Recommendations on Supporting Mental Wellness for Remote and Isolated Indigenous Communities

Substance Use Treatment and Land-Based Healing

July 2021

Task Group on Mental Wellness

THUNDERBIRD PARTNERSHIP FOUNDATION

Preface

We wish to acknowledge the work of other working groups reporting on the pandemic and speaking to substance use. The *What we heard: Indigenous Peoples and COVID-19 Supplementary Report for the Chief Public Health Officer of Canada* report certainly highlighted the Canada Emergency Response Benefit (CERB) in supporting food security for people challenged with substance use, the increased presence of contaminated opioids causing an increase in deaths, and the challenges with community lockdowns impacting access to drugs and alcohol. You will see in this report, we heard similar messaging throughout presentations.

To ensure this document is widely distributed, it was shared with the members of the Federal/Provincial/Territorial Special Advisory Committee on COVID-19, and the Public Health Working Group on Remote and Isolated Indigenous Communities. The document will also be publicly available online on the National Collaborating Centre for Indigenous Health website.[1]

[1] *www.nccih.ca*

Forward

The Task Group on Mental Wellness (Task Group) was assembled to provide insight and recommendations on how best to support and promote mental health and wellness during and post the COVID-19 pandemic, with a focus on northern communities and recognizing that their realities are often different from those in the rest of Canada.

As the Co-chairs of the COVID-19 Public Health Working Group on Remote and Isolated Communities, we would like to express our gratitude to the members of the Task Group for their efforts and for producing this document. These dedicated people volunteered their time and expertise at a time when the COVID-19 pandemic was placing extraordinary pressure on those involved with the health care system and Indigenous organizations. Below are the Public Health Working Group on Remote and Isolated Communities member organizations, health authorities and government partners who extend their thanks to the Task Group.

Assembly of First Nations
Council of Yukon First Nations
Dene Nation
Department of National Defence
First Nations Health Authority
Government of Newfoundland and Labrador
Government of Northwest Territories
Government of Nunavut
Government of Yukon
Indigenous Services Canada
Inuit Tapiriit Kanatami
Métis National Council
National Collaborating Centre for Indigenous Health
Northwest Territory Métis Nation
Nunavik Regional Board of Health and Social Services
Public Health Agency of Canada

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Introduction

The Task Group on Mental Wellness (Task Group) was assembled to provide insight and recommendations on how best to support and promote mental health and wellness during and post the COVID-19 pandemic with a focus on northern communities and recognizing that their realities are often different from those in the rest of Canada. The Task Group members (listed in appendix A) hope that these recommendations may be useful for Indigenous and Federal, Provincial, and Territorial governments; Indigenous communities; and the Public Health Working Group members in their respective spheres of influence to support access and improvements to substance use treatment and land-based healing available to First Nation, Inuit and Métis in northern Canada communities. Community voices and organizations we heard from also contributed to the development of this document (listed in appendix B).

Methodology

The Task Group met over a series of late Friday afternoon meetings to accommodate full participation of members. Each meeting was scheduled for an hour and lasted approximately two and was held using an online web conferencing tool. The Task Group Secretariat prepared summaries of each of the meetings, supported the development of a forward agenda and facilitated invitations to speakers. The Task Group members were responsible for individually reviewing documents and briefs before meetings.

Agendas for the meetings generally followed a similar pattern, with an administrative opening to capture Task Group members' participation, presentations from selected stakeholders with an opportunity for Task Group members to ask questions, followed by a discussion of the information and perspectives provided, and of the implications for recommendations and identification of resources and wise practice examples.

Substance Use Treatment

Context and Data

First Nations data from March 2020 to January 2021 was analyzed using the 1) First Nations Opioid and Methamphetamine survey, 2) the Drug Use Screening Inventory-Revised and the Native Wellness Assessment™ from the First Nations Addiction Management Information System that collects data from National Native Alcohol Drug Abuse Program (NNADAP) and National Youth Substance Abuse Program (NYSAP) treatment centres across Canada.

Key findings that support the recommendations

- **Substance use frequencies** were 4-6% higher in severity (20 or more times per month) during the pandemic (March 2020 – January 2021) compared to pre-pandemic (April 2019 – February 2020) for alcohol, tobacco, stimulants, opioids, sedatives, and hallucinogens. Community members believe that due to the pandemic, substance use has increased and that there is a greater need for harm reduction and access to addictions medicine supports for individuals who use drugs as well as support for their families. Thirty nine percent of First Nations reported lack of access to food during the pandemic. Treatment Centres offering virtual out-patient and outreach care to northern First Nations and Inuit communities report reaching far more clients, and for some this occurred while offering modified day treatment and out-patient programming.
- **Culture makes a difference.** Cultural supports and interventions were needs identified to support communities during the pandemic. Cultural interventions and supports using out-patient and outreach virtual services by NNADAP and NYSAP treatment centres supported on average a 10% increase in mental wellness in areas of Hope, Belonging, Meaning and Purpose.
- **Land-based** specific cultural interventions increased individual mental wellness from 4-18%, with similar findings across all genders. Land-based activities and practices were linked to an increase in connection to culture. This provides the evidence for the need for and importance of land-based practices to support wellness.
- **Prevention.** Cultural supports and interventions, land-based programming, and virtual capacity for connecting to family and community supports were protective factors for substance use during the pandemic and can be used to develop prevention activities and strategies for education.
- **Community based treatment.** Communities believe the practices needed to support those who use substances during the pandemic include family and community outreach supports, cultural practices, and capacity to access virtual supports (i.e., counselling and gatherings).
- **Training** to enhance community capacity for early identification of risk factors for substance use, about the impacts of the pandemic, and how to mobilize community supports for adapting programming and supporting advocacy.

Culture continues through modified outpatient and virtual services

- Smudging ceremony
- Talking circle
- Culture story telling, legends, and teachings.
- Supporting moms participating with their children and teachings.

"Medications are not meant to replace or substitute a person's existing support network including cultural, traditional or community led healing initiatives or practices but are available as an option. How we choose medications and how the plan of care is developed is based on individual readiness and unique health profiles."

Dr. Jeff Harries

We also heard from family physicians working in addiction medicine who reported a decline in substance use during the pandemic, that was observed through support to First Nations communities. This was a surprise as they had anticipated an increase in substance use and were planning ways to reduce risks for overdose deaths for people who lost access to substances as a result of restrictive public health measures such as community and territorial lockdowns. What made the difference in reducing substance use, as reported to the Task Group was turning to the land, community engagement to facilitate a communal commitment to ensuring protection against contracting COVID-19, managed alcohol programs, physicians and nurse practitioners providing telephone and virtual access for emergency calls from family or individuals, supporting radio and live streaming messages of hope, belief, and motivation for community based response to opioids, and methamphetamines, and continuous commitment to mentoring an outreach workforce in trauma informed care.

B.C., Interior Health, Aboriginal Mental Wellness

An education package is currently in development by the Aboriginal Mental Wellness Team to support further dissemination of this community and care provider education.

For more information and education related to Alcohol Use Disorder please visit the link below:

Mental Health Substance Use Documents New Advances in Treating Alcohol Use Disorder Video https://www.interiorhealth.ca/health-and-wellness/substance-use-and-addiction/substance-use-and-addiction-services

Key Principles in Approaches to Supporting Substance Use Treatment

Ensuring Equitable Service Delivery

- Commiting to building equity, and maintaining innovations in community-based services.
- Building relationships and trust with the community.
- Ensuring prescriber support for community development and the ability to support trauma informed care.
- Participation and collaboration among service sectors to provide the highest quality of care.
- Creating barrier-free and community-based service to ensure access to supports, and providing options for those seeking assistance, such as harm reduction, and using tools such as text messaging, and virtual care.
- Commitment to ensuring First Nations, Inuit, Metis governance of Community Programs.

Standards of Care for Service Providers

Ensure the workforce Recognizes the need for choice in how Indigenous people prefer to heal and ensure the opportunity is there with low barrier access;

- Makes a personal investment in understanding the history of the community;
- Has the capacity to work across the social determinates of health; and,
- Is provided with the capacity to ensure continuity of care.

Nishnawbe Aski Nation: NAN Hope Program

(NAN HOPE)

- The NAN Hope program provides community-driven, culturally safe, and timely mental health and addiction support. Nishnawbe Aski Nation community members can reach out to NAN Hope themselves.
- Relationships with referral sources are also necessary to connect with people when they need support, reduce caregiver fatigue, and bridge gaps in support resources at the community, regional and provincial levels.
- The NAN Hope website provides access to live support via a toll-free phone line that is available 24 hours a day, 365 days a year. During work hours, live support is also available via web chat, text, and Facebook Messenger. The website also provides information about the program; shares information about the Wellness Navigation and Counselling teams (with photos and bios); identifies the Nishnawbe Aski First Nation communities served; and provides contact and referral forms. The website is undergoing translation to Cree, Oji-Cree, and Ojibwe.

Recommendations to Support Substance Use Treatment

Inuit, Métis, and First Nations Harm Reduction

1. Increase harm reduction capacity and ensure that delivery methods fit community culture and practices.
    - "Harm reduction approaches are grounded in Inuit, Métis, and First Nations Knowledge, languages, land, and ceremonies. Harm reduction ensures policies, programs and practices are community based, trauma informed, culturally safe and peer led.
    - Recognize and support expanding the focus of harm reduction of substance use to include addressing the broader social and system wide issues that contribute to substance use for Indigenous people." [2]
2. Increase harm reduction training within the community.
3. Increase knowledge of harm reduction approaches and benefits across the whole of community, including leadership, workforce, and cultural practitioners/Elders.
4. Ensure all harm reduction practices have a trauma-informed lens.
5. Ensure communities have the capacity for outreach services (workforce, emergency shelter, food, clothing, water) for people who use substances.
6. Ensure communities have continued access to and distribution of naloxone.

[2] Interagency Coalition on AIDS and Development. 2019. *Indigenous Harm Reduction Policy Brief.* Source: *http://www.icad-cisd.com/pdf/Publications/Indigenous-Harm-Reduction-Policy-Brief.pdf*

‘Not Just Naloxone’ Training

British Columbia First Nations Health Authority

- In 2016, British Columbia declared the first-ever public health emergency following an unprecedented increase in overdose deaths. Five years later, the opioid crisis continues to disproportionately impact First Nations populations in British Columbia. Although British Columbia First Nations only make up 3% of the province’s population, they account for 16% of overdose deaths.
- In June 2016, the British Columbia First Nations Health Authority developed the Framework for Action, which consists of cross-system goals for addressing the Overdose/Opioid Public Health Emergency. As one of FNHA’s responses to the overdose crises from this framework, Not Just Naloxone training was developed.
- As a “train the trainer” workshop, Not Just Naloxone supports community champions by building a greater understanding of addiction, substance use, and harm reduction at the community level. It helps participants develop skills to facilitate their community-based workshops, trainings, and discussions through the lens of cultural safety and trauma-informed care.
- This training is geared towards any interested individuals such as youth workers, support workers, substance use counselors, addiction specialists, Elders, nurses, physicians, paramedics, etc., who are in a position to talk about substance use.
- Elders are involved in the training alongside peers who have a substance use background to share lived experiences. In collaboration with nurses, the training also includes a clinical lens to facilitate a better understanding of substances and their physiological impact.
- Once graduated from the program, students are encouraged to contact each other via lunch and learns, and other networking events to promote emotional connections and discuss barriers and wise practices. Post-training grants are offered up to $5,000 to offer training, and support community-based initiatives in their communities. An example of one community initiative: the trained community-based workforce used their training to provide information and resources to their community. As a result of the increased awareness, the community supported the development and implementation of household signs, visible outside the home that alerted community members that they could obtain naloxone in that home with no questions asked. Community members took on the initiative to monitor naloxone kits, ensuring they were easily accessible, and did not expire. This is a powerful, whole of community, anti-stigma message that says, “we care about your life.”

Trauma-Informed Care and Land-Based Programming

1. Ensure community capacity to address substance use issues and related harms throughAccess and availability to land-based programming
   - Access and availability to counselling, through culture and/or clinical, to address unresolved trauma as people are ready
   - Access and availability of services to stabilize someone in their substance use/recovery journey
   - Ensuring clear benefits for family and community are captured and publicly shared
2. Support the availability of Rapid Access to Addiction Medicine (RAAM) at the community level, through RAAM Clinics, mobile clinical teams,
   - and community outreach workforce to ensure support
   - for virtual/text/chat access alongside culturally relevant land-based programming. *(see appendix C for more on RAAM Clinics and virtual delivery)*
3. Ensure Métis communities have access to these same structural resources and funding for land-based programming, to address substance use issues and related harms at the Métis community level.

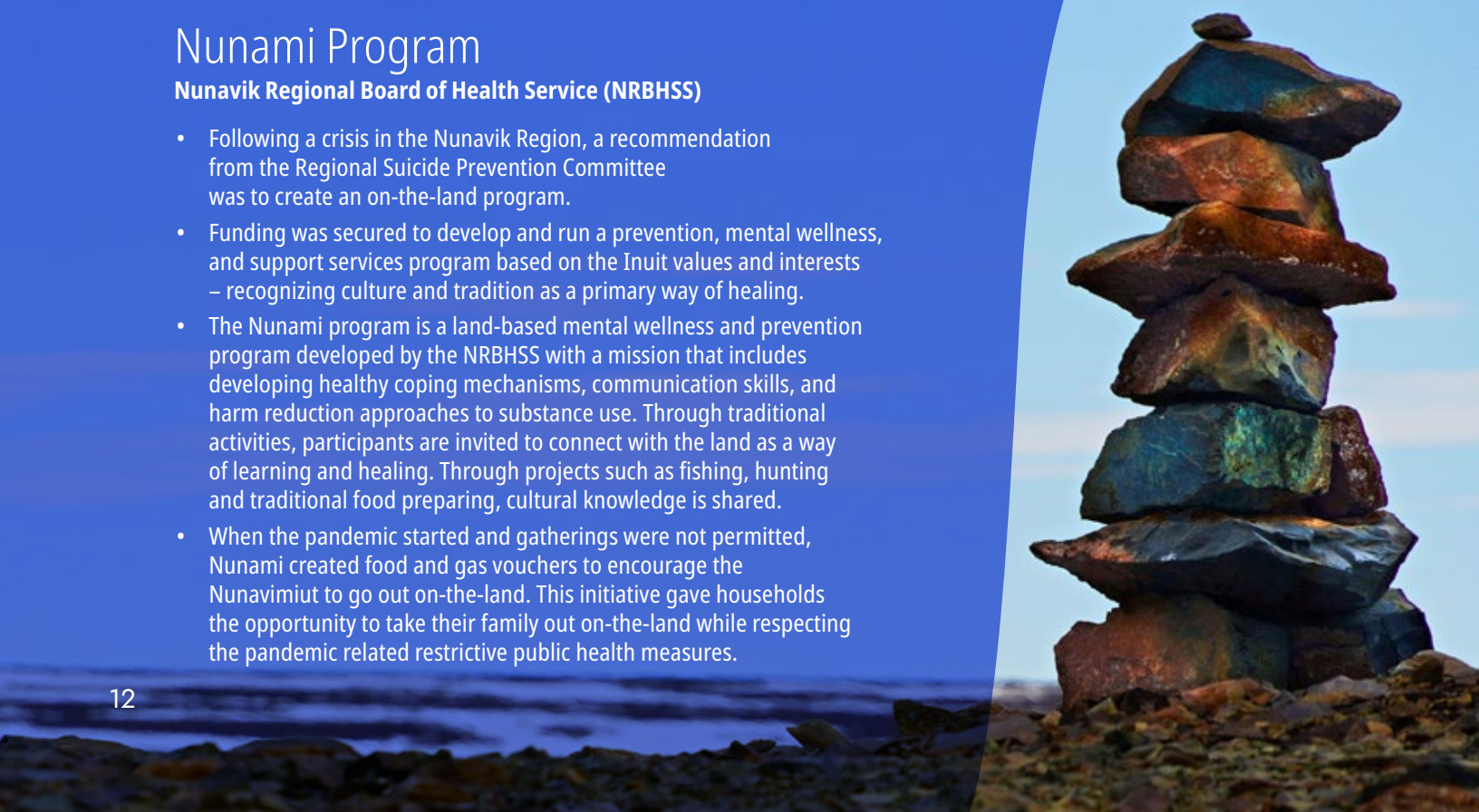
"Trauma is defined as an experience that overwhelms an individual's capacity to cope. Whether it is experienced early in life or later in life, trauma can be devastating. Daily life events may trigger individuals to re-live past trauma, undermining their present mental health."

COMMUNITY-LED BEST PRACTICE

Nunami Program

Nunavik Regional Board of Health Service (NRBHSS)

- Following a crisis in the Nunavik Region, a recommendation from the Regional Suicide Prevention Committee was to create an on-the-land program.
- Funding was secured to develop and run a prevention, mental wellness, and support services program based on the Inuit values and interests – recognizing culture and tradition as a primary way of healing.
- The Nunami program is a land-based mental wellness and prevention program developed by the NRBHSS with a mission that includes developing healthy coping mechanisms, communication skills, and harm reduction approaches to substance use. Through traditional activities, participants are invited to connect with the land as a way of learning and healing. Through projects such as fishing, hunting and traditional food preparing, cultural knowledge is shared.
- When the pandemic started and gatherings were not permitted, Nunami created food and gas vouchers to encourage the Nunavimiut to go out on-the-land. This initiative gave households the opportunity to take their family out on-the-land while respecting the pandemic related restrictive public health measures.



COMMUNITY-LED BEST PRACTICE

Rapid Access Addiction Medicine Clinics

Independent First Nations Alliance, Sioux Lookout, Ontario

- Helping people through a journey to help heal with culture as the foundation.
- The need for culturally relevant access to addiction medicine for individuals seeking help with high-risk substance use founded on the belief that previous approaches in the north solely based on the Western approach of assisting with substance use in treatment and medical interventions using naloxone was not sufficient. Conversations lead to looking at how trauma is the underlying issue of substance use.
- Rapid Access Addiction Medicine (RAAM) approaches were developed with a core concept of "Helping people through a journey to help heal with culture as the foundation."
- RAAM approaches provide individuals with a confidential, safe and non-judgmental space where people receive immediate and rapid access to specialized addiction services in a healing environment. Community resources are pulled together to provide an alternative, evidence-based option that addresses addictions from a wholistic health, social perspective, and offers traditional Indigenous healing options.
- Community workers met people where they are, and often have overcome substance misuse or experiences with a member of their family. With workers being from and looking like others from the community, it creates a sense of understanding, and a non-judgmental outlook to foster the relationship.
- Certificate-based training on trauma care is also underway for front-line workers who are experts in the community culture and language.
- To support community workers, nurses and doctors are being trained to operate in a w holistic fashion that considers culture and historical trauma.
- A hub and spoke model is an example of a community-based approach where the community workers and programs are the centre of the hub (see appendix C). The RAAM clinic provides immediate and rapid access to specialized addictions services as one spoke. The other spokes can include, but are not limited to land-based healing activities, family supports, social programming, trauma informed care, etc.

Building Community Capacity

1. **Culturally Appropriate and Relevant Service Providers**
   Ensure service providers brought into a community, including those on a temporary basis, have the cultural competency to deliver culturally safe services that are respectful and relevant to the community context within the Indigenous determinates of health.

   Communities need capacity to ensure they can assess and provide oversight to monitor cultural competency and safety of service providers within their communities, and especially when developing new community-based programs.

2. **Community-Based Solutions**
   Engage communities in exploring potential solutions that focus on community strengths, capacity, and development.

   - Sustaining land-based programming and community innovations is a priority area; for example, a number of communities joining together to develop a hub and spoke model where the community is the hub and clinical services are the spokes to increase community capacity and ensure rapid access to addictions medicine (see appendix D). Land-based programming has also continued to demonstrate its effectiveness and successful operation while adhering to COVID-19 related public health measures.

3. **Promote Protective factors for Substance Use**
   Support young people and families to build caring, trusting relationships including positive relationships within the youth's home, school, and community to encourage a supportive adult inside or outside their family.

4. **Population-Specific Supports**
   Recognize that population-specific supports are required for populations at greater risk for mental wellness challenges, such as youth (including youth aging out of care), children, families, and Elders.

Investing In

1. **Sustainable Community Development and Capacity** by ensuring long-term funding that is flexible in how and when it can be used, as decided upon by the community, and supports community ownership.

2. **Measuring Outcomes of Additions Medicine** to support the overall wholistic approach to healing by increasing and improving data collection, management, and access.

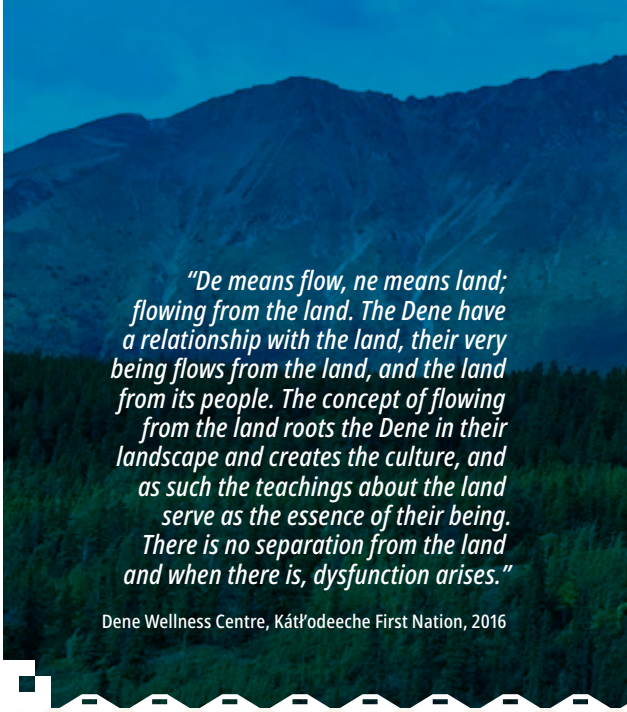
"Elders, and other cultural practitioners are integral to the workforce for the provision of training to develop cultural competency, to provide clinical supervision, and direct client care. Each community is best placed to identify their cultural resources."

First Nations Mental Wellness Continuum framework, 2015

Land-Based Healing

Preamble

It is said that the Great Spirit placed the Inuit, Métis, and First Nations people on this land, we know the land as our Mother the Earth. All the original language names of the many nations across the land reference the relationship of that nation to the Earth and in that way conveys meaning for their identity. Relationship with the land and all the beings of that land is as critical to mental wellness, physical growth, and psychological development across the life span as is the connection and relationship to one's own mother and family throughout life.



"De means flow, ne means land; flowing from the land. The Dene have a relationship with the land, their very being flows from the land, and the land from its people. The concept of flowing from the land roots the Dene in their landscape and creates the culture, and as such the teachings about the land serve as the essence of their being. There is no separation from the land and when there is, dysfunction arises."

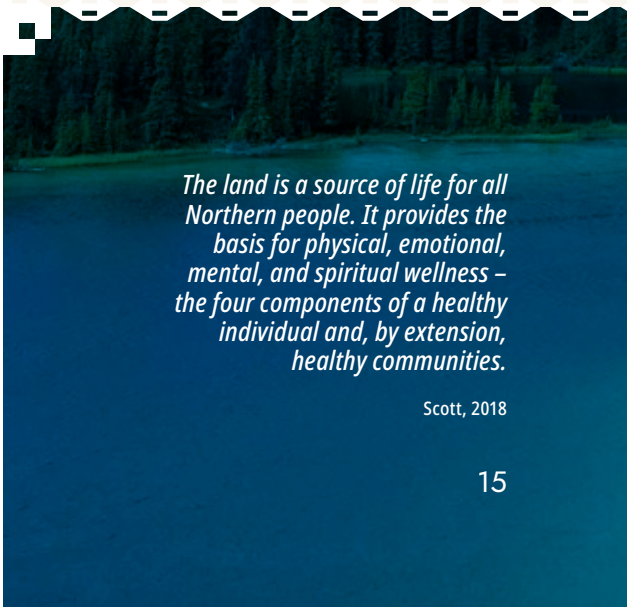
Dene Wellness Centre, Kátł'odeeche First Nation, 2016

Evidence of this worldview is visible in all the ways Inuit, Métis, and First Nations Nations connect with the land. Following are a few examples:

- Ceremonial practices of burying the placenta of a newborn in the earth that is home, ensures a sense of belonging and connection throughout one's life no matter where one lives. The "walking out" ceremony is another culture-based practice that is important for connecting the child to land. At the adolescent stage, the connection to land is supported through rites of puberty ceremonies that are focused on fasting and establishing relationship with land.
- Birthing at home, ensures a connection to land, family, and community. Culture-based birthing practices include roles and responsibility for the entire family and it is through this involvement in birthing that many culture-based teachings about life and death are given such as, family roles and responsibilities, identity, joy of life, pain, prevention of teen pregnancy, and prevention of suicide.
- Supporting families in connecting to land is important, as they understand "the land is alive" (Nunami model). Being in relationship with the land is encouraged using the original language. Land therefore supports language acquisition and revitalization, and it is the language which is the strongest resiliency factor.
- Being on the land strengthens the connection to family and with the support of Elders and Knowledge Holders, a connection to culture and language supports wellbeing.
- Being on the land, learning culture and language, being with family, brings a sense of peace and purpose. Peace and purpose are critical factors in preventing suicide among youth.
- Connection to land and culture also teaches respect for women as they, like the land, are the givers of life. A relationship with the land teaches respect and protection of women. In turn, the values of respect for land, water and all resources within the earth are solidified.

The 2021 National Action Plan for the Missing and Murdered Indigenous Women and Girls' and 2SLGBTQQIA+ identified overarching principles that also support a connection to land: "To facilitate a decolonization approach that ensures cultural safety rooted in recognition of the ***importance of the land****, culture, language, and Inuit, Métis, and First Nations-led approaches, that encourages the revitalization and flourishing of Indigenous cultures, languages, and traditional knowledge."* [3]

It also important to understand that wherever we are, away from our homelands, there is still that connection to the land that continues to be important to First Nations, Inuit, and Métis.



The land is a source of life for all Northern people. It provides the basis for physical, emotional, mental, and spiritual wellness – the four components of a healthy individual and, by extension, healthy communities.

Scott, 2018

[3] 2021 Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ People National Action Plan: June 3, 2021

Data

Data specific to programs, services, and connection to land is beginning to emerge, however, there is a need to support further development and capacity for culture-based and strength- based indicators. Following are some examples of data that was presented to the working group on land-based services.

Hope, Belonging, Meaning and Purpose: Outcome Measures of Indigenous Wellness

Thunderbird Partnership Foundation facilitates access to the Native Wellness Assessment™ for NNADAP and NYSAP treatment centers that offer culture-based practices to facilitate wellness. An analysis of the data collected with the Native Wellness Assessment™ focused on correlating land-based practices with change in wellness over time. The analysis examined data collected over three years, and a total of 2910 self-assessments, and concluded there is a consistent improvement of wellness through culture-based interventions facilitated through land-based services. Specifically, improvements in wellness were observed in the outcomes as follows:

+ 6%

INCREASE IN HOPE: supported by a connection to belief, identity, and Indigenous values.

+ 13%

INCREASE IN BELONGING: measured through culture-based definitions of family, community, relationships, and attitude towards living life.

+ 15%

INCREASE IN MEANING: measured through culture-based indicators of rational knowledge and putting together rational and intuitive ways of knowing to facilitate understanding.

+ 19%

INCREASE IN PURPOSE: achieved through the celebration of unique ways of being, Indigenous specific ways of doing, and wholeness.

Thunderbird Partnership Foundation, 2021

Connection to the Land

Indigenous Science formally known to many biologists and ecologists as Traditional Ecological Knowledge (TEK) have informed how First Nations, Inuit, and Metis have lived in relationship with the land for many years. (Vizina, 2010)

Extreme climatic events (ECEs) are increasing in frequency and magnitude as part of global climate change, with severe consequences for both nature and human societies. The following is but one example of how indigenous science informs safety and risk management on the land. (Zabin, 2022)

Relationship with Creation – for example, star navigation/telling time – how to read the stars to navigate your way home. The north star and the big dipper. Names for all the moons and reading the moons to know the migration patterns of the bird and animals. March is the time when the eagles come back but now they don't come back then because of climate change. Seeing the change in where the sun rises and knowing this effects the weather and the migration. Can't make snow shoes in the spring because this "calls the winter"... snow shoes are only made in the fall. (Maje, 2017)

The health of the land is directly connected to the health of the people. **If the land is not healthy, the water is not healthy, the people are not healthy.** Protecting the land and waterways is vital to safeguarding Indigenous culture and lifeways**.**

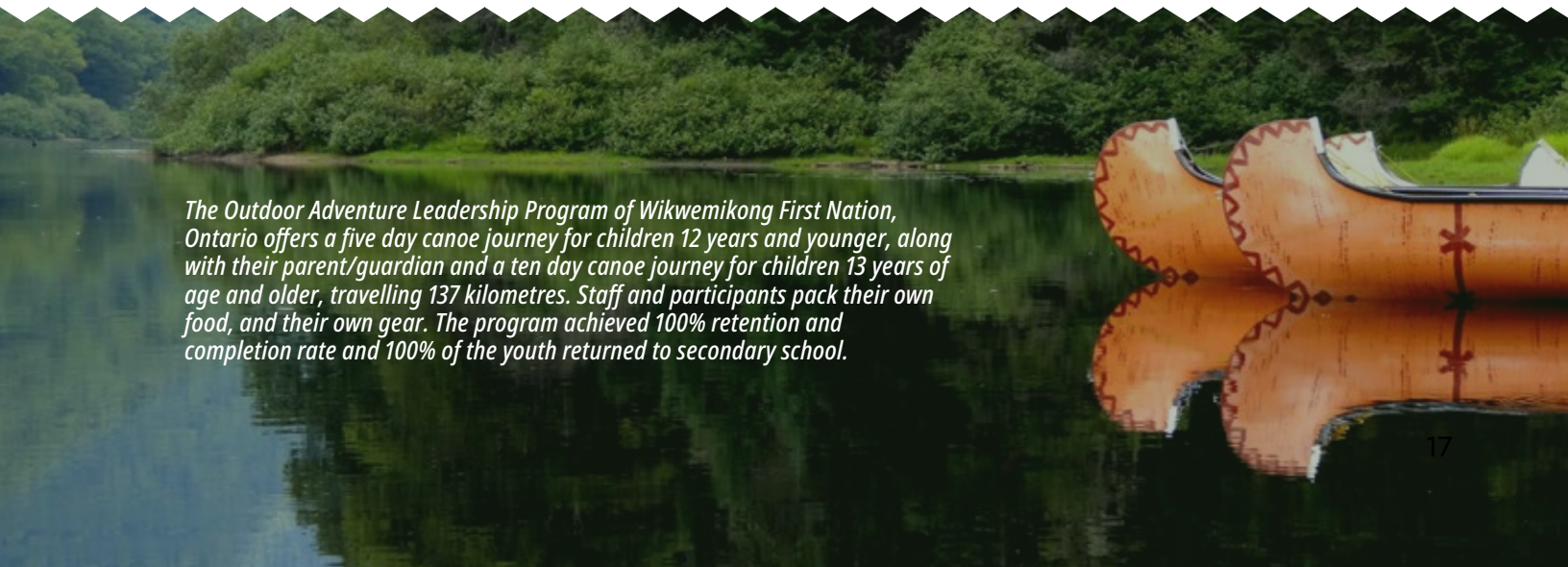
Supporting even one person's access to land- based programs provides a ripple effect across the nation. It is essential to ensure that occupancy, revenue sharing and resources for land-based programs benefit the understanding that the health of the land is the people's health.

The concept of land must be addressed in urban settings, as what is known as homeland is limited to a specific space and is not limited to the reserve. The land is spiritual and imprints no matter where one resides. For urban centres, the urban Indigenous community must identify important and meaningful spaces to them. What comes from the land and their relationship to the land informs what brings comfort and healing.

Way of Life

While land-based initiatives have been identified by presenters as programmatic, or event-based, the presentations also highlighted being on the land as a way of life that facilitates

- **Inter-generational transmission** of knowledge supported through continuous and purposeful involvement of Knowledge Holders/Senators/Elders - the environment on the land supports natural transmission, meaningful conversations.
- **Connection, value-based** food harvesting practices, **maintenance, protection and transmission** of culture and knowledge for living on the land, all of which are important for **maintaining wellness.**
- Grounding their identity through **interacting with the land.** Also supports knowledge of **family identity** in relation to the land such as trap lines, history and **changes in the environment.**



The Outdoor Adventure Leadership Program of Wikwemikong First Nation, Ontario offers a five day canoe journey for children 12 years and younger, along with their parent/guardian and a ten day canoe journey for children 13 years of age and older, travelling 137 kilometres. Staff and participants pack their own food, and their own gear. The program achieved 100% retention and completion rate and 100% of the youth returned to secondary school.

Métis Connection to Land

It is important to remember that the **Métis people are also connected to the land and have a strong sense of stewardship of the land no matter where Métis call home**, urban environments, small towns, settlements or in rural communities. **Land is essential for the wellness of Métis.**

Métis people have a very close connection to the landscape and its ecosystems; the land and water are relied upon by Métis communities for food, medicine, spiritual fulfilment, the transfer of their traditional knowledge to future generations, and livelihood. Put another way, **Métis communities depend upon the lands, waters, and resources of their traditional territories for physical and cultural well-being**.

The relationship between Métis communities and their traditional territories is one of **interdependence**. As such, what happens to these traditional territories in relation to use, development, ecosystems and sustainability is of fundamental importance to the survival of Métis communities. If these territories are permanently changed or damaged, the Métis people and communities will be too. Similarly, Métis people see themselves as stewards of the lands upon which they depend and rely deeply on for the health of their environment, and for their own physical, mental, spiritual and community health.

"We will need to learn and be inspired by the wisdom of our ancestors and the vision of today's guardians of the traditional knowledge of mankind."

(Secretariat of the Convention on Biological Diversity, 2009c, p.2)

Culture as the Foundation for Health

Culture is an essential social determinant of health, and a wholistic concept of health is an integral part of a strong cultural identity for Inuit, Metis, and First Nations. When culture is considered the foundation, all services can be delivered in a culturally distinct and safe way. Métis Nation culture and tradition are diverse, and are fundamental components of Métis identity with no uniform definition.

Culture and tradition are fluid concepts for Métis People and often change over the lifespan. The Metis Culture is an important determinant of Métis well-being, it can be best summarized on a continuum of past to future. *(Toward a National Dialogue on Métis Health Policy, Métis National Council, Oct 2016)*

The result of a conceptual shift toward the inclusion of land will be policies, strategies, and frameworks that are relevant to local community contexts, recognize the importance of identity and community ownership and promote community development. *(First Nations Mental Wellness Continuum framework, 2015)*

Principles

Land based services are about a spectrum of wellness, from enjoying life as a family or with Elders, stewardship of land and water, to healing from trauma. Each of the presentations heard by the Working Group spoke to some aspect of these six principles.

1. **Indigenous Knowledge & Culture**
2. **Creation as Healer**
3. **Experiential Learning**
4. **Community Focused**
5. **Social Inclusion**
6. **Scalable**

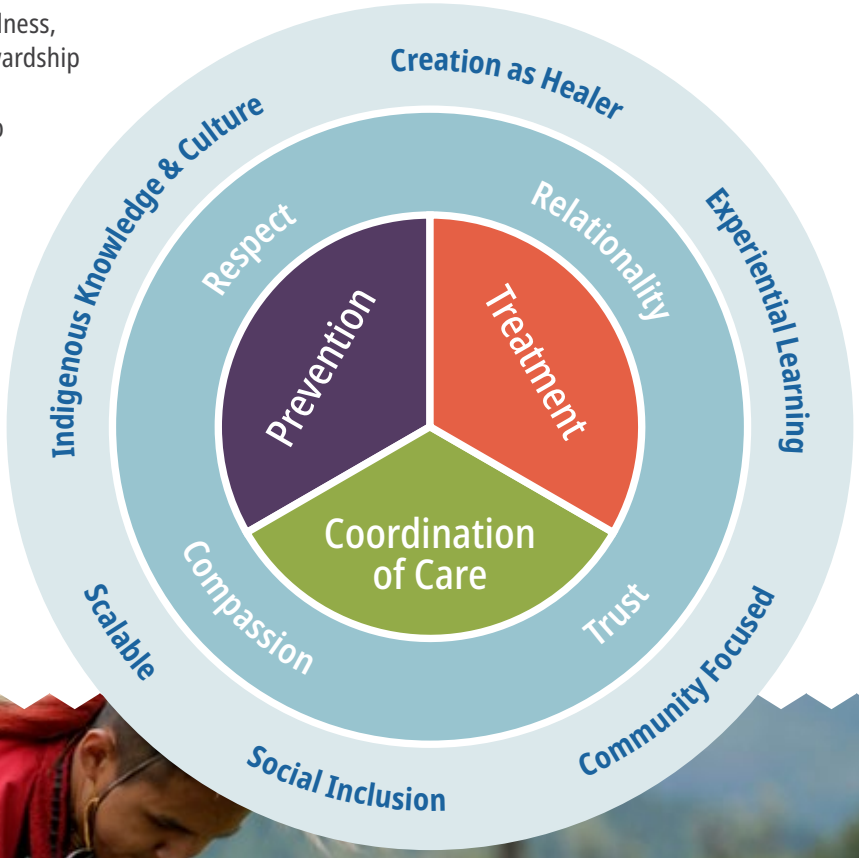


Figure 1: Land Based Service Delivery Logic Model (Thunderbird 2018)

Benefits of Land-Based Healing

The focus of land-based programming is to strengthen overall mental health; increase cultural identity; self- esteem, and sense of belonging; support family relationships; Cultivating healthy family connections, parenting skills, and support networks; healthy coping mechanisms, communication and problem-solving skills; healing from trauma and grief; harm-reduction approach to substance abuse; and physical health and wellness through an active lifestyle, sobriety, proper nutrition, alternative to digital dependency.

It is vital to consider using land-based programming as a preventative tool for those suffering from trauma, especially adolescents. Land-based programming is an effective tool to support youth in feeling connected and not desperate/hopeless. Land-based programming can also connect other community- based social development initiatives and determinants of health sectors, such as individual, family, and community nation-building.

COVID Lesson Learned

On the land programming has been used by families to promote both Cultural Knowledge and Science, Technology, Engineering, and Mathematics (STEM) education during the pandemic while also providing a break from virtual education. For example, picking berries and learning about traditional medicines and the local environment.

Land-Based Service Delivery Model

In the model offered by Thunderbird, land for healing has six dimensions.

Land is:

1. **An aspect of self governance**
2. **A determinant of health**
3. **A core element of culture**
4. **A teacher and healer**
5. **A teacher of relationality**
6. **A teacher of culture specific life-skills**

Figure 2: Land for Healing (Thunderbird 2018)

What Happens at Trauma Camp?

Kwanlin Dün First Nation Land Based Program - Jackson Lake, Yukon

- Detox not provided
- Focus on healing trauma
- Person-centred (choice to clients)
- Honours traditional and clinical approaches to healing
  - Cultural activities, ceremonies, and traditional teachings
  - Clinical healing involves Internal Family Systems, experiential, Cognitive Behavioural Therapy (CBT), and trauma work
- Use of circle and 1-1 counselling
- Privacy of own cabin for sleeping
- Nutritious meals are provided
- Exercise encouraged
- Safety of individuals is paramount

PARTICIPANTS FEEDBACK

"I like the morning smudge and prayers where we state what we expect for us during the day in the morning."

"What I actually loved was learning how to make fish net, drum making, knife making and getting back on the land and learning."

"Jackson Lake was the best decision I've ever made, but the camp was only the beginning, it made a huge difference. I didn't ever think I would be where I am today with a full-time position with my First Nation. If feels good not waking up with a hangover and worrying about your next drink, being able to think clearly and living a healthy lifestyle has been amazing so far. I thank the Creator every day for second chance at life."

Recommendations to Land-Based Healing

Culture as a Foundation

1. **Support Elders and Knowledge Keepers by**
   - Understanding there is a sense of urgency to connect to Elders. Thus, Elders in each community must be included in the development and implementation of the program to provide the linkage to traditional culture based on the season.
   - Ensure they are funded for their role.
   - Provide programs that are not just centred around hunting and fishing, but accessing medicine from the land and the knowledge behind medicine preparation and use. Ensure Knowledge Keepers are funded to assist in identifying medicines and the protocols behind harvesting.
2. **Support knowledge transfer to youth** with proper training to develop community-based capacity to deliver programs and retain traditional culture-based knowledge.
3. **Ensure living off-the-land programming** has traditional cultural components (i.e., sewing, country food, toolmaking, etc.), teaches life-skills for living off the land, supports life promotion, mental wellness, and a sense of pride in identity.
4. Land facilitates **revitalization of First Nations, Inuit, Métis** use and meaning. The Indigenous Languages Act (2019) is meant to support the recovery, reclamation, maintenance, and normalization of Indigenous languages. Being on the land and learning to relate to the land supports intrinsic value for land as relational.
5. Ensure the lead guide is well trained in risk management, or ensure an Elder who has grown up on the land leads land-based activities to teach how to be in relation to the land to ensure safety.

Programming

6. **All land-based healing programs must**
   - Be considerate of family needs and children
   - Include trauma-informed healing
   - Be highly flexible regarding eligibility and establish parameters around how the program is developed to tailor what works best in the community.
   - Consider working with the health unit/department in the area to allow non-Indigenous people to participate in the programming.
   - Include preventative programming for youth, and if possible, include them in the development process.

7. **Collaboration is required** with local organizations and/or local community members *(i.e., schools, youth support workers, family houses, municipalities, etc.)* and may assist with costing if resources are shared.
8. **Form an operational group** that can connect with other land-based programs to share best practices and lessons learned *(Thunderbird Foundation report).*
9. **Create ways to build the credibility of land-based programming** by establishing standards, regulations and licensing based on First Nations, Inuit, and Métis knowledge systems. This may also include developing a comprehensive system of core competencies for the workforce, capacity for application of accreditation and licensing standards, capacity for structural requirements, administrative sustainability, quality control, local autonomy, and professionalism. Risk Management processes might also apply for sustainability of land-based capital/minor capital resources and reducing liability risks.

Nunavik-Nunami Model

Supporting Remote/Isolated Communities example:

- Nunavik-Nunami model can fund and support the land in all communities in their region and not require clients to come to one place.

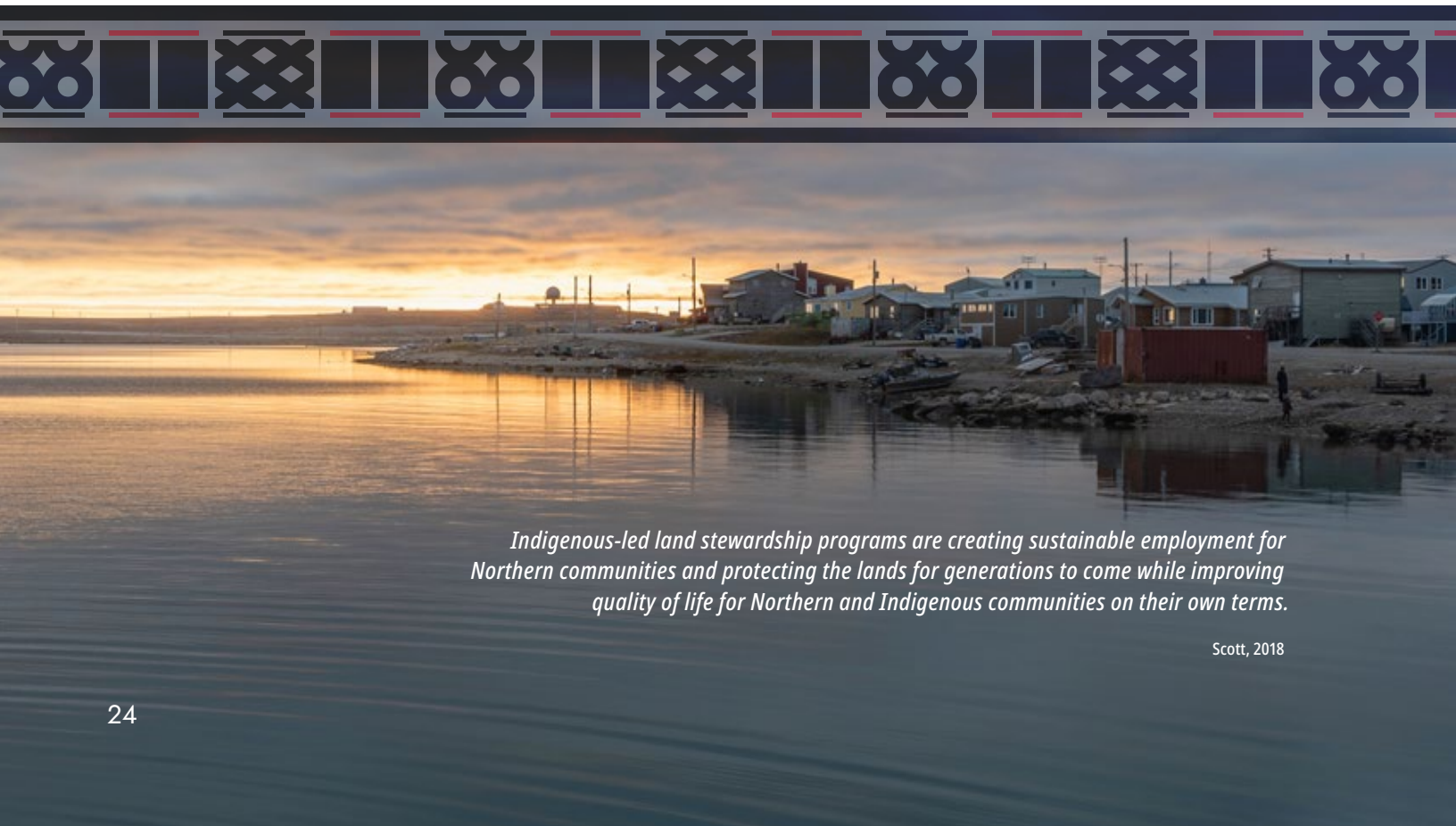
COVID best practice example:

- Nunavik Program was flexible by setting up vouchers that schools, families, and individuals could apply for to help support them going on the land by paying for the tools and groceries needed to go on the land or find a guide to do so.
- The Ilisaqsivik Society of Clyde River, Nunavut, also provided gas money to help support people to go on the land.

Children, Youth and Families

Must ensure access to land and culture, as both are important for **knowledge transfer and mentorship, especially in land and water stewardship**. Youth programs delivered on the land observed that youth did not always do well when they went to treatment but saw significant progress when they participated in land-based programs. Land-based environments facilitate an ethic of non-interference which supports disclosure and **process of trauma, in a gentle indirect cultural way**. Indirect communication styles support the movement through a story of trauma in ways that are client-directed and move through grief in safe ways. Youth do not talk about grief, and through non-intrusive approaches, the youth are not left alone. An adult does not leave the person's side all day. The side-by-side presence supports the transference of tools and skills to build self- esteem. A reduction of instances of self-harm is an important measure.

10. **Consider An Act respecting First Nations, Inuit and Métis children, youth and families** (2020) **that lists factors to be considered that are in the "Best interests of the Indigenous Child", such as the child's connection to territory** (land), language, family relationships, and community relationship and further, emphasizes Indigenous children must be able to access their rights.
11. **Land is also a key aspect of the Indigenous Early Learning and Child Care Framework** (Government of Canada, 2017) and indicates all Indigenous children can experience high-quality, culturally rooted, early learning and childcare programming. Linking children's early childhood development programming to land-based healing is important for facilitating psychological well-being and increasing ability for developmental milestones.



Indigenous-led land stewardship programs are creating sustainable employment for Northern communities and protecting the lands for generations to come while improving quality of life for Northern and Indigenous communities on their own terms.

Scott, 2018

Métis Nation of Ontario

(MNO)

- Prior to COVID-19, the MNO had run March Break camps for high school-aged youth (youth in Grades 10, 11, 12), as well as on the land culture camps using a seasonal model (Spring, Summer, Autumn and Winter camps). Camps involve youth, Knowledge Holders, and Métis Senators to provide a wholistic experience for Métis youth.
- These camps are around four days in duration and host approximately three workshops per day focused on land-based knowledge, storytelling, cultural arts and community building. Programming is in sync with the summer season and engages Métis youth in learning the Métis culture and way of life.
- While the format is different for the culture camps, we have created a camp model that hopes to connect Métis youth to their culture and allows them to practice traditional skills and knowledge from the safety of their own homes and communities. This is particularly important during this time as many Métis youth still seek to connect with their Métis culture and heritage. The cultural summer camp will engage youth through interactions with Métis Knowledge Holders, MNO Senators, MNO staff and facilitators in events/activities that will span the duration of the camp.
- The MNO has also held an Early Learning Family Camp (where young children, their siblings and parents/guardians attend), and it is working to develop further early learning on the land workshops.
- Since COVID-19, MNO has adapted its culture camp model to a remote learning model (for both high school-aged camps and early learning-aged camps). Métis youth register for camps in advance and then attend the land-based sessions that are focussed on specific activities / learning / traditional way of life activities. Camp attendants also receive a package of materials and equipment (in advance) that align/ resonate with the activities in the camp so they can apply what they have learned on their own time in a COVID-safe manner.

Training for Land-Based Healing, Thunderbird Partnership Foundation

This facilitator training supports application of the Land-based Service Delivery Model (LB- SDM). The LB-SDM supports the planning, decision-making, delivery, and evaluation of programs on the land/in-country. It includes templates, sample documents, case scenarios, and other helpful resources to support program implementation. A First Nations-specific SDM conveys principles and standards from an Indigenous lens while ensuring cultural protocols and integrity are valued with the same integrity as standards of practice. From a Western or mainstream lens on service delivery, *culture-based rites* may be defined by license or other credentials that verify knowledge, skill, and scope of practice.

12. Enhance Credibility of Land-Based Healing Programs through training, necessary to ensure:

- Core Elements of Land-based Programming and Healing
- Understanding the Land-based Service Delivery model
- Traditional Healing and Therapeutic Practice
- Risk Management
- Building Land-based Capacity
- On-line Community of Practice

Resource Investments

Note: these costs are significantly higher during the pandemic

13. Long Term Healing to **Stabilize the Community requires an investment in land-based healing.** At a minimum this should include:

1. Operational Costs

a. $9200 per person for 8-week program.

b. Seasonal summer programs that can run at $400 per person.

c. On average, a 4-to-6-week program will cost $60,000-$150,000 per intake in operational expenses, depending on location and whether the land-based program is stand alone or operates as part of another program.

2. Capital Costs

a. Capital has been estimated at $150,000 per cabin. Generally, a minimally equipped camp includes one or two cabins for sleeping quarters with bunk beds, one cabin or permanent meeting space, and an equipment storage facility. Some camps have a separate kitchen and eating space, in others the kitchen and eating space is integrated into one of the sleeping quarters. Additionally, some camps have separate sleeping quarters for program staff and Elders.

b. Startup minor capital for equipment is estimated at $ 500,000.

c. Participant travel to the land-based camp varies and these costs are not generally included. (Thunderbird Partnership Foundation, 2018)

14. Sustainable Resources and Year-Round Access is required to ensure **continuity of *way of life*** and provide the opportunity to plan for programming for all seasons since different seasons offer different knowledge and purpose. This will ensure continuous access to mental wellness through land and learning traditional knowledge of culture-based skill sets.

14. Digital Capacity across Inuit, Métis and First Nations needs equity to ensure access to teachings about land and culture and other resources, that would not otherwise be accessible without digital means (devices and data).

15. Measuring Outcomes of Land-Based Programming to demonstrate the difference land makes in mental wellness, and support the overall wholistic approach to healing and wellness by increasing capacity and improving data collection, management, and access.

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Annex A

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Independent First Nations Alliance

Sioux Lookout Health Authority

Ontario Nishnawbe Aski Nation

Nunavik Regional Board of Health and Social Service

Thunderbird Partnership Foundation

Wikwemikong First Nation

Kwanlin Dün First Nation

Inuvialuit Regional Corporation

Métis Nation of Ontario

Ilisaqsivik Society

Appendix C

Rapid Access Addictions Medicine Hub and Spoke Model

Key Principles

- Services offered within a trauma informed lens
- Involves training for all community workers and leaders
- Community innovation and development are critical components
- Culturally safe and competent service providers

Briefing note on the role of RAAM clinics in expanding access to addiction treatment for rural, remote Indigenous communities

Submitted to the Mental Wellness Task Group
and Dr. Carol Hopkins, Executive Director,
Thunderbird Partnership Foundation

Meldon Kahan MD, 17 May 2021

Introduction

The author of this briefing note is the Medical Director of the Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META: PHI) program in Ontario. META: PHI introduced Rapid Access Addiction Medicine (RAAM) clinics to Ontario. This briefing note examines the potential role of RAAM clinics in improving access to medication-assisted treatment for rural Indigenous communities.

What is a RAAM clinic?

The Ministry of Health in Ontario has funded around 70 clinics in Ontario, and about 30 additional RAAM clinics have formed without government funding. Other provinces have also funded RAAM clinics. RAAM clinics are usually located in a facility that does not charge rent, for example, a hospital, withdrawal management service, or Canadian Mental Health Association office. RAAM clinics are open for walk-in appointments at set times during the week. They are staffed by an NP or physician, and a case manager, social worker, or addiction service worker. The clinicians will see patients without an appointment or referral and will arrange follow-up appointments as needed.

What are the clinical benefits of RAAM clinics?

RAAM clinics are intended to improve access to medication-assisted treatment. They do this in several ways:

1. ***RAAM clinics have no wait times, and treatment is offered on the first visit.*** There is good evidence that wait times are associated with treatment drop out. Patients with an active addiction often find it difficult to keep an appointment that is weeks away.

2. ***Both counselling and medication are provided.*** There is strong evidence that both counselling and medications are needed for effective treatment of substance use disorders. Patients with an opioid use disorder are offered opioid agonist treatment (OAT) with buprenorphine; methadone or slow-release oral morphine (SROM) are prescribed if buprenorphine has failed or is contraindicated. OAT reduces withdrawal symptoms and cravings for opioids. Compared to psychosocial treatment alone, it has been shown to reduce overdose death, improve treatment retention, reduce arrest rates, and decrease infectious disease rates (1-6). Patients with alcohol use disorder are offered anti-craving medications such as naltrexone and acamprosate, which have been shown to improve drinking outcomes and reduce emergency department (ED) visits and hospitalizations (7-12). RAAM clinics also provide office-based management of alcohol withdrawal, reducing the need for an ED visit.

3. ***RAAM clinics provide counselling and trauma-informed care.*** Patients who present to RAAM clinics are usually depressed and anxious, and often feeling profoundly guilty and hopeless. RAAM clinic counselling focuses on providing education about substance use disorder as a treatable biopsychosocial condition rather than a moral failing.

4. ***RAAM clinics manage all substance use disorders, as well as concurrent mental disorders.*** RAAM clinicians treat all substance use disorders, recognizing that patients use substances in part to cope with negative emotions, situations, and memories. RAAM clinics also provide medication-assisted treatment for common psychiatric disorders.

How effective are RAAM clinics?

In an evaluation of the META:PHI pilot, health care utilization in the three-month period prior to the initial RAAM visit was compared to the three-month period following the initial visit for 168 patients who attended one of the six pilot RAAM clinics. ED visits showed a pre-post decline from 247 to 110 (- 55.5%), inpatient days declined from 233 to 54 (76.8%) and estimated health care costs declined from $306,270 to $85,436 (72.1%) (13). In a study of 186 patients attending the Ottawa RAAM clinic and 186 matched controls (14), at 90 days the RAAM clinic patients had a reduction in a composite index of ED visits, hospitalizations, and mortality relative to controls (OR = 0.53, $p < 0.05$). An evaluation of the RAAM clinic at Toronto Western Hospital (15) documented good uptake of anti-craving medications and buprenorphine, with self-reported reductions in alcohol and opioid use. In a randomized controlled trial with patients attending a WMS (16), patients in the rapid intervention group (same day facilitated appointment) had had a much greater initial attendance rate than the delayed intervention group (subjects arranged their own outpatient appointment); ED visits were also lower in the rapid intervention group. A rapid review on rapid access models for substance use treatment (17) concluded that RAAM clinics showed promise as a strategy for improving treatment access.

How effective is medication-assisted treatment for Indigenous communities?

Buprenorphine treatment for opioid use disorder: Several studies have evaluated buprenorphine programs in the Nishnawbe Aske Nation in the Sioux Lookout region of Northwestern Ontario. In a retrospective cohort study of 526 patients attending buprenorphine programs in six First Nations communities, the treatment retention rates at six, twelve, and eighteen months were 84%, 78%, and 72% respectively (18). This retention rate is considerably higher than the provincial average. Another study (19) looked at measures of community wellness in a remote First Nations community with 140 residents on a community-run buprenorphine program. One year after the program began, criminal charges declined by 61%, child protection cases declined by 58.3%, school attendance increased by 33%, and influenza immunizations increased by 350%. In a telephone survey of 38 First Nations students who received buprenorphine while attending a high school in Thunder Bay, 61% continued buprenorphine after high school, and those on buprenorphine were more likely to be employed and abstinent from alcohol than those not on buprenorphine (20). Finally, in a study of First Nations patients with diabetes, those who were on buprenorphine had significantly improved glycemic control than those who were not (21).

Naltrexone treatment for alcohol use disorder: Naltrexone has not been studied in the Canadian Indigenous population to my knowledge but has been studied in a placebo-controlled randomized trial with a sample of 101 Alaskans with alcohol dependence, including 68 Indigenous Alaskans. The naltrexone group had more abstinent days and fewer alcohol-related consequences (22). There were no differences in outcome between the Indigenous Alaskan group and the rest of the sample. Two systematic reviews concluded that naltrexone is a promising treatment for alcohol use disorder in Indigenous patients (23, 24).

What is the current status of buprenorphine treatment for Opioid Use Disorder in Indigenous communities?

The reasons for the remarkable success of the Nishnawbe Aske Nation community-based buprenorphine programs are threefold: The programs are operated by local bands, treatment is delivered on site in the community, and treatment is culturally appropriate and community governed. In a systematic review of the management of alcohol use disorder in Indigenous communities, the authors concluded that community involvement and implementing cultural traditions and healing methods were "important elements in future treatment and prevention strategies" (24).

Unfortunately, access to buprenorphine treatment in First Nations communities is severely limited. Many communities do not have an on-site program. Of those that do, some have capped their size, putting patients on a waiting list. Other communities have outsourced opioid agonist treatment to private clinics in larger surrounding urban centres. These clinics require patients to travel to the urban centre daily to receive their methadone or buprenorphine, which is highly disruptive for the patient and awfully expensive for the community. Furthermore, these programs do not provide counselling, culturally appropriate programming, or land-based activities.

When buprenorphine treatment is unavailable because the on-site program is capped, or because the community has no program, individuals sometimes decide to leave their community and move to a larger urban centre such as Thunder Bay or Sudbury. These centres have some excellent programs, but they also have programs which provide very inadequate care, with little or no counselling and support. Furthermore, they lose the benefits and supports that come from living in the community.

What is the current status of treatment for alcohol use disorder in Indigenous communities?

Anti-craving medications: Naltrexone and acamprosate are covered by NIHB. I have not seen data on prescribing rates, but I suspect they are low, based on conversations with addiction physicians doing consulting work in First Nations communities.

Withdrawal management services: An essential component of the treatment continuum is access to withdrawal management services (WMS). WMS provide a safe place for patients to stay while intoxicated, and they also provide support and medical treatment for patients in withdrawal. The most effective medical treatment is symptom-triggered benzodiazepine treatment, in which diazepam or lorazepam is dispensed every one to two hours for severe withdrawal symptoms. Successful treatment of withdrawal is an essential first step towards recovery; patients usually relapse if their withdrawal symptoms have not been adequately treated.

The Sioux Lookout First Nations Health Authority (SLFNHA), which provides health care to 33 geographically isolated First Nations communities, used to have medical detoxification beds at Meno Ya Win hospital in the town of Sioux Lookout. The service was converted to a less expensive outpatient program, which in turn has been defunded entirely. It is a scandal that this massive territory now has no medical detoxification services.

Psychosocial support: Large urban centres have a continuum of addiction treatment services, ranging in intensity from brief, time-limited counselling interventions to long-term outpatient counselling and day and residential programs. There is no such continuum for First Nations communities. Individuals with alcohol use disorder are sometimes referred to residential programs in large urban centres such as Winnipeg, but aftercare, an essential component of residential treatment, is not available once patients return to their home community.

In the region served by SLFNHA, some communities have mental health and addiction counsellors who either live in the community or are outside consultants. It is uncertain how effective these counsellors are as there is no funding stream for training and no outcome evaluation of their services. National Native Alcohol and Drug Abuse Program (NNADAP) workers are usually not involved in SLFNHA community-based buprenorphine programs.

Management of concurrent mental illness: The lack of medication-assisted treatment for substance use disorders and mental illnesses contributes to the high rates of suicide in Northern communities. In a retrospective cohort study of repeat ED visits by patients with alcohol use disorder in Ontario (25), the one-year overall mortality rate was 5.4%; suicide was a major cause of death. Evidence suggests that treatment for alcohol use disorder reduces the risk of suicide. In a national sample of 3,773 patients with a substance use disorder (26), 9% of the sample attempted suicide in the year before attending treatment, while 4% attempted suicide in the year following treatment.

Would RAAM clinics be useful for Indigenous communities?

With a grant from Health Canada, Dr. Lloyd Douglas is planning to set up a virtual RAAM clinic in Independent First Nations Alliance (FNA) communities. The intent of the service is to provide medication assisted treatment to remote Sioux Lookout communities through telemedicine. We believe this clinic will demonstrate that RAAM clinics are feasible and effective in First Nations communities.

RAAM clinics can help address the treatment barriers that are outlined below. RAAM clinics can deliver clinical services to remote communities through Telemedicine. Telemedicine greatly increases access to clinical services for remote fly-in communities. It is recognized, however, that there are difficulties with telemedicine, including internet access and privacy concerns (27).

RAAM clinics can provide medication-assisted treatment to remote fly-in communities at minimal cost to the band and without federal funding. RAAM clinics based in larger urban centers can provide services to remote communities without funds from the band or from Health Canada. In Ontario, RAAM clinics are funded by Ontario Health, and RAAM physicians are remunerated through OHIP. Setting up telemedicine services in remote communities is not expensive.

Anti-craving medications and buprenorphine can be prescribed via telemedicine. Naltrexone and acamprosate are simple to initiate remotely, and when the patient is stable and in remission, the primary care provider can continue prescribing. Buprenorphine presents more of a challenge, as induction and dispensing are ideally done under observation.

On day 1 of induction, patients could spend several hours at the community's nursing station, where nurses would dispense buprenorphine according to a standardized withdrawal scale. If the community does not have a nursing station, the induction may need to be done at home, although the RAAM clinician could observe the first dose through telemedicine.

What are the steps needed to connect RAAM clinics to Indigenous communities?

1. RAAM clinicians will need to meet with community leaders to address concerns about medication-assisted treatment. In some communities, band leaders have expressed concerns about buprenorphine therapy: it is substituting one addicting drug for another; patients should be quickly tapered off once their withdrawal symptoms are relieved; and buprenorphine tablets are commonly diverted. RAAM clinicians will need to meet with band leaders to address their concerns and reach agreement on several contentious issues: Tapering versus maintenance treatment; the cost and feasibility of daily supervised dosing; unobserved dosing and the risk of diversion; and depot buprenorphine injections.
2. RAAM clinics will need to adapt their protocols and services to meet the needs and resources of the Indigenous communities they serve. The processes of consultation with community leadership are vital to the success of community-based addiction treatment. Across the country, the diverse needs and resources of Indigenous communities need to be taken into consideration to be able to provide RAAM services to their community members. Some communities have well developed health services, but many have only intermittent services or even off-site services. All these diverse issues need to be taken into consideration.
3. RAAM clinicians will need to get agreement from Health Canada nurses on buprenorphine induction and alcohol withdrawal management at the nursing station, and nurses will need to be trained in these protocols. In communities which do not have these health services, the RAAM clinic will need further discussions with band leadership to explore other ways to provide remote care.
4. RAAM clinicians will need to be trained in culturally competent care, and will need to work closely with the community's traditional healers.
5. RAAM clinicians will need to work with the community's primary care providers so that they will take over prescribing of buprenorphine and anti-craving medications when the patient is stable.

Is there a need for additional federal funding for addiction treatment in Indigenous communities?

RAAM clinics can operate with minimal federal funding if they are based outside the First Nations community. However, RAAM clinics by themselves are not enough to compensate for the fact that addiction treatment in First Nations communities is massively underfunded and under-resourced. Sufficient, stable funding is particularly important for buprenorphine programs (28). In most programs, buprenorphine is dispensed daily under the observation of a program staff member, who is paid by the band. NIHB has not provided adequate funding for this; the bands themselves pay for dispensing services out of their operating budget. The Local Health Integration Networks (LHINs), regional decision- makers for the Ontario Ministry of Health, do not fund First Nations communities because they are a federal responsibility. The end result is that, tragically, many individuals living in these communities are unable to access an inexpensive, safe medication that has been shown to save lives. RAAM clinics can prescribe unsupervised doses of buprenorphine tablets, and they can prescribe depot buprenorphine to reduce the need for supervised dosing, but this is less than ideal and may not be acceptable to some band leaders.

Funding is also required for other components of an effective treatment system. For example, the SLFNHA region would greatly benefit from having one or two NPs and a salaried addiction physician, who could work with remote communities to train Health Canada nurses in alcohol withdrawal management and buprenorphine induction, and enhance the capacity of primary care physicians to prescribe buprenorphine and anti-alcohol medications. Funds would also be needed to hire staff with training and experience in traditional healing and land-based activities.

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