Terms of Reference

Atlantic First Nations Health Partnership Mental Wellness Committee
Capacity and Training Working Group

Work of 2016

1.1 Mandate

The *Capacity and Training Working Group* was established by the Mental Wellness Committee of the Health Partnership. For more information about the Health Partnership and the work of the Mental Wellness Committee, see Appendix1.

This group will provide strategic advice to the Mental Wellness Committee from across the region to support the learning and development of front line mental health and addiction staff in First Nations communities level in order to:

- ✓ Provide more effective and culturally safe services
- ✓ Better support workers in the application of learning to improve the delivery of care.
- ✓ Raise awareness in communities of important concepts and practices that everyone can use and benefit from.
- ✓ Integrate collaboration and partnership with others who provide care to First Nations people, families and communities.

Learning and development can include, but is not limited to, the allocation of funding to support the following opportunities and practices:

- Cultural teaching and practices. Strengthen cultural as foundation in communities. Increase access to more culturally competent and safe services in communities and in places where services are received.
- Community-to-community learning opportunities, sharing skills and insights developed across the region.
- Formal training/learning opportunities, such as courses and conferences. Supported by informal learning and practice supports, such as dialogue groups, mentoring, coaching and supervision practices, debriefing and provision of tools and materials.
- Development of capacity and competency profiles.
- For NNADAP-funded workers, certification requirements must be kept in mind.

The Mental Wellness Committee has requested the following activities frame the focus of the ***Capacity and Training Working Group*** activities for 2016:

1. Review and collate core competencies based on the behavioural and technical *Competencies for Canada's Substance Abuse Workforce* (CCSA) and the *Technical Competencies for Working with First Nations Clients* (CCSA and NNAPF).

2. Using the competencies as a guiding framework, create a learning needs assessment process informed by:

- The various types of community-based mental health and addiction teams existing in First Nations communities (acknowledging gaps in the full staffing of such teams);
- An engagement process with community based mental health and addiction teams members in First Nations communities and regional treatment centres in the Atlantic region
- Findings from regional reports and pre-existing learning needs assessments;

3. Based on the findings from the needs assessment, develop a multi-year regional training plan using available funds to address priority needs that includes:

- Formal and informal (supported mentoring, coaching and other practical application supports) learning and development opportunities;
- Options for alternative delivery (online, webinar, videoconference and so on)
- Integrates new needs and opportunities, as they arise.

4. Use the training plan to make recommendations for the allocation of yearly capacity funds. Prioritize recommendations for the allocation of 2016- March 30 2017 funding based on preliminary discussions and findings.

5. When appropriate, collect feedback on learning and development supports, such as standardized tools and more streamlined processes.

The Mental Wellness Committee will take the advice of the working group under advisement and make final decisions as to the allocation of regional capacity and training funds.

2. Membership, Guests, Roles and Responsibilities and Conflict of Interest
2.1 Membership

The *Capacity and Training Working Group* strives for membership that supports informed decision-making with respect to:

- First Nations cultural knowledge and healing practices.
- The diversity of First Nations communities across all provinces in the region.
- The strengths, experience and needs of a continuum of mental health and addiction services, including prevention, treatment, community-based care, aftercare and so on.

Representation will reflect the commitment to demonstrate a First Nations-led, strengths-based change process that keeps First Nations people at the centre of all initiatives. The Mental Wellness committee will review the working group membership and representation based on these factors, not by member names.

In 2016, this working group will be made up of a maximum of 8 people. One FNIHB staff will officially sit on this Working Group. Supporting members of the **w**orking group include:

- The Mental Health and Addiction Policy Analyst and secretarial staff from APC,
- The working group facilitator.

2.2 Guests
Additional FNIHB staff may be invited depending on the focus of discussion. An Elder or knowledge keeper may be invited to participate in the meeting, share knowledge or perform ceremonies. The Elder is free to provide guidance and take part in discussions. At the discretion of APC, the invited Elder will be reimbursed for travel expenses.

2.3 Roles & Responsibilities of Members
All the working group members OR their designated alternates will:

- Attend regularly scheduled meetings;
- Review materials prior to meetings;
- Be prepared to participate in discussions;
- Carry out specific assigned tasks

APC secretariat support includes:

- Organizing meeting logistics;
- Providing advice on the development of meeting agendas with the facilitator;
- Preparing and disseminating meeting packages and materials in advance of meetings;
- Remunerating First Nations members of the working group, according to APC financial policies;
- Recording meeting decisions and actions, and preparing and distributing minutes;
- Providing general policy and procedural support.

2.4 Conflict of Interest
Each member must ensure that he/she does not personally benefit in any way from their official action as a member of the working group. Any member, whose participation in a discussion could lead to a conflict of interest, real or perceived, will declare the potential conflict of interest and the member will excuse himself/herself from the discussion.

3. Decision-making, Attendance and Record of Decisions
3.1 Decision-making
This is a working group, not a committee. Whenever possible, decisions will be made by consensus. Meetings will be facilitated, supported by dialogue and collaborative processes. Decisions will be proposed by the group through these processes with consensus confirmed by the facilitator among group members. In the event that consensus is not possible, differing voices will be shared in the record of meeting. Group members are asked to designate an alternative. The designated alternate will attend the meeting if the regular member cannot.

3.2 Attendance
A quorum is required for the meeting to proceed and for decision-making. This is defined, in this case, as 50% of working group members. Should challenges to attendance limit decision-making, the quorum requirement or the working group membership will be reviewed. Meeting dates will be set and shared in advance to assist with participation.

Members who miss two (2) consecutive meetings without proper notice, valid reason and who have not sent an alternate will be contacted in writing by the APC working group's secretariat requesting clarification of participation. If three consecutive meetings are missed the APC secretariat will request the member be replaced.

3.3 Record of Decisions

A record of discussion and summary of decisions and actions will be compiled by the secretariat and shared with group members and the Mental Wellness Committee within two weeks of meeting, whenever possible. The Mental Wellness Committee reserves the right to not implement a decision of the working group. In the case where a decision of the working group cannot be implemented, the Mental Wellness Committee will share this rationale back to the working group.

4. Tasks and Timelines

The Terms of Reference (TORs) for this working group will be shared with the Mental Wellness Committee and a decision made as to their acceptance. A summary of meeting activities and key deliverables will be shared with the Mental Wellness Committee by the end of May, 2016. A maximum of four meetings will be held within the fiscal year. Three of these will be face-to-face and one via teleconference.

5. Approval and Amendment

Terms of Reference amendments must be approved by the Mental Wellness Committee.

Appendix 1: Atlantic Health Partnership and Mental Wellness committee

The Health Partnership's purpose is to improve the health and wellbeing of Atlantic First Nations through participation of First Nations in the planning, management, and delivery of programs and services funded or delivered by FNIHB Atlantic.

The Mental Wellness Committee's work is focused on the following programs:
Mental Health and Suicide Prevention

- Brighter Futures
- Building Healthy Communities
- National Aboriginal Youth Suicide Prevention Strategy

Substance Abuse Prevention and Treatment

- National Native Alcohol and Drug Abuse Program
- Drug Utilization Prevention and Promotion (DUPP)
- Canada Drug Strategy / National Anti-Drug (NAD) Strategy
- Prescription Drug Abuse Program

Indian Residential Schools Resolution Health Support

In this work, the Mental Wellness Committee discusses the planning, management, and delivery of specified programs and services. When the matter is within the authority/discretion of FNIHB Atlantic and within the Health Partnership's scope of decision making, the committee may recommend decisions related to:

- Providing input to the development of FNIHB Atlantic's annual program work plan(s);
- Allocating FNIHB resources (including the development of funding criteria and project proposal solicitation processes, and funding distribution);
- Submitting regional input on national policy/program design;
- Evaluating FNIHB Atlantic programs;
- Determining areas of focus and approach for capacity development;
- Developing strategic action plans to address Atlantic Chiefs health priorities;
- Collaborating with external partners;
- Formulating regional procedures/processes (that adhere to national policy) for access to FNIHB programs and services; and
- Developing regional communication mechanisms to ensure that clients and communities (including health staff and political leadership) are informed about the FNIHB programs/services and associated changes, and have opportunities to shape them.