an intervener in the community becomes exclusively dedicated to the intake, referral and support of individuals who require help for an addiction problem. It also involves that another intervener becomes exclusively dedicated to prevention. Moreover, this scenario obliges the FNQLHSSC to offer the coaching and clinical supervision services in support of the intervener responsible for the intervention and post-treatment follow-up.

An intervener carries out the intake of individuals and, if required, refers them to a treatment centre whose approach corresponds to their needs and expectations in terms of objectives to achieve in the resolution of their addiction problem. In this scenario, there is no clinical evaluation and the treatment centre admission forms are standardized. Here, there are two ways of dealing with addictions: the so-called medical model and the model based on social learning. In the first case, addictions are seen as a chronic and involuntary disease on the physical, mental and spiritual levels. This being said, substance users must learn to live with their disease through abstinence. The most popular treatments are the twelve steps, support groups, Alcoholics Anonymous and Narcotics Anonymous. In the treatment based on social learning, the remedy to addictions is considered as the learning of inappropriate behaviours, notably antisocial thoughts and actions, through models or patterns. Programs included in this model vary in length, intensity and methods and are not aimed towards abstinence but rather harm reduction. Among the most popular are interventions known as cognitive-behaviour interventions.

Advantages	Disadvantages
• Standardized treatment centre admission form • Requires very few investments in terms of infrastructures and human resources • Ultimate objectives of the goal to reach are clearly defined • Existence of a post-treatment follow-up supervised by a professional resource at the FNQLHSSC	• No clinical evaluation • Does not meet the client's clinical needs • Minor changes for the resources currently in place • No field of expertise in treatment centres (all centres keep their general orientation) • No detoxification and crisis intervention services in the NNADAP network • Status quo of treatment services for youths • No family services • No treatment services of comorbidity and other addictions

Diagram of scenario 3



SUMMARY OF RECOMMENDATIONS REGARDING PREVENTION

Heath Canada	FNQLHSSC	Addiction prevention agents	Communities' political and administrative authorities	Treatment centres
Provide funding for an additional resource dedicated exclusively to prevention and outreach in each community.	Design a comprehensive prevention kit that can be adapted to the reality of each community, promoting cultural identity (based on prevention themes).	Develop a yearly schedule of prevention activities.	Foster the consultation of the community sectors for the development of the yearly schedule of prevention activities.	Include in the therapy program a component specifically addressing relapse prevention.
Provide funding for the development of a comprehensive prevention kit that can be adapted to the reality of each community, promoting cultural identity.	Foster the concentration of prevention work tools so they can be easily accessed by all addiction prevention agents.			
Develop training on the prevention kit intended for community addiction prevention agents.	Collaborate to the organization of the training on the prevention kit intended for community addiction prevention agents.			
Evaluate the impacts of all prevention activities generated by the kit.				

SUMMARY OF GENERAL RECOMMENDATIONS

Health Canada	FNQLHSSC	Community workers (addictions)	Communities' political and administrative authorities	Treatment centres
Show some flexibility in the adaptation of its programs to new realities experienced in First Nations communities.	With Health Canada's support, raise awareness among the communities' political and administrative authorities regarding the role that NNADAP agents should be playing.	Show some flexibility and adaptation in the changes to the work methods required by the rapid evolution of addiction-related problems over the last years.	Integrate the addiction phenomenon to their action priorities so it can be recognized as a major public health issue.	Show some flexibility and adaptation in the changes to the diversification of the service offer that must take into account the clientele's new clinical needs.
Change the name NNADAP for a program title that will illustrate the "addiction" aspect in all the strategies put forth.	In collaboration with Health Canada, develop a 5-year training plan.	Seize all opportunities to improve their knowledge and professional skills in order to increase the efficiency of their interventions with the clientele.	Show rigour in the respect of the amounts of money allocated in order to avoid that the funds dedicated to addiction issues be misappropriated in the interest of other sectors in the community.	Diversify their service offer while taking into account the clientele's new clinical needs.
Redefine the role of NNADAP agents, modify their title and their tasks and adapt them to the current realities.	Pursue networking efforts among addiction workers to strengthen the network among First Nations.	Develop jointly with all the sectors concerned in the community, a work plan that will include prevention activities to be carried out over a 12-month period.	Be respectful of the roles and responsibilities assigned to addiction workers.	Develop a more regional vision for the services they intend to offer the population.
With the FNQLHSSC's support, raise awareness among the communities' political and administrative authorities regarding the role that NNADAP agents should be playing.	Develop partnerships with the Quebec heath and social services network in order to promote First Nations' access to the existing services in the Quebec addiction network.		Ensure that a specific protocol exclusively for patients who must leave the community to pursue a treatment is developed and implemented.	That each treatment centre may define a field of expertise within which it will operate from a regional perspective that meets the needs of the clientele.
Make the required financial resources available to communities in order for them to hire an additional resource whose mandate will be to carry out prevention in the community.	Develop a database tool that includes a regular update of clinical information on addictions accessible to the whole network.		Provide the necessary support to the public security sector in order to fight against the accessibility and sale of illegal drugs.	Pursue their consultation and collaboration efforts among them in order to avoid overlapping of services.

Health Canada	FNQLHSSC	Community workers (addictions)	Communities' political and administrative authorities	Treatment centres
Maintain the funding required to pursue the youth intervention training program delivered by the *Université du Québec à Chicoutimi* and make this training available for all addiction workers in the communities.	Pursue efforts invested in the last past years in terms of research on addiction-related issues.		Show leadership in the mobilization of all the community activity sectors in order to fight against addictions in an efficient and joint manner.	Pursue the development of professional relations with addiction workers in a continuing effort of information exchange and collaboration in order to offer the best possible services to the clientele.
In collaboration with the FNQLHSSC, develop a 5-year training plan.	Support any process deemed appropriate aim at reconfiguring the network's service offer, including the implementation of training or specialized or services.			
Prioritize the addiction workers' salary upgrade.				
Make funds available to allow addiction workers to have access to healing retreats on an annual basis.				
Make funds available to implement professional coaching and clinical supervision services for addiction workers.				
Provide funding for the implementation of detoxification services within the context of a continuum of care.				
Support, through additional human and financial resources, if required, the necessity to carry out a reconfiguration of the service offer delivered by treatment centres.				

CONCLUSION

The risk of intergenerational transmission caused by social integration difficulties, school drop-out, the adoption of problematic behaviours, violence, delinquency, crimes (general deviance syndrome) appears to be part of the consequences of addictions. Among First Nations, the data clearly indicate the complexity of the problems and the great incidence of addiction-related risk factors.

The description of the risk factors shows that drug abuse usually results from a series of negative elements in the life of an individual. The complexity of these factors, which are interrelated, highlights the importance of implementing prevention and treatment programs capable of intervening not only on drug use problems, but also on environmental factors that may contribute to substance abuse, such as family dysfunction, associating with deviant peers, the lack of perspectives for the future, the perpetration of crime or poverty. Furthermore, knowing that early drug use is a key factor in predicting drug abuse among teenagers, it would appear relevant to provide prevention programs adapted for the younger ones

Several studies support the conclusion that the services currently offered exclusively to First Nations by the NNADAP network do not seem to meet the increasing needs. These needs exceed by far the drug- and alcohol-use problems. Confronted with the emergence of new forms of addictions and because of the increased complexity of clinical profiles of individuals who may be dealing with mental health issues, it becomes essential to implement new services. If we deem for the last decades that people requiring assistance are in need of heavier intervention, the same should apply to the network, as it is now defined. That is why a continuum of care is essential to adequately meet the needs of the First Nations clientele, whose service network has significantly falling behind in comparison to the rapid evolution of the addiction phenomenon and the measures to counter it.

This evolution will not stop. Not only will we need to pursue research to always find further information on the addiction phenomenon, but we will also have to keep in mind that we must always be proactive to avoid being overtaken by the devastating consequences of this major public health phenomenon.

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APPENDIX 1: STRUCTURED INTERVIEWS QUESTIONNAIRE

Hello, GRIPMA received the mandate to administer a questionnaire concerning the assessment of the NNADAP program on behalf of the FNQLHSSC.

More specifically, we are collecting information regarding the needs of individuals and stakeholders under NNADAP. Mrs. Melanie Vincent will be the person who will conduct the interviews. She will contact you to set up an interview date and time (30 minutes length).

To be prepared for the interview, please read the questionnaire below. Thank you for your participation!

SOCIO-DEMOGRAPHIC ASPECTS

1.	**Date of interview**	Day Month Year
2.	**Reference number of consent form**	________________________
3.	**Time at beginning of interview**	
4.	**Time at end of interview**	
5.	**Gender of respondent**	☐ Woman ☐ Man
6.	**How old are you?**	________ years ☐ Refuses to answer
7.	**Are you a member of the First Nations of Canada or Quebec?**	☐ Yes ☐ No ☐ Does not know ☐ Refuses to answer

8.	**What language do you use on a daily basis?**	☐ English ☐ French ☐ Aboriginal language
9.	**In what geographical location do you work? (Name of city/community)**	______________________________
10.	**Are you…**	☐ a NNADAP advisor ☐ a member of the medical staff (nurse, doctor, etc.) ☐ a psychosocial worker (psychologist, social worker, specialized educator, etc.) ☐ a member of teaching/school staff ☐ a natural helper ☐ Other ____________________________________
11.	**For how long have you been in this position?**	☐ Less than 1 year ☐ Between 1 and 2 years ☐ Between 2 and 5 years ☐ More than 5 years
12.	**Before working in this position, how long did you work in the alcohol and drug prevention and treatment field?**	☐ Less than 1 year ☐ Between 1 and 2 years ☐ Between 2 and 5 years ☐ More than 5 years

QUESTIONS RELATED TO POTENTIAL DEVELOPMENT OF THE NNADAP PREVENTION PROGRAM

1. In your opinion and in your environment, what kind of prevention activities would be the easiest to apply? (Answer by yes or no)

a)	Activities that would help young people recognize different kinds of drugs and their effects	**NO (0)**	**YES (1)**
b)	Activities that would allow young people to recognize practical techniques and the right attitudes to resist drugs		
c)	Prevention activities for the entire population that are structured and spread over the whole year		
d)	Drug-related prevention activities but also mental health prevention		
e)	Drug-related prevention activities but also prevention for other types of addiction, such as gambling		
f)	Relapse prevention activities to be offered to people who have already received treatment or individual counselling		

2. If you could choose only two prevention activities among those listed above, which would you choose?

1.) ___________
2.) ___________

3. In your opinion, what other type of prevention activity could be easily applied in your environment?
____
____
____

4. Among the following constraints, which represent the greatest barrier to the implementation of prevention strategies in the community/organization where you work? (Please check the box at right, you may check more than one answer)

a) Lack of financial resources ☐

b) Lack of human resources ☐

c) Lack of knowledge about drug abuse prevention among youth ☐

d) Lack of knowledge about drug abuse prevention in the population at large ☐

e) Lack of training for advisors on the subject of prevention ☐

f) Lack of awareness in the community/environment concerning the importance of drug abuse prevention ☐

g) Lack of tools to conduct prevention on a regular basis ☐

h) Lack of time for prevention because most of the time is devoted to crisis management ☐
i) The absence or lack of support from the leadership of the community/organization ☐

5. Any other barriers that have not been mentioned that prevent the implementation of prevention strategies?
____
____

6. Do you believe that the drug abuse prevention activities conducted in your community/environment are effective? (For example, are they effective in helping to reduce consumption and create awareness among youth and the population at large about the harmful effects of substance abuse, etc?)

0. no 1. yes

7. If the prevention strategies are not effective, what would you suggest for drug abuse prevention?
____
____
____

INTERVENTION

We will now talk about direct intervention with the population that needs NNADAP assistance.

1. What kind of tools or programs would be most helpful to allow you to work with people who need help to overcome their consumption problems?

a)	An interview guide which would help measure the motivation of the person seeking help	**NO (0)**	**YES (1)**
b)	A guide for the evaluation of the person in order to be able to refer the person to the appropriate resources		
c)	A clinical supervision and monitoring program (a series of measures to be applied according to progress reports)		
d)	A program to train counsellors working with the drug abuse clientele		
e)	A continuum of drug abuse, care and services (monitor progress of client throughout the rehabilitation process)		
f)	Practices and strategies to improve the treatment of individuals who relapsed		
g)	Mental health support		
h)	Traditional and cultural practices		

2. If you could choose only two of the tools or programs among those mentioned above, which would you choose?

1.) ___________
2.) ___________

3. What other tool or program do you consider necessary and what other tool or program should be developed?
____
____

Now we will talk about the network of rehabilitation/treatment centres.

NETWORK OF REHABILITATION TREATMENT CENTERS

1. ***In your opinion, what kind of interventions should be developed in rehabilitation treatment centres in order to better respond to the current drug abuse clientele?***

	Types	**NO (0)**	**YES (1)**
a)	The centres as they are currently organized meet the needs of the drug abuse population		
b)	A centre should provide detoxification services and intervention in crisis situations		
c)	A centre should offer specialized services for people with addictions and also for people with mental health problems		
d)	A centre should be able to offer specialized services for young addicts who have other addictions, such as compulsive gambling.		
e)	A centre should be able to receive requests for admission at all times (in other words, without a set date for admission, the client will begin treatment as soon as the application is accepted)		
f)	A centre should be recognized for the specialized services it provides to clientele facing court cases		
g)	A centre for teenagers should also provide services to the family		
h)	A wider range of rehabilitation services and options for teenagers		
	A treatment center located in the community		

2. **If you could choose only two types of program among those mentioned above, which would you choose?**

1.) ___________
2.) ___________

3. **Presently, programs promote the AA's 12-step approach; some are based on culture and others are based on a comprehensive psychosocial approach. If you had to redefine the therapies, what would you do?**

____
____
____

4. **Should there be a range of approaches available (AA, cultural, spiritual) within the network in order to meet the needs of all clients admitted to the treatment centre?**

0. No 1. Yes

5. **What approach do you prefer? __________________________________**

6. **Which of the following criteria do you use at your workplace to refer clients to a rehabilitation/treatment centre? (More than one answer may apply)**

i) According to the nation of the client admitted by a centre
j) According to the approach the centre uses for clients
k) According to the centre that has the shortest waiting list
l) According to the closest geographical location
m) According to the mother tongue of the client
n) According to the client needs
o) According to the wishes of the client
p) According to the reputation of the centre
q) Other(please specify): ________________________________

We will now talk about post-treatment.

1. **What type of programs or tools would be most useful to provide post-treatment to individuals who have completed the therapy program**

a)	A post-treatment protocol with a detailed intervention plan for each person	**NO (0)**	**YES (1)**
b)	A post-treatment follow-up kit including various themes to be discussed, such as relapse prevention, anger management		
c)	An intervention guide on conflict resolution		
d)	A joint follow-up protocol with the centre where the client completed treatment		
e)	Clinical supervision and monitoring service		

2. **If you could choose only two of the above mentioned tools or programs, which would you choose?**

1.)___________
2.)___________

3. **What other programs or tools do you think need to be developed?**

____
____

4. **If you had anything to suggest in order to improve NNADAP services, what would be your suggestions?**

____
____
____
____
____
____

Thank you for your participation!

APPENDIX 2: DISCUSSION GROUP FACILITATOR’S GUIDE

NNADAP NEEDS ASSESSMENT

FOR THE

FNQLHSSC

PREPARED BY

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INTRODUCTION

We have developed this facilitator's guide in order to ensure a relatively consistent manner of facilitating discussion groups. This guide was developed in order to help us understand the concepts and issues as they are perceived by various stakeholders working directly or indirectly with NNADAP. It is meant to be used with various groups of stakeholders and managers.

Despite the services delivered by the NNADAP network interveners, the field of addictions has significantly evolved over the last two decades with regards to the type of clientele and services. This new reality represents quite a challenge when it comes to organizing the services so as to meet the population's needs optimally.

As such, in order to better guide future decisions that will need to be made based on the needs identified within the context of this assessment, a number of strategies were used to organize a data collection. Holding discussion groups is one of these identified strategies.

INTRODUCTION TO DISCUSSION GROUPS

Discussion groups designate a qualitative research methodology developed around 1950 by Sociologist Robert Merton. This approach was mainly used in marketing researches in the '60s and later on in the '70s and '80s in social sciences and health researches.

Originally, the discussion group methodology was developed for preliminary work and exploratory studies. But it rapidly revealed to be so time- and cost- efficient that it started being used for a wide range of research projects. It is usually used to:

- guide people in a new area
- develop theories based on observations by informants
- assess various sites or populations who have been studied in the context of research work
- know how participants have interpreted previous studies or discussions
- produce information for planning groups and community discussions

LIMITATIONS OF DISCUSSION GROUPS

By holding discussion groups, we position ourselves in the exploratory level of perceptions that are specific to each of the persons present. Consequently, what people express in this type of group cannot be considered as representative of the majority's opinion. Therefore, the results cannot be generalized. However, one has to admit that an overall orientation usually emerges from the results of the discussion groups, providing a good indication of the perceptions of a given population. To this effect, there seems to be a consensus among the scientific community that the information generated by discussion groups represents valid data.

CONSENT TO PARTICIPATE IN DISCUSSION GROUPS

Once we have welcomed the participants and have presented the objectives of our approach, we will then ask the participants if they agree to participate in the discussion group and whether the discussions may be recorded, if required. On the ethics level, we cannot guarantee that the discussions held within the context of these forums will be kept confidential and anonymous by all of the participants. Consequently, we must inform the participants of this reality when we ask for their agreement. There are two ways of obtaining the participants' agreement to participate in a discussion group. In writing, using the consent form or verbally, by asking each participant to raise his/her hand to agree. Whatever way is chosen, we must read the following paragraph to the participants:

"Before we start and before you agree, I have the duty to tell you that we cannot guarantee confidentiality. We can say that we will not reveal your name, that your name will not appear in any report, and that nothing you will say will be associated to your name or identity. But we cannot certify that none of the participants will repeat your comments. We would appreciate if everybody could agree to refrain from revealing any of the information collected during the discussions to be held in this room, but we cannot promise that it will be the case."

Questions for discussion groups

Summary of instructions:

- Welcome participants.
- Present the objectives of this process.
- Talk about confidentiality and ask the people attending whether they agree to participate and agree that their comments will be recorded. Ask them to sign a consent form (agreement in writing) or, in the case of a verbal consent, register their agreement with the date, time and place.
- Collect 1) information forms, 2) participants consent forms.
- Start by asking questions one after the other.

Questions for discussion groups

1.- First I would like to know your overall perceptions of NNADAP. What are the strengths of the program? What are its weaknesses?

2.- Do you believe in the program's efficiency? In its relevance?

3.- What do you have to say about the interveners who work in the NNADAP network regarding their training needs, for example? According to you, do they have specific needs? What are their main strengths? Their main weaknesses?

4.- Are you under the impression that the clientele is satisfied of the services obtained through NNADAP?

5. In your opinion, are there any services, other than those delivered through the NNADAP program, that should be developed in order to better meet the current and future needs of the clientele?

Closing: I would like to thank you for the information provided. We have gone over several questions. In conclusion, I would like to give each of you the opportunity to talk about any issues we have not covered or add something.

APPENDIX 3: CONSENT FORM

I was informed of the details regarding the nature of this process led by GRIPMA (*Groupe de recherche et d'interventions psychosociales en milieu autochtone*) on behalf of the FNQLHSSC and aimed at assessing the needs of the NNADAP. I have had the opportunity to ask questions about my participation in the survey and obtain any additional details I wanted. I understand and agree to take part in the discussion group but can also withdraw from the process anytime I wish.

______________________________________ ______________________________________

Name of the participant Signature

DATE: ___________________

To my knowledge, the person who signed hereafter agrees to take part in this process on a voluntary basis.

______________________________________ ______________________________________

Signature of the researcher or witness Date

Morgan, David, 1988. *Discussion Groups as Qualitative Research*, Qualitative Research Methods Series, #16, Newbury Park: Sage Publications.