Sioux Lookout
First Nations
Health Authority

Mental Health & Addictions Review Final Report
November 2022

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Contents

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- Natalie Hanson
- Tom Chisel
- Trish Hancharuk
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Miigwetch!

Mariette Sutherland, Marion Maar, Bobbi Roberts

Introduction and Background

Introduction

The Sioux Lookout First Nations Health Authority (SLFNHA) serves 33 First Nation communities across Kiiwetinoong (a geography sharing boundaries with what is also called the Sioux Lookout region in Northwestern Ontario). SLFNHA delivers and plans much needed health services for its member communities and is guided in this work by the Anishinaabe Health Plan.

As part of SLFNHA's regional health planning mandate, SLFNHA has been directed by the SLFNHA Chiefs-in-Assembly through various resolutions to develop regional plans on mental health and addictions. The most recent resolutions include the development of a Youth Mental Health Strategy (Resolution #19-22) and a Comprehensive Addictions Strategy (Resolution #19-21).

The goals of this review are to obtain a full understanding of the current state of mental health and addictions services in communities served by SLFNHA in order to inform regional planning and coordination of services. The results of this review will be used to move towards a more comprehensive, coordinated mental health and addictions system which better meets the needs of community members and communities.

The review explored what services are currently available in the region. Over the past several months, the team has been engaging with communities, tribal councils, mental health and addictions [1] service providers, and individuals in the region to understand the services landscape, service gaps and needs. In addition, an in-depth case review of services was planned for two communities to enable the review team to learn about the unique realities of service delivery and service needs at the community-level. A document review, literature review, and interviews and focus groups with service providers within the region provided the basis for a gap analysis and needs assessment.

Specific goals of the review were to:

- Learn more about the mental health and addictions services currently available, both on and off-reserve.
- Obtain information and suggestions about what is working well, what challenges exist, and to identify service gaps.
- Identify the types of funding received for the provision of mental health and addictions services[2].
- Seek recommendations for a comprehensive regional mental health and addictions strategy.

The results of the review will be used to inform planning of a regional mental health and addictions strategy, as well as to develop recommendations related to coordination of services, youth mental health, and residential and out-patient treatment options.

This report describes findings of the mental health and addictions review, undertaken over a 6-months period between September 2021 and March 2022. These insights provide direction for improvements aimed at strengthening the local system within the context of existing resources.

Background

Providing mental health and addiction services within the large Sioux Lookout catchment area with many remote First Nations communities is fraught with many challenges. It is helpful to consider the context in which mental health and addictions issues are situated and in which services are provided.

SLFNHA serves 33 northern and remote communities [3] which are spread out across a large area in northwestern Ontario. Many are accessible only by air and winter road.

The town of Sioux Lookout, with a population of approximately 5,500, serves as a hub and connects the 23,000 people [4] in these remote northern First Nations communities to hospital, health care, social, and education services. In some of the communities, members must travel to Winnipeg for hospital and health services.

Social Determinants of Health in the Region

In northern First Nations, the social determinants of health (SDOH) such as racist and colonial federal and provincial laws and policies that impact housing, infrastructure, income and economic instability, education and employment have a significant impact on the health and mental health of the people. These Indigenous determinants of health result from centuries of colonial policies and ongoing systemic racism and oppression [5] and have a particularly profound impact on mental wellness. Communities are reeling from the Indian Residential School (IRS) experience, the fallout of intergenerational trauma and more recently, the discovery of mass gravesites at IRS schools.

Other SDOH, such as housing compound the consequences of the colonial SDOH. For example, poor and insufficient housing impacts the mental health of the community in two major ways – overcrowded housing causes high levels of stress for individuals and families and makes it difficult for those who are in recovery to progress in their journey if their housing and environment is unsafe or unhealthy. Lack of housing accommodations for visiting service providers is also an issue that inhibits the communities' access to mental health care and treatment.

Another longstanding concern is the communities' lack of basic infrastructure and dedicated space to adequately deliver services in health and mental health. There are few or no spaces for group programs nor quiet and confidential office space for counselling. Further, there are limited supports and services including mental health promotion, mental illness prevention, early identification, treatment, aftercare, and case management.

Equally important is the lack of employment and education opportunities within communities, which in turn constrains hope and meaningful contribution especially for the younger generation.

The “digital divide” is another social determinant of health in northern communities which disproportionately impacts mental health by reducing access to remote and virtual care. Telecommunication infrastructure and internet services may not support adequate bandwidth for community members to access telehealth or virtual care. It also limits opportunities for workers to access remote training or continuing education and limits their ability to network with colleagues and partners.

These systemic and long-standing infrastructure inequities exacerbate SDOH issues at the community-level. They provide important context to understand the mental health issues as well as the systemic barriers to the pathways to recovery and access to care and services.

More recently during the COVID-19 pandemic, measures taken by communities such as lockdowns, suspension of gatherings, group activities, school closures, and other social distancing measures deepened social isolation and severely impacted many community members’ mental wellness. Further, restricted travel access to communities to reduce the risk of spread of COVID-19 in communities, and the health system focus on COVID-19 response, have had the unintended impact of further reducing access to needed mental health care for community members.

Against this backdrop, communities and service organizations aim to provide quality, culturally-safe, and responsive care to address the mental health and addictions needs of First Nations community members.

The resilience and strength of First Nations peoples and communities is evident in the way in which they are able to support community wellness while navigating the many obstacles and challenges to wellbeing.

Approach and Methodology

This section describes the approach to the *SLFNHA Mental Health and Addictions Review*. We begin with the guiding role of the Working Group, followed by the specific methods that were employed to gather information, as well as the strengths and limitations of this approach.

Working Group Oversight

To ensure community and system-based direction and guidance for the review process, a working group of SLFNHA senior health leaders and managers in the mental health and addictions services programs with strong community experience was convened. The members were: Janet Gordon, Trish Hancharuk, Dr. Terri Farrell, Dr. Lloyd Douglas, Emily Paterson, and Tom Chisel. Their role was to provide advice and oversight to the project and support community engagement.

The working group established Terms of Reference, specifically for their work on this project. Their work was to provide organizationally and locally grounded, community culturally-informed advice and feedback to the design, community engagement, organizational engagement, data collection, interpretation, and analysis of the information gathered. The group met monthly from September 2021 to May 2022. During that time, the group fulfilled the following tasks:

1. **Literature Review**: provided advice on the scope of the literature review and feedback on the draft document.

2. **Document Review and Gap Analysis**: Provided over 80 documents and reports, of which half were selected as the most relevant to inform the review and provided feedback on the draft document.

3. **Key informant interviews, provider, and community focus groups**: Provided contact names, facilitated introductions, and advised on which key individuals to connect with to ensure the voices represented the diverse perspectives of the community members in the region.

4. **Community site visits**: Provided direction on proposed community site visits and assisted in navigating the multitude of challenges associated with visiting communities during the COVID-19 pandemic.

5. **Youth focus groups**: Provided contact names and context and facilitated introductions with individuals who worked with youth to host focus groups.

6. ***SLFNHA Mental Health and Addictions Review*** **Outline and Document**: Reviewed draft materials and received and critiqued an interim draft reports in order to inform the final document.

Overview of Methods

The review relied on multiple methods to gather information, including:

- A literature review
- A document review
- Key informant interviews
- Provider, community, and youth focus groups
- One community site visit

A brief overview of these methods is provided below with references to detailed documents with in-depth information on respective methods, results, and analysis where applicable.

1. Literature Review

The literature review process constitutes the first of two review processes described in this report. This review focused on published academic, peer-reviewed literature. It was conducted to examine what is currently known (from the academic and professional perspective) about Indigenous approaches to mental health, addictions, wellness, and healing services with a specific emphasis on exploring successful culturally and land-based approaches and those appropriate to Indigenous youth wellness. The purpose of this review was to identify the breadth and emergent findings of the current literature. The search methods included searching academic health related databases using applicable search terms for Indigenous mental health and addictions, and youth treatment approaches. However, the process did not set out to meet the stringent methodological requirements of a systematic review or a scoping review.

The review focused on literature published in the past ten years in Canada. A total of 94 publications were included in the literature review.

The scope of the literature included a brief contextualization of the historical context and its clear connection between the colonial harms to present-day manifestations of those harms in the current high rates of ill health, mental unwellness, and addictions. The literature was also reviewed for highlights of key factors and themes that point to promising practices for land-based healing programs and Indigenous youth mental wellness treatment models.

A separate document was produced to outline these findings. It is entitled "*Supporting Healing in Mental Health and Addictions: Wise Practices for Services Development in SLFNHA and Region.*" It can be found in Appendix A of this report.

2. Document Review and Gap Analysis

The document review process constitutes the second review process of existing literature. This process primarily centered on the review of various grey literature supplied by SLFNHA.

This review was focused on describing relevant commissioned evaluation and needs assessment reports, planning meeting summaries, service proposals, program descriptions, and presentation documents provided by SLFNHA. The review mostly covered documents produced during the past 10 years; however, some important older documents were also included based on the recommendations of SLFNHA staff and the project Working Group.

SLFNHA provided a total of 102 documents which were reviewed for their appropriateness of inclusion in the document review report. A total of 53 documents were included in this report.

A separate document was produced to outline all findings. It is entitled "*Document Review and Gap Analysis: SLFNHA and Region Mental Health and Addictions Services*." It can be found in Appendix B of this report.

3. Key Informant Interviews, Provider and Community Focus Groups

A total of 87 Key Informants participated in the qualitative portion of this review (see Appendix C – Key Informants: Interview and Focus Groups Summary and Table 1 for details) including: 22 interviews, 8 focus groups (with a total of 42 participants), and a community visit to Mishkeegogamang Ojibway Nation involving 7 interviews and 1 focus group with 6 participants and surveys completed by 10 youth.

Key informant interviews and provider and community focus groups were mostly conducted using video conferencing technology (Zoom), with at least two consultants present for most of the sessions. Interviews and one focus group were conducted in person during the site visit to Mishkeegogamang Ojibway Nation.

Participants were provided with the questions (see Appendix D – Interview and Focus Group Questions) prior to the interview or focus group whenever possible. The sessions were recorded and partially transcribed after the session. The interview questions were focused on identifying the range of current services, unmet needs and gaps and participants suggestions to improve the service system and barriers to access.

4. Community Site Visits

The Working Group provided recommendations for two communities to be selected for a site visit. Two key criteria in selecting communities for this site visit included the community's capacity to

accommodate a multi-day site visit within the constraints of the ongoing pandemic and their ability to provide insights into the spectrum of mental health and addictions services present within the system in the Sioux Lookout region. One of the communities selected that agreed to host was Mishkeegogamang First Nation. A second community visit was anticipated but could not be completed during the timeframe of the review. Details for all focus groups, interviews and surveys are provided in Table 1.

Table 1: Interviews and Focus Groups by Organization

Type of Session	Number of Participants	Organizations or Departments Represented
Focus Group - Nodin (Oct 20)	7	SLFNHA – Nodin
Focus Group - Nodin (Nov 8)	4	SLFNHA – Nodin
Focus Group - SLFNHA (Oct 25)	2	SLFNHA - Nodin
Focus Group - SLFNHA (Oct 27)	4	SLFNHA- Primary Care Team (PCT)
Focus Group – Outreach (Nov 25)	11	Sioux Lookout Meno Ya Win Health Centre (SLMHC), Canadian Mental Health Association (CMHA); Northwestern Health Unit; SLFNHA (Nodin, PCT)
Focus Group - Community Health Directors (Jan 18)	2	Mishkeegogamang Ojibway First Nation, Deer Lake First Nation
Focus Group – Community and Tribal Council Health Directors (Jan 25)	6	Webequie First Nation, Wapekeka First Nation, Keewaytinook Okimakanak Council, Shibogama First Nations Council
Focus Group - Provider	6	Harm Reduction Team, Approaches to Community Wellbeing

One on one Interviews	22	Dalton & Associates; Pelican High Peak Healing Lodge; Poverty Reduction Strategy; Independent First Nations Alliance (IFNA) Wellness; School Board; SLFNHA Elder; Harrison & Docherty Consulting; First Step Women's Shelter in Sioux Lookout; Keewaytinook Okimakanak Council; Shibogama First Nations Council, Youth Probation Officer; Community mental health, Wapekeka First Nations: (14) Physicians: (8)
Community visit #1 (Dec 13-15)	13	Mishkeegogamang Ojibway First Nation (Interviews: 7; Focus group: 6)
Community visit #2		Not completed
Youth surveys	10	Completed June 24, 2022

4.1. Mishkeegogamang Community Visit

Mishkeegogamang Health Director, Patricia Keesickquayash, facilitated a number of staff interviews and discussion groups during a three-day site visit in December 2021. Patricia helped to promote and schedule interviews and group discussions with staff regarding their mental health and addictions-related work at various agencies and locations in the community. COVID-19 protocols for this community visit were strictly observed.

A total of 7 staff were interviewed and a further 6 participated in a focus group. Interviews were attended by both interviewers, with one interviewer taking detailed notes while the other interviewer led the interview. A summary report was prepared and provided to the health director for feedback and verification.

4.2 Community Visit Report

A community visit report was prepared for the Mishkeegogamang First Nation and reviewed and approved by the community lead contact, Patricia Keesickquayash, before being submitted to the Working Group. The document, entitled "Report of the Community Visit in Mishkeegogamang in December 2021" can be found in Appendix E of this report.

4.3 Second Community Visit

Discussions were underway to coordinate a second community visit (anticipated in June 2022) to further enrich the community perspectives and insights. This visit was not completed.

Strengths and Limitations of the Methodological Approach

SLFNHA's Mental Health and Addictions Review process had been initiated in 2020 but was paused due to the global pandemic. Efforts to gather information and conduct the review were severely hampered due to restrictions, COVID-19 physical distancing, and travel protocols. Though it was relaunched in September 2021, the pandemic remained a concern in our work as data gathering had to be carried out amidst several community outbreaks and lockdowns. Competing priorities at the community-level and reducing the risk of the spread of infection were among some of the consequences of the pandemic which severely limited the possibility of community visits and restricted the amount of time the review team spent in the communities.

Despite limited in-person contact, video conferencing was successfully used for many of the interviews and focus groups. The vast majority of participants were quite comfortable with this approach as many had acquired good familiarity with videoconferencing which had been utilized often during the pandemic. It is important to note that interviews and focus groups required frequent rescheduling due to the pressure on staff to respond to current emergencies, the COVID-19 pandemic and other urgent business. It was not possible to conduct interviews with all individuals we had hoped to speak with due to particularly heavy workloads in responding to the pandemic and other developments. The working group members provided guidance in this area to ensure ample representation of perspectives and voices was maintained throughout the process.

Summary of Findings

In this section we present a high level summary of findings from the various methods of data collection. Full reports for each of the respective lines of evidence are provided in Appendices A – E.

Summary of the Literature Review

Literature which was reviewed and summarized included the most relevant professional literature of the past ten years as well as important older studies related to Indigenous approaches to youth wellness and addictions, mental health and wellness. This section highlights a summary of the main concepts gleaned from the literature review. The detailed literature review with all citations is provided in Appendix A.

The literature clearly connects colonial harms with assaults on the wholistic wellbeing of Indigenous peoples including their physical, mental, emotional, social, and environmental health. Profound cultural

and relational disruptions are direct outcomes of governmental policies which forced children into residential schools, day schools, and the child welfare system; and removed Indigenous peoples from traditional territories. These policies persist to present day and have allowed a disproportionate burden of environmental degradation; provided inadequate infrastructure, unsafe drinking water, and poor housing for healthy living. It is difficult for all people, but especially youth, to thrive under such circumstances.

The impact of the colonial legacy on youth has been dramatic because they are often separated from Indigenous worldviews, culture, practices, language, and the land. Indigenous youth need safe, healing spaces to support their development into healthy adults, capable of withstanding the many pressures of life in addition to the legacy of colonial harms. Currently, youth are deeply affected by social distancing measures of the COVID-19 pandemic**,** which they experience as depressing, isolating, and anxiety provoking. The effects on their mental wellness are compounded as more people in their environment use substances to cope with these stressors.

Indigenous concepts of wellbeing such as the Anishinaabe *mino-bimaadziwin*, that are rooted in an Indigenous worldview and anchored in Indigenous ancestral languages must be honoured in the framework of all services. They are foundational to an understanding of Indigenous healing and wellness, connecting people to each other in healthy relationships with each other and with spirit [6]. Connection to community, land, culture, and identity are key pillars upon which to build wellbeing and healing.

Land-based activities are an important part of these healing spaces and are just beginning to be described in the literature. Such interventions require health system readiness and transformation, including interprofessional education for health care providers to enable seamless integration into a continuum of community-based and regional services, starting with health promotion, and extending into prevention, treatment, and aftercare services. Provider education beyond the Indigenous health system is also important as Indigenous people are simultaneously navigating colonial institutions, such as school or healthcare, on their homelands that often fail to make space for Indigenous lives and worldviews. Governance bodies and funders must also be prepared to support Indigenous land-based healing.

The Thunderbird Partnership Foundation and the First Nations Mental Wellness Continuum Framework (FNMWCF) both advocate for the integration of culture and land-based approaches to mental wellness. Being on the land not only connects Indigenous people, especially youth with their identity but also supports their physiological and psychological health. Culture camps and other forms of land-based education can also strengthen and harmonize the relationships between children, youth, their families, community knowledge holders, and Elders.

However, given the many challenges that Indigenous people have already endured, they also need timely access to clinical mental and addictions health services with a priority for early identification services and rapid access to assessment and treatment for those with mental health problems seeking care.

Other needs are related to the social determinants of health and include basic safety and necessities such as adequate housing. Indigenous youth are particularly vulnerable to homelessness because colonial systems have created significant levels of poverty for First Nations. Homelessness leads to further mental health risks. Among homeless youth, there is a substantial rate of substance use and the risk of victimization is also very high.

Two Spirit individuals (2SLGBTQIA+)[7] experience higher rates of homelessness, victimization to violence (sexual and otherwise), and mental health challenges, particularly if they are forced to hide their identity due to stigma or prejudice directed towards them. To cope with the emotional pain, some may use addictive substances and attempt suicide at a higher rate than other youth.

Indigenous programs such as the Feather Carriers: Leadership for Life Promotion program provide culturally-grounded and life-oriented support that strives to attract youth towards life rather than suicide and premature death. Programs such as the Feather Carriers that embody the recommendations of the FNMWCF provide promising practices. Such programs should be formally connected to treatment services for Indigenous youth through a collaborative care process that connects Indigenous community and regional services with off-reserve services such as hospital-based treatment. Hospital-based programs in turn require shared care approaches that integrate Traditional Indigenous and clinical approaches to treatment and aftercare. Digital supports are also currently being explored to connect youth and these could be assessed for their appropriateness in programs.

In summary, the literature supports the need for a comprehensive wrap-around approach to community mental wellness with a focus on approaches tailored for Indigenous youth. The approach needs to integrate cultural and clinical services to support individual and community resilience with the long-term goal to move from ongoing crisis to community healing. Developing services for Indigenous youth and communities requires an intentional focus on culturally safe service options and a culturally-based continuum of care. There is an urgent need to focus on sources of cultural strengths and resilience that support mental health and recovery from mental health issues and addictions during the pandemic. Cross-sectoral collaborative practices are needed for an effective response and supportive technological innovation can also play a role.

Most important for mental wellness is system-level support for the development of an innovative continuum of mental health/addictions services through service transformation.

Summary of the Document Review

The document review considered relevant grey literature, reports, presentations, guidelines and other materials supplied by the Working Group. This review of over 100 documents created by consultants, governmental groups, Political Territorial Organizations (PTOs), advisory groups, and Sioux Lookout regional service providers, reveals many of the same messages repeated over and over. These include:

1. There is a need forincreased resources, both human and financial to match the demand for services and to address gaps in infrastructure.

2. Lack of consistent training and understanding of all providers in mental health, addictions, cultural safety, and/or trauma-informed care impedes clients' healing in far too many cases and can be harmful.

3. Many service providers are near burnout due to the overwhelming caseloads and ongoing crises.

4. Lack of ability to match client needs with appropriate services creates a feeling of being overwhelmed and hopeless which further contributes to staff burnout and attrition.

5. Lack of a full continuum of care and lack of family-focus creates gaps which negatively impact clients' healing and recovery.

6. Siloed services and lack of coordination of care results in much of the hard work not translating into therapeutic outcomes or healing.

7. The most urgent need appears to be for clients who require comprehensive services for serious mental illness, have concurrent disorders, and/or are at risk of self-harm or suicide.

8. Social determinants, such as lack of housing and employment, negatively affects mental health and addictions, as well as recovery of individuals and their families.

9. System level social determinants, such as lack of appropriate buildings, spaces, and other infrastructures, as well as lack of appropriate health human resources often reduce access to services, even when service funding is available.

However, there are many opportunities for positive change within the current health system. The following recommendations could contribute to significantly improved services:

1. Improve interagency collaboration and service integration across the continuum of care.

2. Expand interprofessional collaboration and shared care among traditional Indigenous, clinical, professional, and para-professional service providers to optimize synergy of services and explore task shifting where appropriate.

3. Focus on education and training of clinical and traditional/cultural providers on the role and benefits of the various healing traditions and explore shared or collaborative care models that optimize services for clients.

Some suggested emerging practices, organized according to a comprehensive continuum of care are included in the *Document Review and Gap Analysis- SLFNHA and Region Mental Health and Addictions Services* in Appendix B. "Wise practices" are highlighted in each of the following areas:

- Health Promotion, Prevention, Community Development, and Education
- Early Identification and Intervention

- Crisis Response
- Coordination of Care and Care Planning
- Detox
- Trauma-informed Treatment
- Support and Aftercare

This document review supports the notion that Indigenous mental health and addictions services require an intentional focus on trauma-informed treatment options and a culturally-based continuum of care in order to appropriately serve Indigenous peoples. However, it is important to note that this is not without its challenges. Interprofessional collaboration needs to include healing practices based on culturally grounded care and the integration of western/clinical and Indigenous modalities requires sound governance, planning, education, and respectful collaboration across these different knowledge systems.

Moreover, coordination of care, collaborative approaches, and integration of services is a complex undertaking with many different drivers and decisionmakers in the Sioux Lookout area, yet it needs to be urgently addressed as a priority.

This is made more challenging by the complexity in supporting community approaches when communities are, themselves, in a cycle of overload and ongoing crisis compounded by lack of access to needed services. This continuous cycle of crisis hinders the development of upstream prevention and community development approaches.

The issues and needs identified in this document review are not new and remain difficult to resolve, mostly due to the funding, infrastructure, care coordination, and health human resources challenges in this complex system.

Findings Emerging from Interviews and Focus Groups

A Vision for Anishinaabe Wellness

Since 2006, a recommended path forward towards an ideal system for Anishinaabe wellness has been described in the Anishinaabe Health Plan. The plan espouses an unwavering ideal of a system which embodies the best of Anishinaabe cultural ways, community leadership and decision making and coordinated, responsive clinical services.

"*We envision our communities as safe, clean places where everyone is respected, people are healthy in spiritual, physical, mental, emotional and social aspects of their being and where all have access to affordable food and clean water, education, employment, healthy housing, and necessary health services staffed and governed by Anishinaabe*." (Anishiaabe Health Plan, 2006)

Principles by which this vision are to be achieved are described in the Plan as:

- Grounded in Anishinabe ways
- Holistic
- First Nations directed
- Accessible
- Highest quality
- Accountable
- Organized
- Balanced
- Patient and flexible
- Developmental

This vision and associated principles expressed in 2006 shine light on a path towards wellness that remains true to this day. Implicit in this vision is the recognition of the social determinants of health in mental wellness and the need for appropriate infrastructure and services to address mental health. Moving forward, progress in improving mental health and addictions in the region rests on a number of key drivers, which are discussed in the following sections.

Individual and family-centered, community-driven

The First Nations people who are using the services must be involved in planning and developing programs and services to meet their needs. Additionally, recognition of the person, family and community as holders of knowledge and lived experience which can support providers in planning care that respects their values, desires, family, community context, lifestyle, and cultural norms is needed.

Cultural responsiveness

Northern First communities and the Anishinaabe who dwell there have their own unique cultures. Ensuring services are culturally safe and respectful of local Anishinaabe history, culture, and governance is key to healing and recovery. Providing access to cultural or traditional healing practices if requested in accordance with the Truth and Reconciliation's Calls to Action is also important.

Integrated and coordinated care

An integrated approach is ideal as this ensures that people who use services and programs within the region only "have to tell their story once" and care is efficiently coordinated amongst the various organizations who deliver mental health and addictions care.

The full continuum

A comprehensive continuum of care is needed comprising prevention, promotion, early identification and intervention, trauma-informed treatment and counselling, crisis response, and aftercare.

Capacity-building

Increasing both front line community capacity and regional specialized services to fill gaps in the continuum of care is needed. Strengthening community-based programs, providing training, and knowledge exchange for community workers and forging stronger linkages within the continuum of care to specialized services is part of this.

Evidence-based practice and practice-based evidence

Data and information to support performance monitoring for high quality care must be coupled with lived experience and practice-based evidence emerging from First Nations communities. Learning from "what works for this context and community" is key.

Accountability and evaluation

Mechanisms for feedback from communities are essential. Continual learning from ongoing evaluation helps programs and services to ensure quality care. Mistakes and corresponding corrections are part of any learning system.

A life course perspective across all programs and services

Mental wellness approaches must be cultivated which tend to the unique needs of all stages across the lifespan – early , childhood, youth, adulthood, families, and Elders.

Gap Analysis – Narrative and Matrix

A detailed gap analysis matrix (see Appendix F) highlights the key themes that emerged through focus groups and individual interviews. The matrix and accompanying narrative describe the strengths and gaps of services and resources throughout the area. These are broken into five key gaps:

- Staffing issues
- Service structural issues
- Service delivery issues
- Treatment and service options
- Funding issues

Additional points of concern include hospital-specific issues, challenges created by the pandemic, and concerns about cultural safety. At its broadest level, all of these challenges are brought about by the lack of capacity within regional and local services. Each of these areas intersect different systems: human resource systems; operational capacity; policies; inter-agency collaborations; communications, and; community-based resources and infrastructure. These systems are impacted by both internal and external drivers, such as internal capacity to write grants for extra funding or the inability to significantly influence government funding policies.

What is clear from the data is that all services attempting to provide robust supports to clients and communities are stretched exceedingly thin. Staff needs may vary across individual organizations, but as a whole, key areas of need include equitable pay across the human service sector with appropriate supports in place for adequate clinical supervision, debriefing, networking, and opportunities for ongoing training locally.

The staffing issue, though, does not exist in isolation; new hires needing to relocate have extremely limited access to housing and require cultural training. Certain jobs are harder to fill because of unique factors, such as overnight shifts, the need for travel and relative professional isolation. Caseloads are

untenably high, which, along with the high degree of emotional labour required, contribute to excessive burnout, compassion fatigue, and vicarious trauma for workers. There are very limited funds to hire staff with professional designations, adding to the undue burden placed on workers who may lack the skills and knowledge required for their positions, also contributing to burnout. As well, training and professional development, along with clinical supervision, peer mentoring and networking are vital to support the long-term retention of workers and to help offset burnout.

Treatment and service options are lacking at the local level. Regionally, there is a range of services, many of which have working relationships with different communities. The data shows there have been repeated calls for land-based treatment options in the communities, but that the staff must have the capacity to support clients with complex trauma.

There are limitations in how the services are offered (for example the conventional 28-day treatment model or two-week camps are considered too short-term as a therapeutic approach for individuals who have a complex trauma history) or in the consistency of access and sharing of client information within the circle of care, across programs and agencies.

Case management remains a key gap, and often counsellors are functioning as system navigators rather than as counsellors. Communication is vital for smooth transitions between programs and between agencies but is impacted profoundly by internal policies and staffing issues, as well as at the inter-agency level as high turnover rates reduces continuity of staff connections and "corporate memory" of what each service offers. In addition to this, services such as the hostel and addictions treatment are often lacking inter-agency support or are perceived to be functioning in isolation. Staff members on overnight shifts, for example, are limited in how much support they can directly offer individual clients who may be experiencing a need to talk about their trauma because they are the only staff member on, and other organizations operate only during business hours.

In general, youth with high mental health needs are often forced to leave their communities to access services, which can exacerbate the challenges they are experiencing. Mental health supports become something of a catchall service for clients who may experience mental health issues and who do not have access to services which are tailored or appropriate to their specific needs. Youth with complex needs have extremely limited options, requiring them to go even further away from their communities to places like Toronto. The resulting disconnection from family and community has implications for client success and follow-through when returning home from treatment. Too often family are not involved in the youth's treatment, and local workers do not receive documentation to note treatment or discharge plans.

Crisis response has been the default orientation of mental health and allied services, rather than an upstream, proactive preventative approach. The crisis needs remain high; as one person stated, in a community of about 600 people, about half (adults and children) are experiencing substantial mental health needs. Chaos within communities and disruption within families, a harmful legacy of colonization, has become the norm for families and communities over time, which shapes service structure and delivery. Organizations constantly deal with crises, leaving staff little energy and time to develop

alternative services. It means that workers may struggle to engage individuals, especially youth (and their families) in longer term therapeutic work. Countering chaotic environments through building stability and engaging in healing efforts is difficult, with clients needing to be ready to engage; chaotic home life can disrupt these efforts very quickly.

Trauma, in general, remains persistent for First Nations communities in both the ongoing trauma experiences, for example sexual and domestic violence, as well as the long-term and intergenerational experiences, including residential schools. Within many communities, trauma experiences impact intra-familial relationships. Too often, individuals feel unable to talk about their experiences. This is particularly true for male survivors of sexual violence. There are no easily accessible supports that address this and workers providing counselling support to sexual violence survivors require a very specialized knowledge and skills set to be effective. For the longer term, intergenerational traumas, such as residential school graves being uncovered, more and more effective anticipatory supports are needed to respond to potential and actual crises that arise.

Communications and treatment planning are required to address particular client group needs. Firstly, Suboxone treatment, which has been quite successful with many clients to curb cravings and withdrawal symptoms when the necessary supports are in place, was heavily impacted during pandemic lockdowns. For long-term healing of the underlying issues that led to the addictions, trauma-informed counselling, and land-based healing services are urgently needed in conjunction with pharmacological treatment. Clients who are struggling are often under scrutiny of their communities and may experience judgmental labels that perpetuate stigmas. From this, tensions may arise making it more difficult to offer safe environments for clients to access treatment. Secondly, concerns were raised about Two Spirit and LGBTQ youths who may be confronted with negative views as a result of heavy Christianization in their communities. The need to create safer spaces for clients with various needs requires ongoing capacity building within their communities, and within regional services that they access. Thirdly, clients needing to access services through telehealth and videoconferencing need to have their privacy and confidentiality ensured through the creation of appropriate, safe and confidential spaces within agencies and nursing stations, along with having at-home access to stable internet. Utilizing school facilities makes a great deal of sense for this as so many youths live in homes that have little privacy for difficult conversations.

In all, though, there were many strengths that were described by the key informants. Interviews with various service providers demonstrate that there are many compassionate and passionate individuals all working to support First Nations youths in achieving wellbeing despite the many challenges they are faced with. Organizations and services have developed creative and adaptive strategies to meet the needs of clients given the limitations and constraints imposed by funders, by community locations and capacities, by infrastructure limitations, and the constraints of policies and legislation.

It is clear, however, that the needs of all including youth, in particular, remain persistently high and that more is needed in terms of funding and service development. Services of all types need to be able to ensure culturally safe environments for their clients. Workers need to have the resources that enable them to fulfill their responsibilities in ways that support their retention, growth and overall wellbeing.

Inter-agency collaborations can develop new and adaptive programs and pathways to support clients' wellbeing over time. But that requires external drivers, such as government funders, to adapt to the needs of northern communities, and for external services to understand the local contexts that people live within so that they can better, more seamlessly, ensure continuity and efficacy of care.

Youth needs

As part of this review, a special emphasis on youth mental health was prioritized. Best efforts were made to engage with youth (age 16+) from the First Nations communities to better understand their perspective regarding youth mental health and addictions needs and concerns.

Two strategies were selected to engage with youth. One approach was to offer focus groups (60 minutes), arranged with the support of SLFNHA's Approaches to Community Wellbeing community youth workers to talk with youth about wellness in their community. In order to extend the reach and give more youth an opportunity to provide their perspective on these questions, similar questions were also provided for feedback as part of an electronic survey. This report provides the outcomes of this electronic survey. A total of ten respondents shared their insights (see Appendix G for the full Youth Survey Summary Report).

Responding to the question "What do youth in your community need to be well (mentally, physically, spiritually, emotionally)", youth responded with several recommendations, including the need for a trusted person to talk to and offering youth time on the land, as well as a place to go to.

Key themes described by survey respondents included:

- A trusted person to talk to
- Land and culturally-based activities
- Facilities and programs in the community
- Overall good health
- Community cohesion and good relationships
- Mental health

A trusted person to talk to

Youth expressed they needed to have trusted knowledge keepers, elders and counsellors available to speak with them when they are in need of guidance or when they are in need of assistance with difficulties in their lives. Their responses included:

- *We need to have more Elders that we can talk to. I guess more knowledge keepers.*
- *Someone to talk too. Some where to go for help.*
- *I believe what the youth in my community needs to be well mentally and emotionally is someone to talk to their worries or problems, someone such as a therapist or a counsellor. My reasoning is that I see many posts from the youth professing their worries and or problems on social media.*

Land and culturally-based activities

The need for land and culturally bed programs and activities with family, peer, and community involvement and support was mentioned frequently. Responses included:

- *More on the land-based counseling [is needed]. All about bringing them back to the old ways. Learning Language and ways to live off the land.*
- *The youth in my community need a strong family bond, family activities as well as with their peers.*
- *I see a lot of them enjoying outdoor life where they go up and down the coast with quads and is like medicine to them, hunting and fishing. They enjoy community activities, sports but more of those need to happen.*
- *In our community I think what the youth need to be well mentally is to be out and about in the land doing stuff with their peers and family I think that will help physically, emotionally, mentally.*

Facilities and programs in the community

The importance of infrastructure and youth programming were also mentioned as important to support youth wellness by several participants. Their responses included:

- *In our community we need an after-school building filled with arcade games, video games, a place to hang out, a screen for movie nights etc. Sports, hockey baseball soccer swimming etc., we have no sports going for our kids.*
- *I believe that the youth in our community need more gyms and activity facilities, physical health can help with mental health and allow youth to meet more people as well as staying active.*

Overall health

Finally, youth also mentioned the importance of overall good health for well-being.

Responding to the question “What does community wellness look like from your perspective?”, youth responded with a variety of responses, however many stressed the importance of good relationships in the community.

Community cohesion and good relationships

Youth respondents stated the importance of cohesion and good relationships among community members for community wellness. Their responses included:

- *For me, community wellness is members need to get along and interact. Elders need to be listened to and to be seen as guides. It’s also to love one another as a community.*

- *From my perspective, I would say that community wellness is that the community is willing to support other members of the same community.*
- *Community wellness from my perspective looks like when people from the communities are doing well for themselves and talking with others being friends with others.*
- *Coming together as a whole to support one another without judgement.*

A variety of perspectives

The remaining responses showed a range of perspectives on community wellness, stressing the current struggles, importance of economic wellness, education and pride in the community:

- *Active people, fed people, motivated and educated people.*
- *Not bad, but with economy I see increase in mental issues arises due to financial difficulties.*
- *Not good.*
- *To brighten our generation and fill them with happiness and pride.*

Youth respondents also described what would help them stay on their path to wellness as well as their interests in culture and land-based healing. These elements are described in the summary report in Appendix G.

Recommendations emerging from the summary of youth responses which are also aligned with findings of the literature review include:

1. Create, maintain, and strengthen safe and supportive social spaces for youth, on the land, but also in buildings and programs in the community.
2. Develop a collaborative care model that connects Indigenous community and regional services to ensure youth are comfortable with mental health workers by choosing between regional and local workers.
3. Focus on developing a model of care that integrates Traditional Indigenous and clinical approaches from prevention to aftercare.
4. Focus on community healing, because youth require a community that has good internal relationships in order to experience wellness.

Finally at the broader level, responding to these recommendations requires system level transformation and cultural safety within organizations in order to embed approaches based on cultural strengths. Specifically, this entails:

1. Interprofessional knowledge of the value of these services may need to be promoted among health care providers. Ensure community, regional and off-reserve staff understand the importance of traditional Indigenous land-based healing practices and cultural teachings in relation to various mental health issues, Indigenous well-being and suicide prevention/ life promotion.

2. Integrate land-based activities and healing seamlessly into promotion, prevention, treatment and aftercare.
3. Focus on social determinants of health, including housing and buildings for programs as well as program development.

The Current System – Successes, Challenges, Specific Needs and Gaps

Within the region at present, though there are a range of mental health and addictions services. Whether the service is funded by the Ministry of Health, Ministry of Community and Social Services, Indigenous Services Canada, Health Canada, Ontario Health (formerly the Northwest Local Health Integration Network), Jordan's Principle, or other sources, there are an intricate set of rules, both formal and informal, requiring organizations and workers within this system to act in certain ways.

These program mandates have at times been described as creating "silos" of services with many policy barriers to the integration of services. Nonetheless, the people behind the programs are trying their best to be responsive to the complex trauma and pressing needs of the community members served.

As a starting point, it is helpful to reflect on the strengths of the system as described by key informants.

Strengths perceived by participants

1. Strong leadership and advocacy for improvements to the regional mental health and addictions system.
2. Cohesive and collaborative relationships between Tribal Councils and their member communities.
3. Anishinaabe language and culture remains strong in many communities, affording opportunities to incorporate cultural components into mental health and addictions programs.
4. Knowledgeable community workers are an indispensable part of the system.

   "*The workers have a lot of knowledge of the communities; a lot of background on people, know what is going on, they know "everybody" at the community-level. The language is a big part of it*."
5. Community Suboxone programs have stabilized many and saved lives.

   "*Suboxone programs have enabled many to become stable and be able to be employed*."

6. NAN Hope [8] is well coordinated and, along with Choose Life programs, have been well received by communities.

7. Improved access to primary care through SLFNHA's primary care team has been helpful for those struggling with addiction who have primary care needs as well.

8. The OPP have taken steps to align service with culturally sensitive diversion programs through NAN Legal and Youth Probation.

9. SLFNHA services such as Nodin and contracted Developmental Services like Firefly are seen as culturally safe and strong in this area. The school board (Kenora Patricia District School Board) is working to integrate the Truth and Reconciliation Calls to Action in their strategic plan and staff training.

10. Youth have been receptive to online engagement via social media (where bandwidth and privacy needs are met).

11. Some pathways for coordination exist and the desire for collaboration is strongly evident.

12. A range of service providers provide access to some mental health services in the communities via different providers or through different platforms.

13. Partnerships such as the Crisis Response and Harm Reduction Mobile Outreach Teams involving Nodin, the Northwest Health Unit, and Canadian Mental Health Association (CMHA) have been seen as effective.

14. Virtual outreach and appointment options have allowed certain populations more access, and help lines such as NAN Hope offer options that are more culturally sensitive and refer into local community services and other regional service providers.

15. The emergency room assisting with mini detox to help those struggling with addiction has helped fill a gap, but much more is needed.

16. A community which has organized an annual Family Healing Camp described it as a success.

17. Communications and collaboration between external providers work well when connecting with community workers.

    "*What worked well was the outside counsellor touching base with NNADAP* [9]*, mental health worker, community-based worker and other workers to get referrals that way*."

18. "*Clients get care when they need it*." Nodin's Outpatient Mental Health Services has a more integrated and team-oriented approach with the ability to make referrals to psychology on the same day, in the same building.

19. Nodin has developed a reputation for confidential services due to strict protocols and explicit consents for sharing within the circle of care. This has helped to build trust.

20. Land-based healing and cultural camps are well received by communities when organized and funded appropriately.

Though there are many successes and strengths upon which to build, the challenges in which programs and services are being operated are numerous.

Challenges perceived by participants

1. Poor and inadequate infrastructure to deliver mental health programs and services in communities underscores a longstanding need for capital investments.

2. The recruitment and retention of health human resources is incredibly difficult for this region as many organizations are competing for the same personnel amongst a small pool of qualified and competent individuals.

3. Housing shortages in Sioux Lookout are having a huge impact on recruitment and retention of human resources as well. Accommodations shortages in in the communities for visiting mental health providers are also a huge issue.

   "Housing in Sioux Lookout is an issue for new staff – we recruit but no one has a place to stay."

4. From an administrative perspective, the systems and services are in place but there are many barriers including the cost of living, access to childcare and a competitive environment for qualified staff which makes it exceedingly difficult to keep them adequately staffed to provide those services.

   "We have structure and plans and experience but need staff."

5. There are not enough community-based mental health and addictions workers. Recruitment of such community-based workers is challenging.

6. Outreach to the communities requires extensive travel or relocation to the north which is a significant lifestyle consideration for those who are hired.

7. Mental health and addictions workers have exceedingly high caseloads which is exacerbated by the ongoing vacancies and lack of human resources.

8. Staff turnover heavily impacts service delivery and collaboration.

   "There are high turnover rates everywhere, so you are always chasing who is in charge of what at the community, tribal councils, everywhere."

9. There is no system for case management at the community level nor specifically identified roles or community-based workers who can fulfill this function.

"There have been a lot of mental health crisis calls over the last year including 2 suicides and 1 overdose and we saw some suicide ideation and attempts. There is a revolving door to Lake of the Woods psychiatric unit and Thunder Bay Pediatrics Mental Health unit and Sioux Lookout Meno Ya Win Health Centre….there was no case management or discharge plan for work in the community afterwards. There is no case management available in community, and there are a lot of them who need it. Counsellors have high caseloads and people are falling through the cracks when they come home." Key informant

"When someone is sent out for mental health, people come home with no plan and fall through cracks." Key informant

10. COVID-19 pandemic – though communities were set up to use OTN, there were no confidential spaces for virtual services in nursing stations. A segment of the population was cut off from health services during the pandemic as they lacked phone and internet access.

11. Contaminated illicit drug supply – due to pandemic restrictions, people who use illicit drugs were put at further risk of exposure to drugs contaminated with fentanyl and other highly potent synthetic opioids, causing increased overdoses.

12. The multiple layers of jurisdiction (I.e., federal, provincial, regional) and lack of cohesive public health system leads to challenges in system coordination and service redesign. There is no central coordinating body in the region that is accountable for mental health and addictions.

13. Locums, doctors and agency nurses who are new to the region may not understand the local service landscape and availability when referring. A referral form which outlines and describes available services is needed.

These challenges point to a range of needs and gaps within the current system. Though not exhaustive, the following section highlights some of the gaps.

Needs and Gaps

1. Community awareness and education to reduce the stigma associated with addictions and harm reduction is needed.

2. Capital investments to support building the necessary infrastructure for service delivery and programming was a recurrent theme echoed in every single interview and focus group.

"Where are we supposed to do this service delivery?"

3. A regional treatment center or service for youth is needed. There is a need for a strong, local and integrated treatment response for youth struggling with addictions, mental health and trauma.

"Having a treatment center or options locally for students struggling with addiction would be helpful. There is counselling available now but it is not a 'be-all and end-all' solution."

4. Regional youth camps for various age groups are needed to encourage youth to learn about other communities and establish friendships. This could be augmented by online interactive events to support ongoing connection.

5. Case management is nonexistent in most communities as multiple funding programs operate in silos. This lack of case coordination in community and between outside organizations, represents a missed opportunity for care alignment as well as worker capacity-building.

   "[We] Struggle with lack of case management in community – setting up appointments but lots of no shows and lack of coordination."

6. There is no inpatient, secured unit at a hospital level for individuals at high-risk for self harm, especially youth. A multidisciplinary team is required.

   "*The hospital is not set up for high-risk individuals*."

7. The full suite of addictions services is needed for the region including, harm reduction, medically managed withdrawal or detox, access to addictions specialists and long-term healing programs.

   "*Detox and access to a range of local treatment options, including family treatment is needed."*

8. There are few communities which have access to Indian Residential Schools - Resolution Health Support Program (IRS – RHSP) for their Elders, IRS survivors and those who are intergenerationally affected.

   "*There is an IRS worker who is focusing on travelling to communities but we need one per community."*

   "Some are using the Residential School program to have clients flown to Thunder Bay or Winnipeg for counselling."

9. Inadequate availability and access to services means that sometimes it could be months between visits by service providers.

   "Our tribal council mental health team has funding for 3 mental health workers, which is not a lot to serve 6 or 7 communities."

10. The region lacks appropriate access to specialists, such as psychologists and psychiatrists.

    "Often, youth have to leave the community to see a specialist or psychiatry. Somebody in Sioux Lookout would be much better."

11. There are little to no supports nor appropriate housing for those with serious mental illness and/or developmental disability.

"The referrals that take most resources have lifelong chronic needs that may not improve with outpatient counselling what they need is supportive living therefore services are misused or ineffective. But who can do the work? It's not there… There are no resources to follow up in community, to connect to culture. A band aid instead of focusing on evidence-based practice. Staff get burnt out, as it is always crisis mode instead of a full program."

12. There is no safe temporary accommodation for individuals coming to Sioux Lookout to attend mental health services. The hostel is not appropriately equipped or staffed for this.

13. A standalone, community governed Traditional Healing Program is lacking and very much needed.

14. Transitional youth programming is needed for those that are aging out of available programs.

"Jordan's Principle eligibility ends at age 18 which is too young of a cut-off for youth. No matter what the age is, there shouldn't be financial barriers to care."

15. There is a lack of post crisis care and aftercare when an individual returns from treatment and a lack of clarity as to who holds accountability for long term care.

"Follow up after person comes back to the community [is lacking], after care is often not there and is as important as the initial care."

"*Nursing station staff do not know when people are coming back into the community, often no hand-off."*

16. A service gap at the hostel is a lack of interagency collaboration and a lack of mental health staff who can intervene in crisis situations between 6 pm and 2 am if needed. Staff at the hostel are not a part of the circle of care with the hospital's Mental Health and Addictions Program (MHAP) and Nodin and often do not have client's health information so that services can be in place. If someone is coming for suicidal ideation with no escort, hostel staff are limited in what they can do beyond wellness checks. A position entitled "After Hours Crisis Brief Counsellor" has been developed for this but has been challenging to fill.

17. Generally, there is a significant lack of *long-term* mental health care in Sioux Lookout. Though short-term and acute care services are available through the hospital, there is a level of visibility when an individual accesses the hospital's Mental Health and Addictions Program which impacts confidentiality.

Funding Issues and Flexibility

Programs and services in the region are delivered within a scaffold of jurisdictional constraints, core and one-time funding, varied accountability, and reporting obligations.

Over and over, respondents described the need for additional funding for all services, programs, and infrastructure. More importantly, they shared how harmful time-limited and siloed funding is when accessed for profoundly complex and longstanding mental health and addictions needs in the region. Calls for increased flexibility around funding so that resources could be deployed in the most effective and responsive manner were repeated by a number of key informants.

Communities require more decision-making power to use programs in the way that aligns best with their community needs. However, funding models, service systems and rigid policies, although well intended, often get in the way of healing and recovery at the present time. Permanent full-time positions, training, offices, resources and buildings are needed for effective community-based service provision.

In addition, funding models are often culturally unsafe. For example, cultural etiquette may require that generosity and gratitude be shown to program participants and visitors, however gift giving may be considered inappropriate by funders.

Pay Equity

Staff who work in mental health and addictions experiences many challenges and stressors. There needs to be an appropriate investment to pay workers, counsellors and staff reflective of the nature of the work and sufficiently attractive to retain experienced staff and workers.

Investment

Recently, the provincial government announced a $4.2 million investment under the Addictions Recovery Fund for 37 new addictions treatment beds [10] for some communities involved in the Sioux Lookout Friendship Accord. Though a welcomed development, the need is much larger than that which can be addressed through this new investment.

According to estimates provided by Nishnawbe Aski Nation in 2012, over one-third of the 25,000 population in the Sioux Lookout area experiences addiction to opioid substances (approximately 9,000) [11].

In some NAN communities rates of between (50% - 75%) of the adult population and up to half of high school students misuse prescription opioids according to the 2011 NAN Annual Report.[12]

In response to the escalating opioid crisis observed throughout the 1990s, in 2012, FNIHB adjusted the formulary to allow buprenorphine-naloxone to be funded. This opened an avenue for a number of First

Nation communities (26 in the Sioux Lookout zone alone) to establish their own opioid agonist treatment programs with the support of community leadership and Sioux Lookout physicians.

This has not been without its challenges, however, as the necessary supports, training, mentorship, mental health counselling and aftercare were at times inadequate or unavailable.

Some programs began with inadequate funding and have had to cap or limit the number of clients enrolled. More pressing has been the need to secure long-term funding for these programs once initiated. Community-based suboxone treatment programs with appropriate long-term supportive counselling, land-based healing, and aftercare programs have a legitimate place within the mental health and addictions system.

What is needed is a long term, appropriately resourced strategy to ensure sustainable funding flows to the communities, SLFNHA and primary care partners to support such programs with treatment and aftercare planning, culturally-appropriate implementation, and evaluation.

Sustainable, adequate core funding, similar to that which is available for other chronic illnesses like diabetes, is needed at the community, tribal council, and regional levels. This requires building understanding at the community level and amongst partners as to the nature of addictions – a chronic condition accompanied by significant changes in brain function, not a moral weakness, lack of willpower or personal choice.

Infrastructure

A critical challenge in program delivery, as noted earlier, is the lack of available facilities, programming space, private consultation and office spaces within First Nation communities to house services. This impacts both community workers and visiting care providers.

Infrastructure challenges also relate to a lack of accommodations for visiting care providers. Capital funding to support the development of new programs and office space are needed not just for mental health but all health programs.

Cost of community outreach

Health directors noted that travel for outreach to communities, though a significant cost in service delivery, must not be a limiting factor. Being in the community is where service providers have the opportunity for true engagement and understanding, they stated. Throughout the COVID-19 pandemic, the need to use charter flights was a significant expense. Despite this concern, it was a vital pathway that was welcomed for health service providers who were able to visit. Appropriate resources for travel must be protected.

"Nothing beats being in the communities to learn what their needs and strengths are and to meet the people. Be in the community even if travel dollars have to be upped - a minimum of 22 trips per year to be there on the ground in communities." - Health Director

Priorities for System Improvement

System Strengthening

As a starting point, key informants described the need to better collaborate and coordinate existing services and programs so that their effectiveness and efficiency is maximized. The areas for system strengthening include:

- Improvedinternal communications and collaboration
- Addressing system barriers
- A regional centre to offer training and development for mental health and substance use
- Community capacity building and training
- Collaborative leadership for mental health and addictions
- Clarifying roles and responsibilities
- Strengthened coordination between Meno Ya Win MHAP and Nodin
- Strengthening partnerships and networking
- Supporting system navigation and case management
- Supporting communities in crisis response

Each of these areas were highlighted in key informant interviews, focus groups and document review as representing potential opportunities for a strengthened system level approach.

Communications & Collaboration Internally

SLFNHA's rapid growth over the years, with numerous departments, positions, and complexity in the organization makes it hard to clarify and understand roles and responsibilities and even harder to communicate regularly.

This is in large measure due to the exceedingly high workloads and continuous cycle of crisis in communities. This has been further exacerbated by COVID-19 pandemic during which time all departments and staff were necessarily drawn off to other duties in regional pandemic response.

Staff key informants noted that this disconnect resulting from little to no information sharing between departments of SLFNHA has resulted, at times, in duplication of efforts. There are limited opportunities to regularly share information or undertake cross-departmental training to understand the functions of staff.

Recommendations:

1. An orientation and onboarding process for new staff which builds awareness and understanding of the role of the many departments and programs at SLNFHA is needed.

2. This should be augmented by regular opportunities for updates and information-sharing both internally and with the First Nation communities and other partners.

Addressing System Barriers

Key informants described formal recognition of a registered provider as a systemic human resources barrier to improving services. Under the Psychotherapy Act, all providers must be registered under a professional college. This forms a barrier to staff who may be qualified professionals but are unregistered or who are in the process of being registered or completing their education.

Often staff who can best provide culturally appropriate care are the people who have knowledge of their community's culture or have lived experience. However, many cannot assume these care provider roles because of the formal education and registration requirement. They represent an untapped pool of knowledgeable paraprofessionals who are able to do the work but whom are not registered or have no designation. An example is the Nodin's Children's Mental Health and Addictions workers who are titled "worker" and not "counsellor" to circumvent the registration barrier. These are people who live in their community and know their community intimately. They provide services for children and youth under 18.

A further challenge for community workers is that it is quite difficult to provide supervision and training owing to barriers such as internet access. When workers cannot chart in the EMR, are unable to connect to supervisors, or cannot access online training, the likelihood of them functioning effectively in their job is decreased.

Recommendations:

1. Develop worker job descriptions within structured team support, clinical supervision, and policies such as employer supported training, and a clear path towards career progression to eventual registration. This might entail a training program and leave policies supporting the worker to attend further education.

2. For some workers, whose gifts or interests are in the area of local traditional or cultural wellness approaches, a plan for learning from knowledge holders, apprenticing or mentoring with healers and those with knowledge of traditional medicine or land-based healing should be developed.

A regional training center for mental health and substance use

"Regional capacity-building, building communities of practice and strategies to strengthen families can increase capacity to avoid drug use/substance misuse."

Investing in a regional training center or program is pivotal to ensure communities have access to training support to build community-capacity. There is a real strength within communities amongst the people who have an innate understanding of their community, its dynamics, and history. They know who everyone is, can speak the language, have extended networks and are there for the long term. A regional training center would mean that they can build their skills and knowledge in mainstream and Indigenous wellness approaches while staying within their community and not having to leave for training or education.

Within this training center people can be supported while they work, with supervision and mentoring from both mainstream cadres within the helping disciplines as well as Elders, healers and knowledge holders from their territory who can assist them in building their competencies and confidence.

Recommendation:

1. Invest in a regional training center to build locally-relevant community capacity in mental health and addictions care.

Community Capacity-Building and Training

Capacity-building relates to not only having the needed personnel on the ground in communities and in agencies but also building on their skills and competencies. Building capacity encompasses the empowerment and inclusion of community workers within the circle of care, ensuring access to specialized training, and supports as well as opportunities or a localized pathway to achieving qualifications and competencies needed.

Community worker and regional provider training needs include:

- Crisis intervention training in order to safely intervene when someone is in the midst of a crisis.
- Mental Health First Aid for First Nations.
- LGBTQ2S needs.

- Care for complex needs including those diagnosed with Fetal Alcohol Spectrum Disorders (FASD) and Attention Deficit Hyperactivity Disorder (ADHD).

- Training in providing care for sexual trauma, sexual abuse (including historical abuses which happened in the region) and family violence.

- Ways to reduce stigma and have safe conversations and dialogues about trauma and substance misuse.

- Culturally appropriate and trauma-informed care to support workers to prepare for IRS trauma burden as gravesites are uncovered.

- Land-based and cultural approaches for healing and aftercare.

- Healthy parenting to break the intergenerational cycle of trauma.

Collaborative Leadership for Mental Health and Addictions

Key informants described many areas of need while also illuminating that there are few or stretched resources with which to respond. Collaborating to maximize resources is vital in order to assess, support, treat, and care for community members.

Though services exist, there is a lack of protocols and pathways for organizations to facilitate easy access to needed services and support for clients. Most programs and services connect selectively with a small number of partners or affiliated service providers, usually clustered by tribal councils.

An example of one such networking and information sharing table is NAN's Mental Health and Addictions Pandemic Response Program, NAN Hope, which provides an integrated network of supports for the region. NAN Hope provides 24/7 rapid access to confidential crisis services, navigators who can link community members to services within their home communities and amongst existing regional supports and rapid access to clinical and mental health counselling.

The program seeks to bridge existing gaps to ensure access to culturally safe and community-based services when needed. Ongoing communications and networking in support of the program is co-lead by the lead partners – Dalton Associates and KO-ehealth. This allows partners and front-line staff to share information and augment referral pathways.

This corresponding coordination table involving administrators and decision-makers, forms a robust network. This network is inclusive of all partners which allows for the formation of pathways, defining the relationship between organizations as well as the protocols to be followed to access services offered by different organizations.

Recommendations:

1. Establish structured, ongoing opportunities for community engagement, and collaboration amongst partners across all sectors.

2. Continue to participate in collaborative tables with the goal of formulating processes for information sharing, coordinated outreach and case management.

Defining Clear Roles and Responsibilities

"…we all have 100 referred people, but they may be all the same people, so service was diluted. If we all shared better, we could have 25 and do a better job. Resources are wasted or ineffective."

"Communication is an issue – did someone get seen at Nodin? Mental Health and Addictions Program has a discharge note which is in the patient chart and is helpful for referees but of the 12 Nodin referrals, we have no idea if they were seen. There needs to be some basic communication back to the referring provider." Key informant

Role clarification is key to improving services for clients. Formal arrangements such as a Memoranda of Understanding (MOU) between agencies and partners which clearly outline roles and responsibilities, can help increase understanding among those accountable for service delivery. Similarly, the creation of formalized referral networks with other agencies can maximize the positive impact of existing services.

An example of one such agreement being developed is that of SLFNHA, SLMHC, and the Mental Health and Addictions Program (MHAP) who are working towards a Memorandum of Understanding which can clarify roles, a process for shared intake and streamlined referrals, and expand ER crisis stabilization with additional supports. Though much work remains to be done, for example, concerning the necessary information sharing, this represents a positive step towards better leveraging existing resources and building accountability into one shared systematic approach.

Some components under discussion include:

Centralized Intake: a centralized intake is proposed for SLMHC and SLFNHA mental health services including psychiatry and specialty services with navigators who understand the full breadth of services available and can help triage referrals or requests for service internally and across agencies. Such a centralized intake and streamlined pathway for referrals would reduce clients accessing multiple services.

Communications: A pillar of this approach is to ensure that there are consistent and open communications opportunities between all participating service providers, partners and medical staff so that clients don't have to tell their story over and over. Clear protocols and processes for information sharing are needed.

Increased Mental Health Supports at the ER: These would include psychiatric nursing, counselling, therapeutic watch, and psychiatry.

Proactive/preventative approach: While it is important not to lose sight of the need for crisis stabilization and acute counselling services, a proactive approach which extends to prevention offering additional supports and specializations may enable more progression through healing and less dependency on the revolving door of services. Short term and longer term treatment programs are very much needed.

Recommendations:

1. Ensure that any MOUs, care coordination plans or services agreements, which define roles and responsibilities, are supported with adequate resources and staff capacity for implementation.

2. Ensure that communications strategies are also developed so that system partners are aware of the proposed approach or protocol.

3. Build evaluation and accountability measures within these implementation plans.

Shared Response - Meno Ya Win Mental Health and Addictions Program and Nodin

Key informants described a gap in communications between Meno Ya Win's MHAP and Nodin Mental Health Services. These two service providers are essential components of the system. Until recently, clear pathways for information-sharing and communications were not in place. Both have a range of different providers and activities, however, regular coordination between the two entities had been sporadic. This is also affecting other services as they don't know who is doing what and are not informed as to what is happening.

Recently however, in March 2022, both MHAP and Nodin announced a new shared ER response plan to collaboratively triage all acute ER Mental Health referrals so that patients can receive timely care with the most appropriate mental health service.

This new process eliminates the need for physicians and other acute service providers to determine the most appropriate mental health follow up organization for emergent patients as the new Shared ER Referral form engages both services. All acute care referrals (including evenings and weekends) continue to be sent to MHAP for crisis intervention services to occur in the ER setting, including suicide risk assessment and safety planning. Following initial intervention and stabilization, case conferences between MHAP and Nodin allow for the transition of patients to follow up services as appropriate. With this collaboration, MHAP and Nodin have taken the first steps towards integrated, seamless mental health care.

It should also be noted that Nodin and Meno Ya Win have instituted the use of a standardized tool for suicide assessment. Still needed, however, is in-patient care accommodation in a secure and safe environment which would ideally be closely linked with a multi-disciplinary care team for mental health and addictions.

Recommendations:

1. To further improve coordination and care, MHAP and Nodin should take a leadership role in working together to expand the circle of care to include other service providers in the region who are not part of the hospital or Nodin so that they are included in the coordination of care for clients.

2. In years past, physicians and mental health workers had regular opportunities for face-to-face contact during rounds when patients were admitted. Opportunities for face to face networking to share information on patient needs and to collaboratively plan care needs to be reinstituted.

3. Work to establish an in-patient secure and safe environment in the hospital for mental health and addictions care so that individuals are not sent to the hostel for accommodations.

Strengthening Partnerships and Networking

Enhancing mental wellness and addressing addictions crosses program mandates and sectors. There is no one agency, community or organization that can do this on their own. An important first step is to map the services and programs of all partners so they can identify how to work together more effectively. Some of this work in documenting all services has been accomplished by NAN Hope who link callers to available services and programs.

Since mental health and addictions are impacted by the social determinants of health, there is a need to collaborate within and across health, child welfare, employment, education, justice, and social services. Working collaboratively is a key mechanism to ensuring a comprehensive continuum of mental wellness services is available.

Nowhere is this more important than in the early identification and intervention for children and youth in schools. Even earlier than high school, children should be learning about self-awareness, mindfulness and wellness. Empowering messages about mental health need to be integrated in classes from an early age. Earlier intervention at younger ages, mental health promotion, and maintenance rather than allowing matters to escalate into needed crisis response are critical. To support teachers and guidance counsellors, additional supports such as mental health counsellors and social workers in grade school through to secondary school are needed.

"Schools are uniquely positioned for mental health promotion, early identification, prevention, and early intervention services. While we have a supportive role to play in crisis management and can provide accommodations and classroom strategies for students struggling with a mental illness, we do not have responsibility for intensive mental health services.

We need to work in partnership with community and health partners, as part of the system of care. Our priority contribution is ***upstream promotion and prevention****."*[17]

Key informants described how this is supported and benefits students in communities:

"Collaboration between people at the school is important for the students, everyone gets together at the school to work together to help the youth, to keep it client and youth-centered."

Recommendation:

Strengthen partnerships through ongoing opportunities for networking and collaboration between mental health and other sectors including education, justice, policing, housing, child welfare and others. Such opportunities may span service planning or case management for individual clients on through to shared cultural safety training opportunities and collaborative program planning. As an example, the OPP have taken steps to align service with culturally sensitive diversion programs through NAN Legal and Youth Probation. Gladue reporting is an additional example of ways that institutions which typically criminalize and survey individuals living with mental health can use Indigenous approaches to justice and healing.

Supporting System Navigation and Case Management

Key informants noted that communications, case management and the sharing of information was limited at best and non-existent most times.

"A huge missing part of the picture is case management and advocacy, further complicated by the many silos in our system." Key informant

The Personal Health Information Protection Act (PHIPA) which governs how personal health information is collected, used and disclosed is described as a barrier to coordination and collaboration. However, efforts to create a mechanism for information sharing within the Circle of Care do exist.

"*PHIPA restricts coordination and collaboration. One master Circle of Care*[18] *sheet would ease the burden of 'chasing paper'."*

Though nursing stations may seem a logical focal point for central coordination and case management, they are not necessarily set up for this and nursing staff have high services demands with their existing

community nursing responsibilities. This must be a dedicated community position who is qualified and can fulfil the requirements of health information custodian under PHIPA in order to facilitate the sharing of information for collaborative care.

"Referrals seem to go nowhere (into the ether) so in-community programs not only help with frontline plus also case management."

A further complication is that sometimes mental health is broadly assigned when people are unsure where the client might benefit the most from a service. An example of such an inappropriate referral is when individuals requiring developmental services and complex care services are referred to a mental health counsellor as opposed to the other necessary and relevant service providers

"*People are getting lost in the system and using counselors as system navigators*."

Recommendations:

1. Work with communities, tribal councils and key service partners to establish a community case management and services navigation system with key roles at the community-level identified.

2. Secure funding for community case managers (clinical) and/or community navigators to support implementation of the case management system.

Community support in crisis response

In small communities, some clients benefit from working with community staff, but there are also times when staff members are too closely related or know the client personally. It is important to offer clients choices in these cases. Some communities are able to collaborate and call on each other for support in these cases and very often, this occurs in crisis situations.

Nodin's Crisis Response Program works with communities in such instances to support and mobilize their crisis response team. Upon leadership request, crisis workers (i.e., counsellors or cultural workers), and non-clinical volunteer crisis teams (from neighboring communities) are mobilized to communities and/or communities receive support to form their own community-based volunteer teams. In this regard, Nodin also works closely with Tribal Councils, NAN, community leadership, and community crisis coordinators.

Crisis Response is a short term intervention to manage immediate crisis after tragedy. There is currently no capacity to do work in prevention or aftercare. Moreover, funding to support this and the mental health providers to fulfill this, whether through Nodin or Tribal Councils, is lacking.

Recommendation:

1. Work with regional providers, Nodin and Tribal Councils to strengthen existing community crisis response plans, such as:

    a. Clarify and define roles related to crisis response. More work needs to be done in communities to build a support system at the community level, assess their crisis response capabilities, build and train volunteer teams and build competencies to manage and advocate for what is needed.

    b. Ensure that crisis response plans are inclusive of the full continuum from prevention through to aftercare.

    c. Situate crisis response within a fuller case management protocol.

    d. Provide resources to compensate volunteer crisis teams.

Community at the centre

The regional system can only be transformed when communities are in the driver's seat taking ownership and control over how their mental health and substance use services are delivered. Moreover, transforming and decolonizing approaches must be draw on and amplify community voices and be built on community knowledge and cultural strengths.

With this in mind, key informants spoke to the following as key priorities for keeping community always at the centre of any improved mental health and addictions system:

- Community ownership and control.
- Building on community knowledge and cultural strengths.
- Embracing a "two-eyed seeing" approach.
- Addressing stigma and harm reduction.

Each of these areas are described in turn in the following sections.

Community ownership and control

The current system and funding model is not functional for communities because it is not designed to support the strengthening and recovery of the community as a whole. The communities are not supported in their roles as active participants in the healing of their community. Community members

have an in-depth understanding of their community and a vision of recovery, culturally-safe services, and long-term wellbeing. In addition, funding models are often culturally unsafe. More community control over their own programs supporting mental wellness is needed.

This should extend to discussion as to how government funding agreements administered by SLFNHA for Community Mental Health and Addictions Workers should transition directly to communities, so that there is greater community control and ownership.

Recommendations:

1. Work with communities to build their mental health plans in accordance with the community's strategic visions. Engage with community and health leadership, Elders and youth to devise a community mental health and substance use vision and plan.

2. Support communities in exercising self-determination and control over their mental health programs.

3. Advocate for culturally safe administrative structures and funding to support communities in their mental health planning and vision.

Building Upon Community Knowledge and Cultural Strengths

Many communities have knowledge holders who use their language, cultural ways of knowing, and practices out on the land. Identifying and tapping into this pool of local resources is the best avenue to build culturally-based program interventions and support services. In some communities, health promotion, prevention, National Native Alcohol and Drug Addictions Program (NNADAP) and National Youth Solvent Abuse Program (NYSAP) workers have been able to look inward for their own community's resources for culturally adapted approaches to addressing mental health and addictions.

Land-based activities can enhance mental wellness, increase connection to nature, culture, family, and community. Strengthened connections to ancestral teachings and cultural identity is a protective factor for mental health issues such as suicidal ideation and substance use [13].

Community based treatment and aftercare programs can leverage these cultural and land-based practices to support those who are recovering from substance misuse and mental health. This can include supports for family and community outreach, Elders counselling and communal activities like community hunting trips, feasts, and gatherings.

Capacity-building and networking to share cultural and land-based approaches are key as not all communities have a ready pool of individuals who hold and share this knowledge. Each community is unique within its cultural strengths, stories, and practices, however, a common feature is resiliency in the face of accumulated crisis and stressors and the delivery of programs within the seasonal context of the north.

Recommendations:

1. Establish an Anishinaabe Advisory Panel comprised of knowledge holders from communities, tribal councils and partner organizations to support a long-range strategy for cultural strengths-based approaches in mental health and addictions program design.

2. Ensure cultural safety is built into workforce development and organizational structures to ensure a conducive environment is in place for the development of culturally strengths-based approaches.

A more fulsome discussion of community capacity building in the area of cultural and traditional wellness approaches as well as the development of a "two-eyed seeing" approach and cultural safety, is also needed.

Embracing a "two-eyed seeing" approach

Championing an integrated service approach which values both First Nations cultural and clinical or mainstream approaches is needed. While counselling and clinical services delivered by external providers or at hospital-based programs are very much needed, community and cultural knowledge is equally important to support effective mental health and addictions service provision.

Recommendations:

1. It is recommended that regional visiting workers (non-Indigenous as well as Indigenous) collaborate with local First Nations community workers to assist with community engagement, cultural understanding, facilitating acceptance and supporting interpretation. The learning should be reciprocal with both parties providing knowledge to the other in order to come up with safe and effective ways to serve the community and its members.

2. Structure regular opportunities for knowledge sharing, collaborative training and co-learning between community workers and other providers.

Community workers as part of the circle of care

Knowledgeable and dedicated community workers are an indispensable part of the system as they have an intimate understanding of their community, its dynamics and history, know the extended families

and background of the people, can speak the local language and have a commitment to community well-being and long-term development.

Depending on the local situation, in some communities, there are mental health workers, NNADAP workers, Choose Life workers, Suboxone Program Coordinators, Suboxone DOT workers, Harm Reduction Team workers, Nodin community based positions as well as visiting counsellors and clinicians.

Opportunities to collaborate and share information within a Circle of Care, however, are limited with community workers and others working in isolation.

Community members who are well or doing well in their recovery should be recruited to carry out some of the mental health and addictions service provision roles using a task shifting approach. As an example, some Tikinagan and Choose Life staff have been recruited from local community members to fulfil specific roles in the continuum of care.

Such an approach, however, requires strong service integration with specialized staff support, training, and supervision by experienced professionals. This also includes addressing accountability and pay scale issues which differ across service agencies and communities.

Implementing a mental health task shifting model

"Task shifting is the name now given to a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications with supportive supervision by health care workers who traditionally provided these services.

By reorganizing the workforce in this way, task shifting can make more efficient use of existing human resources and ease bottlenecks in service delivery. Where further additional human resources are needed, task shifting may also involve the delegation of some clearly delineated tasks to newly created cadres of health workers who receive specific, competency-based training."[14] This can be particularly effective when tasks are shifted to the community level with support from more specialized visiting providers.

SLFNHA has done work of a similar nature for its Community Health Workers (CHWs) – Diabetes Program which focused on equipping community workers to support diabetes self-management and the promotion of healthy lifestyles.

Program goals[15] included:

1. Delivery of evidence-based diabetes care within a multi-disciplinary team environment at the community-level that emphasizes the role of CHWs within the patient's circle of care providers.

2. Developing locally customized, community-governed approaches to the implementation, evaluation and knowledge sharing of the program.

To advance such an approach to address mental health and addictions, specific roles, tasks and associated competencies would need to be identified.

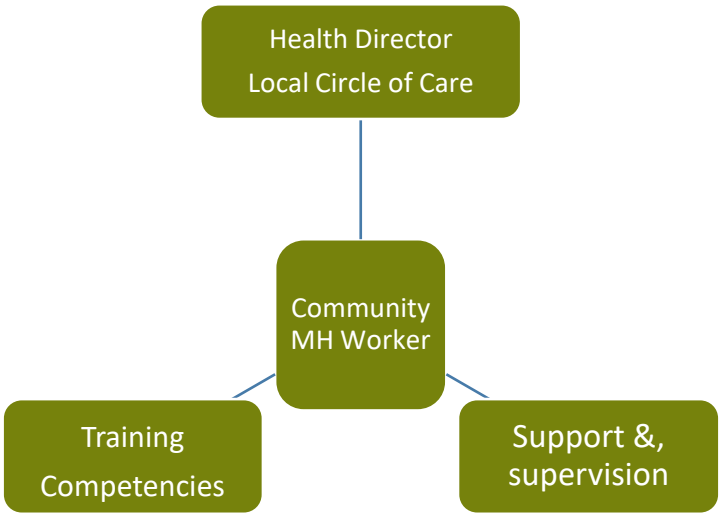
Community workers need local leadership support, integration within care teams so that information is shared, supportive policy, guidance and service manuals, training and professional development of specific competencies, and interprofessional collaboration support from specialized providers to build capacity locally.

Further, community staff who interact with clients with high needs must be very well supported by specialized providers to prevent staff from feeling overwhelmed, helpless and hopeless. Program development must include training, interprofessional support from experienced professionals through accessible telephone support from people with the right expertise, as well as peer support from a community of practice.

In addition, workers should be supported with access to mental wellbeing services specific to providers. It may be useful to prioritize regular staff check-ins and debriefing through team sessions, promotion of an Employee Assistance Program (EAP) and/or a shared-care model where staff are able to support each other in their workload if it becomes overwhelming.

A visual depiction of this proposed approach is portrayed in Figure 1.

Figure 1 – Task shifting approach involving local mental health workers



In this approach, a local Circle of Care is created in which local community mental health workers, primary care workers, visiting providers and clinicians meet regularly and share information as consented to by the client. The community mental health worker is supported to participate in the Circle of Care and is provided not only administrative supervision through their Health Director but also receives support and supervision from a more experienced mental health provider or clinician lead. Training is provided to build the CMH competencies so that they are able to take on specific tasks related to the client's care as delegated by the Circle of Care team and as appropriate to their skills and training. Policy and procedure manuals would be developed to help define this in consultation with the community and workers.

Recommendations:

1. Explore lessons, challenges and emerging wise practices from the Community Health Workers – Diabetes Program to inform the approach and design of a task shifting model for community mental health and addictions workers.

2. Delineate specific roles and competencies for community mental health and addictions workers. Design training curriculum and job descriptions based on these roles and competencies.

3. Develop specific protocols for integration and inclusion of community mental health and addictions workers within the circle of care.

Addressing Stigma and Harm Reduction

In many communities in the region, there is a concern that harm reduction approaches may encourage drug use, which mirrors the concerns in many other communities across Canada prior to public education. Community capacity in this public health prevention approach should be built. Specifically, awareness and education campaigns, targeted at leadership, schools, health and social services and the community at large should accompany harm reduction strategies. SLFNHA's Harm Reduction team staff are doing some of this work. The benefits of harm reduction in saving lives and preventing illness in the **community as a whole** need to be further promoted for the harm reduction approach to gain more acceptance. This wholistic messaging should be aligned with the Anishinabe Primary Care Model described in the Anishinaabe Health Plan.

The purpose of a harm reduction approach is to reduce the harm and premature death associated with using drugs through a variety of public health interventions. Despite being a key pillar of community prevention, one of the biggest barriers to this approach is the stigma associated with drug use.

Many people have been led to believe that addiction is a choice whereas, in many instances, it is a trauma response. Indigenous ways of knowing can be helpful in understanding that reducing the impacts of colonization require harm reduction strategies and this means supporting individuals where they are at. Not only is harm reduction from an Indigenous point of view about saving lives, but it is also about wellness and life promotion.

Stigma is best understood as a deeply-held set of false beliefs about a group of people with at least one attribute in common. These beliefs allow for judgment, oppression, and discrimination through overt actions or silent complicity.

Stigma not only prevents people from receiving care for their substance use, it also prevents them from even seeking care in the first place. It stems from the belief that people who use substances are choosing to have a disorder. The science shows us, however, that the causes are a much more complex mix of adverse childhood experiences, trauma, genetics, and brain chemistry, among other factors[16].

Recommendation:

> Build community capacity for awareness and leadership advocacy for a harm reduction approach. Communicate and promote the benefits of a harm reduction approach which is anchored in the primary care model of the Anishinaabe Health Plan.

Supportive Structures

An additional avenue in which the system can be enhanced includes the various supportive structures which underpin a well-functioning mental health and addictions system.

These include:

- Information sharing and privacy
- Electronic medical records and documentation

Information Sharing and Privacy

As described earlier, PHIPA has inadvertently had the effect of restricting coordination and collaboration. Community and provider education is needed around the intent and appropriate implementation of PHIPA. Some individuals choose not to permit sharing of their information as they do not trust local staff or workers to keep their information confidential. Education to help community members understand how their information is protected as well as the benefits of sharing information would be helpful when asking for consent to share information. Similarly, such education and training is needed for community health staff to understand and implement privacy mechanisms such as policies, secure storage, etc.

Nodin and other providers have developed a reputation of confidentiality due to their strict adherence to PHIPA. This has helped to build trust, however, a downside is that workers cannot share any information with the local community team or tribal councils, even during a crisis. A solution must be found as this is an issue, especially in relation to crisis response in communities.

Key informants have described the critical need for one overall form which documents consent for information sharing within the circle of care. On the other hand, some community members do not want their information shared and worry about secure storage of documents and information. Another area of concern is with respect to consent forms which are not set up to allow parental disclosure. This makes it difficult to update parents. As a consequence, parents are hesitant to send their children out for services, even though they are high risk and require services.

Recommendations:

1. Engage with communities and partners to discuss the development of an overall consent form for information sharing amongst partners in mental health and addictions.

2. Conduct a community education campaign about privacy and confidentiality.

3. Provide training and assist in developing policies and procedures for providers and community workers concerning PHIPA.

Electronic Medical Record and Documentation

Having access to health information is critical to good care. Electronic charting systems help staff to appropriately share information, manage follow-up, and communicate within and across teams. Charting systems capture and provide health information and data at the provider's fingertips and assist clients so that they no longer have to tell their story over and over.

SLFNHA's Health Information Team is implementing a unified Electronic Medical Record (EMR) – Mustimuhw. Since April 2022, psychiatrists who work with Nodin have been set up to chart within the Mustimuhw EMR but there are difficulties as information is still being faxed to doctors' medical assistants and nurses are still charting on paper. This results in time consuming steps to find information and access doctor's or psychiatrist's reports.

Since this has not yet been implemented at present, there is not enough information sharing and communication amongst Nodin, other SLFNHA departments and communities as to what kind of services and care a client is receiving. Notably, hostel staff do not have access to the EMR which makes it hard for hostel staff to know what kind of care the clients need or how to better accommodate them.

SLFNHA (Nodin) Referral forms and documentation

Other barriers exist with information sharing with external entities including tribal councils and hospitals and obtaining information in standard ways. Nodin has numerous forms which were recently updated. Further, external organizations are not using these referral forms correctly resulting in missing information. Presently, referral forms are being redesigned. It will be important to provide communications and orientation with respect to changes on these referral forms so that external organizations are able to use them correctly.

There is also the issue of including non-health related services on the informed consent form that clients sign.

Participants shared that Subjective-Objective-Assessment-Plan (SOAP) notes were perceived as not the best way of charting client data for counselling at all times. Nodin is working to develop a better way of gathering the needed information that best fits the situation rather than try to fit within existing templates.

Recommendations:

1. Support SLFNHA's Health Information and Information Technology team to implement a common EMR for patient charting and sharing of information, service/care plans and documentation. Engage with SLFNHA providers and staff to clarify privacy issues, consents,

permissions as to what health information a counsellor can see versus what others see and so forth.

2. Continue working with Nodin's mental health providers to help devise and improve templates for use in Mustimuhw.

Reorienting Approaches

Throughout the information gathering, consistent themes emerged in the discussions, reflecting important needs which hold the key to service improvement and service orientations which hold potential to enhance service delivery. These include:

- Resources
- A second level service approach
- Client-centred care

More detail is provided in the following passages.

Resources

Over the years, multiple reviews have highlighted the same needs and gaps. Issues like the need for youth stabilization, inpatient mental health beds, inpatient withdrawal management, housing, a lack of mental health counsellors are repeatedly discussed.

Key informants stressed that there needs to be a plan and resources available to implement and action the many recommendations highlighted in such reviews. For example, a recent review of Nodin's intake process highlighted a number of improvements and ways to do things differently which the organization is attempting to implement. However, limited capacity within the existing staffing complement coupled with recruitment challenges for new staff poses a barrier to actioning these improvements.

Though the resultant document is a good plan, there are too many vacancies and too much competition for staff within the system regionally. Nodin has lost several staff to NAN's mental wellness teams where wages and conditions are more favorable.

Recommendations:

1. Ensure ample resources for implementation of any service improvements, including the needed space and facilities, and staffing. Advocate for wage parity across service providers and agencies.

A second level service approach

Though Nodin offers mental health services, it is but one service to access and is not an overarching system able to meet all types of mental health needs.

Over the past few years, Tribal councils have begun to build robust mental wellness teams, involving Indian Residential Schools – Resolution Health Support Programs, Choose Life, primary care, Approaches to Community Wellbeing Facilitators, Jordan's Principle, and other contract staff as needed. Tribal councils also have developed close working relationships and linkages with member First Nations. As Tribal Councils continue to focus on building their own teams and moving into direct service delivery roles, there is a need to plan for the long term and ensure that there is no duplication within the system. Community engagement to explore whether communities are wanting service delivery through Nodin's in-community mental health counsellors would assist in determining effective deployment of resources.

Recommendations:

1. Engage with communities to explore potentially reorienting Nodin's role to focus on specialty services and supporting community-capacity building rather than sending in mental health counsellors.

2. Each community has a very different service landscape. Nodin and other mental health partners should work with communities and tribal councils to support case coordination and management.

Client-centered care

Key informants perceived that there is presently a lack of client-centered care which honors the lived experience of clients nor amply reflects wholistic care needs. Though small steps are being taken to give more tools to clients so they have more of a feeling of choice and control, presently all encounters in mental health sessions are in the control of the provider with forms and tools which have been designed for the provider and not the client. This does not support cultural safety or empower clients to see that mental health services are there to serve them not direct them. To address this, Nodin has recently developed a positive outcomes tool which empowers clients to share what their needs are and to facilitate improved communications with providers and referral sources.

Further, multiple reporting requirements of both provincial and federal funders emphasize information and statistics which don't adequately reflect the full picture and wholistic nature of client-centred care. One composite annual report reflecting how investment from all sources has been leveraged to provide quality care to clients would be a more efficient use of administrative resources.

Recommendations:

1. Establish a patient advisory group to include the patient voice and to inform mental health and addictions services development.

2. Encourage and build competency in client-centered care as a focus of all service providers. Training programs are available which encompass primary care, mental health, and cultural safety.

3. Advocate amongst funders for simpler reporting reflective of the full picture of service provision.

Cultural Strengths Based Care

An approach which draws upon community and cultural strengths holds promise as described in both the literature review and document review and further amplified by community and key informant voices. Such an approach includes:

- Embedding culture into the programmatic approach
- Cultural safety in the organizational environment and workforce

These two areas are intimately linked and are a precursor for any land based or culturally healing approaches being developed.

Embedding cultural strengths into the programmatic approach

Though many of the staff at SLFNHA are First Nations and community workers have lived experience of their culture, staff and community workers are not all at the same level in terms of learning and understanding cultural safety. Prior to the COVID-19 pandemic, staff were able to take part in cultural safety training, however, this has not been continued over the past two years. Recently, SLFNHA had been developing resources to provide staff with an overview of the history of the region as part of staff training. In addition, staff have been learning basic phrases in the local language to help people feel more comfortable and culturally safe when they come into the various work settings and departments. Each area in the organization, however, has different needs for cultural safety training.

At SLFNHA there are cultural liaison workers in various departments and the organization has developed a Kizhi Itwa-Inan cultural working group to help build a culturally appropriate approach within departments. Approaches to Community Wellbeing has hired a Cultural Advisor to support the

team in building a cultural base into their programming. However, every department has different needs. In particular, there is also a need for more traditional knowledge keepers and traditional support and elders at all departments within SLFNHA. SLFNHA is developing a Traditional Healing Program which will serve the whole organization in this regard.

Cultural and land-based approaches and using the land for therapeutic counselling is important. For example SLFNHA now has a sweat lodge located in Sioux Lookout. Apart from sweats and ceremony for healing, counselling can benefit from land-based approaches. An option to have Outpatient Mental Health Services delivered on the land and incorporating land based activities with culture and counselling is needed.

When workers are in the community, they can do more for culturally safe care by going outside to conduct counselling rather than meeting clients in a clinic room, which can be very sterile and uncomfortable. Some people prefer being outside and walking in nature when discussing difficult topics. It is important to "meet people where they are at" and be flexible in meeting where they are most comfortable. Cultural competency to enable such approaches is necessary.

Recommendations:

1. Work with communities to identify and build a roster of knowledge holders and Elders to work with as part of the Kizhi Itwa-inan Cultural Working Group. NAN has been developing a Database of Cultural Helpers which can serve as a helpful starting point [19].

2. Learn from hospital and community experiences with programs which incorporate land-based healing and cultural strengths-based approaches for mental health and addictions. SLFNHA has recently conducted a review of Anishinabe Wellness Practices which has guidance for inclusion of traditional and cultural approaches in health care settings.

3. Develop and implement policies with respect to program delivery so that it is appropriate to the area's Anishinabe people and respectful of diverse spiritual frameworks.

Cultural safety in the organizational environment and workforce

Concepts such as cultural awareness, cultural sensitivity, cultural competence, and cultural safety are variously used and understood amongst organizations and providers within the region.

Perhaps more helpful is the definition of cultural safety which was coined by Dr. Irihapeti Ramsden and Māori nurses in the 1990s which encourages a reflection upon and acknowledgement of the barriers that arise in the power differential between the provider and the patient. Cultural safety moves beyond

simple awareness and sensitivity of cultural difference to a self-reflective practice, understanding how position, and privilege deepen mistrust and disconnect in the therapeutic encounter and is grounded in the notion that it is the recipient of a given service who decides if an interaction is culturally safe.

In mental health and addictions services, cultural safety becomes increasingly important as people who use substances may have experienced significant trauma in their lives, may be intergenerationally affected and/or experience discrimination and racism in health settings. Additionally, stigma can significantly deter individuals from seeking help and contribute to their further marginalization in health care settings.

Rather than simply trying to understand and become aware of cultural differences, there is a need to recognize and disrupt colonial power structures and institutional norms. Organizations and partner providers in the health system are obligated to move towards culturally safe care.

Cultural safety is not just about what happens in the interface between a provider and a patient. It extends to the context in which a given service is offered. This is critically important if traditional Anishinabe healing approaches are to be utilized in a health care setting.

A multi-pronged approach is therefore needed. The following are some key recommendations:

1. Establish processes for developing cultural safety in organizational policies and professional development.

2. Clarify and co-create local, working definitions for cultural safety that fit the need and context of mental health and substance use service provision in the Sioux Lookout area:

    a. Cultural safety must be framed within an understanding of historical and societal power dynamics and the resultant health inequities and discrimination within health care interactions.

    b. It is important to situate cultural safety within the Indigenous determinants of health and the movement towards health equity .

3. Develop a strategy to embed *cultural safety* within SLFNHA organizational policies and practice. This is critically important to the culturally safe provision of traditional approaches to care.

4. Focus on *cultural safety* which includes confronting and addressing internal and unconscious bias. Build reflexive practices including self-reflection and cultural humility as a professional skillset.

5. Ensure that cultural safety is not limited to training but has accountability mechanisms to ensure it is demonstrated within and across all settings, practices, systems, structures, and policies.

In terms of human resources strategizing, some key recommendations include:

1. Provide opportunities and build accountability for engagement and learning about cultural safety in activities, onboarding, training and professional development.

2. Ensure cultural safety is included as a requirement for organizational accreditation and ongoing certification.

3. Embed standards of practice which are reflective of values within the SLFNHA code of ethics and include this explicitly within performance evaluations.

4. Systematically assess and monitor how cultural safety is being developed within the mental health/substance use workforce and within the organization.

5. Require *cultural safety* training and performance monitoring for all senior supervisory staff, managers, directors and board members.

If an Anishinaabe focused approach to mental wellness and addictions treatment is ever to gain traction, cultural safety in practices, processes, policies, and decision making is critical.

Land Based Healing Approaches

Foremost amongst the many suggestions provided by key informants was a wish for a regional, land-based treatment program for substance use and long-term healing.

Regional Land-based Healing Centre for Land-based healing and treatment for substance use

Communities have lived out on the land and derived meaning and wellbeing from the land since time immemorial. This intimate connection to the land has been disrupted through centuries of colonization, assimilation, resource extraction, and harmful government policies. Many key informants spoke of the importance of land and land based healing practice being central to healing and the journey to wellness.

A land-based healing and treatment centre for the region is needed which would interweave land-based healing activities, culturally-based programming, and clinically-based treatment components.

Although there are pockets of innovation where communities have begun to establish their own land-based healing programs – few are equipped to provide individuals the full suite of services needed to address addictions and longer-term healing. For example, a lack of facilities in the region for medically supervised detoxification or withdrawal management has been identified as an issue and similarly, there

are few resources for comprehensive and sustained aftercare. More importantly, the programs in place are limited in terms of funding and are therefore only able to offer short term (2 to 4 weeks) of land-based healing. Funding shortfalls for equipment and supplies also limit the programs' effectiveness.

This under-resourcing and limited ability to collaborate or integrate with other services further hampers these programs' effectiveness.

A treatment model is needed which not only encompasses the full continuum of care but could blanket the individual and their family in culturally appropriate care. A *regional* residential treatment facility coupled with extended land-based healing programming would offer the needed services at scale.

A fully integrated model would afford seamless transitions throughout the continuum of care from detox/withdrawal management, stabilization with intensive counselling and supports, opioid agonist therapy (OAT), land-based healing, follow-up and aftercare as the client returns to the community. Pretreatment homes and recovery homes as well as safe homes for youth are needed as part of this continuum.

Such a program would require close collaboration between SLFNHA, SLMHC, program partners, and community resource people with expertise in land-based and cultural healing approaches.

Recommendations for the key elements required for this approach would include:

1. Stabilization - A safe, supportive environment is needed for an individual who is in crisis. This is needed to stabilize the client before they are able to start any treatment or healing. Intensive counselling and supports such as group therapy, traditional healing, and withdrawal management comprise this stage which may take from 1 to 2 weeks [20].

2. Land-based and culturally-based programming - Once stabilized, the individual and their family may take part in a structured, month long (or longer if desired) program of land based, and cultural activities. Thunderbird Partnership Foundation's "Land for Healing: Developing a First Nations Land Based Service Delivery Model describes several examples of land based healing programs of varying duration (between 1 to 3 months)[21].

3. Transitional housing - Supervised transitional housing in Sioux Lookout is needed for clients and families accessing the healing center, so that they can continue to build upon skills learned in their programing and strengthen their internal resources.

4. Community Re-integration, Follow up and Aftercare - A care plan would be developed, integrating the traditional and clinical supports needed to help the client as they return to community. This would include ongoing counseling, aftercare and follow up. Opportunities for education, volunteerism or employment need to be offered at this stage.

Community land based healing programs

Communities in the region are uniquely positioned to develop cultural strengths-based land based after-care programs as a companion service supporting the regional family treatment centre. Some of the key strengths in communities include their beautiful territory, enduring connection to land, and strong Anishinaabe language.

A land-based treatment and healing program would help individuals to reconnect to land and support them to reclaim Anishinaabe wellness practices.

Land-based healing strengthens an individual's relationship to the land and allows one to access both their internal resources and resiliency as well as the healing capacity of the land to address mental health and addictions issues.

Many of these issues stem from soul wounds caused by adverse childhood experiences, sexual abuse, family violence, intergenerational trauma, poverty, racism, and other forms of marginalization.

A trauma-informed approach, which supports individuals to regain choice and control over their healing journey, is needed.

Respect for an individual's spiritual framework would be critical as they seek recovery on a path combining land-based healing with western clinical approaches.

The land is central to Anishinaabe identity; however, generations of colonial assault has served to disrupt and disconnect individuals from this source of innate wellness – the traditional territories which have sustained the people since time immemorial.

Important features and attributes

A land-based treatment and healing model would be built around:

- A wholistic, cultural strengths-based, and trauma-informed approach to healing.
- Anishnaabe language, Elders, healers and other cultural resource people.
- Strong self-determined, local leadership, and governance with strategic collaboration with service partners.
- Focus on using local capacity and continually strengthening this capacity so that the knowledge and expertise is from the home territory and remains so over the long term.
- Emphasis on experiential learning and skills building, to foster resilience, and individual empowerment.

Factors which must be in place to ensure success include:

- Willingness to test alternative approaches, to build community-capacity and establish trusting relationships amongst partners.
- Ensuring that any primary care or prescribing provider understands the community's vision and commits to supporting community-lead development of the program.
- Encouraging the participation of community staff and ensuring the collaboration of all partners to provide quality of care.
- Creating a stigma-free environment for those seeking assistance, and building awareness and understanding of harm reduction.

Programmatic approach:

The programs would incorporate a range of prevention and promotion efforts alongside land-based treatment and healing according to each community's capacity and priorities. Activities would reflect a wholistic approach including mental, emotional, physical and spiritual (in whatever way is most meaningful to people and which respects their choice in spirituality) aspects. Some examples include:

- Family culture and language camps, traditional parenting programs, youth programs.
- Traditional food harvesting, hiking and medicine walks, berry picking, fishing, hunting, trapping.
- Elders and youth camps to share teachings, rites of passage, stories and history of the area, medicines, and plant knowledge.
- Seasonal ceremonies and celebrations on the land.
- Family treatment camps so that healing is promoted within the family unit, as well as within couples and amongst individuals.
- Cultural and land-based activities for people struggling with substance use.
- Sharing circles with elders.
- Prayer circles with faith leaders.
- Sweats, prayer, ceremony with healers for those who wish it.

Recommendation:

Engage with communities and partners to develop a full treatment continuum which incorporates land-based and cultural strengths. Each of these aspects require community and partner input in order to design an appropriate framework for the necessary components and build out key logistical and operational considerations. From this preliminary design work, a service model for submission to federal, and provincial funders could take shape.

Community Based Suboxone Treatment Programs

"More people have died from substance use than Covid in our region…I am not sure if [people] realize how much [the suboxone programs] are doing for the north in terms of safety. Lives are being saved big time!" (Key informant)

"Our suboxone program – we changed from DOT (Directly Observed Therapy) to six day carries and went from 28 to 34 people. We now have many who are stable and able to be employed." (Key informant)

It is evident from our review, that people are seeing benefits from this harm reduction intervention which is helping to save lives and helping move people towards wellness and reduce the negative consequences of substance use.

Overview of findings:

As one of the many responses needed within the service system to address the opioid crisis, community-based Suboxone treatment programs have an important role to support the recovery of clients living with Opioid Use Disorder (OUD) in the region.

Many key informants in this study spoke of the program helping clients to regain stability in their lives to take care of their children, participate in community life, seek employment and plan for their future. There was also general agreement that Suboxone treatment helps to create a window for healing for clients with opioid use disorder, but it is important to stress that it does usually not provide a "quick fix" for underlying addictions. Rather it is the beginning of healing.

Most importantly, it needs to be combined with other culturally-based wellness approaches such as land-based activities, traditional counselling and mental health and addictions clinical services to help clients to recover from the underlying trauma that may be linked to their addiction.

The findings in the SLFNHA region are similar to findings in other areas and it is important to see Suboxone treatment as one part of OUD treatment. Outcomes for clients can be significantly improved within an integrated approach including a basket of culturally-based mental health and wellness services, social services, housing, employment and other supports, depending on their needs.

Background to the opioid crisis and Suboxone treatment programs:

Since Health Canada approved the opioid pain medication *OxyContin* in 2000, which was aggressively and unlawfully marketed by manufacturer Purdue Pharma (Stamford, CT), communities all over Canada have been affected by the opioid crisis, and many First Nations are disproportionately affected. Over the past two years, the COVID-19 pandemic has exacerbated opioid-related harms by restricting services such as Suboxone treatment programs and increasing the illegal trafficking of increasingly stronger synthetic opioids.

The Nishnawabe Aski Nation (NAN) declared a state of emergency in 2010 due to widespread prescription opioid misuse [23]. In 2015, the highest number of opioid-related deaths per capita were reported in Nishnawbe Aski Nation communities Northern Ontario, with some NAN communities reporting anecdotally that 50% - 75% of their community's population being prescription opioid addicted. Drug manufacturers bear responsibility as well as the healthcare system for having played a key role in "inappropriate prescribing, overprescribing, and use".

Studies show that integrated clinical mental health and addiction services combined with medications for opioid addictions (methadone and/or suboxone) and culture-based treatments, can support reducing (and for some clients eliminating) substance misuse among Indigenous clients, especially when supported by a continuum of health and social programs [24].

In 2012, both the Ontario government and Non-Insured Health Benefits added buprenorphine-naloxone (trade name Suboxone, Indivior PLC) to its drug formulary [25].

The College of Physicians and Surgeons of Ontario permitted physicians to prescribe buprenorphine-naloxone and this enabled many communities to establish their own Suboxone treatment programs to address OUD.

For the treatment of Opioid Use Disorder, Suboxone was taken up in the Kiiwetinoong area because methadone was seen as a less safe option due to the higher risk of overdose. In addition, methadone also has a higher risk of drug diversion (i.e. illegally using and/or selling medications or prescriptions for non-medical purposes). The lack of emergency services in many communities, the lack of access to a pharmacy operating 7 days a week, and the limited number of physicians with the ability to prescribe methadone, made Suboxone the better option for the region.

Between 2012 and 2017, 26 community-based Suboxone maintenance treatment programs were created in the Sioux Lookout region with the support of community leaders, medical providers, and nurse practitioners. Several studies were undertaken in the region over the past ten years to monitor and evaluate these programs.

Mae Katt, in collaboration with SLFNHA and CAMH, studied the pilot project of the Suboxone treatment program in one community in the region in 2012 and concluded the following [26]:

1. Community-based Suboxone taper-to-low-dose-maintenance is feasible and effective as an initial treatment for PO [prescription opioid]-dependence in remote First Nations populations, although abstinence is difficult to achieve and longer term maintenance may be required.

2. More research on OST (opioid substitution therapy) for First Nations people is needed; existing OST options, however, should be made available to First Nations communities given the acute need for treatment. (pg 52)

An article in Canadian Family Physician in 2013, describes how study author, Dr. Uddin, spoke with community members in Eabametoong (Fort Hope) who explained that their reason for implementing the program was a sense of loss in family and community life and their strong concern over the effect of the opioid crisis on children and youth. Many clients accessed treatment with the hope of bringing their families back together. The physician noted that part of the program's success relates to the community's ownership of the Suboxone program and the fact that many community members had the understanding that the opioid addiction requires healing on a physical, mental, spiritual, and emotional level of support[27].

Kanate and colleagues measured changes in the number of criminal charges, addiction-related evacuations, child protection, school attendance and attendance at community events in North Caribou Lake First Nation one year after the establishment of the program. Their evaluation showed the following improvements: overall criminal charges dropped by 61.1%, child protection cases decreased by 58.3%, school attendance increased by 33.3% and attendance at community events increased by 20%[28].

Six First Nations designed their own community-based program with a 'Land' aftercare program that included days of fishing, hunting, traditional walks for memorial events, and community gardening programs. Elders and experienced First Nations counselors provided individual and group healing sessions when possible. A research team found high retention rates and low drug use rates among clients in the program. They stressed the importance of local primary care physicians as prescribers and sustainable core funding is needed for programming, long-term aftercare, and trauma recovery[29].

The findings show that early on in the development of the programs, it was becoming clear that:

1. Suboxone programs will reduce overdoses and criminal activity and help some clients to gain back their families.

2. Suboxone could be effective at helping to stabilize clients' lives by taking away cravings and withdrawal symptoms; many were able to seek no or fewer drugs.

3. Suboxone does not treat the underlying issues of trauma such as the effects of colonization and breakdown of traditional lifestyles, exposure to racism, intergenerational trauma, IRS or day school trauma, and various forms of abuse encountered. Understanding and viewing addiction

through a lens of maladaptive survival or trauma related responses is critical to help reduce stigma.

4. Land-based, cultural programs and clinical mental health and addictions services must be offered in a coordinated manner with the Suboxone program in order to support clients who are ready to explore the role of these services in their recovery from addictions and trauma.

A recent study in another community in Northern Ontario confirms these findings. In a community clinic dispensing methadone and Suboxone, one client explained the lifeline that opioid agonist therapy has played for many clients and their community:

"Honestly, like maybe over a year ago, I was really bad. Like just over a year, I was really, really bad. I didn't care about if I lived or died. I must have OD'ed three times in one week. I still kept going when I got up. I got up after just OD'ing, and I'd just do some more. I was bad. I'm trying to get over that life, and this program has helped me lots. Not only the [medication] but the counselling…I started smudging, that really helped too. … I think that's when I really started opening my eyes." (OAT Client)[30]

…It decreases the amount of criminal activity in our community… there were a lot of home invasions, there was a murder based on opiates, there were people – parents getting their medication stolen. All of this stuff was happening without this clinic being in the community[31]. (OAT staff)

In the same study, staff emphasized the need for community advocacy for people living with OUD and adjusting what the community sees as a measure of success in this long-term healing process:

"*Harm reduction is totally different from an abstinence-based program. Our community members are accustomed to abstinence-based programs…[for opioid substitution therapy] success is not abstinence, instead success is when the clients walk through the door." (Service Provider)*[32].

Ongoing Program Development

In 2016, SLFNHA's Approaches to Community Wellbeing developed a "Workers Guide to Community Based Treatment of Opioid Addiction" based on current best practice and the experiences of communities who had established programs. The guide provides a wealth of information about addictions, opioids, recovery and treatment, opioid agonist treatment, Suboxone, starting a community treatment program and aftercare.

Staffing at the outset for most of the community programs included a coordinator, someone to dispense medication and a mental health counsellor (either in-house or a visiting provider). Nurses and visiting physicians were responsible for medical assessments, bloodwork and prescribing Suboxone during group intakes for induction. Each program endeavored to include programming such as group activities, going out on the land and counselling with Elders or clinicians.

Many family physicians in the area have received additional training in addictions medicine certification such as the British Columbia competency certificate. This is actually not required to prescribe buprenorphine/naloxone but it is helpful that many physicians are well prepared to do this work

Each community has their own Suboxone dispensing program with programmatic approaches that vary significantly. Similarly, the approach to providing support for these programs by physicians and other service providers also differs by provider and circumstances. Nonetheless, overall, there have been client success stories with some clients reconnecting with family, furthering their education, and holding jobs. Their efforts are inspiring and should be encouraged.

However, unfortunately, over time it was observed that the intended therapeutic or counselling component was not being provided as counsellors were not available and programs were not able to offer support outside of the dispensing of Suboxone. It seems that many have little or no cultural or land-based services that can be consistently accessed. Some diversion of carries was also noted in communities, which can be expected, but closer monitoring of clients' progress and engaging community staff in client support and case management could reduce the diversion and improve client successes.

There is much worker turnover and burnout, as the roles are under-supported in multiple ways. Many jobs are designed with patient-centered care in mind, however, embracing a model with traditional and contemporary knowledge skills and values can benefit both those receiving and giving care. Responding to the needs of workers needs to be a major focus of improvement efforts moving forward.

Enhancing or re-inventing the regional training model to further encourage capacity development in community workers will likely engage, retain, and enhance the work currently done in community. Professional development can be facilitated by the organizations already servicing communities (inxlusinf Nodin) as they have local knowledge and insight as well as great skill.

Status of Taper-to-low-dose-maintenance:

Initially, there was an impression from a medical perspective and within health centers and organizations that there would be significant tapering and clients would be weaned off Suboxone over a relatively short period of time. This has not happened as much as was originally hoped and there are several reasons for this:

1. Some people may not be able to taper due to changes in the brain that have occurred due to long-standing addictions. It is unclear if these clients can indeed taper without relapsing.
2. There is no consistent offering of cultural/traditional and clinical/therapeutic support programs to help clients deal with underlying complex trauma that has resulted in using addictions as a coping strategy with individual and systemic abuse experiences. Programming with focused interventions to heal from the underlying emotional dysregulation is generally provided as part of such treatment programs.

3. Similarly, there is no consistent offering of cultural/traditional and clinical/therapeutic support programs to help clients to both attain and then learn how to maintain healthy lifestyles.

4. The region lacks a strategy for intersectoral collaboration to address the social determinants of health for clients, including safe housing. Clients who are on their healing journey also need access to education, training or employment opportunities.

5. People have different goals in terms of addictions. Those with mild or moderate addictions in terms of severity are potentially not given the opportunity to safely taper as there is not sufficient support accessible for them. Without adequate psychosocial and cultural supports in place, few are able to taper and sometimes the prescribing physicians are hesitant to advise tapering. In general, differences in prescribing have been noted by some in local family physicians versus the addictions specialists from southern Ontario who focus their practice in this area and are most familiar with different populations such as those in Toronto.

6. The level of interprofessional collaboration or shared care between community staff, including those dispensing, mental health and addictions staff and prescribing physicians, is insufficient. Collaboration models and task shifting should be urgently explored.

Weaning together/Being together

Having a sense of purpose and belonging are a huge part of wellness and recovery.

When someone is trying to quit substances, it is often recommended that they remove themselves from those who are using.

When someone weans off Suboxone, there is a loss of support, socially, mentally and emotionally as these are often their social circle, support and / or family network.

Finding ways to meaningfully incorporate “hope, purpose, meaning and belonging” and weaving this into recovery is key. To drift with no purpose leaves one with a vulnerability toward relapse. Addressing the part of the healing journey and continuum with aftercare that builds hope, purpose, meaning, and belonging can change someone’s story. Land-based and cultural activities linked to the caring for the environment and reconciling relationships should be part of this. Holding weaning cohorts or ‘wean weeks’ where people can be supported as a group with a common goal and have that peer support and encouragement while having their medical and withdrawal management needs met is something to aim for.

Status of training and support for community staff and dispensing programs

The program coordinators and dispensing staff require more support in general. Staff who fulfill the task of dispensing are minimally compensated as all medication is to be dispensed in a short window of time

according to the funding model (1 hour). However, there is a strong sentiment among workers that there is a need to dispense for longer periods outside of these small windows of service.

Many community staff are supporting a large number of clients who come in for dispensing but as community members, they also provide supportive conversations, often without having received any clinical training in addictions. These staff members require qualified clinical addictions staff for debriefing and to alleviate the stress involved in this work. Support is needed also from traditional and cultural support persons for these staff members.

It would benefit the program to have staff attend related training on an ongoing basis. Training on addictions and how to work with people with addictions (e.g. Rolling with Resistance[33], dealing with people who are angry, de-escalating situations and so forth) are necessary.

Many of these aspects are outlined in the 2016 Workers Guide, however, staff we had met with expressed that they had little training, orientation or onboarding and no network opportunities to discuss their experiences with others. It is unknown as well if any of the staff have knowledge of the Workers Guide as there has been significant turnover in these roles[34]. Some programs operate with just one worker who dispenses the medication.

Key informants spoke of the need but also the risks and limitations associated with Suboxone programs.

"Communities need more than a NNADAP counsellor but there is no training and people are trying to fill gaps which can be dangerous – Suboxone programs don't fix all."

Substance use treatment involves a range of services of which Opioid Agonist Therapy is just one component. The full breadth of services should extend from detox, treatment, aftercare and supportive reintegration to the community. A longer-term strategic focus which builds in community and cultural strengths and leverages land-based healing is therefore needed.

Opportunities to improve Opioid Agonist Therapy Programs (Suboxone programs)

The gaps differ between communities as they have been structured around existing community supports, needs, and access to funding. Some major gaps include:

- Support for program staff
- Community strategies
- Family and land based healing
- Structural supports

These are each described in turn in the following section along with recommendations to address these gaps.

Support for program staff

1. Community coordinators of Suboxone programs require integration into the circle of care. As they have daily face-to-face interactions with clients, they are in a unique position to identify and intervene with clients who are struggling, which no other provider has. They also understand the clients as a community member and know the supports they have or lack.

2. Coordinators are in a unique position of interaction and trust with clients. However, they require an investment into their position to increase their knowledge about addiction and the treatment in order to support clients in a supportive role and referring role. Dispensing staff also need such support.

3. Clients with addictions can be difficult and stressful to work with. Dispensing community staff require trauma-informed care and self-care training in order to cope with clients who may be vocally complaining and demanding. This training would be standard practice in southern clinics for these positions due to the stressful nature of the job.

4. Programs need to be explicitly linked with skilled mental health and addictions workers and therapists for consultation. Over time, in many programs, this support has been inconsistent with services available in some clinics but not others, available for a period of time but then withdrawn, or only available occasionally when visiting staff are in the community for a brief stay.

5. Some local doctors conduct brief interventions with their patients on craving management and goals, but many are not trained as addictions therapists who can help people to recover from the addictions. Similarly, there are many excellent community workers with social work degrees who are great in supportive roles but are not trained to be addictions therapists. Addictions therapists could collaborate with physicians and with Suboxone program coordinators (i.e. dispensing staff) as well as with other addictions programs (solvent and alcohol).

Community Strategies

1. Community-level healing strategies are needed so that the Suboxone program is integrated within the services and programs of the community rather than operating apart. This is something that is needed so that the Suboxone program is seen as, and is, nested within a fulsome community healing or substance use treatment approach.

2. There are differing and polarized sentiments in communities towards harm reduction in general. Community awareness, education and dialogue is needed to reduce harmful stigma towards program participants[35].

3. More community and client engagement are required around the injectable Sublocade. Sublocade consistently and continuously releases the medicine buprenorphine all month meaning that the patient only needs to have the injection once every 28 or 29 days. This may be a good option for clients who would like to seek employment or education away from the community. Communities need more information and opportunities for conversation about this option. Some people respond best to being seen daily as there is a therapeutic effect involved in

the routine check-in for some, while others will not prefer this as an option for their own reasons.

Family, land-based healing

1. Some communities have included a land-based healing component using local culture and local knowledge keepers for their Suboxone program. This should be available in all programs. Cultural approaches to healing and treatment, for example traditional counseling with knowledge keepers and Elders and spending time in traditional activities, are an important pillar of aftercare and programming. More of this is needed and the activities need to be run by local community people.

2. A year-long, trauma-informed, land-based program with families involving effective and age-appropriate interventions with kids and parents is needed. This land-based healing program would be an integral part of the overall approach to community healing. Such community wide healing will allow people to "get back to normal", get their children back and reconnect as families and community members. At present however, communities receive a small amount of funding to undertake a two-week land-based program which is helpful but doesn't sustain the recovery. Relapse is common.

3. Support for parents who are struggling with addictions is also needed, including parenting skills, therapeutic support, housing, conversations around contraception for those who would prefer no more children, etc.

Structural Supports

1. Sustained long-term funding to support community-based Suboxone programs are needed as well as the counselling and land-based aftercare programming that is also necessary.

2. Programs also need better infrastructure including, buildings with counselling rooms for clinical counselling since many of the clinical rooms are in trailers and the walls are too thin for confidential conversations with care providers.

3. There is currently no capacity for accessing Suboxone treatment statistics, analyzing tapering trends or the level of related mental health and addictions services or traditional/cultural services. Regular analysis of electronic records for continuous quality improvement is urgently needed.

4. For those wishing to make a quick exit from maintenance therapy, or to bypass it altogether, there is no feasible access to a focused detoxification/withdrawal management support. If this is created in Sioux Lookout, there is a great opportunity for collaboration with partners to enhance access to wraparound care by integrating access between community programs and such a support. This relationship to the detox/Rapid Access to Addictions Medicine (RAAM) means people who are ready to receive such support have timely access. This may be a great area of focus for Nodin in the future.

Opportunity to enhance community treatment programs

Apart from addressing supports for staff, embedding such treatment programs in a fuller community wide strategy and addressing the need for sustained funding and resources, situating programs within land based, family treatment approach could strengthen and enhance client outcomes considerably.

Treatment for families on the land

A family healing program which offers accommodations for individuals and their families is needed - The treatment course will be for 4-6 weeks (42 days) and include a wholistic care model encompassing Suboxone treatment, one on one counselling, peer support groups and family centered therapy.

Land-based detox and treatment would be supported with medical monitoring. Opioid agonist treatment (Suboxone) would be augmented with counselling (clinicians and Elders) as well as with land based and cultural activities.

Aftercare

A supportive recovery program would integrate the necessary aftercare for those who have completed their treatment cycle. Clients would receive support for up to 10 months in order to progress through this stage.

The supportive aftercare program would strengthen implementation of individual recovery goals and help build skills and resiliency so that individuals can progress in their healing journey.

Transition planning would be done in concert with community resources so that individuals are well supported in their home community. The community environment significantly influences their risk for both addictions and relapse. When individuals return from treatment, they may encounter the same triggers such as family dynamics, friend groups, community norms, and physical associations that remain unchanged while they attended treatment.

Conclusions

Despite a number of constraints during the timeframe over which the review was conducted, the many lines of inquiry resulted in a detailed snapshot of the mental health and addictions service landscape as well as critical service delivery gaps, challenges, and opportunities.

The review uncovered not only what is missing or needing to be addressed but a number of pockets of excellence in innovative programming delivered by knowledgeable and experienced leaders in mental health and addictions. Though communities may face many hardships and a history of traumatic experiences which gives rise to poor mental health, they still find ways to care for their people in an Anishinabe way steeped in relationship to their identity and language and strong connection to their land.

Creating a responsive and effective approach to mental health care and addictions treatment for the region will need to draw on knowledge from mainstream systems and approaches as well as community's own inherent gifts and ways of knowing.

Key areas for system enhancement include:

- Capacity building within communities and amongst the regional workforce.
- Coordination and closer collaboration to maximize resources amongst provider agencies and partners.
- Structural supports including case management and information sharing processes and protocols.
- Supporting health leadership within communities to take up their rightful role in mental health and addictions services planning and delivery.
- Building an orientation to cultural and land based healing which spans the mental health and addictions treatment service continuum from prevention, early intervention, treatment, and aftercare.
- System wide advocacy is needed to address persistent and longstanding human resources and infrastructure challenges.

Thorough and comprehensive planning involving communities and their system partners is a needed next step.

Appendices

Appendix A: Literature Review

Appendix B: Document Review and Gap Analysis – Mental Health and Addictions Services

Appendix C: Key Informants in Interviews and Focus Groups

Appendix D: Community Visit Report to Mishkeegogamang

Appendix E: Questions for Interviews and Focus Groups

Appendix F: Gaps Analysis

Appendix G: Youth Survey Report

References cited:

[1] A note on terminology – "substance misuse" or "substance use disorder" is the preferred term in place of "addictions" which has harmful and stigmatizing connotations.

[2] As data and information to support this objective was not provided, the report reflects insights and perspectives of key informants, partners and communities to illuminate and describe gaps and needs.

[3] Community members have challenged their being described as "remote" when in fact, they are quite connected to family, community and land.

[4] According to statistics provided by Approaches to Community Wellbeing.

[5] Kim PJ. Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System. Health Equity. 2019 Jul 25;3(1):378-381. doi: 10.1089/heq.2019.0041. PMID: 31346558; PMCID: PMC6657289.

[6] Spirit and spirituality can be expressed in relations and experiences that enable a sense of connection or belonging, a sense of purpose in life, along with a sense of awe or wonder, creativity and gratitude. It includes traditional Indigenous was as well as religions. Depending on Elders' own experiences they may or may not be comfortable with or able to support the youths' interest in reclaiming of Indigenous spirituality, healing practices or ceremonies.

[7] Persons identifying as Two Spirit, lesbian, gay, bisexual, transgender, queer and questioning, intersex, asexual, and additional affirmative ways people choose to identify their gender and sexual orientations (2SLGBTQIA+).

[8] NAN Hope offers a 24/7 toll free rapid access to confidential crisis services, navigation to mental health and addictions support services, and rapid access to clinical and mental health counselling.

[9] National Native Alcohol and Drug Addiction Program

[10]https://www.drydennow.com/articles/ontario-to-build-new-addictions-treatments-for-sioux-lookout-area.

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[13] Culture Forward: A strengths and culture based tool to protect our Native youth from suicide. John Hopkins Centre for American Indian Health, O'Keefe et al, February 2019.

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[16]https://www.healthinsight.ca/wellness/mental-health/substance-use-stigma-causes-harm-and-we-need-to-address-it/

[17] School Mental Health Ontario https://smho-smso.ca/school-and-system-leaders/learn-more/mental-health-leadership-strategies/think-in-tiers-and-focus-on-the-positive/

[18] A circle of care refers to care providers or agencies who are servicing the same client and whom have consent from their client to share information for the purpose of delivery of services and care planning.

[19] NAN Database of Cultural Helpers https://www.nan.ca/resources/choose-life/

[20] A resource guide entitled British Columbia Biopsyhcosocialspiritual Withdrawal Management Services for adults suggests the stabilization stage of withdrawal management may take anywhere from 4-7 days. Though it doesn't specifically describe First Nations needs, a suggestion is that this stage be extended to up to two weeks. https://www.health.gov.bc.ca/library/publications/year/2017/adult-withdrawal-management-services-guidelines-final.pdf

[21] https://thunderbirdpf.org/wp-content/uploads/2018/07/Thunderbirdpf-LandforHealing-Document-SQ.pdf

[22] Shibogama Land-based Traditional Family Healing program has offered space for up to 5 families. A regional family treatment program could scale up to allow up to 8 families to participate.

[23] CRISM Ontario. (2016). Topic summary: prescription opioid misuse and interventions in Northern Ontario and First Nations communities. [Topic Summary]. http://crismontario.ca/SiteAssets/topic-summaries/PO_misuse_in_Ontario.pdf

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[25] Suboxone is a combination of two medicines used to treat the addiction to opioids. Suboxone helps to prevent cravings and the severe withdrawal symptoms without providing a high. Suboxone includes the opioid agonist naloxone, which deters relapse to IV use..

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[30] Maar, M., Ominika, T. & Manitowabi, D. (2022) Culturally-based Programs and Community-based Data Governance: Foundations of First Nations-led Recovery from the Opioid Crisis. International Indigenous Policy Journal. Volume 13, Issue 2 (in press).

[31] Ibid.

[32] Ibid.

[33]https://health.mo.gov/living/healthcondiseases/chronic/wisewoman/pdf/MIRollingwithResistance.pdf

[34] Approaches to Community Wellbeing which developed this resource experienced staffing limitations during the Covid pandemic to support community suboxone programs. Dissemination and training in the use of this resource is further constrained owing to a lack of dedicated source of funding for staff to support community suboxone programs.

[35] Approaches to Community Wellbeing has utilized a community readiness framework in two communities to provide insights into community awareness and opinions. This should be explored further.