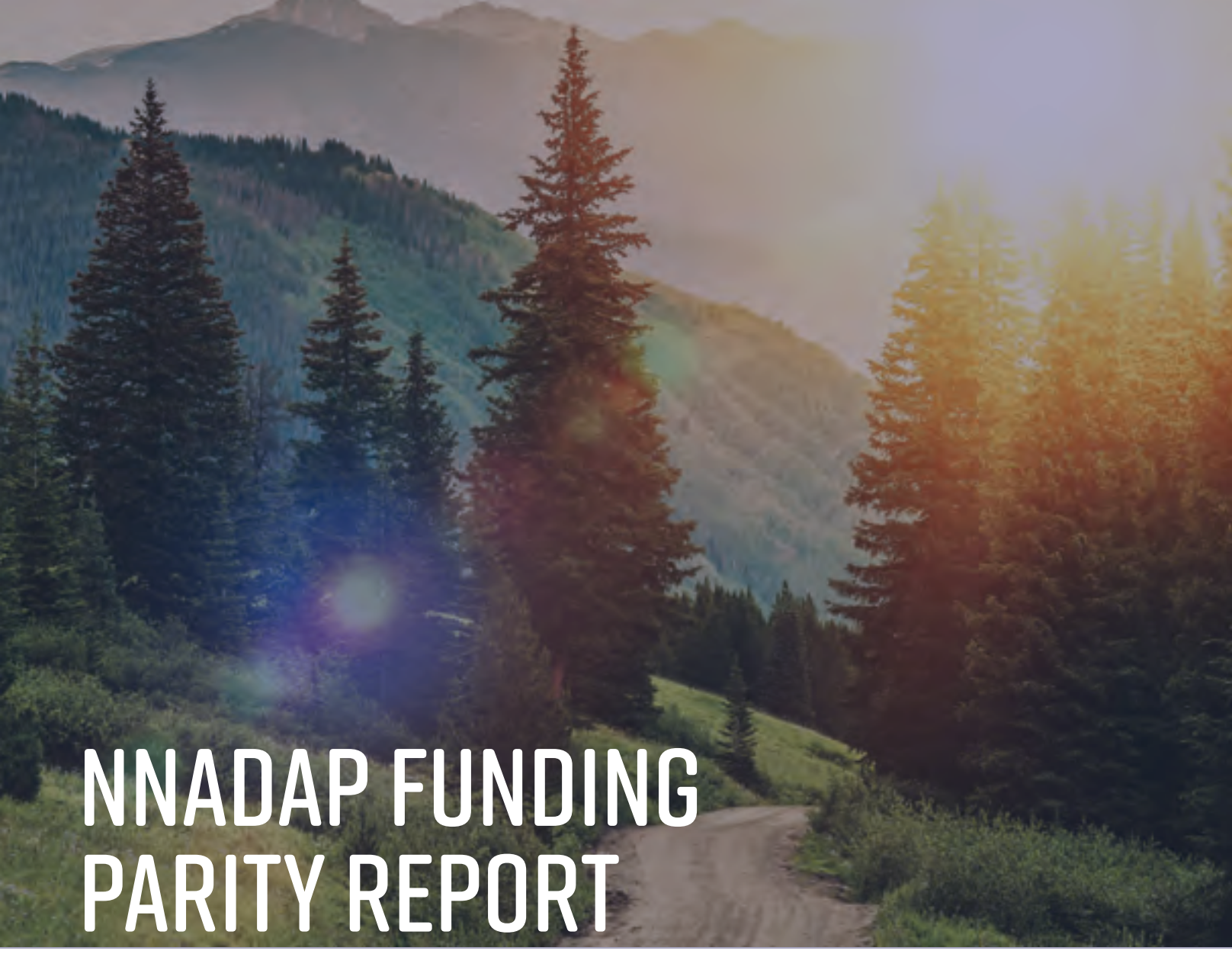

NNADAP FUNDING PARITY REPORT

ONTARIO REGION **CASE STUDY**

EXECUTIVE SUMMARY

THUNDERBIRD PARTNERSHIP FOUNDATION

CHIEFS OF ONTARIO

NNADAP FUNDING PARITY REPORT
Ontario Region Case Study

Executive Summary

Prepared by Bourget Consulting Services for the Joint Technical Working Group 2017.

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The Thunderbird Partnership Foundation is Canada's leading authority on First Nations substance use and mental wellness research and advocacy. Thunderbird champions culturally based substance use and mental wellness services for First Nations in Canada, advocating for and creating a collaborative systems approach that empowers Hope, Belonging, Meaning and Purpose. Our core mandate is the implementation of the Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (HOS) and the First Nations Mental Wellness Continuum (FNMWC) framework. The Thunderbird Partnership Foundation is a division of the National Native Addictions Partnership Foundation (NNAPF) Inc.

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CONTEXT OF REPORT

The Assembly of First Nations and the Chiefs of Ontario support the investigation and continued advocacy for funding opportunities to address substance abuse issues in First Nations communities as defined in the Honouring Our Strengths Renewal Framework (Assembly of First Nations Resolution 23/2014 and Chiefs of Ontario Resolutions 13/07, 14/28).

THIS TRANSFORMATIVE SHIFT AIMS TO **STRENGTHEN COMMUNITY, REGIONAL AND NATIONAL RESPONSES TO SUBSTANCE USE AND ASSOCIATED MENTAL HEALTH ISSUES** AMONG FIRST NATIONS PEOPLE IN CANADA.

Further to these resolutions, in May 2016, the National Native Alcohol and Drug Program (NNADAP) Joint Technical Working Group with representation from Ontario First Nations, Ontario Regional Addictions Partnership Committee (ORAPC), Thunderbird Partnership Foundation - formerly known as the National Native Addictions Partnership Foundation, Chiefs of Ontario (COO), the Assembly of First Nations (AFN) and the First Nations Inuit Health Branch of Health Canada (FNIHB) retained professional services to undertake a regional review, consistent with identified investment needs for NNADAP community-based and treatment centre programs, as per the *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* (HOS) and the *First Nations Mental Wellness Continuum* (FNMWC) framework.

The specific purpose of the analysis is to focus on current capacity building needs, effective, culturally based approaches to addictions, and investment required to provide adequate funding levels for sustainable programming and operating needs of ON Region NNADAP community-based programs and NNADAP/NYSAP Treatment centres, including validation of existing wage parity data, and to support and provide policy and program direction to leadership at AFN, COO, and FNIHB.

The paradigm shift to be mobilized is the move toward the creation of a continuum of services and supports; inclusive of multiple jurisdictions and partners, with the use of Indigenous knowledge and inherent strengths of First Nations and Inuit peoples as the foundation. This transformative shift aims to strengthen community, regional and national responses to substance use and associated mental health issues among First Nations people in Canada.

OVERVIEW OF NNADAP AND SUBSTANCE USE ISSUES

As outlined in the *Honouring Our Strengths Renewal Framework*, First Nations people face major challenges such as high unemployment, poverty, poor access to education, poor housing, remote location from health services, the displacement of Indigenous language and culture, and social and economic marginalization; all of which continue to impact their health and well-being. In this context, substance use issues and associated mental health issues continue to be some of the more visible and dramatic symptoms of these underlying challenges.

The primary network in place to respond to First Nations substance use issues is the Health Canada funded National Native Alcohol and Drug Abuse Program (NNADAP). NNADAP was one of the first programs developed in response to community needs. It evolved from the National Native Alcohol Abuse Program (a pilot project in 1974) to a Cabinet approved program in 1982. This network of on-reserve services has since evolved into 49 alcohol and drug abuse treatment centres, more than 550 NNADAP community-based prevention programs, and since 1995, a network of National Youth Solvent Abuse Program (NYSAP) residential treatment centres which now includes nine centres across Canada. First Nations also access substance use and mental health-related services from other sectors throughout the health care system both on- and off-reserve, as well as various other systems and sectors, including social services, child welfare, justice, housing, education, and employment. These other services, particularly off-reserve mainstream services, represent significant potential partnership opportunities for NNADAP in moving towards a collaborative, systems approach to care.

Initially, NNADAP services were largely based on the Alcoholics Anonymous model, with the maidifference being the infusion of First Nations cultures. Over time, many treatment centres and community-based programs have moved toward the use of other therapeutic interventions, such as cognitive behavioural approaches, while also strengthening their culturally-specific interventions and incorporating more mental health-focused services. In addition, since the NNADAP network was further expanded in 1995 to include NYSAP treatment centres, communities have had access to a range of highly innovative and effective treatment programming for First Nations youth. NNADAP services are more culturally competent, i.e., have First Nations community and history context as the foundation of care and therefore tend to be more trauma informed. This has meant that NNADAP has operated from a trauma-informed care approach long before the term became more therapeutically defined. As one good example, NNADAP has attended to the complex grief often presented by clients within treatment and has understood suicide ideation from a community wide trauma perspective and issues versus services that do not operate from a trauma informed basis and tend to treat suicide ideation as an individual trauma.

NNADAP AND NYSAP'S MANY SUCCESSES OVER THE YEARS CAN BE LARGELY ATTRIBUTED TO **FIRST NATIONS GOVERNANCE OF THE SERVICES, AS WELL AS THE CREATIVITY, DEDICATION, MOTIVATION, AND INNOVATION OF NNADAP WORKERS.**

NNADAP and NYSAP's many successes over the years can be largely attributed to First Nations governance of the services, as well as the creativity, dedication, motivation, and innovation of NNADAP workers. NNADAP centres and workers have continued to show their commitment to strengthening the program by pursuing accreditation and certification, respectively. Through the creation of community NNADAP worker positions, NNADAP has contributed to the development of local leadership. In addition, many NNADAP workers have pursued post-secondary education and some have moved into high level positions within the community, as well as taking on roles in the public and private sectors.

NNADAP has been reviewed several times during its long history, including a comprehensive review in 1998 *(1998 NNADAP General Review*), which generated 37 recommendations, including the need for communities, regions, and all levels of government to better coordinate services and supports to meet the needs of First Nations communities. Some of these recommendations have been addressed, while others are informing current renewal efforts.

Since the 1998 review, the urgency and complexity of issues facing communities increased considerably. Prescription drug abuse has emerged, for example, as a major issue in many communities, and the recognition of the unique treatment needs of certain populations (e.g., youth, women, and people with mental health issues), has also become more defined. Likewise, the number of people who specifically identify their trauma and associated substance abuse issues as being linked to Indian Residential Schools and child welfare experience has also increased. There is broad recognition of the need for strong health promotion, prevention, early identification and intervention services within the context of community development for the rapidly growing First Nations youth population. These factors have dramatically changed the landscape upon which systems were designed. With diverse systems across various jurisdictions and increasingly complex needs, a challenge for communities, regions, and all levels of governments is to coordinate a broad range of services and supports to ensure First Nations have access to a comprehensive client centred continuum of care.

In response to this need, in 2007, the Assembly of First Nations (AFN), the National Native Addiction Partnership Foundation (NNAPF), and the First Nations and Inuit Health Branch (FNIHB) of Health Canada oversaw a comprehensive, community-driven review of substance use-related services and supports for First Nations people in Canada. This review was led nationally by the First Nations Addictions Advisory Panel, which was responsible for both guiding the process and developing a national framework. The review was also informed by the First Nations and Inuit Mental Wellness Advisory Committee's *Strategic Action Plan for First Nations and Inuit Mental Wellness*, which was developed in 2007 to provide national strategic advice on efforts related to First Nations and Inuit wellness. This led to an extensive process of engagement and feedback, culminating in the publication in 2011 of *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada*.

A national leadership team with a mandate to guide implementation of the Honouring Our Strengths Framework served a mandate of three years. There was no new funding specific to implementation although some of the "opportunities for improvement" have had action. However, the Framework promotes a continuum of care and there has been expectation that First Nations communities will identify how to create the continuum of care either through realigning their tcommunity health funding envelop or by linking with provincial / territorial services to fill the gaps. Beyond the continuum of care, there are key supporting elements identified within the Honouring Our Strengths Renewal Framework, workforce development (and wage parity) being one of them. It is this section of the HOS Renewal Framework that sets out the mandate for this project.

Since Honouring Our Strengths was released, we have seen an intensification of the opioid crisis, and the

emergence of other issues and potential treatment options. First Nation leadership and community workers have identified a pressing need to expand treatment options for those community members who are addicted to opiate drugs (oxycodone, morphine, codeine, fentanyl, hydromorphone, heroin). The non-medical use of prescription drugs has been linked with the impoverished health status of First Nations across Canada, and a growing number of First Nations have associated elevated rates with increased levels of violent criminality, illicit prescription drug trafficking, and suicide within their communities.[1] For example, in early 2012 Cat Lake First Nation in Ontario was the latest First Nations community to declare a state of emergency to federal and provincial officials due to the widespread use of prescription drugs.[2] The First Nations Regional Longitudinal Health Survey, released in 2011, reported that addiction was the primary challenge (83%) to on-reserve community wellness—a greater challenge than both housing (71%) and employment (66%). [3]

Based on data collected from the Addictions Management Information System (AMIS) at NNADAP adult treatment centres in Canada for 2016/2017[4], 67% of males and 61% of females were abusing cannabis, while 74% of male clients and 73% of female clients were abusing opioids. The latter numbers are approaching the percentage of those clients abusing alcohol, which stand at 84% and 81% for males and females respectively. While youth use of opioids is lower than that of adults, figures for youth clients in the same year provided by NYSAP treatment centres show that a staggering number of young people were abusing cannabis: 95% of females and 93% of males. This is higher than the numbers abusing alcohol, which were 86% and 70% for females and males respectively.[5]

A substitute treatment option for methadone in the form of Suboxone, which was approved by Health Canada in 2007 for opioid drug dependence in adults, is now being more widely used. Suboxone is a combination of two different drugs: buprenorphine (a partial opioid agonist) and naloxone (a pure opioid antagonist).

There is a growing focus on implementing effective harm reduction strategies for substance misuse within a community development approach, as opposed to abstinence/ prohibition only approaches. Some interesting research has been done with regard to which harm reduction approaches might work best for Indigenous people and communities. The pending legalization of cannabis in Canada also presents some unique challenges for First Nations within the context of the high level of substance abuse identified within First Nations communities. All of these changes highlight the need for resources to address the issue of opioid and cannabis misuse in communities and treatment centres.

There have been calls to review NNADAP funding resources for many years, and while the program's services have been reviewed, renewed and evaluated, with numerous recommendations put forth, the funding has not been examined in any significant way. We are certain that the funding in the program has extended far beyond the original intent, services have been added as best as possible, and it is past due to invest in this program. The NNADAP workforce provides valued addictions services and First Nations need investments in the program.

1 -Dell, C.A., Roberts, G., Kilty, J., Daschuk, M., Hopkins, C. & Dell. D. (March 28, 2012), Researching Prescription Drug Misuse among First Nations in Canada: Starting from a Health Promotion Framework. Substance Abuse Research and Treatment. 2012; 6: 23–31. doi: 10.4137/SART.S9247

2 - Ibid

3 - Ibid

4 - NNADAP/NYSAP 2016/17 Annual Report Infographics.

5 - Ibid

NNADAP IN **ONTARIO REGION**

Of specific relevance to this project are the Treatment centres and the workers (treatment centre and community-based) supported by NNADAP/NYSAP within the Ontario Region. In the First Nation and Inuit Health Ontario Region, there are five Provincial Territorial Organizations (PTOs), 18 Tribal Councils and 133 First Nations (116 of which have NNADAP workers in place). There are 11 Treatment centres: two are outpatient programs, seven are residential NNADAP and two are NYSAP.[6] There were 207 NNADAP addictions counsellors as of FY 2013-2014.[7]

Treatment Centres

NNADAP/NYSAP Treatment centres in Ontario Region are as follows:

- **Reverend Tommy Beardy Memorial**
  PO Box 131 Muskrat Dam ON P0V 3B0
  807-471-2554 Family
- **Native Horizons Treatment Centre**
  130 New Credit Road Hagersville, ON N0A 1H0
  905-768-5144 – Alcohol and Drug 18+ and Summer Family Intakes
- **Sagashtawao Healing Lodge**
  PO Box 99 Moosonee, ON P0L 1Y0 705-336-3450 – Alcohol and Drug 18+ and Family Intakes
- **Benbowopka Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre**
  Box 568 Blind River, ON P0R 1B0 705-356-1681 – Alcohol and Drug 18+
- **Dilico Anishnabek Treatment Centre**
  200 Anemki Place FWFN Thunder Bay ON P7J 1L6
  807-624-5820 – Alcohol and Drug 18+
- **Migisi Alcohol and Drug Abuse Treatment Centre**
  PO Box 1340 Kenora, ON P9N 3X7 807-548-5959 – Alcohol and Drug 19+
- **Ngwaagan Gamig Recovery Centre Inc.**
  PO Box 81 56 Pitawanakwat St Wikwemikong ON P0P 2J0 705-859-2324 – Alcohol and Drug 18+
- **Ka-Na-Chi-Hih Solvent Abuse Treatment Centre**
  1700 Dease Street Thunder Bay, ON P7C 5H4
  807-626-1692 – Solvent 16-25 years
- **Nimkee Nupi Gawagan Healing Centre**
  RR1 Muncey, ON N0L 1Y0, 519-264-2277 – Solvent 12-17 years.
- **Anishnawbe Health Toronto**
  225 Queen St E, Toronto, ON, 416-360-0486 – Outpatient mental health and addiction services.
- **Fort Frances Tribal Area Health Services**
  1460 Idlywild Dr, Fort Frances, ON P9A 3M3, 807-274-2042 – Program intakes, outpatient, pre-treatment and after-care services.

National Anti-Drug Strategy (NADS)

While not provided directly through NNADAP annualized funding, there is another initiative germane to this review: the National Anti-Drugs Strategy (NADS) for the modernization of treatment services. NADS funded the 2007 review of NNADAP/NYSAP and provided 9 million in ongoing funding nationally to NNADAP/NYSAP, which is the modernization funding. This is funding directly to NNADAP/NYSAP to support training, certification, and certification incentive payments as well.

The fiscal investment in Ontario Region ongoing is $622,914. The primary priority area for proposal driven funding has been identified as:

- *Re-profiling Treatment centres (re-shaping or altering existing treatment services) to respond to identified needs of First Nations communities*

Other priorities that had limited investments through a competitive proposal process include:

- Providing targeted withdrawal services appropriate for the specific type of addiction and within a culturally safe model, and training community-based workers in detoxification and pre-treatment services.

6 - Regional Presentation on Key Renewal Achievements and Plans to Date, Presentation to Chiefs of Ontario, Honouring Our Strengths: National Renewal Forum (January 24, 2012), ORAPC

7 - Certification Roll-Up FY 2013-2014, Health Canada.

- Strengthening and formalizing after-care support links between Treatment centres and communities: developing a community-based after-care model based upon best practices and using multiple community support services.
- Developing a coordinated continuum of care model with treatment centres and community-based programs that would focus on case management supports from the first point of contact with an individual seeking treatment services to withdrawal, pre-treatment, treatment, after-care and relapse prevention.

Community Development & Mental Wellness Teams

Apart from NNADAP annualized funding but potentially relevant to this review with regard to partnership opportunities, there are three provincially funded community development wellness teams in Ontario Region. These were implemented to assist communities in developing strategies to address prescription drug abuse. However, there are no new resources for communities to implement the strategies or new programs or address the issues. In Ontario Region, the community wellness development teams are currently located as follows:

- One at Sioux Lookout First Nation Health Authority, Sioux Lookout
- One at Dilico Adult Residential Treatment Centre, Fort William First Nation
- One at Native Horizons, Hagersville

There is also one Mental Wellness Team (MWT), which is federally funded, in Ontario Region in the community of M'Chigeeng, Manitoulin Island. The concept is a community-based and multi-disciplinary team approach to providing mental health and addictions services in First Nations and Inuit communities that blends or enhances traditional, cultural and mainstream approaches.[8] The MWT approach is designed to complement and support efforts that are currently in place in First Nations on-reserve and Inuit communities.

There will be 32 new Mental Wellness Teams established across Canada over the next three years. Discussions are underway currently between Health Canada and the Chiefs of Ontario on the increased number and location of teams in the Ontario Region.

8 - Mental Wellness Teams: Key Learnings from 8 Projects (July 2014), Health Canada.

THE CONCEPT IS A COMMUNITY-BASED AND **MULTI-DISCIPLINARY TEAM APPROACH** TO PROVIDING MENTAL HEALTH AND ADDICTIONS SERVICES IN FIRST NATIONS AND INUIT COMMUNITIES THAT **BLENDS OR ENHANCES TRADITIONAL, CULTURAL AND MAINSTREAM APPROACHES.**

CALLS TO ACTION AND RELEVANT POLICY FRAMEWORKS

This report has been guided by two recent policy frameworks: Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) and the First Nations Mental Wellness Continuum Framework (2015). It is important to note that to date, no funding has been allocated for the implementation of these policy frameworks. This report, which attempts to put forth the initial costs needed for adequate NNADAP/NYSAP resourcing and to address the long outstanding issue of wage parity, also aligns with specific Calls to Action of the Truth and Reconciliation Commission of Canada in 2015.

TRUTH AND RECONCILIATION RECOMMENDATIONS: **CALLS TO ACTIONS**

The Calls to Action issued by the Truth and Reconciliation Commission and more specifically, some of Calls to Action related to Health, which are replicated below, are of particular relevance to this review.

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes, between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.

ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii. Provide cultural competency training for all healthcare professionals.

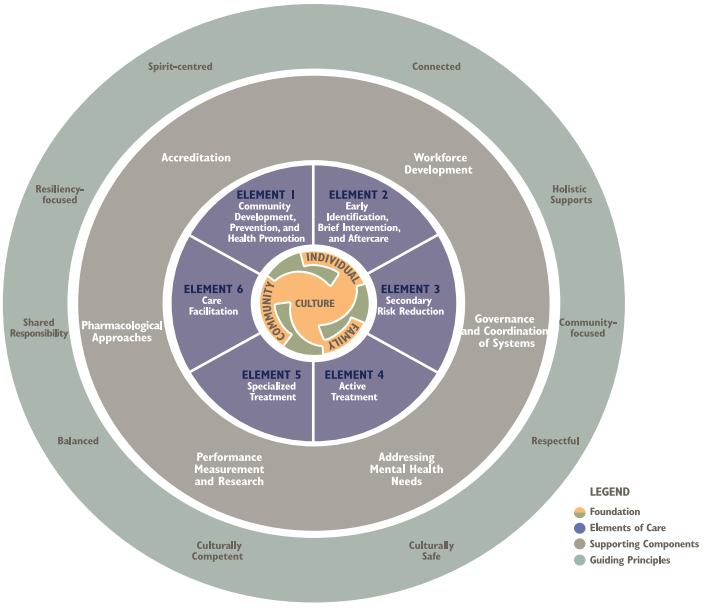
HONOURING OUR **STRENGTHS**

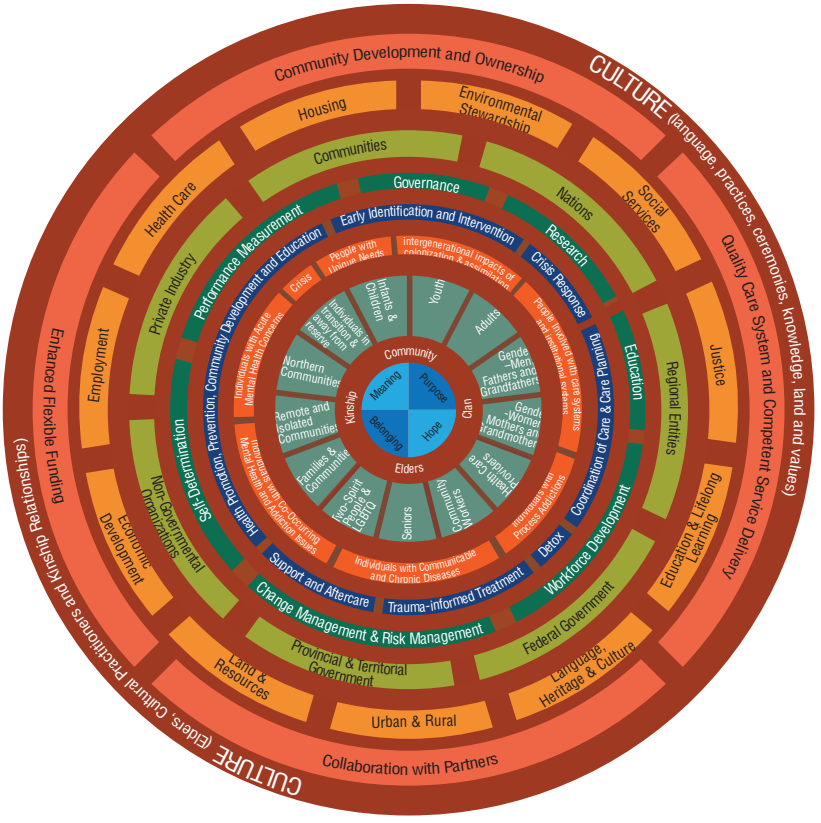
Honouring Our Strengths (2011) is an evidence-based framework that outlines a continuum of care to support strengthened community, regional, and national responses to substance use issues. It provides direction and identifies opportunities to ensure that individuals, families, and communities have access to appropriate, culturally-relevant services and supports based on their needs at any point in their healing process. This vision is intended to guide the delivery, design, and coordination of services at all levels of the NNADAP/NYSAP program, as well as other substance abuse and mental health programs that service First Nations populations.

The continuum of care outlined in Honouring Our Strengths consists of six key elements of care. These six elements respond to the needs of individuals, families, and communities with a wide range of substance use issues. They are also designed to meet population needs throughout the life-span and across unique groups (e.g., women, youth, and those affected by mental health issues). They range from universal to highly specialized services and supports, as follows:

1. **Community Development, Universal Prevention, and Health Promotion**
2. **Early Identification, Brief Intervention, and Aftercare:**
3. **Secondary Risk Reduction**
4. **Active Treatment**
5. **Specialized Treatment**
6. **Care Facilitation.**

Honouring Our Strengths also speaks to six key supports to the continuum of care. These include: workforce development; governance and coordination of and within the system; addressing mental health needs; performance measurement and research; pharmacological approaches; and accreditation.





FIRST NATIONS MENTAL WELLNESS CONTINUUM FRAMEWORK

Developed in partnership with First Nations, the First Nations Mental Wellness Continuum framework presents a shared vision for the future of First Nations mental wellness programs and services and practical steps towards achieving that vision. A response to the mental health and substance use issues that continue to be a priority concern for many First Nations communities, the Framework's overarching goal is to improve mental wellness outcomes for First Nations.

The Framework outlines a First Nations Mental Wellness Continuum which, similar to Honouring Our Strengths, is rooted firmly in culture and promotes access to supports and services for individuals and families across the lifespan, including those with multiple and complex needs. The continuum of essential services includes:

1. **Health Promotion, Prevention, Community Development, and Education**
2. **Early Identification and Intervention**
3. **Crisis Response**
4. **Coordination of Care and Care Planning**
5. **Detox**
6. **Trauma-informed Treatment**
7. **Support and Aftercare**

As noted in the Framework, not all of the services described above or in Honoring Our Strengths will be available in every community; however, through collaboration and comprehensive planning, all communities should be able to have access to the key services they need.

Additionally, a central premise underlying both models (Honouring Our Strengths and the First Nations Mental Wellness Continuum Framework) is that the continuum must be ***coordinated***. Additionally, both models position ***culture*** as the foundation of the continuum. It is also important to note that while the First Nations have actively engaged in the development of these Frameworks, it will be impossible to implement the full range of services with outdated funding levels.

ADDICTIONS IN **ONTARIO REGION**

The high incidence of health and social problems experienced by Indigenous communities today cannot be understood without an appreciation of the ongoing effects of historical trauma resulting from colonization. Many Indigenous cultures around the world have been subjected to similar processes, the effects of which are akin to the disruptions and collective trauma experienced by victims of war and natural disasters.[9] Several researchers have pointed out that trauma, particularly collective trauma, is inter-generational in its effects, as the experiences associated with the trauma are passed on to the next generation.[10,11,12,13,14] It is therefore not surprising to find that patterns of mental health and addictions issues in the Canadian Aboriginal population are similar to those found in other Indigenous populations who share a history of colonization and mental health and addictions in Indigenous communities must be approached with an understanding of this history and its associated risk factors. For example, up to 98 percent of residential school survivors may be afflicted (or were afflicted) with a mental health disorder, including substance abuse problems, Post-Traumatic Stress Disorder, major depression and chronic depression. [16]

Available data on substance abuse problems in Indigenous communities in Ontario Region support these research findings, showing higher rates of substance abuse compared to the non-Indigenous population. For example, an analysis of relevant data done by the North East Local Health Integration Network with regard to Aboriginal people living off reserve recently noted that:

> *....a subset of data from the Canadian Community Health Survey (CCHS) was conducted for the development of this framework. It includes Aboriginal people's data, collected from self-identified, Aboriginal people living off reserve.....These CCHS results show that Aboriginal people in Ontario rate their mental health as poorer. In addition, they also report more risk factors for mental health and addictions than non-Aboriginal people in Ontario (see Table 1). The differences were statistically significant.[17]*

Table 1: Select Mental Health Risk Factors, Ontario

	Aboriginal Respondents	Non-Aboriginal Respondents
Perceived mental health - very good or excellent	**66.1 %**	**75.1 %**
Heavy Drinking	**23.3 %**	**16.3 %**
Smoking (daily or occasional)	**40.3 %**	**20.2 %**

9 - Royal Commission on Aboriginal Peoples, (1995). Choosing Life: Special Report on Suicide among Aboriginal People. Ottawa: Canada.

10 - Yehuda, R., Schmeidler, J., Wainberg, M., Binder-Byrnes, K and Duvdevani, T. (Sept, 1998) Vulnerability to Posttraumatic Stress Disorder in Adult Offspring of Holocaust Survivors. American Journal of Psychiatry. 155:1163-1171.

11 - Wesley-Esquimaux, C.C. & Smolewski, M. (2004) Historic Trauma and Aboriginal Healing. Prepared for the Aboriginal Healing Foundation. Canada.

12 - Adler, T. (October 16, 2005). The impact of residential schooling on Aboriginal parents as first teachers. Presentation at the Native Mental Health Conference, Symposium on Early Care and Education.

13 - White, J. & Jodoin, N. (2004) Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies. Centre for Suicide Prevention: Calgary, Alberta.

14 - Daud, A., Skoglund, E., & Rydelius, P (2005) Children in families of torture victims: transgenerational transmission of parents' traumatic experiences to their children. International Journal of Social Welfare 14 (1), 23–32.

15 - Kirmayer LJ, Brass GM, Tait CL. (2000) The mental health of Aboriginal peoples: transformations of identity and community. Can J Psychiatry, 45(7):607-616.

16 - Fast Facts on the mental health of Aboriginal peoples. In Canadian Psychiatry Aujourd'hui. Volume 3. 2007.

17 - Aboriginal/First Nation and Métis Mental Health and Addictions Framework (January 2011), NE LHIN

With respect to people living on-reserve, the most recent First Nations 2008/10 Regional Health Study (RHS) found that when asked the question *'at the present time, do you smoke cigarettes?'*, more than one third (38.6%) of First Nation adults in Ontario Region self-identified as daily smokers with an additional 10.9% self-identifying as *occasional smokers*.[18] In comparison, Statistics Canada (2010) reported that 19.4% of the general Canadian population (2007-2008) were smokers. Close to one-third of people in the RHS (31.4%) reported binge drinking (five or more drinks on a given occasion) between once a month and more than once a week. Among Canadians in general, Statistics Canada found that in 2008, 17% reported binge drinking once a month or more in the previous year, while in Ontario, the figure was 16.5%.[20]

The 2008/10 RHS findings also showed that in the past year, 9.8% of First Nation adults in Ontario Region reported using non-prescription cannabis once or twice, 2.0% reported using it monthly, 3.6% reported using it *weekly* and 9.6% reported using it *daily* or *almost daily*. Youth entering treatment at NYSAP shows that 81% report using non-prescription cannabis regularly in the past year.[21] In contrast, in 2011, only 9% of Canadians reported using non-prescription cannabis at all in the past year.[22]

In Ontario between 1991 and 2007, the number of prescriptions for oxycodone increased by 850%. In 2015 at least 551 people died in Ontario from opioid overdoses, up from 421 in 2010.[23] Emergency department visits due to opioid poisoning are also increasing in Ontario, up 24% between 2010/11 and 2014/15, from 20.1 per 100,000 people to 24.9 per 100,000 people.[24] The increasing availability of potent new street sources of synthetic opioids is exacerbating the challenge. By 2015, fentanyl and hydromorphone became the top two opioids most commonly involved in opioid related deaths in Ontario, both having surpassed oxycodone.[25] With regard to the use of opioids without a prescription, one study in Ontario confirms "the extraordinarily high prevalence of opioid addiction in FN communities. Among adults age 20-50 years, 28.0% were on buprenorphine-naloxone, double the rate of adults in these communities who have been diagnosed with Type 2 Diabetes (14.1%)." Other First Nations community-led surveys in several northern Ontario communities reported a prevalence of prescription opioid abuse between 35% and 50%. *"In addition, a three-fold increase in the number of aboriginal people (mostly First Nations) seeking treatment for addiction to prescription opioids in Ontario occurred from 2004 to 2009."*[27] While we do not have any similar studies in southern Ontario we know the issue is growing there as well. In contrast, in 2012, the numbers of Canadians reporting having misused opioids in the past year was .9% of the population.[28]

18 First Nations Regional Health Survey (RHS) Phase 2 (2008/10) Ontario Region Final Report (2012). Ontario Region Report on the Adult, Youth and Children Living in First Nations Communities

19 http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health74b-eng.htm

20 http://www.statcan.gc.ca/pub/82-229-x/2009001/deter/hdx-eng.htm

21 YSAC Mental Health, June 2016. Addictions Management Information System.

22 Canadian Alcohol and Drug Use Survey Summary of Results 2011, Health Canada). http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-eng.php

23 Office of the Chief Coroner, Ontario Forensic Pathology Service. Ontario Opioid Related Toxicity (2010-2015). Note: The 2015 figure is preliminary figure, and subject to change

24 Canadian Institute for Health Information, Canadian Centre on Substance Abuse. Hospitalizations and Emergency Department Visits Due to Opioid Poisoning in Canada – Data Tables. Ottawa, ON: CIHI; 2016

25 Government of Canada. Joint Statement of Action to Address the Opioid Crisis. November 19, 2016. Available from: https://www.canada.ca/en/health-canada/services/substance-abuse/opioid-conference/joint-statement-action-address-opioid-crisis.html

26 Mamakwa, S. et al (2015). Evaluation of 6 remote First Nations community-based buprenorphine programs in Northwest Ontario (in press).

27 Kanate et al (2015) Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence: *Evaluating outpatient buprenorphine-naloxone substitution therapy in the context of a First Nations healing program* (2015).

28 Canadian Centre on Substance Abuse, Canadian Drug Summary, July 2015 http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Sumary-Prescription-Opioids-2015-en.pdf

In terms of most-abused substances, Williams (2009) in a needs assessment for NNADAP in Ontario region noted the following....

> *study findings from all lines of enquiry confirm that alcohol is still the highest ranked substance abused in Ontario First Nations communities followed closely by cannabis (in the form of marijuana and hash), cocaine and oxycodone, (including Oxycontin and Percocet). However, the study findings also firmly indicate that poly-substance abuse is rampant with Ontario First Nations people, such as alcohol and oxycodone.*

While Ontario-specific figures are not currently available, Canada-wide data suggests these trends may be changing[29] as treatment centres are reporting that opioids are now the second most commonly abused substances after alcohol among adult clients, followed by cannabis. For youth, cannabis abuse has now exceeded alcohol abuse.

Access to treatment for opioid addictions is still alarmingly difficult in the absence of access to treatment and for First Nations communities who struggle with funding to support transportation to services outside the community. The Thunderbird Partnership Foundation has heard concerns from the Ontario Provincial Police over the increase in crystal meth labs in southern Ontario as well as from addictions specialists who provide community based opioid replacement therapy that the first entry into drug use for teens is now through injection use. Additionally, the rate of neo-natal abstinence syndrome has increased four-fold over ten years and is reported as 30% of births in some northern cities in Ontario. [30]

29 - NNADAP/NYSAP 2016/17 Annual Report Infographics

30 - The Mental Health of Children and Youth In Ontario: A Baseline Scorecard. March 2015 ICES

STRENGTHS AND SUCCESSES OF NNADAP

Since the NNADAP renewal process began in 2007 to develop a vision for the program's direction over the next five to ten years, a number of important successes and strengths have been identified through evaluations and reviews, nationally and in Ontario Region. These include:

- **Very little overlap or duplication among mental health and addictions programs.**[31]

- **New resources** such as access to Suboxone treatment; Indigenous children's mental health workers funded through the Ministry of Child and Youth Services; Health Canada's Health Services Integration Fund; and Community Wellness Development Teams. [32]

- **Improved treatment options,** such as access to opioid replacement therapy using Suboxone, improvements in telemental health and treatment using a trauma-informed care approach ; and an improved range of treatment options (e.g. within communities and treatment centres) including traditional and cultural programming.[34,35]

31 - First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.

32 - Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.

33 - Ibid

34 - First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.

35 - National Native Alcohol and Drug Abuse Program Treatment Centre Outcome Study (Phase II) 2012 Summary Report, Final Draft (April 2013). Mental Wellness Division. Inter-professional Advisory and Program Support Directorate, First Nations and Inuit Health Branch, Health Canada

• **Improved overall capacity:** community providers have become more knowledgeable in the area of opioids and opiate replacement therapies; certification of addictions services workers has increased, as has accreditation of treatment centres and, in some communities, these are supported through community wellness development teams.[36,37] Additionally, despite minimal investments, there have been incredible improvements in scope of service delivery in NNADAP in Ontario. This includes accreditation of all residential treatment centres, certification through external certification bodies of the majority of workers in Treatment centres, and ongoing professional development for both treatment centre workers and community-based workers. Additional resourcing to address wage parity and program shortfalls would allow more of the recommendations in the Honoring our Strengths and First Nations Mental Wellness Frameworks to be implemented.

• **Reduced stigma** related to mental health and addictions treatment.[38]

• **Improved awareness** of the root causes of addictions as a consequence of residential school attendance and multigenerational trauma. [39]

• **More participation in mental health and addictions programs and services** and increased practice of healthy behaviours due to mental health and addictions programming.[40,41] Measures of well-being are assessed by treatment centres at intake and exit in response to cultural interventions using the Native Wellness Assessment™, which was launched in June 2015 and is the first instrument of its kind in the world.[42] They include: hope, belonging, meaning and purpose.

• **Increased community control** over services.[43]

• **Increased recognition of the importance of culture and traditions** as central pillars in mental health and addictions programming and, within communities, increasing readiness and mobilization to develop these services.[44 45]

• **Improved partnerships, collaboration and information sharing** about mental health and addictions.[46]

• **New policy directions as vehicles for action and transformative change** (e.g., Honouring our Strengths and the First Nations Wellness Continuum Framework). [47, 48]

36 - Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.
37 - Ibid
38 - Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.
39 - Ibid
40 - First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada
41 - National Native Alcohol and Drug Abuse Program Treatment Centre Outcome Study (Phase II) 2012 Summary Report, Final Draft (April 2013). Mental Wellness Division. Inter-professional Advisory and Program Support Directorate, First Nations and Inuit Health Branch, Health Canada
42 - Ibid
43 - Ibid
44 - Ibid
45 - Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.
46 - First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada
47 - Ibid
48 - Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.

GAPS AND CHALLENGES REQUIRING IMMEDIATE RESOURCING

The key areas discussed below have been identified as in need of immediate need of investment for capacity building are based on an extensive review of the various data sources used for the project. Investments in these areas will provide the resources required to move toward a full continuum of care as outlined in Honouring Our Strengths.

It should be noted that studies have shown that there is a significant social return on investments (SROI) on capacity building investments as described in this report. For example, one pilot program at a Treatment Centre found that every dollar of funding invested in a year provided a social return of $3.85 over three years.[49] Another study calculated the SROI of providing trauma-informed, culture-based treatment for pregnant and parenting women for one year, followed by support for two more years, was $4.21 per $1 invested. The authors also noted that: *"Given the profile of the women involved, and their likelihood of success with the right support, the SROI may well be closer to $25 per $1 invested."* [50]

49 - Social Return on Investment NNADAP Treatment Centre Pilot (2015), Health Canada;
50 - Social Return On Investment (SROI) Case Study: Minwaashin Lodge Addictions Treatment Centre

1. WAGE **PARITY**

1.1 NEED FOR **WAGE PARITY**

Numerous sources highlight the need for wage parity and workforce development, including an appropriately trained certified workforce which is financially compensated in accordance with provincial equivalents, and which recognize established First Nations standards. [51] [52] [53] [54] [55]

For decades, the lack of wage parity between NNADAP/NYSAP and mainstream workers has been identified as an issue in Canada. In 1991, Health Canada set out base financial compensation for treatment centres using a funding formula[56], which has not since been evaluated or reformulated, and at that time salaries had been directed at a level of at least 10% lower than mainstream.[57] At some point, funding formulas were abandoned, and it appears the same amount of funding was disbursed each year, with a small annual increase. In addition, the National Anti-Drug Strategy funding is not core funding and cannot be used for salary enhancements.[58]

While this document is specific to Ontario Region, for comparative purposes, wages across Canada will be discussed first. A general review of NNADAP in 1998 found that, nationally, wages are low and as a result treatment centres were having difficulty recruiting and retaining staff. [59] An associated financial review to the afore-mentioned report further noted that "the level of resourcing identified in 1982 as necessary for an adequate and comprehensive strategy into First Nations and Inuit drug and alcohol abuse was reached and exceeded in the prevention and training components of NNADAP *but not with respect to treatment*" (emphasis added). The report goes on to state that "Overall, NNADAP expenditures peaked in the mid-1990's and more recently have fallen due to transfer and integrated agreements. NNADAP's decrease has been attributed to transfer solely. However, expenditures in the community health program, another area where transfer agreements are occurring, more than doubled between 1990-91 and 1995-96, at the same time NNADAP resources decreased by 10.7%, and suggest program enrichment in other service delivery areas but not in NNADAP. Per capita treatment resources in 1995-96 were 83.4% of what was recommended for 1986-87 when the program matured if real not current dollars are considered in order to have comparable spending power.[60]

Since that time, the issue of low wages and the need for wage parity between NNADAP and mainstream addictions workers have been raised many times over the course of numerous reviews and research initiatives with respect to NNADAP.

Fair and equitable compensation helps programs to recruit and retain qualified and dedicated workers, thus contributing to effective treatment. To stabilize staffing, salaries must be competitive with other potential employers, as noted in a document which highlighted the major findings and conclusions of the 1998 NNADAP Review prior to its release. [61] Prior to the *Kelowna*

51 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.

52 Ontario Region First Nations Addictions Service Needs Assessment, Final Report (March 28, 2009). Williams Consulting.

53 Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario

54 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada

55 Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP) (2009), McCormick and Quantz.

56 Memorandum: NNADAP Treatment Formula – Centres Meeting Minimum Standards (February 12, 1991) Government of Canada.

57 Ontario Regional Addictions Partnership Committee (ORAPC), Briefing Note for the Chiefs of Ontario, July 18, 2013

58 ORAPC, Briefing Note for the Chiefs of Ontario, July 18, 2013

59 National Native Alcohol and Drug Abuse Program (NNADAP) General Review, Final Report (1998), NNADAP, pg.

60 NNADAP General Review: A Financial Review of the National Native Alcohol and Drug Abuse Program 1983-84 to 1996-97, (1998), NNADAP, pg. viii.

Accord, the Assembly of First Nations (AFN) Health Secretariat and Chiefs Committee on Health identified seven health priorities, of which sustainability of human resources and programs was the number one priority, with wage parity for First Nations Band employees being one of the considerations.[62] The National Native Addictions Partnership Foundation (NNAPF), now known as Thunderbird Partnership Foundation echoed these findings in 2005, stating that "funding for salaries is often too limited to retain highly qualified staff."[63] Regarding NNADAP renewal program elements to be established, it was also recommended in 2005 that:

> *A **Salary Review and Revision** be undertaken with the understanding that, if appropriate, a more competitive salary grid linked to experience and training, the population size of the community, and remoteness and environmental risk indices, be developed and funding based on that grid be made available, both to treatment programs and prevention programs.*[64]

Thunderbird (NNAPF) was contracted by the First Nations and Inuit Health Branch (FNIHB), to conduct an examination and analysis of addictions workers' salaries in both the federal and provincial systems, with a draft report having been produced in 2007. The report reiterated previous findings that wages have not attained parity with those of mainstream workers and that standardized and equitable pay grids need to be developed.[65] Within that same report, there are references to two unpublished FNIHB documents: one report (2004) and one PowerPoint presentation (2007). Both acknowledged that NNADAP salaries were still well below their counterparts in the provincial system, making it extremely difficult to attract and retain staff, with the 2007 presentation adding that addressing wage parity would also:

- **support job laddering and incentives to advance;**
- **increase the quality of services;**
- **increase the number of evidence-based programs; and ultimately,**
- **reach service levels [and wage parity levels] that are comparable to the provinces.**

It was further noted that Alberta and Manitoba had made efforts to address wage parity for NNADAP workers by proposing wage parity scales to bring NNADAP worker salaries comparable to that of their provincial counterparts, with the Alberta grid having been fully implemented by 2004.

The need for a comprehensive review and revision of salaries was raised again in 2009 in a research paper exploring opportunities for improving the integration of mental health and addictions programming within NNADAP. The authors recommended a review of current prevention and treatment salaries for mental health and addictions workers, the development of a national salary grid based on training, experience and remoteness indices, and increased funding for NNADAP workers and competitive compensation for costs for tuition, travel, sustenance, books, etc.[66] The same need was highlighted again in a 2010 discussion paper about renewing NNADAP.[67] Yet another report based on various national and regional needs assessments and training plans done between 2004 and 2013 reflects similar concerns, with findings showing significant disparities in wages for NNADAP- NYSAP workers compared to mainstream addictions workers across the country.[68]

61 NNADAP General Review, NNADAP Review Steering Committee, circa 1998, pg. 14, cited in NNAPF (October 2007) Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce.

62 Health Background Paper, Health Sectoral Session, Assembly of First Nations, November 2004, pg. 2, cited in Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce (October 2007), NNADAF.

63 NNADAP Renewal Framework – Implementing the Strategic Recommendations of the 1998 General Review of the National Native Alcohol and Drug Abuse Program, National Native Addictions Partnership Foundation, streamlined edition, 2005, pg. 59.

64 Ibid

65 NNAPF (2007)

66 Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP) (2009), McCormick and Quantz, pg 39.

67 Bobet, E. (2010). Renewing NNADAP: Common themes from the regional needs assessments reports and the January 2010 NNADAP national renewal forum. Discussion paper prepared for NNADAP Regional Partners and members of the First Nations Advisory Panel.

68 Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager, January 20, 2013

1.2 INCREASED SCOPE OF PRACTICE AND **IMPROVED TREATMENT OUTCOMES**

It is generally acknowledged that the wages of all addictions workers have been and continue to be low, that credentialing is variable, that the work is often perceived as low status, that there are few or no defined career ladders, and that recruitment and retention are affected as a result.[69] Despite this, compared to mainstream workers, NNADAP and NYSAP addictions workers (both treatment and community-based workers) have expanded their scope of practice considerably in order to respond to the changing needs of First Nations and Inuit communities. They have done this by moving from generic residential programs to community-based day treatment, outpatient and land based services and supports, and by developing more linkages to support clients entering treatment with opioid agonist prescriptions, prescriptions for psychological diagnosis and for chronic health conditions.

In many communities, there is only one NNADAP worker who provides a broad range of services and supports, which may include: crisis intervention, assessment and referral to withdrawal management and residential treatment, referrals to mental health and other health and social service programming, treatment planning, supportive and therapeutic counselling and therapy (both one-on-one and group models), case management, home visits, aftercare, educational presentations and workshops, community event/activity coordination, suicide education/prevention/intervention, grief work, gambling, smoking cessation, FAS/FAE, cultural programming, lateral violence, health promotion, sexual abuse, family violence, concurrent disorders, diabetes and nutrition, and the abused substances of the day.[70]

NNADAP and NYSAP are also addressing intergenerational trauma by formalizing their approach to address concurrent disorders, partnering with child welfare to be more responsive to the needs of women and families addressing addictions issues as a measure of conditions for getting their children back from foster care, and in response to the changing legislation for conditional discharge sentencing which mandates treatment for some criminal offenses.

The NNADAP and NYSAP workforce has met these challenges by pursuing more high-quality education and training leading to certification, and the national rate of certification has been continuously increasing. By 2014, 54% of workers across Canada had achieved certification nationally, including 78% of the workers at treatment centres.[71] This is not necessarily the case for the mainstream workforce. As noted by the Canadian Centre on Substance Abuse:

> *While more than 50 substance abuse or addictions programs are delivered at Canadian colleges and universities, these* ***graduates are the minority in the addictions workforce.***[72] *(Emphasis added)*

The increased numbers of certified NNADAP and NYSAP workers appears to have contributed to improved treatment outcomes. For example, the rate of client completion of treatment (in treat-

69 Ogborne A. and Graves G. (2005) Optimizing Canada's Addiction Treatment Workforce: Results of a National Survey of Service Providers, Canadian Centre on Substance Abuse, pg. 2.; NNAPF (October 2007) Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce.

70 Ontario NNADAP Funding Issues and Worker Retention Incentives. (October 2013) Ontario Regional Addictions Partnership Committee.

71 Health Canada, Certification Information Roll-Up, FY 2013-2014.

72 http://www.ccsa.ca/eng/topics/Workforce-Development/Pages/default.aspx

ment centres) improved from 66% in 2005[73] to 75% in 2012.[74] By 2012, treatment outcomes for NNADAP and NYSAP clients showed that:

- 71.2% of clients terminated use of alcohol post-treatment, 67.4% terminated use of cannabis, 81.8% terminated use of cocaine and 72% discontinued misuse of opioids
- Of those who did use post-treatment, 94.9% used less than pre-treatment use
- Post-treatment supports most used were cultural/social (71.4%) and cultural/spiritual (72.2%)
- 90% of post-treatment clients reported they have more control over their life, improved positive relationships, can ask for help when needed, and have a sense of purpose. [75]

> ***Based on these findings, ensuring wage parity is a high priority for NNADAP addictions workers and other NNADAP staff who support addictions programs and services.***

73 Health Canada, 16 year review of The Addictions Recovery System and Substance Abuse Information System databases, 2005
74 Health Canada, NNADAP and YSAP Treatment Outcome Study, Phase 2, 2012.
75 Ibid

I.3 ANALYSES OF WAGE PARITY FOR ADDICTIONS WORKERS IN CANADA AND IN ONTARIO REGION

Several analyses have been done over the years to identify what a fair and equitable salary grid for NNADAP addictions workers would look like compared to the wages of mainstream counterparts. The information about wages paid to NNDAP workers has been collected over the years through numerous surveys and needs assessments, both national and provincial.[76] Information about provincial wage rates has been collected using a variety of means: searches of provincial job bank databases for wages of Family, Marriage and Other Related Counsellors – National Occupation Code (NOC) Code 4153 which includes addictions workers; reviews of collective agreements for addictions workers; and searches of job advertisements for addictions workers.

These analyses include (but are not necessarily limited to) the following documents:

- A Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce conducted for NNAPF, now known as the Thunderbird Partnership Foundation - October 2007
- A Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager – Updated to January 10, 2013 - NNAPF
- Investing in NNADAP, Ontario Regional Addictions Partnership Committee (ORAPC), Chiefs of Ontario – February 2015
- Investing in NNADAP, Rationale and Case Example – Ngwaagan Gamig Treatment Centre Analysis
- NNADAP Resourcing and Wage Parity, ORAPC – May 31, 2016

76 Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager, January 10, 2013

In Ontario Region, specifically, it is clear that lack of wage parity continues to be a problem. Reports already cited, which include data from Ontario, raise these concerns[77], as do reports specific to Ontario. For instance, in 2009 an Ontario Region First Nations Addictions Service Needs Assessment noted that lack of wage parity contributes to staff turnover.[78] Additionally, in Ontario, the rates of certification are increasing, and the majority of addiction workers have a college or university degree (76% in a 2007 ORAPC survey of workers), but turnover remains an ongoing challenge.[79]

Data used to calculate at what level wages for Ontario Region NNADAP addictions counsellors would have to be to achieve parity with the wages of mainstream workers include the following:

1) In 2015, the average wage for a NNADAP addictions worker in Ontario was estimated by ORAPC at $35,000.50, with a range observed based on experience and training from $20,001 to $50,000. [80]

2) In 2010 (last revised in January 2013) a Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager (see above) reviewed salaries for NNADAP and non-NNADAP mainstream addictions workers in several provinces and proposed the following wage range for NNADAP addictions counsellors for 2009: $35,437 - $47,130. Updated to 2016, with a 2% annual increase, the range would now be **$40,705 to $54,138, with an average of $47,422**. [81]

3) In 2014, a lobby package for ORAPC estimated that the salary range for a mainstream addictions worker, based on Ontario public service employee union wage range for an uncertified addictions c ounsellor, would be $47,892 - $55,048.50, which when used to calculate wage parity for NNADAP workers, would amount to **$48,827 to $57,272** for 2016 (including a 2% annual increase), with the average wage being **$53,050**.[82]

4) In 2015, ORAPC proposed a salary range to the Chiefs of Ontario for 2014 (updated from 2009 and based on a comparison of job descriptions to similar off-reserve job descriptions and wage levels) of $41,081 to $54,637. With a 2% annual increase, the 2016 range would be **$42,741 - $56,875,** for an average of **$49,808**.[83]

5) In 2016, based on data from the Ontario Region, a range of **$40,286 - $59,467** was recommended, and the average would be **$49,877** (not including workers with no certification).[84]

6) ORAPC recommended average salary (May 2016) of **$58,625**.[85]

7) A salary and remuneration grid developed for a youth Treatment centre in 2015. Brought up to 2016 with a 2% increase, this gives a range of **$44,552 to $53,243**, with an average of **$48,897.** [86]

77 NNAPF (October 2007) Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce; Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager, January 20, 2013; Investing in NNADAP, Ontario Regional Addictions Partnership Committee (ORAPC), Chiefs of Ontario – February 2015; Investing in NNADAP, Rationale and Case Example, Ngwaagan Gamig Treatment Centre Analysis; NNADAP Resourcing and Wage Parity, ORAPC, May 31, 2016

78 Ontario Region FN Addictions Service Needs Assessment, Final Report, (June 2009), Williams Consulting.

79 ORAPC Addiction Counsellors Survey (2007). Preliminary results.

80 Final 2015 Ontario NNADAP Workforce Survey Results, ORAPC, approved March 2016.

81 Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager, January 20, 2013

82 Investing in NNADAP Draft Rationale and Case Example, 2014

83 Investing in NNADAP, Ontario Regional Addictions Partnership Committee (ORAPC), Chiefs of Ontario – February 2015

84 NNADAP Resourcing and Wage Parity, ORAPC, May 31, 2016

85 Ibid

86 Salary and Remuneration Grid for a Youth Treatment Centre (2015)

1.4 COST ESTIMATES TO ACHIEVE WAGE PARITY FOR ADDICTION COUNSELORS IN ONTARIO REGION

In an attempt to identify if the above numbers are representative of what fair and equitable wages would look like now for NNADAP addictions workers in the Ontario Region, we have compared data on mainstream salaries to NNADAP addictions counsellors salaries.

8) **Example 1:** A set of calculations is shown below in Grid 1, based on the salary range for Ontario Region for the NOC code 4153 in 2013 (which includes addictions workers) and as found online at: https://www.jobbank.gc.ca/marketreport/wages-occupation/2265/22437 The salary per hour ranges from $15.15 to $36.40, with a median rate of $25.00. The grid assumes 2080 hours of work annually.

Grid 1: NOC Code 4153 Ontario: Family, Marriage and Related Counsellors (updated to 2015)

Counsellor Classification/ requirements	Baseline Salary (2013)	Baseline Salary updated to 2016 (2% annual increase)
Level 1 – Low End	$31,512	$33,441
Level 2 – Median	$52,000	$55,183
Level 3 – Top End	$75,712	$80,346
Average		$56,323

http://noc.esdc.gc.ca/English/noc/QuickSearch.aspx?ver=11&val65=4153

9) **Example 2:** The author located a recent collective agreement between the Canadian Union of Public Employees and Durham Mental Health Services, expiring in 2019, at the following site: http://www.sdc.gov.on.ca/sites/mol/drs/ca/Pages/default_en.aspx. As of April 1,2016, the hourly rate of an Aboriginal Mental Health and Addictions Outreach Worker ranged from $25.62 to $26.39. At 2080 hours per year, the salary range would be **$53,289.60 to $54,891.20**, with an average of **$54,090.40**. Of additional interest is the salary paid to a Peer Support Specialist which is a position presumably requiring less formal training. The hourly rate for this job is $25.28 to $25.68, giving an annual salary range of **$52,582.40 to $53,414.40**.

10) **Example 3:** Another collective agreement was accessed through the link above between the Canadian Union of Public Employees and Community Addictions and Mental Health Services of Haldimand-Norfolk for the period April 1, 2012 to March 31, 2015, with the last salary grid effective to October 1, 2014. The position is called Addictions Counsellor. The salary rises in increments over a five-year period. Converting the hourly rate to a salary at 2080 hours per year and bringing the wage range forward to 2016 with an annual increase of 2% gives a range of: **$50,141 to $62,671**, with an average of **$56,406**.

11) **Example 4:** ORAPC previously located a 2012 wage grid for addictions workers under the OPSEU Institutional and Health Care Bargaining Unit. The wage range at that time was $47,736 to $57,304. Brought forward to 2016 at a 2% annual increase, the range would be **$51,671 to $62,027** with an average of **$56,849**.[87]

87 Ontario NNADAP Funding Issues and Worker Retention Incentives. (October 2013) Ontario Regional Addictions Partnership Committee

12) **Example 5:** The Canadian Executive Council on Addictions has provided figures for salaries for comparable positions in Prince Edward Island. The ranges and average salaries for each are **$42,307 to $43,908 – average $43,107.50**.[88]

13) **Example 6:** The Canadian Executive Council on Addictions has provided figures for salaries for comparable positions in Cape Breton, Nova Scotia. The ranges and average salaries are **52,978 to $64,938 – average $58,958**.[89]

All of these figures (numbers 1 through 13) are set out in Table 1, below.

88 Canadian Executive Council on Addictions Salaries for Addiction Workers, provided by the Thunderbird Foundation October 2016.

89 Ibid

Table 1: Comparison of Proposed and Actual Wage Ranges for Addictions workers, Updated to 2016

DESCRIPTION *Note: Salaries do not include benefits and totals have been rounded off. Wages estimated based on a 40 hour work week.	2. WAGE RANGE	3. AVERAGE ANNUAL SALARY
1. ORAPC current wage range for NNADAP Addictions Counsellors	$20,001 - $50,000	$35,000
Comparators		
Proposed salaries related to NNADAP Renewal Assessments		
2. Proposed wage range for NNADAP Addictions Counsellors from Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager	$40,705 - $54,138	$47,422
3. ORAPC lobby package estimating the salary range for a mainstream addictions worker, based on Ontario Public Service Employee Union Wage Range for an Uncertified Addictions Counsellor	$48,827 - $57,272	$53,050
4. ORAPC proposed salary range for NNADAP Addictions Counsellors based on a comparison of job descriptions to similar off-reserve job descriptions and wage levels	$42,741 - $56,875	$49,808
5. ORAPC proposed NNADAP addictions worker salary range using 2016 Ontario data	$40,286 - $59,467	$49,877
6. ORAPC proposed average addiction worker salary as of May 2016		$58,625
7. Youth Treatment Centre salary grid	$44,552 - $53,243	$48,897
Summary of Proposed Salaries for NNADAP		
Average proposed salary range (averages of figures in rows 2 to 7, column 2)	$40,286 - $59,467	
Average overall proposed salary (average of figures in rows 2 to 7, column 3)		$51,280
Mainstream Wage Comparisons		
8. NOC Code 4153 Ontario: Family, Marriage and Related Counsellors (example 1, page 22)	$33,441 - $80,346	$56,893.50
9. Collective agreement between the Canadian Union of Public Employees (CUPE) and Durham Mental Health Services: Aboriginal Mental Health and Addictions Outreach Worker (example 2, page 22)	$53,290 -$54,891,	$54,090
10. Collective agreement between CUPE and Community Addictions and Mental Health Services of Haldimand-Norfolk: Addiction Counsellor (example 3, page 22)	$50,141 - $62,671	$56,406
11. OPSEU Institutional and Health Care Bargaining Unit (2012) updated by 2% to 2016 (example 4, page 22)	$51,671 - $62,027	$56,849
12. Canadian Executive Council on Addictions: Addictions workers in PEI	$42,307 - $43,908	$43,107.50
13. Canadian Executive Council on Addictions: Addictions workers in Cape Breton, Nova Scotia	$52,978 -$64,938	$58,958
Summary of Mainstream Wage Comparisons		
14. Mainstream annual salary range (from averaging the figures 8 to 13, column 2)	$47,471 - $61,463.50	
15. Average annual mainstream salary (averaging of each salary in rows 8 to 13, column 3)		$54,384

It should be noted that some of the salary ranges discussed, e.g., those taken from collective agreements, go up in increments related to years of service, not necessarily levels of training and certification. Because those same positions are unionized, they may pay more than similar, non-unionized positions. In addition, the 2% annual increase used to update wages to 2016 where required is based on wage forecasting by the federal government for 2016, which falls between 1.8% and 2.1%.[90] Nonetheless, they do represent a relevant and comparable range of pay scales for addiction worker positions. Table 2, below, summarizes the findings from the analysis.

As shown in Table 2, the summary of the results from the various data sources indicates that an annual average salary for a NNADAP addictions counsellor, to achieve wage parity with mainstream counsellors, would be approximately $56,894. This suggests that many of the salaries previously proposed by NNADAP and other relevant analyses to achieve wage parity may have been low. However, the average annual mainstream salary is fairly close to the most recent figure proposed by ORAPC which is $58,625 (Table 1, Row 5 & Appendix A). This appears to be a reasonable figure in view of the fact that all addictions workers, both mainstream and Indigenous, tend to be under-paid as noted previously,[91] and that the scope of practice of NNADAP addictions counsellors has expanded significantly to meet existing and emerging needs, both in the community and at treatment centres, and treatment outcomes have improved accordingly.[92]

90 Government of Canada, Wage Forecasting for Collective Bargaining in 2016 http://www.labour.gc.ca/eng/resources/info/publications/collective_bargaining/wage_forecast.shtml

91 Ogborne A. and Graves G. (2005) Optimizing Canada's Addiction Treatment Workforce: Results of a National Survey of Service Providers, Canadian Centre on Substance Abuse, pg. 2.; NNAPF (October 2007) Review of Aboriginal, Provincial, Federal and International responses concerning Wage Parity / Salary Scales pertaining to the Addictions Workforce.

92 Ontario NNADAP Funding Issues and Worker Retention Incentives. (October 2013) Ontario Regional Addictions Partnership Committee

Table 2: Summary: Salaries for Addictions Workers: NNADAP (Proposed) and Mainstream (Actual)

	Salary Range	Average Proposed Salary		Salary Range	Average Annual Salary
NNADAP Proposed Average Salaries: from NNADAP Renewal Work on Wage Parity (Table 1, pg. 33)	**$40,286 –$59,647**	**$51,280**	**Mainstream Actual Average Salaries (Table 2, pg. 23)**	**$33,441 - $80,346**	**$56,894**

1.5 WAGE PARITY ANALYSIS FOR OTHER NNADAP STAFF POSITIONS

In addition to addictions counsellors, a number of other staff are employed by NNADAP/NYSAP including but not limited to program managers/ supervisors, case managers and administrative staff, and within treatment centres including executive directors , program coordinators, support counsellors, intake workers, attendants, cooks, maintenance staff and bookkeepers. Wage parity with mainstream counterparts has been raised as an issue for these staff also and given the findings from the analysis of addictions workers' wages, it is reasonable to assume that wage parity is indeed an issue for other staff.

Although there has not been as much wage parity analysis done for these staff positions compared with that done for addictions workers, some work in this area has been completed. For

example, ORAPC produced a document in May 2016 outlining proposed salaries for all of these positions to bring NNADAP wages up to par with mainstream wages using job advertisements to estimate salaries for mainstream positions.[93] An analysis of the costs for various positions at a youth treatment centre in Western Canada was also completed, which can be used for comparative purposes (the estimates were brought forward from 2015 to 2016 at a 2% increment).[94] We also found two recent collective agreements that address four of the job categories referenced above.

Table 3: Comparison of Proposed and Actual Salaries for Other Positions (2016)

Job Title	Source	Wage Range *Based on a 40 hour work week	Proposed and Actual Average Annual Salaries
Executive Director/ Treatment Centre Director	ORAPC		$92,000 (proposed)
	Youth Treatment Centre	$87,975 to $114,604 (proposed)	$101,209.50 (proposed)
Administrative Assistant	ORAPC		$45,000 (proposed)
	Youth Treatment Centre	$23,338 to $37,537 (proposed)	$30,407.50 (proposed)
	CUPE and Durham Mental Health Services Collective Agreement	$43,680 to $48,755 (actual)	$46,217 (actual)
	CUPE and CMHA Ottawa Carleton Collective Agreement	$50,690 to $52,520 (actual)	$51,605 (actual)
Case Manager/System Navigator	ORAPC		$53,000 (proposed)
	CUPE and CMHA Ottawa Carleton Collective Agreement	$68,869 to $75,795 (actual)	$72,332 (actual)
Maintenance Worker	ORAPC		$36,230 (proposed)
	Youth Treatment Centre	$37,450 to $44,861 (proposed)	$41,155.50 (proposed)
	CUPE and Durham Mental Health Services Collective Agreement	$42,224 to $43,389 (actual)	$42,806 (actual)
Cook	ORAPC		$36,230 (proposed)
	Youth Treatment Centre	$35,362 to $42,273 (proposed)	$38,871.50 (proposed)
Night attendant	ORAPC		
	CUPE and Durham Mental Health Services Collective Agreement	$35,196 to $37,461 (actual	$34,756 (proposed) $36,328 (actual)

It should be noted that the wages from the collective agreements represent unionized positions which may pay more than non-unionized. In addition, one of the cost estimates for the Youth Treatment Centre – for the administrative assistant position – is low compared to the other sources. Overall however, the range of wages presented in Table 3 indicates that ORAPC's proposed salaries are comparable and reasonable to actual and proposed salaries for similar staff positions.

1.6 EMPLOYEE **BENEFITS**

Direct benefits are optional, non-wage compensation provided to employees in addition to their normal wages or salaries. There are many intrinsic advantages to providing employees with a comprehensive benefit plan. For most, it is the ability to find and keep highly qualified staff that is the key driver.[96] It should be noted that smaller businesses, with fewer employees, pay significantly more per capita than larger employers. This is because lower insurer expense loads and the ability of larger employers to assume greater risk reduce insurer risk charges. [97]

According to a report commissioned by the Ontario Chamber of Commerce in 2011, benefits on average were 34.6% of cost as a percentage of pay in 2007.[98] Employer sponsored plans represented 23.6% of this total, as shown below, while statutory costs, for which First Nations are exempt (Worker's Compensation, Employment Insurance, Canada Pension Plan and Provincial Medicare) represented 11%.

Benefits Covered Through Employer Sponsored Plans

- Life, health, dental and short and long-term disability insurance – 11%
- Savings, pension, bonus and profit sharing – 12.6%

The same report makes the following cost projections for anticipated changes to annual premiums over time (based on demographic changes and low investment returns):

- life insurance increase of 3%
- long-term disability increase of 6%
- non-drug health increase of 5% (applies to 20% of total health costs)
- drug increase of 15% (applies to 80% of total health costs)
- dental increase of 5%.

Based on this information, the direct benefit cost proposed by ORAPC of 18% of gross payroll, is entirely reasonable and may in fact be low. [99]

96 http://hrcouncil.ca/hr-toolkit/direct-benefits.cfm

97 Cost Trends in Health Benefits for Ontario Businesses: Analysis for Discussion. Commissioned 97 by the Ontario Chamber of Commerce for release at the Ontario Economic Summit, 2011. http://www.occ.ca/Publications/Cost-Trends-in-Health-Benefits-Report.pdf

98 Ibid

99 NNADAP Resourcing and Wage Parity, ORAPC, May 31, 2016

1.7 SUMMARY

Overall, this analysis suggests that the wages and benefits proposed by ORAPC for NNADAP workers to achieve wage parity in Ontario Region are reasonable. (Appendix A contains the wage parity budgets prepared by ORAPC in 2016). The wage parity budgets include proposed wage enhancements for existing staff (both community-based and treatment centre staff). There are also estimated costs for new required health human resources to implement the full continuum of services outlined in Honouring Our Strengths. Table 4 (pg 27), shows cost estimates for wage parity, for existing and additional new required human resources.

OVERALL, THIS ANALYSIS SUGGESTS THAT THE WAGES AND BENEFITS PROPOSED BY ORAPC FOR NNADAP WORKERS TO **ACHIEVE WAGE PARITY IN ONTARIO REGION ARE REASONABLE.**

Table 4: Summary of Estimated Wage Parity Costs (ORAPC Budgets, 2016, Appendix A)NNADAP

Note: These estimates do not include program, operating, capital or administrative costs.

Wage Parity	Cost Estimate
Wage parity costs for existing staff	
1. Community-based wage parity for existing workers only (counsellors, managers and admin staff) including benefits	**$4,582,318** (see Note 1)
2.Treatment centre wage parity for existing workers only, including benefits	**$1,554,003** (see Note 2)
Wage parity costs for new required HR	
3.Community-based wage parity with additional required Human Resources (counsellors, managers, outreach workers, intake staff, admin staff, etc.) including benefits	**$26,133,521** (see Note 3)
4.Treatment ctentre wage parity with additional requiredt Human Resources including benefits	**$3,020,116** (see Note 4)
Total cost for wage parity for new required staff	**$29,153,637**
TOTAL WAGE PARITY COSTS (EXISTING AND NEW REQUIRED STAFF)	**$35,289,958**

Note 1: The above figures are estimates based on First Nation on-reserve population figures; and the number of NNADAP workers, managers/coordinators hired in each First Nation. The cost for wage parity was calculated by subtracting the actual costs for existing staff at the community level – counsellors, managers and administrative staff ($6,838,100) – Appendix A, Budget 1 – from the estimated costs to achieve wage parity for the same staff ($11,420,418) – Appendix A, Budget 2 – resulting in the figure **$4,582,318.**

Note 2: The current cost for existing staff at treatment centres has been estimated based on costs provided by three centres at $1,151,639. Divided by three, this results in an average cost per centre of $383,879 (Appendix A – Budget 4). Multiplied by 11 centres, this gives a total estimated actual staffing cost of $4,222,669. Costs have also been calculated by ORAPC to achieve wage parity for existing staff for three residential centres (Appendix A, Budget 5) at $1,575,456, at an average cost of $525,152 per centre, and for a total of $5,776,672 for 11 centres. Subtracting the actual estimated cost for existing staff ($4,222,669) from the estimated cost to achieve wage parity for the same staff ($5,776,672) results in a total estimated investment of **$1,554,003** to implement wage parity for existing staff.

Note 3: The estimate was made by taking the salary and benefit costs estimated to achieve wage parity for existing and additional required HR at the community level ($37,553,939) – Appendix A, Budget 3 – and subtracting the cost estimated to achieve wage parity for existing staff ($11,420,418) – Appendix A, Budget 2 – to arrive at the figure of **$26,133,521**.

Note 4: Three treatment centres have calculated the cost for additional workers based on the new staffing required to implement a full continuum of care, at wage parity levels. This would include positions to support accreditation needs, such as managing assessment and outcome data; working with families pre and post treatment; case management functions for care facilitation and care transitions as per Honouring Our Strengths; and outreach for prevention and early intervention work, and continuity of care. The average estimated salary and benefits cost per centre would be $799,708. Multiplied by 11 centres, the total amount required would be $8,796,788 (see Appendix A, Budget 6). Subtracting the estimated costs for wage parity for existing workers, which is $5,776,672 (Appendix A, Budget 5), gives a total required investment of **$3,020,116**

It should be noted that with additional staff, additional office space and equipment would also be required.

2. WORKFORCE **DEVELOPMENT**

2.1 CERTIFICATION

Six Canadian organizations offer certification to substance abuse and allied professionals:

- Canadian Addiction Counsellors Certification Federation (CACCF)
- Canadian Council of Professional Certification (CCPC)
- Canadian Counselling and Psychotherapy Association (CCPA)
- Canadian Society of Addiction Medicine (CSAM)
- Employee Assistance Professionals Association (EAPA)
- Indigenous Certification Board of Canada (ICBOC).

Nationally, the scope of practice of addictions workers has increased and the NNADAP and NYSAP workforce has been pursuing more high-quality education and training leading to certification. By 2013, 54% of all workers across Canada had achieved certification, including 78% of the workers at treatment centres.[100] In Ontario Region, 73% of treatment centre workers were certified and 74% of all NNADAP workers responding to a NNADAP workforce survey in 2014 were eligible for certification, having received some type of post-secondary diploma or degree, and 64% of those who were not certified indicated they were planning to seek certification.[101] [102]

As noted in Honouring Our Strengths, certification provides valuable knowledge and skills training to workers.[103] More addictions counsellors, particularly community-based workers, should be encouraged and supported in acquiring certification. In recognition of this, Health Canada announced a retention initiative for certified NNADAP workers through the National Anti-Drug Strategy funding in May 2008. However, many certified community-based NNADAP workers in Ontario have experienced difficulty receiving their retention incentive from their employer First Nation. More than half received the incentive as a lump sum or as an addition to their salary. Those who did not receive the incentive, report that incentive money went back into programming, was absorbed by the First Nation or was spent on training. In some cases, the worker is unsure where the incentive money went. These situations have created conflict between the employee and their supervisors and/or

100 Health Canada, Certification Information Roll-Up, FY 2013-2014.
101 Ibid
102 2014 Ontario NNADAP Workforce Report, ORAPC, Approved June 10, 2015
103 Honouring Our Strengths, A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.pg. 66.
104 Retaining Ontario NNADAP Workers, ORAPC, November 2013.

leadership over the retention incentive. [104]

This is a systemic challenge for First Nations communities as wages of non-NNADAP community-based staff tend to be low. Chiefs and councils are faced with the difficult situation of paying one type of employee at parity (NNADAP) while others remain at lower rates of pay. However, there are examples where First Nations communities have engaged in a process where they have looked at capacity for managing wages for all staff in a way that has parity, including other compensation strategies. These could be explored further by First Nations communities in a way that honours employees' efforts to increase their knowledge and skills while respecting the rights of the communities as employers to establish salaries for their staff.

2.2 CULTURAL KNOWLEDGE AND SKILLS

Of equal importance to the knowledge and skills gained through formal education (including certification and other forms of post-secondary education) is traditional cultural knowledge drawn from an Indigenous worldview, which is of immense value to First Nations communities struggling with issues of substance abuse.[105] Cultural knowledge and skills should be as recognized, valued and well-compensated as mainstream, Western knowledge and skills,[106] and a growing body of research testifies to the importance and efficacy of cultural approaches to healing.[107] As stated by Thunderbird (NNAPF) in 2013:

> *No different than a Western worldview which recognizes academic levels of knowledge relative to professional standards and affiliation, an Indigenous worldview has equal merit relative to the status and wisdom of Elders and Traditional Healers in Aboriginal communities and treatment settings.* [108]

Implementation opportunities identified in the First Nations Mental Wellness Continuum framework include adding cultural competency to human resources, accreditation and certification standards in order to strengthen access, quality and safety of health services across the continuum of care.[109] In recognition of the importance of culture to addictions work, Thunderbird developed the grid below. It organizes cultural-specific knowledge, skills and/or community rights to cultural practice into a series of levels that relate to other types of education and experience, and which could be converted into a salary grid (Table 5, pg 30).

105 Honouring Our Strengths, A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada. pg. 66

106 Wage Parity Review of NNADAP-NYSAP Addictions Counsellor Level I-III & Case Manager/Program Manager, January 20, 2013

107 Hopkins, C. & Dumont. J. (February 2010). Cultural Healing Practice within National Native Alcohol and Drug Abuse Program/Youth Solvent. Addiction Program Services. Discussion Paper for the Mental Health and Addictions Division, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada

108 Ibid

109 First Nations Mental Wellness Continuum Framework, Implementation Opportunities (July 2014)

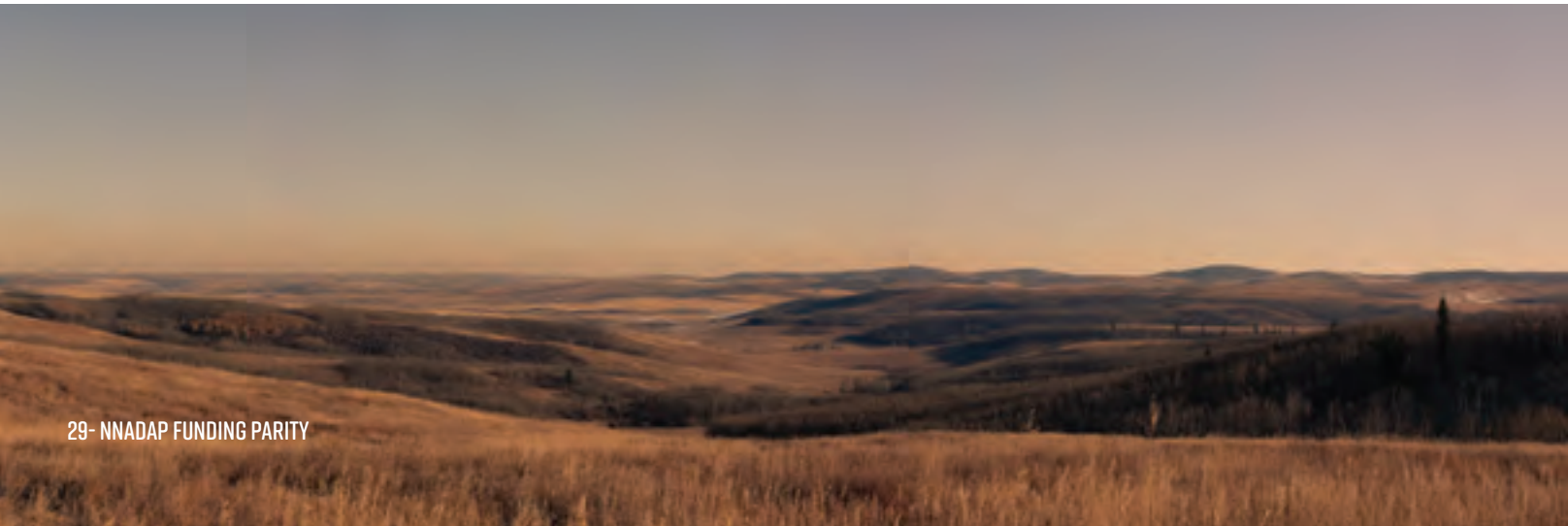


Table 5: Statement of Qualifications

ADDICTIONS COUNSELLOR

LEVEL	**Level I:** Has relevant education (non-certified) and NO previous addictions work-related experience.	**Level II:** Has relevant education, a minimum of 1-year addiction work-related experience is preferred, and NO clinical supervisory responsibilities.	**Level III:** Has relevant education, addictions work-related experience and NO clinical supervisory responsibilities.
EDUCATION	Completion of a minimum two-year relevant diploma or degree, with addictions training.	Completion of a minimum two-year relevant diploma or degree, with addictions training.	Completion of a three or four-year bachelor's degree in Social Work or other addictions/social service-related University program from an accredited post-secondary institution.
CERTIFICATION	Willingness to obtain certification as an addictions counsellor from one of the recognized Canadian Certification bodies (e.g. FNWACC, CACCF, CCPF, etc.), with emphasis on Cultural Competency, within the initial three (3) years of employment.	Certification as an addictions counsellor or specialist from one of the recognized Canadian Certification bodies (e.g. FNWACC, CACCF, CCPC etc.), with emphasis on Cultural Competency.	Certification as an addictions counsellor or specialist from one of the recognized Canadian Certification bodies (e.g. FNWACC, CACCF, CCPC etc.), with emphasis on Cultural Competency.
EXPERIENCE	One to 2 years work experience in good standing (e.g. performance reference check).	Three to five years work experience in good standing (e.g. performance reference check).	Minimum three to five years (5-10 for treatment facility) of work-related experience in good standing (e.g. performance reference check).
CULTURAL KNOWLEDGE/ABILITY	Recognition of cultural-specific knowledge, skills and/or community sanctioned rights to cultural practice.	Recognition of cultural-specific knowledge, skills and/or community sanctioned rights to cultural practice.	Recognition of cultural-specific knowledge, skills and/or community sanctioned rights to cultural practice.

2.3 COMPENSATION FOR TRADITIONAL HEALERS AND CULTURAL PRACTITIONERS

It should also be noted that communities place a high value on traditional healers and cultural practitioners. Many of these may not have formal Western education in the field of addictions, but their important work needs to be acknowledged and recognized and there need to be dedicated resources to build this recognition, including compensation where appropriate.[110] As noted in the First Nations Health Authority's Traditional Healing Framework for BC:

> *Policies that support traditional healers are being explored as a means to ensure that traditional healers are not only acknowledged for their important work but that they are compensated, where appropriate. This may be similar to what exists for mainstream physicians but with a focus on non-traditional compensation such as gifts, honorariums, payment for travel and other methods of having their living needs met. Support in building accreditation for traditional healers has been recognized as a priority for some time. Efforts need to be focused on supporting communities to identify and utilize their healers.*[111]

This issue was also highlighted in the Truth and Reconciliation Commission's Calls to Action, i.e.:

> *22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.*

110 First Nations Health Authority, Traditional Wellness Strategic Framework (2014), British Columbia. http://www.fnha.ca/wellnessContent/Wellness/FNHA_TraditionalWellnessStrategicFramework.pdf

111 Ibid

3. ADDITIONAL **CAPACITY BUILDING** REQUIREMENTS

Additional investments are required to implement a comprehensive continuum of care, including: resources for governance and coordination of systems; program, operating and capital costs; and additional treatment costs related to medical transportation, outpatient services and prescription drug abuse services.

3.1 GOVERNANCE AND **COORDINATION OF SYSTEMS**

As Honouring Our Strengths points out:

> *"Strong governance and coordination among and within systems are vital to developing and maintaining a continuum of care in a First Nations community".*[112]

Also noted:

> *"Community decision makers and leadership have significant roles in reducing substance use issues within a community. Without clearly defining governance structures, the roles can be unclear between a First Nations community governance body and the addictions or mental health service, especially with respect to who is responsible for setting policies and standards"*[113]

A comprehensive model to build and maintain a systems approach is required. This could include establishment of a regional planning body which would help to support within and cross-jurisdictional partnerships and networks, capacity building support to assist with community development planning, mechanisms for knowledge exchange, education and training, mechanisms for collaborative planning, and the coordination of reporting requirements and data systems.

Increased Flexibility in Planning and Programming

Self-government and community control over services and supports are key components of healthy communities.[114] [115] [116] This means that communities themselves must identify their own needs and priorities with regard to the basket of services and supports required, and they must be able to design and deliver programs in a way that addresses their needs and priorities, utilizes their

112 Honouring Our Strengths, A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada. pg. 72.
113 Ibid, pg. 73
114 First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.
115 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
116 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada

cultural knowledge and builds on their strengths. Within communities, programs that function in "silos" can result in a lack of information sharing and coordination. As noted in the First Nations Mental Wellness Continuum framework, there are flexibilities within existing funding structures that would allow for the modification of programs or direct funding to address community priorities, but these are not always well understood. Awareness of the flexibility that is in existence needs to be increased so communities can take advantage of associated opportunities. Greater flexibility at the community level is also required to support implementation of a continuum of care responsive to unique community needs.

There have been increases in local control, flexibility, and increased cultural expression in programs. However, there remains a need for divestment of control over programming to the community level, along with stable, long-term funding for substance abuse programs and services. In some cases, for example, existing funding arrangements are inhibiting local control and ownership over services. As noted in the 2012 Health Canada MHA Cluster Evaluation:

> *Community health directors south of the 60th parallel noted that current funding arrangements permit communities to choose those programs that are appropriate for the community, **but do not sufficiently promote community design of programming** (emphasis added).*

The 2015 PDA Needs Assessment Report concurs, stating that:

> *While there are many examples of proactive community driven program developments, they are chronically underfunded and under-resourced and mostly short term in nature. Therefore, communities are often in a position where they have to draw from other resources and funding envelopes to support and sustain needed treatment and intervention services. Currently, communities are beginning to take ownership over addictions, however the inadequate funding remains a major barrier.*

There are several possible implementation opportunities for enhanced flexible funding: additional funding (e.g., leveraging resources across the continuum through a common investment model); less time-limited and siloed funding (e.g., ensuring strengthened connections among federal funding bodies and between federal and provincial and territorial funding bodies); and flexible funding (e.g., using community wellness plans as a frame to reorient existing resources into clusters and reduce or eliminate silos).[117]

Community development is an important element in building capacity to define, develop,

THERE REMAINS A NEED FOR **DIVESTMENT OF CONTROL OVER PROGRAMMING TO THE COMMUNITY LEVEL,** ALONG WITH STABLE, LONG-TERM FUNDING FOR SUBSTANCE ABUSE PROGRAMS AND SERVICES

117 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada

implement and evaluate required services and supports. Skills that support these activities include building relationships, engaging natural or informal supports within the community, communication, team-building, decision-making, and planning. Community wellness plans are critical tools to help communities to realign their programs and services along a continuum, and some communities will need support and resourcing to develop and implement these plans.

Treatment centres and programs also need access to more funding and more flexible funding models, so that they are able to address changing environments and increasing needs and implement a full continuum of care. As the wage parity analysis earlier in the document demonstrates, staff at Indigenous treatment centres and programs tend to make less than their non-Indigenous counterparts. Similarly, the survey results indicated that Indigenous-led centres and programs appear to receive less funding on average than mainstream centres and programs, as shown in Tables 6 & 7 below.

Table 6: Annual Operating Budgets: Indigenous-led Centres and Programs (N=12)

$1,800,000
$1,800,000
$1,155,577
$920,000
$800,000
$800,000
$800,000 for MH &A
($5,000,000 for entire agency)
$788,464
$600,128
$500,000
$468,424
$200,000

Average: $886,049

Table 7: Annual Operating Budgets: Non Indigenous-led Centres and Programs (N=7)

$3,000,000
$2,769,256
$1,300,000
$1,205,063
$1,000,000+
$465,000
$400,000

Average: $1,448,474

Indigenous-led organizations responding to the survey also identified several areas requiring more need for investments, including infrastructure, human resources, and service-specific needs. The latter include cultural services, family healing, trauma-informed services, and services for those with special needs such as pregnant women, high risk youth and individuals with complex mental health issues. Below is a sample of their comments:

- *Clients are wanting community-based healing, family healing*
- *Clients need family/worker involvement and support*
- *Need for more cultural events and ceremonies*
- *We need addiction medicine supports that are culturally safe*
- *Gap in service reaching high risk youth, pregnant mothers (FASD), need for family and behavioural therapists, dedicated smoking cessation and gambling counsellors*
- *Noting increased needs in trauma informed services for complex MH needs. i.e., PTSD. Need to increase access to Neurological Assessments i.e., FASD/ARND.*

Governance training for health boards and treatment centres would be helpful. This would

include training on good governance practices and work plan development, as well as ways to enhance collaborative relationships among key partners (internally, as well as those that are interdepartmental, inter-jurisdictional, and system wide.)

An additional identified barrier to effective treatment is the lack of flexibility in FNIHB medical transportation policies, which may not allow for access to the right kind of care based on the needs of the client nor support a return to treatment when required, even where there has been a recent attempt at treatment.

Support for Data Management and Meeting Accreditation Standards

In support of good governance and systems coordination, treatment centres and community-based programs need more data management capacity and capacity to meet accreditation standards. This includes Addictions Management Information System (AMIS) capacity development for treatment centres, as Health Canada has seen requests for more training funds, and the realignment of work flow for case management. AMIS presents a unique and incredibly beneficial resource because it is one national database that holds data on addictions, mental health, and mental wellness for First Nations people in Canada. However, to ensure AMIS is consistently used to support data needs to inform decision making, program planning and design, program evaluation and accreditation, users of the system require support in realigning and allocating responsibility across their workflow. Training in case management would support treatment centres in increasing capacity for the use of client assessment and for pursuing the results of the assessment in establishing appropriate client plans of care. Training in the function and use of AMIS would ensure consistent data entry and reporting.

Accreditation assesses addiction treatment centres against national standards of excellence, which measure clinical, operational, and governance-based performance.[118] There are several accrediting bodies in Canada. At this time, one hundred per cent of the nine NNADAP residential treatment centres in Ontario Region have demonstrated their credibility through achieving accreditation, compared to 62% of non-native treatment programs in Canada.[119] The accreditation programs require treatment centres to demonstrate how they comply with standards

118 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.

119 An unpublished report of the Canadian Executive Council on Addictions, 2011.

of excellence by putting forward evidence on the outcomes of services and among other things, for demonstrating client safety. The rate of client completion of treatment has also improved across the trend of changes from 66% in 2005 to 75% by 2012. However, treatment centres need ongoing support to bear the cost of ongoing compliance with accreditation standards, and to incorporate the improvements necessary to maintain the standards and quality of care.

Another significant area that requires support is with developing capacity for risk Management programs. Accreditation results provide feedback on recommendations and each recommendation is assessed for risk. While this process of accreditation provides an assessment of risk, accreditation standards also require service providers, such as treatment centres, to have a risk management program in place to regularly and systematically assess and mitigate risk associated with client services, resource management, and legal and regulatory compliance. While the Thunderbird Partnership Foundation has provided support through sample templates and risk management policies, treatment centres still require support to build their capacity through training to use these resources consistently.

There is also a need for support for knowledge exchange among centres that is specific to accreditation, so that centres can share successes. This could be done through a mechanism to promote accreditation champions and knowledge sharing.

3.2 **PROGRAM, OPERATING** AND **CAPITAL** (MAJOR /MINOR) COSTS

Program and Operating Costs

It is important to note that the small increases to annualized funding for treatment centres have not matched the increases in facility operating costs required to meet the needs. For example, the costs of food, utilities, telecommunications, audits, health and safety requirements, and IT have risen much more than two percent and have been estimated at approximately 23 percent per year for treatment centres.[120] For some, these costs are even higher. For example, Appendix B, Budget 1, shows that operating costs have increased by more than 50% of revenues since 1992. This means that funding for treatment has been reduced.

Adequate program and operating costs at both the community and treatment centre levels are required to ensure that treatment is prioritized and not eroded by ever increasing operating costs. Additional community based treatment services, which are often located within community health centres, will have everyday capital needs addressed through FNIHB budgets for community health. However, not all community based substance use and mental health / well-

AS NNADAP HAS EXPANDED TO OFFER DAY PATIENT AND MORE FOCUSED OUT-PATIENT SERVICES OR EARLY INTERVENTION PROGRAMS, THERE ARE **INCREASING CHALLENGES IN LOCATING SPACE FOR SUCH SERVICES** WITHIN EXISTING COMMUNITY INFRASTRUCTURE.

120 Multi-Year Budget Analysis by Executive Director of Ngwaagan Gamig Recovery Centre

ness services are housed within community health centres/ buildings. As NNADAP has expanded to offer day patient and more focused out-patient services or early intervention programs, there are increasing challenges in locating space for such services within existing community infrastructure.

Table 8, below, shows estimates for program/operating costs, based on the various proposed budgets reviewed.

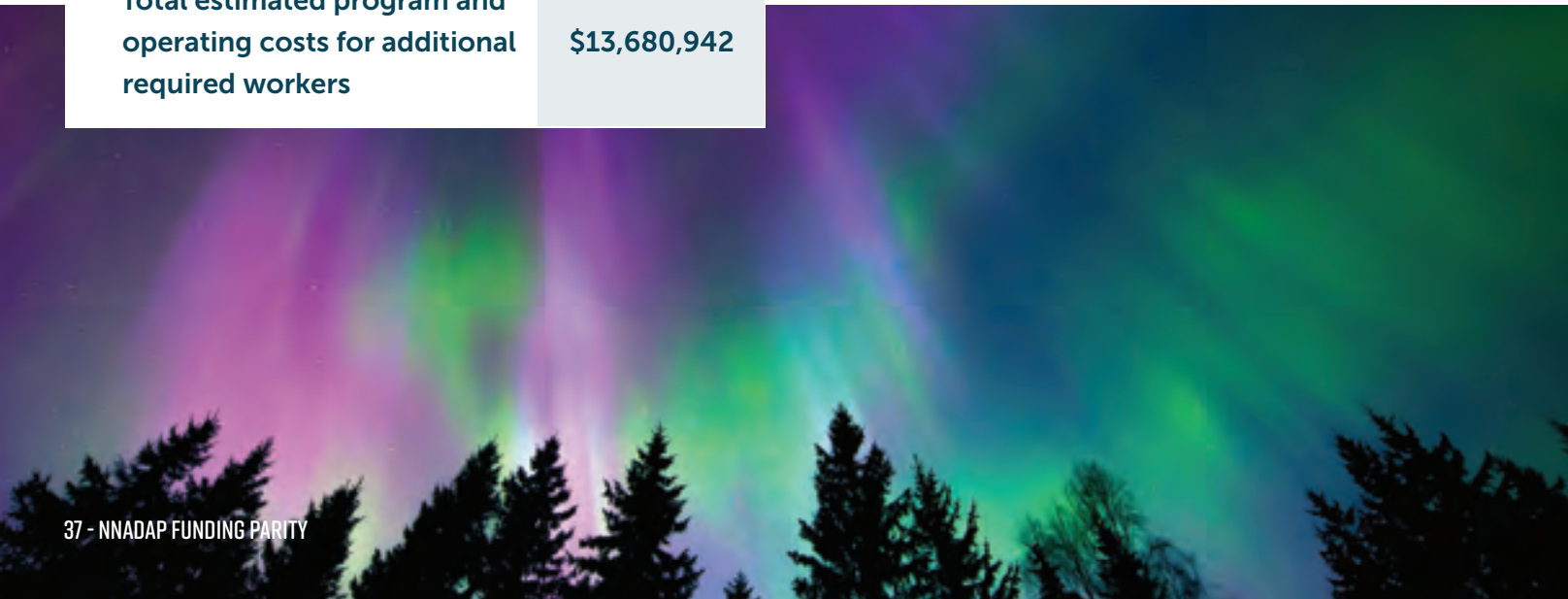
Table 8: Estimated Required Program and Operating Costs for NNADAP community-based services in Ontario Region

	Estimated Cost
1. Community based: Estimated program/operating costs with wage parity for existing workers only	*$1,359,162 (see Note 1)*
2. Community based: Estimated program/operating costs with wage parity for additional required workers	*$7,751,468 (see Note 2)*
3. Treatment Centres: Estimated program/operating costs with wage parity for existing and additional required workers	*$4,570,312 (see Note 3)*
Total estimated program and operating costs for additional required workers	**$13,680,942**

Note 1: Current program and operating costs at the community level have been estimated at $2,028,250 – Appendix A, Budget 1. Program and operating costs at the community level, for wage parity for existing workers, were estimated by ORAPC at $3,387,412 – Appendix A, Budget 2. Subtracting the current costs from the additional program and operating costs required for wage parity gives a figure of ***$1,359,162*** *for the program and operating costs required to implement wage parity for existing staff.*

Note 2: The estimate was made by taking the estimated program and operating costs at the community level for wage parity for existing and new required HR ($11,138,880) – Appendix A, Budget 3 – and subtracting the program and operating costs associated with wage parity for existing staff only ($3,387,412) – Appendix A, Budget 2 – to arrive at the figure of ***$7,751,468*** *required for new required HR.*

Note 3: Treatment centres receive $9,724,069 in total NNADAP/NYSAP/NADS funding annually in Ontario region. It has been estimated that approximately 47% in additional funding would be required for program and operating costs to support the increase for wage parity levels and additional staff hired to implement Honouring Our Strengths – see Appendix B, Budget 2. This would amount to ***$4,570,312*** *annually. This is an approximation of what is required, and more work is needed to finalize this figure.*



Capital Resources for Traditional Healing Approaches

Traditional healing approaches need to be fully integrated into the continuum of care, including screening, assessment, treatment and outcome measures. Cultural programming has and is being implemented to a greater degree at treatment centres and at the community level (e.g. land-based programming) and funding for cultural resources needs to be provided to support this, including capital investments to adequately resource a full range of culturally-based healing approaches.

A specific emerging need is capital resources, both major and minor, to accommodate *land-based* programs. Some of the national Mental Wellness Teams[121] and community-based prescription drug abuse programs[122] [123] rely on culture and land-based environments for delivery of services. These environments range from permanent camps with a number of buildings that accommodate cooking, meeting space, sleeping cabins while others include make shift camps that use tents or tee-pees. A common element of the land-based camps is minor capital equipment needed to access land outside of First Nations communities such as boats/boat motors, snowmachines, all-terrain vehicles, chain saws, canoes, tee-pee tarps, hunting equipment, food storage, etc. Thunderbird Partnership Foundation has a study underway to explore a First Nations Service Delivery Model for Land Based programs that will include a review of costs associated with setting up and operating such service delivery environments as land-based camps.

Capital Costs for Facility Improvements

With regard to treatment centres, as shown below in Table 9, most of the nine NNADAP/-NYSAP residential centres were built in the late 1980s or early 1990s. Of those, only one has had a facility condition report in the last decade. Two centres have provided recent building inspection reports (2015). Both of these showed issues with the condition of the buildings which require capital investments to mitigate. The information to do a complete analysis of capital costs was not available at the time this report was being developed, but these needs should be further investigated and addressed.

121 First Nations Mental Wellness: Mobilizing Change through Partnership and Collaboration (2015). Brenda M. Restoule and Carol Hopkins Thunderbird Partnership Foundation, Jennifer Robinson Assembly of First Nations, Patricia K. Wieb Health Canada. Canadian Journal of Community Mental Health, vol. 34, no. 4.

122 Kanate et al (February 2015) Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence: Evaluating outpatient buprenorphine-naloxone substitution therapy in the context of a First Nations healing program. Canadian Family Physician. 61.

123 Prescription Drug Abuse Strategy: Take A Stand. (2010). Chiefs of Ontario

Table 9: NNADAP/NYSAP Ontario Region Facilities and Facility Condition Reports

Treatment Centre	Address	Program Type	Year Built	Last Facility Condition Report
Reverend Tommy Beardy Memorial	PO Box 131 Muskrat Dam ON P0V 3B0	Family	1991	2000
Native Horizons Treatment Centre	130 New Credit Road Hagersville, ON N0A 1H0	Alcohol and Drug 18+ and Summer Family Intakes	1988	2013
Sagashtawao Healing Lodge	PO Box 99 Moosonee, ON P0L 1Y0	Alcohol and Drug 18+ and Family Intakes	1991	2000
Benbowopka Substance Abuse Treatment Centre	Box 568 Blind River, ON P0R 1B0	Alcohol and Drug 18+	1990 with some original structures dating to 1926	2005
Dilico Anishnabek Treatment Centre	200 Anemki Place FWFN Thunder Bay ON P7J 1L6	Alcohol and Drug 18+	1989	2005
Migisi Alcohol and Drug Abuse Treatment Centre	PO Box 1340 Kenora, ON P9N 3X7	Alcohol and Drug 19+	1989	2000
Ngwaagan Gamig Recovery Centre Inc.	PO Box 81 56 Pitawanakwat St Wikwemikong ON P0P 2J0	Alcohol and Drug 18+	1991	2001
Ka-Na-Chi-Hih Solvent Abuse Treatment Centre	1700 Dease Street Thunder Bay, ON P7C 5H4	Solvent 16-25 years		
Nimkee Nupi Gawagan Healing Centre	RR1 Muncey, ON N0L 1Y0	Solvent 12-17 years		FN workplan requested $ for FCR, approved; work underway

3.3 PRESCRIPTION DRUG ABUSE, NON-PRESCRIPTION OPIOID ABUSE AND CANNABIS ABUSE SERVICES

A full and adequately funded continuum of services would include increased funding to support the needs of people affected by prescription drug abuse (PDA), non-prescription opioid abuse and cannabis abuse. Sufficient long-term funding is needed to support access to community-based treatment programs (e.g. opioid substitution therapy with methadone or Suboxone, land-based treatment and other cultural treatments), harm reduction approaches, nursing, and capital and program resources. Such programs are showing good outcomes, as are supports for women who have given birth and their infants, and who are affected by opioids. Treatment centres also need enhanced capacity to accept clients who are using methadone or Suboxone.

Among Indigenous-led centres and programs which responded to the survey and who indicated they have some restrictions on program entry, a significant number do not accept clients on methadone (46%) and to a lesser degree, Suboxone (31%). Also, four (31%)

are generally unable to accept pregnant women or pregnant women past the first trimester, although one will sometimes accept pregnant women on a case by case basis. With regard to residential services, specifically, of the 11 Indigenous-led treatment centres/healing lodges which reported restrictions on accepting clients, one cannot serve clients on methadone, one cannot serve clients on methadone except for pregnant women, two are unable to serve clients on either Suboxone or methadone, and two are able to serve clients on Suboxone but not on methadone. Two do not serve pregnant women at all, and one can only serve pregnant women up to the fourth month of pregnancy. These are findings of concern. Within the context of the current opioid crisis, capacity building in this area should be considered a priority.

There have been several research studies conducted on best practices for managing PDA, including studies that show better outcomes for infants of pregnant women treated with buprenorphine and naloxone, as opposed to methadone, [124] [125] and significant improvements in community wellness in a remote First Nation following a comprehensive approach including a combination of intensive addictions counselling, First Nations healing strategies, and substitution therapy with buprenorphine-naloxone. [126]

There is also a growing interest in implementing comprehensive and culturally-based harm reduction strategies. A recent overview of relevant research literature explored Indigenous harm reduction strategies in residential treatment programming that address opioid and cannabis usage.[127] One of the key findings was the need to integrate best practices, noting that *"culture-based practices are a priority, but also are the integration of Western and Traditional practices. Integrative and innovative practice are the way forward."*

Successful strategies will take the following components into consideration:

1. Services address complexities in accessing services (e.g., stigma, the effects of trauma, lateral violence, barriers to access, mistrust of health services)
2. Services engage treatment centres in conversations about their constraints (e.g., stigma, the need for training and other capacity building to treat clients on Suboxone or methadone and/or pregnant women, the prohibition approach adopted by many communities, funding constraints)
3. Treatment options are carefully analyzed supporting the whole-person to direct the approach
4. Beyond Recovery: Healing for Indigenous People (e.g., embracing of Indigenous knowledges and teachings, restoring of Indigenous identities and recognition of strengths and cultural pride)
5. Culturally informed and flexible family-based treatment
6. Government support and policy adoption of rapid scale-up techniques (e.g. through inter-ministerial cooperation and collaboration regarding program funding and implementation)
7. Exploration of innovative balanced with cost effective treatment methods.

124 Wiegand et al. (2015). Methadone vs Maternal Buprenorphine and Naloxone. Obstetrics and Gynecology. 125:2

125 Dooley et al (April 2016) Buprenorphine-naloxone use in pregnancy for treatment of opioid dependence Retrospective cohort study of 30 patients. Canadian Family Physician. 62

126 Kanate et al (February 2015) Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence: Evaluating outpatient buprenorphine-naloxone substitution therapy in the context of a First Nations healing program. Canadian Family Physician. 61.

It is important to note PDA funding is currently proposal driven and not meeting the demands of communities. Treatment centres include services for those affected by prescription drug abuse. Community based treatment, including but not limited to land-based treatment is needed for PDA. Additional resources, including capital and minor capital will also be needed to support this.

The Thunderbird Partnership Foundation has prepared a detailed plan for managing PDA, including a number of priority areas for action (Appendix E).[128] It has also developed a plan and budget for community wellness through culture and community-based treatment (Appendix F), and a community-based Suboxone treatment model, inclusive of a budget (Appendix G). These three documents represent useful resources for planning and program development in the context of the opioid crisis and the challenges inherent to the pending legalization of cannabis.

128 Hopkins, C., Katt, M.., Cirone, S. & Chase, C. Thunderbird Partnership Foundation: Priorities for PDACC

4. SUMMARY OF **IMMEDIATE INVESTMENTS REQUIRED FOR CAPACITY BUILDING**

Table 8, below, summarizes the estimated annualized cost for capacity building for NNADAP in Ontario Region, inclusive of wage parity for existing staff, additional required staff at wage parity, programming and operating costs and allocated administration costs.

Table 8: Summary of Estimated Costs for Capacity Building in Ontario Region

Cost to implement wage parity for existing staff	Costs to hire new required staff at wage parity levels	Program/operating costs with existing and required new staff at wage parity	Sub-total	Admin costs at 10%	TOTAL ESTIMATED ANNUAL COST
$6,136,321	$29,153,637	$13,680,942	$48,970,900	$4,897,090	$53,867,990

Note: Figures have been rounded off. Also, the following additional investment needs have not been included in the estimated costs above.

- *Capital investment needs, which have yet to be assessed*
- *Costs required to enhance governance and coordination of systems*
- *Costs for cultural resources, including for Elders/cultural healers*
- *Specific costs for capacity building for data management and for meeting accreditation requirements over and above hiring additional staff*
- *Costs for treating prescription drug abuse at the community and treatment centre levels over and above hiring additional staff*
- *Costs for additional medical transportation services and for outpatient treatment at treatment centres and at the community level.*
- *Costs for additional equipment, furniture, etc. related to new staffing models.*

5. **RECOMMENDATIONS** OF THE JOINT TECHNICAL WORKING GROUP

As per the Statement of Work for this project, an analysis and review of documentation has been done to support the recommendations below, to provide policy and program direction to leadership at AFN, COO, and FNIHB. It is beyond the scope of this project to identify all relevant and required costs but those which have been supported by the document review are provided below. There are additional gaps that have been identified during the course of this work: many of these are described in the following section of the report and recommendations have been developed in relation to them for future consideration.

Note: Recommendations aligned with specific Truth and Reconciliation Calls to Action are denoted with an orange feather icon.

WAGE PARITY AND WORKFORCE DEVELOPMENT

1. That the amount proposed for wage parity for existing NNADAP/NYSAP staff be accepted and implemented.
2. That the amount proposed to recruit new required human resources to implement a full continuum of care at wage parity levels be accepted.
3. That the retention incentives be maintained as recognition of added credentials of certified staff.
4. That regional needs continue to define priorities for ongoing training of the NNDAP/NYSAP workforce and a committed budget be established to ensure capacity is maintained.

PROGRAM AND **OPERATING COSTS**

5. That community-based and treatment centre budgets be increased as outlined in the document to cover required program and operating costs.

CULTURALLY-BASED TREATMENT

6. That the costs to fully implement culturally-based treatment at the treatment centre and community-based level be assessed and implemented as a key element in transformative change and implementation of the wellness continuum.

7. Further to the above, that FNIHB policies be adapted as required to support a cultural role in health and healing by providing resources (such as professional fees) for cultural practitioners and Elders comparable to other professional providers; covering travel costs, including those of cultural practitioners and Elders visiting treatment centres to provide cultural support; and acknowledging the community's right to define what a cultural practitioner is and "sanction" specific cultural practitioners.

8. That cultural protocols be developed to guide relationships between cultural practitioners and communities/treatment programs.

CAPITAL INVESTMENTS

9. That the capital needs of treatment centres for required facility improvements and upgrades be assessed and resourced as required.

10. That the capital needs at treatment centres and in communities to implement a full range of services and supports along the continuum of care be assessed and incorporated into annualized budgets. This includes costs for space to accommodate additional required human resources, costs for culturally-based programming (such as land-based activities), and costs for trauma-informed care, as well as increased use of telehealth and other technologies.

11. That the use of existing crisis lines and helplines be explored with a view to implementing these at treatment centres as a helpful resource.

GOVERNANCE AND COORDINATION OF SYSTEMS

12. That there be a change to current funding arrangements for treatment centres to provide them with the flexibility they need to address changing environments and increasing needs, and implement a full continuum of care.

13. That community capacity building costs to access more flexible funding be assessed and implemented.

14. That costs be assessed and implemented to develop an effective regional model to support governance and coordination of systems.

15. That the costs required to support treatment centres in continuing to meet compliance requirements for accreditation standards be included in treatment centre annualized budgets.

16. That resources should also be established for a governance program for the Addictions Management Information System (AMIS) in order to support ongoing enhancements and development of the system and for ongoing planning.

17. That the resources required for AMIS capacity development be assessed and included in treatment centre annual budgets.

18. That the AMIS system develop capacity to serve community needs.

OUTPATIENT SERVICES

19. That costs to provide a full continuum of care for outpatients be assessed for treatment centres and for community-based programs, and incorporated into annual budgets.

MEDICAL **TRANSPORTATION**

20. That FNIHB review and modify medical transportation policies to allow for access to the right kind of care based on the needs of the client and to support a return to treatment when required, even where there has been a recent attempt at treatment.

ADDRESSING **OPIATE MISUSE AND RISK**

21. That a commitment to funding community-based opioid agonist treatment programs be assessed and incorporated into community health envelopes.

22. That federal policies be revised to ensure that buprenorphine and naloxone are the first line of treatment for opioid replacement therapy, and that distribution strategies be developed to ensure users have ready access to naloxone when needed.

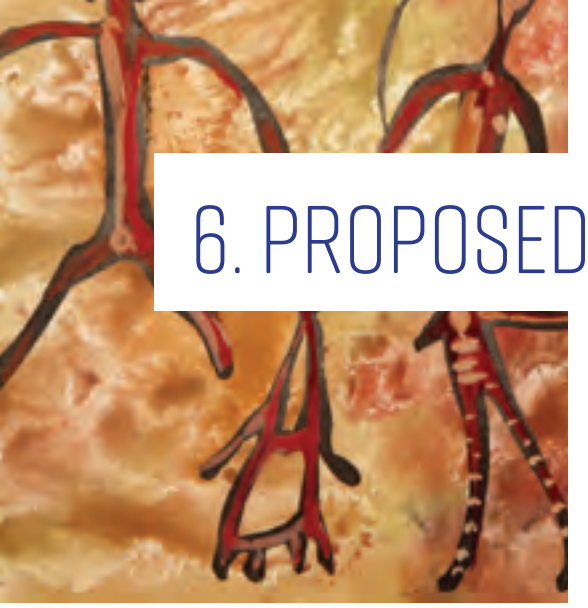
23. That a commitment to funding community-based opioid prevention programs that support women of childbearing years be established.

24. That a commitment to funding community-based, cultural-based programming for mothers and infants who have experienced neonatal abstinence syndrome be established.

25. That the priority actions by the Thunderbird Partnership Foundation for the management of Prescription Drug Abuse (PDA) be adopted for Ontario Region; and that a detailed budget and plan for accomplishing the same be developed and implemented.

IMPLEMENTATION **STRATEGY**

26. That the planned and staged implementation strategy in relation to the recommendations be adopted as outlined.



6. PROPOSED **IMPLEMENTATION STRATEGY**

The proposed implementation strategy in relation to the recommendations is outlined in the chart below:

PHASE 1 - IMMEDIATE ACTION, UPDATING FUNDING INSTRUMENTS

A. Wage Parity
- based on Ontario Case Study, implement wage parity nationally

B. Capital Investments
- Invest in renovations and repairs
- Invest in capacity and minor capital to support culturally-based programs with additional space within buildings and on the land/in country, and program material resources / equipment
- Secure additional office space for capacity development/increased human resources

C. Operational Expenses
- Increase NNADAP / NYSAP operating budget to reflect increased costs for hydro, heat, water, phone, internet connectivity, insurance

PHASE 2 - OPERATIONS (HOS: CONTINUUM OF CARE & WORKFORCE CAPACITY)

D. Capacity Development
- Invest in additional mental wellness human resources (addictions & mental health) staff for community & treatment centres to meet current needs
- Invest in Indigenous Knowledge Practitioners & cultural competency
- Invest in cultural-based Programming / Treatment
- Invest in Community-based opiate misuse treatment & harm reduction
- Invest in capacity development towards a continuum of programs/service delivery (ie. outpatient / land-based / crisis prevention & response)

PHASE 3 - PERFORMANCE MEASUREMENT & RESEARCH

E. Invest in building capacity for data management & performance measurement strategies

F. Accreditation - support for meeting accreditation standards

G. Invest in national addictions management information system

PHASE 4 - GOVERNANCE & COORDINATION OF SYSTEMS

H. Support full implementation of the Continuum of Care with more staff in community, capacity to support partnerships for service delivery, or for collaborative care approaches

GAPS AND CHALLENGES FOR FUTURE INVESTMENTS

A number of other gaps and challenges within NNADAP for consideration with regard to future investments to build a full continuum of care were identified in the course of the document review. These are identified below.

EFFECTIVE COORDINATION AND COLLABORATION [129 139 131 132 133]

Federal and provincial funders tend to operate separately, creating gaps in services and impacting continuity of care. Some partnerships exist with provincial governments and with mainstream services (such as mental health and detoxification services). In some areas, communities and tribal councils are increasingly involved in leading change and developing innovative partnerships, such as with NGOs, local health integration networks, physicians, pharmacists, hospitals, family health teams and others; these need to be further developed. Partnerships at the regional and community level are important as well, not least because they can lead to increased provincial investments in First Nations programming and reduce current gaps in programming. As an example, partnerships could lead to a full and coordinated referral system that allows for referrals between on-reserve and off-reserve resources, and among mental health, addictions, and primary care services.

> The First Nations Mental Wellness Continuum framework points to British Columbia as an example of strong collaboration between First Nations health organizations and provincial and regional health authorities that offer acute mental health services, i.e. *greater collaboration has encouraged the provincial and regional health authorities to take more responsibility for First Nations communities as part of their service mandates, and…provincial services are increasingly based on community-identified priorities and aligned with existing services to address gaps.* ***The importance of collaboration between all sectors and jurisdictions cannot be understated.***

A systems approach is needed to ensure accessibility to a full continuum of services and supports. As noted by theCanadian Centre on Substance Use and Addiction

129 Ontario Region First Nations Addictions Service Needs Assessment, Final Report (March 28, 2009). Williams Consulting.
130 Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.
131 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
132 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada
133 First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada

with regard to mainstream addictions services:

> *"Individual jurisdictions have developed their own systems of services and supports, with little emphasis on consistency and co-ordination within or between jurisdictions. The result has been fragmentation and inconsistency, rather than [an] integrated systems of services and supports."*[134]

This is a particularly acute issue for First Nations people, who may require care funded across several jurisdictions (e.g. federal and provincial). It can be difficult to know which door to use to access services and once services have been accessed, it can be equally challenging to navigate through the various programs and services required, who often do not communicate effectively with each other.

Care must also be culturally competent and safe. Collaborative relationships among key partners (internally, as well as inter-departmental and inter-jurisdictional) are required for this transformation to occur. Stronger relationships between treatment centres and referral workers (or communities) and with social services and employment services would also support effective aftercare, which has been continually identified as a high priority need.

134 National Treatment Strategy Working Group (CCSA). (2008). A Systems Approach to Substance Use in Canada: Recommendations for a National Strategy.

IMPLEMENTATION OF **FULL CONTINUUM OF HOLISTIC SERVICES** [135] [136] [137] [138] [139] [140] [141] [142]

This includes community development, health promotion, prevention, early identification, brief intervention, secondary risk reduction, crisis intervention, treatment (including trauma-informed treatment), care facilitation (integrated treatment plans and case management services) and aftercare services.

With respect to developing a full continuum of care, there is an urgent need for funding to support the needs of people affected by substance abuse and addictions, as well as **people with mental health issues.** A full continuum of care would support access to appropriate addictions services and mental health related services and supports for people with concurrent disorders, as between 75 and 100% of those seeking treatment for substance abuse have a concurrent mental health issue. Addiction services tend to be better developed and easier to access than mental health services, which are usually provided through NIHB and the provincial mental services (off reserve). Specialized mental health supports such as psychiatry and psychology are difficult to access in communities. Medically supervised detoxification is also often accessible only off-reserve through the mainstream provincial health system.

These gaps call for the following: the need for coordinated referrals, service planning and treatment; cross-training of staff to manage concurrent disorders; access to appropriate treatment services, including specialized services; medical transportation policies that allow for access to the right kind of care based on the needs of the client and support a return to treatment when required, even where there has been a recent attempt at treatment; and enhanced NNADAP treatment centre capacity to manage psycho-tropic medications.

Staff training could be addressed, at least in part, through telemedicine. The challenge of accessing specialized mental health supports such as psychiatry

135 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
136 NNADAP Gap Paper: Improving Mental Health Services and Supports in NNADAP (September 2009), McCormick, R & Quantz, D.
137 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada
138 First Nation Mental Wellness Continuum Implementation Opportunities (July 2014)
139 First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.
140 Ontario Region First Nations Addictions Service Needs Assessment, Final Report (March 28, 2009). Williams Consulting.
141 Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.
142 Final Report, Prescription Drug Abuse Strategy: Take a Stand. (November 18, 2010). Advisory Panel to Chiefs of Ontario.

and psychology in communities could also be addressed through an increased utilization of telemedicine.

Capacity for addressing mental health issues can also be addressed through appropriate culture-based knowledge and cultural practitioners sanctioned with rights to practice in this area, which also includes the use of natural medicines and ceremonial practice. Support is required to decolonize the approaches to mental health care to include Indigenous cultural knowledge and practices by ensuring appropriate funding is in place to contract cultural practitioners, provide training for staff to ensure a respectful multi-disciplinary approach inclusive of cultural practices, and to support Indigenous practitioners in understanding the nature of addictive substances.

Cultural training would help to educate mainstream service providers (e.g. physicians) about the factors that influence substance abuse and mental health issues among First Nations people, as would information about the importance of the role of Elders and of cultural supports as part of a multi-disciplinary team.

Trauma-informed treatment is showing great promise and should be more widely implemented.[143] Additional resources will be needed for training and implementation of this treatment approach across the service system.

Clinical services are also needed to build the capacity of para-professionals and to provide training, clinical supervision, and case consultations.

Self-help and peer support options represent an additional element in a continuum of care: these could involve things such as self-assessment of levels of risk for addiction through the use of community or individual risk assessment tools, and the adaptation of programs like Mental Health First Aid for First Nations, as well as the implementation of peer support groups. Peer support groups provide support to new or changing lifestyles, provide hope and encouragement and understanding as others can relate to the stories, the concerns, the issues, and appreciate the triumphs.t

The lack of comprehensive **aftercare** has been identified over and over again as a critical gap in the documents reviewed for this report. Aftercare services have been assumed in the inadequate budgets of the last four decades. Guidelines for after-care have been developed[144] and core components include: access to clinical services including trained and skilled staff; case management services; outreach; monitoring strategies, including frequent contact for the first six to 12 months; and involvement in self-help activities and with senior peers. Other required elements for effective aftercare identified in Honouring Our Strengths include:

- Stronger relationships between treatment centres and referral workers (or communities) in all phases of client treatment, as defined and supported by policy development.

- Treatment centre counsellors could use tele/video conferencing to connect the client with the local care worker as part of the aftercare/discharge planning process. Other opportunities to support these linkages include networking forums for addiction workers each year and cross-training opportunities.

- Better recognition of social determinants of health in discharge planning and aftercare through greater collaboration with social services and an increased focus on life skills, emotional intelligence, or job training, both within programs and as a key aspect of aftercare planning.

143 Social Return On Investment (SROI) Case Study:Minwaashin Lodge Addictions Treatment Centre

144 Substance Abuse Aftercare and Post Treatment Follow-up (October 2001) Substance Abuse Program Office: Florida Department of Children and Families

- Stronger support for relapse prevention, with a focus on wellness as defined by the Itndigenous wellness framework and perhaps based on the Marlatt model that focuses on both immediate determinants of use (e.g., high-risk situations, outcome expectations, and coping skills), covert antecedents (e.g., lifestyle factors, urges, and cravings), and seeks to strengthen family, community and cultural supports.

- Development and support for community-based peer support programs to assist individuals and families in recovery.

- Using new electronic approaches to support clients (e.g., e-mail, social media, hotlines, an anonymous online discussion forum for aftercare), and providing "booster" or refresher programs for former clients at risk of relapse.[145]

With regard to **other elements of the continuum of care,** it is worth noting that a 2012-13 CBRT National Summary Report by FNIHB[146] showed that Ontario was lagging behind other provinces on the following, which may represent opportunities for investment:

- ✓ School-based programs to support awareness of substance abuse and addictions (59.4% of communities in Ontario/63.8% of communities nationally)
- ✓ Addictions recovery support groups (48.5%/60.7%)
- ✓ Service linkage for mental wellness promotion (78.2%/81.9%)
- ✓ Service linkage for addictions treatment and aftercare (75.2%/79.3%)
- ✓ Service linkage for detoxification services (60%/69.4%)
- ✓ Service linkage for suicide prevention (69.3%/79.3%)
- ✓ Service linkage for crisis response (70.3%/74.8%)
- ✓ Service linkage for mental health treatment and aftercare (74.3%/77.2%).

145 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.

146 Community-Based Reporting Template (CBRT) National Summary Report for the 2012-13 Reporting Year Surveillance, Health Information Policy and Coordination Unit, Strategic Policy Planning and Information Directorate, First Nations & Inuit Health Branch (FNIHB), Health Canada.

MORE USE OF **TELEMEDICINE** [147] [148] [149]

Telehealth and E-health could be used more, for assessment, training, supervision and case consultations, as well as for treatment and aftercare. Previously, the issue of coverage of the costs of telemedicine consultations for First Nation clients under NIHB was a barrier to provision of services. However, this was resolved in March 2015. Now that there is coverage, telemedicine services and supports could be further developed.

The Ontario Telemedicine Network (OTN) is an ideal vehicle for these uses, particularly with regard to clients living in remote or rural locations. Sixty-nine of 133 First Nations either have OTN or have it under development, as do all of the 12 Aboriginal Health Access Centres in Ontario Region, and 19 Métis Nation sites.

As described in Honouring Our Strengths, a good example of how this could work is Keewaytinook Okimakanak Telemedicine and K-Net—Ontario, a program of Keewaytinook Okimakanak (KO), a First Nations tribal council established by the leaderships of Deer Lake, Fort Severn, Keewaywin, McDowell Lake, North Spirit Lake and Poplar Hill bands.

K-Net provides information and communication technologies, telecommunication infrastructure and application support to these First Nations communities across north-western Ontario, as well as in other remote regions in Canada. K-Net recently partnered with KO to provide First Nations access to the Ontario Telemedicine Network for clinical, educational, and administrative services. KO Telemedicine (KOTM) is a complete telemedicine program, connecting remote

147 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.

148 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada

149 Final Report of the Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment (March 2015) Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario.

First Nations communities with health service providers. This technology has helped facilitate access to psychiatric services and supports. KOTM also includes an education program, which provides access to education sessions, training and support for community front-line workers and health staff, and supports the sharing of knowledge for and among addictions workers through online access. The service also includes Elder visitations, which feature an Elder presenting teachings such as traditional medicine and storytelling through video conferencing to community workers and members. This partnership model could be expanded to provide similar services and supports to First Nations and Treatment centres across the province.

CAPACITY TO DEAL WITH THE NEEDS OF **DIVERSE POPULATIONS, INCLUDING CHILDREN, YOUTH, FAMILIES, WOMEN, MEN, SENIORS, OTHER PEOPLE WITH SPECIAL NEEDS, AND MEMBERS OF THE LGBTQ2S COMMUNITY** [150] [151] [152] [153]

Different groups of people have unique needs to which services must be responsive. For instance, women who have been sexually abused may feel more comfortable with female workers; they may also need childcare and/or transportation to participate in programming. Pregnant or nursing women who are addicted may need specific supports, such as enhanced care to promote maternal/child bonding.

Seniors may be more likely to have direct experience with residential schools and having had their children removed by the child welfare system. There is also often a need to work with the entire family when an individual is struggling with substance abuse, especially in the case of youth.

150 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
151 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada
152 First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.
153 Final 2015 Ontario NNADAP Workforce Survey Results, ORAPC, Approved March 2016.

EFFECTIVE MODELS FOR **SERVICES AND SUPPORTS IN RURAL/REMOTE COMMUNITIES** [154]

Remote and rural communities experience more gaps in programming compared to other areas, while at the same time people living in these communities show increased vulnerability to mental health problems and substance abuse due to isolation and reduced access to services and supports.

In some remote communities, for example, very few (if any) community-based addictions services exist. As noted in the 2015 PDA Report:

> *Essentially all parts of the continuum can be said to be absent and referrals out are often tied to long wait lists.*

While it can be challenging to implement a full continuum of care in remote/rural communities, innovative and effective models of care are being developed. These include mobile treatment and/or multi-disciplinary teams, as well as an increased use of telemedicine.

154 Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP) (2009), McCormick and Quantz

ACCURATE DATA ON THE NATURE, PREVALENCE AND INCIDENCE OF ADDICTIONS AND MENTAL HEALTH ISSUES [155] [156]

There is limited population-level data specific to First Nations with regard to substance use and mental health that can be used to support planning and monitoring of programs and service outcomes. Existing data often excludes on-reserve populations and samples are often too small to identify the needs of First Nations people living off-reserve.

155 Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP) (2009), McCormick and Quantz.
156 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.

ACCURATE AND USEFUL PERFORMANCE MEASURES [157] [158] [159] [160] [161]

Identification of the need for quality assurance programs dates back to the 1998 national review of NNADAP. This has been reiterated many times since in subsequent reports. There is a high level of interest in confirming the effectiveness of intervention approaches through research, including development of First Nations specific indicators and First Nations specific processes to track data on mental health and addictions that respect First Nations autonomy.

Specific performance measures would allow for a comprehensive assessment of the effectiveness and efficiency of addictions services and supports, and identification of enhancement opportunities. These are to be well-designed and ongoing processes, strengths-based, and developed with communities. Both client and program level information should be collected and managed within communities and treatment centres. Ongoing analysis of data should be used to inform system design and delivery and to improve wellness outcomes. As this system or systems evolve, there may be opportunities to coordinate with provincial data systems. Ideally, these systems will be aligned with community-based planning processes and with work on standards occurring within FNIHB, and will reduce the reporting burden for communities. Other requirements will include: working with communities to ensure the system is compatible with community values and meaningful to communities; ongoing capacity development and training opportunities; and ongoing analysis of performance measurement data at all levels to continually inform system design enhancements and ongoing development.

157 National Native Alcohol and Drug Abuse Program (NNADAP) General Review, Final Report (1998)
158 Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program (NNADAP) (2009), McCormick and Quantz.
159 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
160 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada
161 First Nations and Inuit Mental Health and Addictions Cluster Evaluation 2005/6 – 2009/10 Final Report (September 2012). Health Canada.

COORDINATED RESEARCH AND KNOWLEDGE EXCHANGE STRATEGIES [162] [163]

Coordinated, systemic and sustainable research and knowledge exchange strategies are needed to build a comprehensive evidence base of which programs and services work best for addiction prevention and treatment, to support effective planning, implementation and evaluation of programs, to support required workforce development, to support integration of addictions and mental health programming, and to identify priority areas for research, such as prevention strategies, and research on specific populations. Research also needs to be based on Indigenous knowledge and culture, and be respectful of the First Nations Research Principles of OCAP™ (ownership, control, access, and possession) to ensure that First Nations control data collection processes in their communities and how the information is used.

162 Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011) AFN, NNAPF, Health Canada.
163 First Nations Mental Wellness Continuum Framework (January 2015) AFN, Health Canada

ADDITIONAL RECOMMENDATIONS FOR FUTURE CONSIDERATION

TRAINING AND SKILL DEVELOPMENT

1. That long-term education programs incorporating distance education strategies be developed to build capacity amongst workers, many of whom wish to build on their cultural knowledge and clinical skills

2. That a mechanism be developed to support knowledge exchange among centres that is specific to accreditation, so that centres can share successes.

PERFORMANCE MEASURES AND RESEARCH

3. That a network of partnerships – community-based, regional and provincial – be developed to design and implement an effective approach to research, performance measurement and knowledge exchange, in collaboration with the First Nations communities and treatment centres, which have already established a research policy that includes ethical review processes, review of research methods, and compliance with OCAP Standards (see Governance and Coordination of Systems below).

4. Resources are required to build capacity for the use of culturally-based and culturally-informed assessments; such as, the Native Wellness Assessment™ (measure mental wellness from a culture and strengths based perspective), the Drug Use Screening Inventory (measures addictions, mental health, and trauma), and the national First Nations Opioid Survey (various modules that measure prevalence, use patterns, and impact of prescription drug abuse).

USE OF TELEMEDICINE

5. That the KO Telemedicine (KOTM) partnership model be expanded to provide similar services and supports to First Nations and treatment centres across the province.

6. That telemedicine be used to provide NNADAP staff with training on mental health issues.

7. That the use of telemedicine be expanded to ensure access to specialized mental health supports such as psychiatry and psychology in First Nations communities.

8. That cultural competency training opportunities be developed for allied service providers (e.g. physicians) about the factors that influence substance abuse and mental health issues among First Nations people, including information about the importance of the role of Elders and of cultural supports as part of a multi-disciplinary team. This could be done through online education programs as developed by the Canadian Depression Research Intervention Network (CDRIN) for physicians with regard to PTSD.

APPENDIX A: ORAPC PROPOSED NNADAP BUDGETS ONTARIO REGTION

I. COMMUNITY-BASED PROGRAMS: EXISTING STAFF (COUNSELLORS, PROGRAM MANAGERS AND ADMINISTRATIVE STAFF) AND PROGRAM COSTS

NNADAP Resourcing (May 2016)

Community-based Programs--Present Wage Levels

	Category	A	B	C	D	E	
	On-Reserve Population	Under 500	510-2000	2001-5,000	5001-10,000	10,001-20,000	TOTALS
	# of First Nations communities	81	38	8	1	1	129
	# of workers (counsellors)	1	1	2	4	5	
	# of positions (counsellors)	81	38	16	4	5	144
Present Levels							
35,000	Counsellors	2,835,000	1.330,000	560,000	140,000	175,000	5,040,000
42,000	Program Manager/Supervisor			336,000	42,000	42,000	420,000
35,000	Case Program Manager					35,000	35,000
30,000	Administrative			240,000	30,000	30,000	300,000
	Total Salary	2,835,000	1,330,000	1,136,000	212,000	282,000	5,795,000
0.18	Benefits	510,300	239,400	204,480	38,160	50,760	1,043,100
0.35	Program Costs	992,250	465,500	397,600	74,200	98,700	2,028,250
	Ongoing Capital Costs						0
	TOTAL	4,337,550	2,034,900	1,738,080	324,360	431,460	8,866,350
0.10	Administration Fees	433,755	203,490	173,080	3,436	43,146	886,635
	One-Time Capital Needs						
	TOTAL	4,771,305	2,238,390	1,911,888	356,796	474,606	9,752,985

Notes: The above figures are only estimates based on First Nation on-reserve population figures; and the number of NNADAP workers, managers/coordinators hired in each First Nation. There are a number of First Nations without community-based NNADAP workers.

2. COMMUNITY-BASED PROGRAMS: WAGE PARITY FOR EXISTING STAFF ONLY (COUNSELLORS, PROGRAM MANAGERS AND ADMINISTRATIVE STAFF) AND PROGRAM COSTS

NNADAP RESOURCING (May 2016)

Community-based Programs--Wage Parity Only

	Category	A	B	C	D	E	
	On-Reserve Population	Under 500	510-2000	2001-5,000	5001-10,000	10,001-20,000	TOTALS
	# of First Nations communities	81	38	8	1	1	129
	# of workers (counsellors)	1	1	2	4	5	
	# of positions (counsellors)	81	38	16	4	5	144
Wage Proposed							
58,625	Counsellors	4,748,625	2,227,750	938,000	234,500	293,125	8,442,000
73,282	Program Manager/Supervisor			586,256	73,282	73,282	732,820
53,500	Case Program Manager					53,500	52,500
45,000	Administrative			360,000	45,000	45,000	450,000
	Total Salary	4,748,625	2,227,750	1,884,256	352,782	464,907	9,678,320
0.18	Benefits	854,753	400,995	339,166	63,501	83,683	1,742,098
0.35	Program Costs	1,662,019	779,713	659,490	123,474	162,717	3,387,412
	Ongoing Capital Costs						0
	TOTAL	7,265,396	3,408,458	2,882,912	539,756	711,308	14,807,830
0.10	Administration Fees	726,540	340,846	288,291	53,976	71,131	1,480,783
	One-Time Capital Needs						0
	TOTAL	7,991,936	3,749,303	3,171,203	593,732	782,438	16,288,613

Notes: The above Figures are only estimates based on First Nation on-reserve population figures; and the number of NNADAP worders, managers/coordinators hired in each First Nation. There are a number of First Nations without community-based NNADAP workers.

3. COMMUNITY-BASED PROGRAMS – RESOURCING AND WAGE PARITY FOR EXISTING AND ADDITIONAL REQUIRED HR

NNADAP RESOURCING (May 2016)

Community-Based Programs--Resourcing & Wage Parity

	Category	A	B	C	D	E	
	On-Reserve Population	**Under 500**	**510-2000**	**2001-5,000**	**5001-10,000**	**10,001-20,000**	**TOTALS**
	# of First Nations communities	**81**	**38**	**8**	**1**	**1**	**129**
	# of workers (present)	**1**	**1**	**2**	**4**	**5**	
	# of workers (needed)	**1**	**1**	**1**	**2**	**2**	
Wage Proposed							
58,625	**Counsellors**	**9,497,250**	**4,455,500**	**1,407,000**	**351,750**	**410,375**	**16,121,875**
	# of workers (present)			**1**	**1**	**1**	
	# of workers (needed)	**0.25**	**1**				
73,282	**Program Manager/Supervisor**	**1,483,961**	**2,784,716**	**586,256**	**73,282**	**73,282**	**5,001,497**
	# of workers (present)					**1**	
	# of workers (needed)			**1**	**1**	**2**	
53,500	**Case Program Manager**	**0**	**0**	**428,000**	**53,500**	**160,500**	**642,000**
	# of workers (present)						
	# of workers (needed)			**1**	**1**	**1**	
47,000	**Intake Worker**	**0**	**0**	**376,000**	**47,000**	**47,000**	**470,000**
	# of workers (present)						
	# of workers (needed)		**1**	**1**	**1**	**1**	
47,000	**Aftercare Worker**	**0**	**1,786,000**	**376,000**	**47,000**	**47,000**	**2,256,000**
	# of workers (present)						
	# of workers (needed)	**0.50**	**1**	**1**	**1**	**2**	
47,000	**Outreach Worker**	**1,903,500**	**1,786,000**	**376,000**	**47,000**	**94,000**	**4,206,500**
	# of workers (present)			**1**	**1**	**1**	
	# of workers (needed)	**0.50**	**0.50**				
	Administrative	**1,822,500**	**855,000**	**360,000**	**45,000**	**45,000**	**3,127,500**
45,000	# of workers (present)						
	# of workers (needed)		**0.50**	**1**	**1**	**1**	
35,000	**Receptionist**	**0**	**665,000**	**280,000**	**35,000**	**35,000**	**1,015,000**
	Total Salary	**14,707,211**	**11,667,216**	**3,909,256**	**664,532**	**877,157**	**31,825,372**
0.18	Benefits	**2,647,298**	**2,100,099**	**703,666**	**119,616**	**157,888**	**5,728,567**
0.35	Program Costs	**5,147,524**	**4,083,526**	**1,368,240**	**232,586**	**307,005**	**11,138,880**
	Ongoing Capital Costs						**0**
	TOTAL	**22,502,032**	**17,850,840**	**5,981,162**	**1,016,734**	**1,342,050**	**48,692,818**
0.10	Administration fees	**2,250,203**	**1,785,084**	**598,116**	**101,673**	**134,205**	**4,869,282**
	One-Time Capital Needs						**0**
	TOTAL	**24,752,235**	**19,635,925**	**6,579,278**	**1,118,407**	**1,476,255**	**53,562,100**

4. TREATMENT CENTRES – ESTIMATED COSTS FOR CURRENT STAFF AND PROGRAMS/OPERATIONS

Present Budgets	A	B	C	D	E	F	TOTAL
Total Salaries Budgeted				263,379.00	1,041,083.00	448,065.00	
Total Benefits Budgeted				6,927.00		49,792.00	
Total Salaries and Benefits			383,476.00	270,306.00		497,857.00	1,151,639

Note: Average estimated cost for wages and benefits is $383,879 ($1,151,639 divided by 3). Multiplied by 11 centres, this gives an average estimated overall cost for salaries and benefits of $4,222,669.

5. TREATMENT CENTRES – WAGE PARITY FOR EXISTING STAFF ONLY

ORAPC

NNADAP RESOURCING (May 2016) - Treatment centres--Wage Parity Only

	Treatment Centre	A	B	C	D	E	F	G	TOTAL
		1	1	1	0	0	0	0	3
	# of treatment beds	12	8	15					35
	# of day patients		4						4
Wage Proposed	# of workers (present)	1	2	3	0	0	0	0	
58,625	Treatment Counsellors	58,625	117,250	175,875	0	0	0	0	351,750
	# of workers (present)	1.00	0.50	1					
92,000	Executive Director	92,000	46,000	92,000	0	0	0	0	230,000
	# of workers (present)	0.50	0.50	1					
45,000	Administrative	22,500	22,500	45,000	0	0	0	0	90,000
	# of workers (present)	1	1	1					
73,282	Program Coordinator	73,282	73,282	73,282	0	0	0	0	219,846
	# of workers (present)			3					
47,000	Support Counsellors	0	0	141,000	0	0	0	0	141,000
	# of workers (present)		1	1					
47,000	Intake Worker	0	47,000	47,000	0	0	0	0	94,000
	# of workers (present)	2	4						
34,756	Attendants	69,512	139,024	0	0	0	0	0	208,536
	# of workers (present)	1	1	1					
36,230	Cooks	36,230	36,230	36,230	0	0	0	0	108,690
	# of workers (present)	1	0.16	1					
36,230	Maintenance	36,230	5,797	36,230	0	0	0	0	78,257
	# of workers (present)			0.25					
35,000	Bookkeeper	0	0	8,750	0	0	0	0	8,750
	Total Salary	315,919	445,056	574,160	0	0	0	0	1,335,132
0.18	Benefits	56,865	80,110	103,349	0	0	0	0	240,324
	Total salary and benefits								1,575,456
	FTE (present)	7.50	10.16	12.25					

6. TREATMENT CENTRES: RESOURCING AND WAGE PARITY FOR EXISTING AND REQUIRED NEW HUMAN RESOURCES

	Treatment Centre	A	B	C		E	F	G	TOTAL
	# of treatment centre	1	1	1		0	0	0	3
	# of treatment beds	12	8	15					
	# of day patients	0	4	0					
	# of workers (present)	1	2	3	0	0	0	0	
Wage Proposed	# of workers (needed)	1	1	2	0	0	0	0	
58,625	**Treatment Counsellors**	117,250	175,875	293,125					586,250
	# of workers (present)	1.00	0.50	1		0	0	0	
	# of workers (needed)		0.50		0				
92,000	**Executive Director**	92,000	92,000	92,000		0	0	0	276,000
	# of workers (present)	0.50	0.50	1					
	# of workers (needed)	0.50	0.50		0	0	0	0	
45,000	**Administrative**	45,000	45,000	45,000					135,000
	# of workers (present)	1	1	1		0	0	0	
	# of workers (needed)				0				
73,282	**Program Coordinator**	73,282	73,282	73,282		0	0	0	219,846
	# of workers (present)			3					
	# of workers (needed)			2	0	0	0	0	
47,000	**Support Counsellors**	0	0	235,000					235,000
	# of workers (present)					0	0	0	
	# of workers (needed)		1	1	0				
58,000	**Cultural Coordinator**	0	58,000	58,000		0	0	0	116,000
	# of workers (present)		1	1					
	# of workers (needed)	0.50			0	0	0	0	
47,000	**Intake Worker**	23,500	47,000	47,000		0	0	0	117,500
	# of workers (present)					0	0	0	
	# of workers (needed)		1		0				
58,000	**Case Manager**	0	58,000	0					58,000
	# of workers (present)								
	# of workers (needed)		1	1	0				

	Treatment Centre	A	B	C	D	E	F	G	TOTAL
47,000	**Outreach Worker**	0	47,000	47,000	)			)	94,000
	# of workers (present)	2	4						
	# of workers (needed)	2		2					
34,756	**Attendants**	139,024	139,024	69,512	0			0	347,560
	# of workers (present)	1	1	1					
	# of workers (needed)			0.75					
36,230	**Cooks**	36,230	36,230	63,403	0			0	135,863
	# of workers (present)	1	0.16	1					
	# of workers (needed)								
36,230	**Maintenance**	36,230	5,797	36,230	0			0	78,257
	# of workers (present)			0.25					
	# of workers (needed)								
35,000	**Bookkeeper**	0		8,750	0			0	8,750
	# of workers (present)	0	-						
	# of workers (needed)	0		1					
34,756	**Janitorial**	0	0.50	34,756	0			0	52,134
	# of workers (present)		17,378						
	# of workers (needed)			2					
60,000	**Elder**	0	1.00	120,000	0			0	180,000
	# of workers (present)		60,000						
	# of workers (needed)		1.00	1					
35,000	**Intake Clerk**	0	35,000	35,000	0			0	70,000
	# of workers (present)								
	# of workers (needed)		1.00	1					
80,000	**Clinical Supervision**	0	80,000	80,000	0			0	160,000
	Total Salary	490,056	630,181	912,924	0			0	2,033,156
0.18	Benefits	88,210	113,433	164,326	0			0	365,969
	Total salary & benefits	578,266	743,614	1,077,250					2,399,125
	FTE (present)	7.50	10.16	12.25	0.0	0.0	0.0	0.0	
	FTE (needed)	4.00	7.50	12.75	0.0	0.0	0.0	0.0	

Note: Average estimated salary and benefits cost: $ 2,399,125 divided by 3 = $799,708 x 11 centres = $8,796,791.

APPENDIX B: TREATMENT CENTRE PROGRAM AND OPERATING COSTS

I. TREATMENT CENTRES: CASE EXAMPLE: INCREASED OPERATING COSTS OVER 23 YEARS AT A TREATMENT CENTRE

Actual Case Example

BASED ON THE AUDITED FINANCIAL STATEMENTS

Fiscal Year Ending	1992	1999	2014	23 yr Annualized Average	23 yr Dollar Value Accumulated
Revenue Treatment/Prevention	**$459,140.00**	**$489,377.00**	**$691,880.00**	**2.20%**	**$232,740.00**
Specific Expenses					
Office & General	$19,528.00	$18,841.00	$34,047.00	**3.23%**	**$14,519.00**
Food	$18,076.00	$25,556.00	$51,112.00	**7.95%**	**$33,036.00**
Utilities	$10,654.00	$9,966.00	$24,991.00	**5.85%**	**$14,337.00**
Telephone	$6,146.00	$5,402.00	$11,293.00	**3.64%**	**$5,147.00**
Insurance	$2,566.00	$1,705.00	$16,672.00	**23.90%**	**$14,106.00**
Audit	$4,855.00	$3,125.00	$15,920.00	**9.91%**	**$11,065.00**
Total of these specific operating expenses	**$61,825.00**	**$64,595.00**	**$154,035.00**	**54.48%**	**$92,210.00**

I. TREATMENT CENTRE: CASE EXAMPLE REQUIRED BUDGET FOR HONOURING OUR STRENGTHS STAFFING MODEL WITH WAGE PARITY

Required Budget for PROPOSED STAFFING MODEL

Description DIRECT COST	Budget	Treatment	Prevention	NIHB transportation
Program Wages & Benefits				
Salaries:				
Positions F/T Treatment Program mgmt & staff	$974,940.00	$618,940.00	$356,000.00	
Cost-shared positions: Administration	$155,990.40	$99,030.40	$56,960.00	
Benefits at 15% (WC/EI/pension/ext. health)				

I. TREATMENT CENTRE: CASE EXAMPLE REQUIRED BUDGET FOR HONOURING OUR STRENGTHS STAFFING MODEL WITH WAGE PARITY (CONT.)

DIRECT COST	Budget	Treatment	Prevention	NIHB transportation
Program Specific Operations				
Programming aids and materials	$16,000.00	$8,000.00	$8,000.00	
Staff development training 19 f/t staff x $2,000.00 /year	$38,000.00	$25,000.00	$13,000.00	
Casual workers & vehicle costs	$23,000.00			$23,000.00
Travel	$17,400.00	$8,000.00	$9,400.00	
Office materials & supplies	$18,000.00	$12,800.00	$5,200.00	
Maintenance contracts ie generator, snow removal, inspections	$14,000.00	$10,000.00	$4,000.00	
Minor capital replacements	$12,000.00	$8,000.00	$4,000.00	
Professional services	$8,000.00	$4,500.00	$3,500.00	
Postage, shipping & freight	$4,800.00	$2,800.00	$2,000.00	
Telephone/fax/communications	$14,000.00	$9,950.00	$4,050.00	
Publishing & printing	$12,000.00	$7,000.00	$5,000.00	
Insurance	$19,000.00	$8,000.00	$6,000.00	$5,000.00
Professional services i.e. psychologist/ psychiatrist	$7,200.00	$7,200.00		
Audit fees	$23,000.00	$18,000.00	$5,000.00	
Vehicle & building repairs and maintenance	$30,000.00	$14,000.00	$8,000.00	$8,000.00
Utilities - hydro/propane/fuel	$30,000.00	$24,000.00	$6,000.00	
Food costs for programming	$66,000.00	$62,000.00	$4,000.00	
Rentals	$3,000.00	$1,000.00	$2,000.00	
Janitorial supplies	$5,500.00	$3,500.00	$2,000.00	
Accreditation process	$63,000.00	$45,000.00	$18,000.00	
Advertising & promotion	$12,000.00	$8,000.00	$4,000.00	
SUBTOTAL DIRECT COST	**$1,566,830.40**	**$1,004,720.40**	**$526,110.00**	**$36,000.00**

I. TREATMENT CENTRE: CASE EXAMPLE REQUIRED BUDGET FOR HONOURING OUR STRENGTHS STAFFING MODEL WITH WAGE PARITY (CONT.)

DIRECT COST	Budget	Treatment	Prevention	NIHB transportation
BAND ADMINISTRATION/ MANAGEMENT FEE - (MAX 10% of salary + benefits, 2% of travel) Administration / Management Ftees				
Office materials and supplies	$6,500.00	$4,000.00	$2,500.00	
Travel	$4,000.00	$2,000.00	$2,000.00	
Computer equipment	$4,200.00	$2,100.00	$2,100.00	
Telephone and communications	$4,000.00	$2,000.00	$2,000.00	
Material and equipment rental	$1,500.00	$750.00	$750.00	
Maintenance and repairs (office materiel and equip.)	$5,000.00	$2,500.00	$2,500.00	
Postage, shipping	$2,400.00	$1,200.00	$1,200.00	
Admin fees	$3,600.00			$3,600.00
Governance/board	$12,000.00	$8,000.00	$4,000.00	
Finance services bank charges	$2,100.00	$1,300.00	$800.00	
SUBTOTAL (BAND ADMINISTRATION/ MANAGEMENT)	**$45,300.00**	**$23,850.00**	**$17,850.00**	**$3,600.00**
TOTAL BUDGET	**$1,612,130.40**	**$1,028,570.40**	**$543,960.00**	**$39,600.00**
CURRENT BUDGET 2016 (includes $150,000.00 Non-core funding)	**$855,717.00**			
Difference under proposed staffing model	**$756,413.40**			

47% additional funding required

Also, is less than counsellor wage parity of $864,000.00, not received by all centres (9 positions x $4,000.00 x 24 years)

APPPENDIX C: PROPOSED WAGES AND SALARY RANGES

1. SALARY RANGES AGREED TO BY TREATMENT CENTRE DIRECTORS IN 2015

	Position	Rate Salary Should be	Current Level	Comparison Mainstream	
Governance			lower end	lower range	higher range
Administration	Executive Director	$92,000.00	$64,685.00	$96,000.00	$145,000.00
	Administrative Assistant	$45,000.00	$35,000.00	$38,938.00	$54,400.00
	Secretary	$37,000.00	$26,000.00	$33,910.00	$42,354.00
Programming	*Elder	$130,000.00		$130,000.00	
	Cultural Coordinator	$58,625.00	$43,088.00	$50,000.00	$69,000.00
	Program Coordinator	$73,282.00	$48,000.00	$62,000.00	$71,000.00
	Treatment Counsellor	$58,625.00	$35,237.00	$42,593.85	$71,000.00
	Intake /Aftercare Worker	$47,000.00	$33,926.00	$49,631.40	$57,084.30
Support Staff	Attendants	$34,756.00	$26,000.00	$33,871.00	$42,354.00
	Cook	$36,230.00	$28,000.00		
	Maintenance	$34,756.00	$28,000.00		
	CHR	$46,000.00	$36,000.00		

*** current - only one with this position**

2. PROPOSED NNADAP WAGE RANGES, 2015-2016
COMMUNITY-BASED PROGRAMS

	Experience	Certified	Education	Base	Increment	Increment
Addictions Worker (prevention/education/support)	1-2 years	NON	High school certificate	30,000	31,650	33,296
Addictions Counsellor -Level I	1-2 years	certified	2 year diploma	40,286	42,495	44,714
Addictions Counsellor-Level II	3-5 years	certified	2 year diploma	46,933	49,148	51,365
Addictions Counsellor-Level III	5-10 years	certified	3-4 year degree	53,581	56,528	59,467
Program Manager/Supervisor/ Coordinator	5-10 years	certified	3-4 year degree	66,359	70,009	73,650
Treatment Director	5-10 years	certified	3-4 year degree	78,030	82,322	86,602
Case/Program Manager	5-10 years			52,731	55,998	59,264

APPENDIX D: ONTARIO TREATMENT CENTRE BED AND CYCLES LISTING

Centre Name	# of beds	# of cycles/year	# of residential clients served annually at 100% occupancy	Outpatient Clients served annually
Anishnawbe Health Toronto				297
Benbowopka Treatment Centre	16	10	160	
Dilico Adult Residential Treatment Centre	20	8	160	
Ka-Na-Chi-Hih	12	2 Treatment Phases (Phase I = 17 weeks, Phase II = no time specified) Clients can stay 6 months to 2 years	24 (max)	
Migisi	14	10	140	
Native Horizons	15	7	105	108 (approximate average)
Ngwaagan Gamig Recovery Centre Inc.	8	10	80	224
Nimkee Nupigawagan Healing Centre	9	3	27	
Reverend Tommy Beardy (Muskrat Dam)	20	6	120	
Sagashtawao	12	8	96	
Fort Frances Tribal Council				175 (outpatient and pre-treatment)
Sub-totals			792	804
Total			**1596**	

Note: Not all centres have reported outpatient clients.

APPENDIX E: THUNDERBIRD PARTNERSHIP FOUNDATION: PDA PRIORITY ACTIONS

(Submitted to PDACC, May 2016. Prepared by: Mae Katt LPN, Dr. Sharon Cirone, Dr. Claudette Chase and Carol Hopkins)

PRIORITIES FOR ACTION

1. Governance and coordination of care must support First Nations governance of services.

- Strong governance and coordination among and within systems are vital to developing and maintaining culturally responsive care in a First Nations community.
- Key components that support both the governance and coordination of systems include:
  - Community-driven addiction services;
  - Inter-jurisdictional relationships and collaboration;
  - System level partnerships and linkages.

(Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada, p 72)

2. First Nations health care providers and addiction medicine institutions should develop an on-line training course and long distance clinical support system on buprenorphine for primary care physicians working in First Nations communities.

- There are a number of physicians, nurse practitioners and nurses in Sioux Lookout with many years of experience in prescribing and dispensing buprenorphine in First Nations communities.
- These practitioners are capable of delivering training and clinical support through a long-distance mentorship network.

3. When invited to do so, addiction physicians should be supported to assist in buprenorphine treatment in First Nation community-based programs.

- Currently, a group of addiction physicians from Toronto and Sudbury regularly fly to isolated Sioux Lookout communities to do buprenorphine inductions.
- Support is necessary because family physicians simply do not have the time for buprenorphine inductions during their fly-in visits.
- The program is funded by the CPSO, which covers travel costs from Toronto to Thunder Bay, and by the Sioux Lookout Regional Health Authority, which provides daily stipends for the addiction physicians.

4. Nurse practitioners should be allowed to prescribe buprenorphine.

- Currently, many nurse practitioners work in isolated rural and northern communities with very high rates of addiction and limited access to addiction physicians.
- Buprenorphine is much safer than methadone or other potent opioids.
- Permitting NPs to prescribe buprenorphine will significantly enhance treatment capacity in the north.

5. NIHB and FNIH, Health Canada needs to ensure sustainable, stable operational funding for Prescription Drug Abuse (PDA) programs, including treatment with buprenorphine, addictions recovery, relapse prevention counselling, culture and land-based programming.

- Currently, Health Canada limits the number of days, per patient that nurses may be involved in buprenorphine dispensing to less than one per month
- Health Canada funding for community-based PDA programs was recently transitioned from one year grants to three year grant cycles.
- Sustainable program funding is required to build sustainable programs for complex chronic illnesses, such as prescription drug addiction.

6. Health Canada should provide training and support for recovery from intergenerational/Historical Trauma and PTSD. There should be funded support for:

- Wellness retreats for chief and council leadership (a request for funding has come directly from former Ontario Grand Chief Isadore Day);
- Training of prescription drug abuse program workers in trauma-informed care; and
- Aftercare programs that support individual, family and community healing from PTSD and historical trauma transmission.
- Prescription drug abuse and other addictions before this recent epidemic, including alcohol use disorders, are a symptom of underlying issues, sorrow and pain.

7. Indigenous communities should be offered support in establishing local, community-based treatment programs.

- Buprenorphine is emerging as an effective and feasible alternative to methadone treatment in Indigenous communities.
- According to regulations of the Non-Insured Health Benefits program, physicians requesting buprenorphine for First Nations patients must confirm that buprenorphine will be dispensed through a community treatment program that is able to store buprenorphine in a secure location.
- This ensures that patients receive appropriate counselling and support, and that safe and standard prescribing and dispensing protocols are in place.
- In the Sioux Lookout area, approximately 1500 patients living in remote First Nations communities have been treated in community-based buprenorphine treatment programs, with strong support from the communities' leaders.
- Buprenorphine treatment is initiated either by the community's primary care physician or by urban addiction physicians through telemedicine or fly-in locums.

- The primary care physician continues prescribing once the patient is stable.
- Buprenorphine is dispensed daily under the observation of nurses, nurse practitioners or community workers.
- Each of these communities has established a recovery program that involves community mental health workers who provide both conventional counselling and culturally appropriate, traditional healing practices.
    i. This comprehensive approach has enabled many patients to stop their opioid use and return to work, school and family.
    ii. Kanate and colleagues (2015), documented remarkable results for a buprenorphine program in North Caribou Lake First Nation.
    iii. A year after program initiation, criminal charges and Medevac transfers decreased, the needle distribution program dispensed less than half its previous volume and rates of school attendance increased.

References:
1. Kanate, D. Folk, D., Cirone, S., Gordon, J., Kirlew, M., Veale, T., Bocking, N., Rea, S., & Kelly, L. (2015). Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence. Evaluating outpatient buprenorphine-naloxone substitution therapy in the context of a First Nations healing program. Can Fam Phys,61(2):160-165.
2. World Health Organization. Dept. of Mental Health, Substance Abuse, World Health Organization, International Narcotics Control Board, United Nations Office on Drugs, & Crime (2009). Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.

8. First Nations patients living on reserve who are attending off reserve opioid substitution programs, should be offered to enter community-based PDA recovery programs. All patients requesting to return to or enter PDA programs in their communities should be supported to transition from methadone maintenance treatment (MMT) to buprenorphine. The college of physician and surgeons should encourage all MMT providers to support transition to buprenorphine prescribing where requested, by First Nations patients.
Patient choice should be supported, patient-centred care should be mandated.

- Many First Nations patients on MMT face significant barriers either travelling to their home communities or returning to live in their communities because of maintenance on methadone.
    i. Some patients report encountering resistance from MMT providers to transition to buprenorphine prescribing.
- Many communities are financially supporting expensive transportation for their community members to travel from the community to off reserve 'methadone clinics' and pharmacies.
    i. The First Nations that develop and maintain community-based programs can repatriate their community members to their own buprenorphine prescribing programs.

9. Youth should have access to services specific to their developmental needs.

- There are very few providers of addiction treatment services and specifically medical treatment of opioid use disorders who provide youth specific services, or at the very least integrate services adapted to the needs of young people.
- Young people, up to the age of 25, have challenges unique to the adult population.
    - "the human brain does not reach full maturity until at least the mid-20s..."
- The majority of young people with substance use disorders have concurrent mental health issues, such as anxiety and mood disorders.
- Homeless, street-involved, and marginalized youth often have complex psychological and social issues.
- Two excellent examples of services adapted to the needs of youth are:
    - School based program at Dennis Franklyn Cromarty High School in Thunder Bay
    - The Breakaway Toronto Opiate Support Team

10. Family physicians, nurse practitioners, and any other clinicians providing opioid substitution therapy should be prescribing buprenorphine/naloxone and have access to education in providing youth specific services.

- Youth often do not seek services through their family physicians or other health care providers because they:
  - have concerns about confidentiality or stigmatization;
  - do not have a primary care provider or have lost contact with their usual provider; and
  - are often not aware of treatment options.
- Family physicians and other providers often do not feel confident providing clinical care to adolescents and youth with alcohol and substance use disorders and the concurrent mental health disorders.
- Many primary care providers work in environments that do not purposefully provide youth specific services.

11. Any adolescent or young person, particularly those under 25 years of age, especially whose home community is a First Nation, seeking care for opioid use disorders, should be offered a full range of treatment options, including abstinence-based treatment and/or opioid substitution therapy. All those consenting to opioid substitution therapy should be counselled in the expectations of duration of treatment and be offered the opportunity to taper down and off of OST, throughout the course of treatment. The advantages of buprenorphine versus methadone for OST in young people should be discussed.

- There are an increasing number of clinical trials on treatment interventions for adolescents and youth with opioid use disorders.
- There are many instances however, where patients prefer buprenorphine, where their expectations of treatment or where their living circumstances, or geographic location would suggest that buprenorphine is preferable over methadone.
- Many young people are concerned about the long duration of treatment that is typical of methadone, they express concern about side effects, including sedation and/or they are worried about the stigma and regulation of methadone versus buprenorphine.
- There is anecdotal evidence and a pharmacologic basis for supporting the use of buprenorphine over methadone for patients anticipating tapering off of and discontinuing OST.
- Many young people seeking treatment for prescription drug abuse (PDA) have had shorter durations of use, with less progression to high risk use (IV use, high dose use, daily use).
- It is a great concern when the duration of OST treatment is exponentially longer than the duration of illicit opioid use.
- All youth on OST should be offered and supported in efforts to taper down and off of OST.

12. Buprenorphine should be designated as first line of treatment for Aboriginal women who are pregnant.

- Women can return home more easily to be with their families and receive support from their communities.
- Treatment has the same outcomes as other monitored opioids for pregnant patients.
- Studies show less intense and shorter duration of neonatal abstinence syndrome (NAS) with buprenorphine over methadone.

13. Treatment has to have a gender lens.

- Social control through social service agencies and medical providers are punitive drug policies and effect women as double and triple punishment. Is impossible to protect children by locking up their mothers for their drug use and it's impossible to ensure the wellbeing of children by detaching them at birth from their mothers.
- Treatment must attend to the needs of women through the provision of child care, removal of disqualifying criteria for pregnant women, support breast feeding women, and meet the needs for transgender populations
- Treatment for mothers and their new born babies must accommodate access to health care while giving attention to poverty

APPENDIX F: COMMUNITY WELLNESS THROUGH CULTURE AND COMMUNITY BASED TREATMENT

Prepared by Mae Katt, N.P.

INTRODUCTION

A legacy of historical policies such as residential schools in Canada has resulted in widespread trauma and disconnection from homes, family, land and culture for First Nations, Indigenous, Metis & Inuit People's in Canada. The complexity of intergenerational trauma, violence and abuse requires a major shift in healing methods and program delivery that is initiated and implemented by each community.

> *"We call upon the federal, provincial, territorial and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools ... "* (Truth & Reconciliation. 2015. P. 322)

The Thunderbird Partnership Foundation has created community, government and non-government organization partnerships to promote a paradigm shift toward using culture as foundation, supported by the First Nations Mental Wellness Continuum (FNMWC) framework to assist communities to address community wellness (aka recovery).

> *"We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders ...* (Truth & Reconciliation. 2015. P. 322)

This paper outlines an approach to sharing practice-based evidence to address opioid addiction, opioid agonist treatment, trauma, grief and loss and a message of Hope, Belonging, Meaning and Purpose to revitalize and sustain individual and community wellness through a strength-based approach.

CULTURE AS INTERVENTION

COMMUNITY ENGAGEMENT MODEL

A community engagement model has been designed and developed through partnership with health professionals and delivered to a number of First Nations to assist them in achieving the following goals:

1. Assume authority over community healing and wellness through chief and council exercising jurisdiction over community wellness programs;
2. Identify and use community strengths, existing health team, history, local teachings and values to develop and deliver community-based and land and culture-based initiatives to rebuild families and communities affected by addiction and historical trauma;
3. Create partnerships with clinical providers such as physicians, nurses, nurse practitioners, social workers, psychologists and traditional knowledge keepers to deliver community based interventions with opiate agonist treatment (with Suboxone) to start a wellness path for clients, families and communities.

ENGAGEMENT PROCESS

On invitation from the community's delegated authority – usually the health director – a team of experts will provide on-site information sessions over a period of two days to the community health team, community members, band council, Elders, traditional people, clergy, counsellors, teachers, health professionals and others.

THE TEAM

Physician(s) with experience and specialization in addiction medicine; nurse practitioner with an addiction specialty; knowledge translator(s)/Elders; knowledge broker from Canadian Centre on Substance Use and Addiction, , an addictions policy analyst from the Assembly of First Nations, a clinical liaison from Indivior Canada and others as required.

EMPATHY IS AN INTERVENTION

Information is presented on these specific areas:

1. Adolescent treatment in a First Nation high school and trauma informed care
2. Community-based suboxone treatment and impact: community wellness indicators
3. Pharmacology of suboxone (buprenorphine/naloxone)
4. Culture as foundation
5. First Nations Mental Wellness Continuum (FNMWC) framework
6. Best practices and policy development
7. Access to opioid agonist treatment in Canada
8. Documentary on community-based suboxone programs in Northern Ontario. You Tube search for: **"Rings of Fire"** or the non-broadcast title **"In This Heaven"** can be shown – 47 minutes

ENGAGING WITH COMMUNITY LEADERSHIP

The Team recognizes self-government principles and the first line of authority in decision-making is the chief and council. The Team will (if invited) make a presentation to the council to seek consideration of a band council resolution to initiate a community-based treatment program.

SAMPLE BAND COUNCIL RESOLUTION

Whereas (name of First Nation) has held education and information sessions with the community and leadership about combatting the health and social impacts caused by members addicted to illicit opioids and have been directed to provide community based Suboxone treatment and supportive aftercare to those receiving treatment;

Whereas the (name of First Nation) is a rural (or remote) community and requires First Nations and Inuit Health funding to support program delivery, counselling and administration of Suboxone, including Non-Insured Health Benefits coverage of the medication;

Whereas the (name of First Nation) has reviewed options for treatment and have determined a community-based program developed and delivered in the community, through collaboration with health professionals, is the approach chosen by the community and band council members;

Therefore, Be It Resolved that Chief and Council of (name of First Nation) have authorized a community-based Suboxone treatment program in the community and directs First Nations and Inuit Health and other departments (as required) to fully support our decision and cooperate fully with planning, policy support and funding for a community-based Suboxone program.

POTENTIAL RESOURCES

Health professionals (physicians, nurse practitioners) have experience with the delivery of adolescent and community based Suboxone programs that are highly successful in Ontario. Clinical approaches are integrated with the community's culture and land-based programming that respects the values and beliefs of each community.

Thunderbird Partnership Foundation is the national voice advocating for First Nations culturally-based substance use and mental wellness services.
Website: **thunderbirdpf.org**

Assembly of First Nations, Health Unit is mandated to protect, maintain, promote, support and advocate for First nations inherent, treaty and constitutional rights, holistic health and the well-being of First Nations.
Website: **afn.ca**

Canadian Centre on Substance Use and Addiction is a national non-profit organization with a mandate to reduce drug related harms. It fosters a knowledge translation environment where evidence shapes policy, practice and action.
Website: **ccsa.ca**

Indivior Inc has developed Suboxone (buprenorphine/naloxone) for the treatment of Opioid dependence and have partnered with governments, policy makers and health professionals about the value of office and community-based treatment.

TERMINOLOGY

Land based describes an Indigenous way of life rooted in traditional knowledge, where everything is connected and related to land and water.

Land-based healing describes a set of culturally-defined healing practices in which land and cultural activities are part of the healing process. There is a focus on renewing a person's relationship and connection to the land in order to restore balance and identity.

SUMMARY

A two-day community engagement visit can be made to requesting First Nations and experts can make presentations to the community health team, professionals, Elders and leadership to discuss the process and benefits of establishing a community-based treatment model. In the past, the team has made a number of visits across the country, resulting in the creation of community-based treatment programs that have repatriated their members from towns and cities to supportive environments in their home community. Through local control the clients are supported, employed, nurtured and provided healing programs to sustain their wellness path.

The estimated budget will support the hiring of clinical experts (physicians and nurse practitioners) as well as engage their own traditional knowledge translators to travel to First Nations and Inuit communities to implement an approach aligned with the First Nations Mental Wellness Continuum framework in opioid agonist treatment.

The other participating organizations have existing resources.

BUDGET

Professional Fees:

Clinical services are $ 1000/day x 2 days x 2 clinicians = $ 8,000 x 10 visits	**$ 40,000.00**
Traditional knowledge keepers/Elders $1000/day x 2 days x 10 visits	**$ 20,000.00**
Travel & Accommodations Average trip $ 2,000 x 3 people x 10 visits	**$ 60,000.00**
Total for Community Engagement	**$120,000.00**

APPENDIX G: COMMUNITY-BASED SUBOXONE TREATMENT MODEL

INTRODUCTION

There are 133 First Nations in Ontario that provide a number of on-reserve programs and services. First Nations have active band councils with long histories of diversifying employment, economic development and delivering health and social services programs to serve the community and to provide options for its members. With the current state of widespread opioid addiction and overdoses, the leadership is focusing on treatment options for members who are addicted to opiate drugs. One primary goal is to ensure that a stable workforce is available for future training and employment opportunities and to build healthy families.

First Nation leadership and community workers have identified a need to expand treatment options for those community members who are addicted to opiate drugs (oxycodone, morphine, codeine, fentanyl, hydromorphone, heroin). For years First Nations have experienced high rates of opiate addiction, specifically to a drug called OxyContin, with many community members now seeking alternate substances, as the drug OxyContin is being replaced by OxyNEO (stated to be less tamper-proof).

Also, after years of being on methadone, members have expressed a need to try an alternate substitution treatment using a drug called Suboxone. Clients who desire transition to Suboxone from methadone need to be on less than 60 mg of methadone per day to be considered for treatment.

This paper outlines the costs and phases to deliver a Suboxone treatment program that consists of a 30-day taper program and maintenance program as well as the cost to initiate 20 people on Suboxone during each treatment cycle.

COMMUNITY BASED SUBOXONE® TREATMENT

The substitution drug called Suboxone has been approved in Canada since December 2007 for use in opiate dependence. Data suggests that specifically for the treatment of opiate dependence, Suboxone may be somewhat superior to methadone, partly due to the action and safety and ease to administer in a community-setting. Currently this drug is considered a full benefit on both Non-Insured Health Benefits and Ontario's Drug Benefit Program for those who request this treatment.

An experienced treatment team is available to work with community leaders and community health workers to provide a community-based Suboxone treatment program in any First Nation. The treatment team has experience in using Suboxone as a substitution drug for opiate treatment and short-term maintenance.

The duration of Suboxone treatment and maintenance is determined by:

- the length of time that clients have been abusing opioid drugs and the amount of daily opioid intake
- the drug and alcohol history of the client (multiple substances over many years may take longer)
- the route(s) of ingestion of opiate drugs (people who use drugs intravenously have more complex needs)
- history of traumatic events in life and presence of concurrent disorders such as depression, anxiety, post-traumatic stress disorder, unresolved grief and complicated grief

PROGRAM PARTICIPANTS

Inclusion criteria includes:

(a) to be 16 years old or older

(b) to meet the criteria for opioid dependence on DSM-V

(c) to be in stable physical and mental health

(d) to be able to give informed consent (understands the treatment plan)

(e) if female, to agree to a pregnancy test (can use Subutex formulation)

(f) to agree to abstain from benzodiazepine drugs and alcohol

(g) to agree to random urine drug tests (usually Day 1, 30 and 90)

EXCLUSION CRITERIA

Those with the following will be excluded from participating:

(a) people who may have an untreated medical condition (e.g. acute hepatitis, unstable heart condition, liver or kidney disease)

(b) allergy or sensitivity to the drug components – buprenorphine or naloxone

(c) severe psychiatric condition in need of immediate treatment or imminent suicide risk

(d) has a current pattern of benzodiazepine use (Ativan, Valium, clonazepam) and alcohol which precludes safe participation in the program

PLANNING PHASE

Firstly, the chief and council decide to obtain the services of the treatment team through contact with the treatment team coordinator. Once a treatment date is selected, the First Nation will provide a treatment location and support staff to assist the treatment team during induction, follow-up visit and support to the clients during all aspects of treatment.

The community-based health team are usually the main group involved during this phase. The steps involved in planning are:

- Identify those requiring or requesting Suboxone treatment for opiate addiction
- Method of client selection – 20 clients or less each intake
- List of names, date of birth, health card number (for lab requisitions) and 10-digit status number (to obtain medication) is provided to the treatment team coordinator and case manager
- Laboratory tests done at nearest provincial location
- Date of treatment is mutually selected
- Prescriptions prepared, signed by physician or nurse practitioner and delivered to the pharmacy for delivery to the community health facility on start date (labelled, correct dosage)
- Initiate low-dose, short-term treatment model – top dose of 16 mg (cover 92% of opioid receptors at 16 mg); goal is to stabilize withdrawal symptoms and eliminate craving
- Ancillary medications available for each client – NIHB covered with status number: clonidine, Gravol, trazadone, ibuprophen
- Urine drug screen kits purchased
- Advise clients to stop taking opiate drugs by midnight the day prior to initiation of treatment

TREATMENT PHASE – 30-Day Taper

- Induction is 2-3 days – Day 1 starts with a 4 mg "test-dose" to make sure there is no allergy to Suboxone; top dose is 2 mg on Day 1 (new product monograph)
- Days 2 and 3 for dose increments to control withdrawal symptoms and craving
- Assess withdrawal symptoms with Clinical Opiate Withdrawal Scale (COWS)
- Clients who are in moderate withdrawal can start treatment (score 13 or over)
- First 2 days the clients will have withdrawal symptoms – increase Suboxone dose to goal of 16 mg
- Physical exam and medical and drug histories completed
- All doses are direct observed therapy for 10 days (registered nurse or registered practical nurse to monitor) until client reaches stabilization
- Training on-site by nurse for unregulated care provider (usually an existing community worker) who will administer Suboxone daily to clients
- COWS done while withdrawal scores are over 5 (usually 7 – 10 days)
- After Day 2 – takes less than an hour per day to obtain medication
- Case management meetings and client summaries provided on Day 3 to review progress

MAINTENANCE PHASE – 6 to 12 Months

- Start maintenance dose at client's top dose e.g. 8 mg, 12 mg, 16 mg and remain there up to 9 months then offer slow taper
- Unregulated care providers to administer Suboxone and ancillary medications
- Record-keeping and safe medication storage (usually a lockbox)
- Adjust dose based on client perception and craving episodes or intensity
- Treatment team coordinator communication between clients, UCPs, nurses and physician

CULTURE AS FOUNDATION

- Ongoing care in a cultural context – higher retention with supportive care with culture as foundation
- Trauma-informed care and counselling that includes education about trauma, colonization, drug education is provided by the First Nation and current service providers
- Referrals to existing treatment centres may be considered for some clients

PROGRAM IMPLEMENTATION

Each client will undergo a medical and drug history, focused physical examination and laboratory testing prior to initiation of treatment. This will determine medical fitness and identify any pre-existing medical conditions requiring treatment and referral to specialists. Any abnormal results will be reviewed by the treatment team coordinator, who will consult with the physician or nurse practitioner, and a follow-up plan will be developed for this client with appropriate medical providers.

Each client will receive a copy of the *Community Based Suboxone Program – Policies and Procedures for Clients*. Each client will then sign the treatment contract to enter the program and a consent to release information form (if required).

On Day's 1 and 2, the clients will go to the health centre to begin the Induction Phase and to adjust their dosage to the optimum range (usually takes 2 to 3 days). Once the optimum dosage is reached, the clients will continue to go to the health centre daily to receive their Suboxone dose. Titration of the drug upward and downward will take place in the community. The goal is to have all clients at the lowest possible dose of Suboxone so clients can start maintenance therapy until they feel there is adequate recovery that they can discontinue Suboxone and not experience high craving for opioid drugs that may cause relapse.

Each client will be assessed daily prior to Suboxone administration. A Clinical Opiate Withdrawal Scale (COWS) score will be obtained before the client receives their dose of Suboxone. If withdrawal symptoms are present, a prescription for an ancillary medication will be given for home use. After being individually assessed, the client will receive ibuprophen, Gravol, clonidine and trazadone (dosages at higher end, for example, ibuprophen 600 mg every 6 hours; clonidine 0.2 mg every 6 hours; trazadone 50 mg tablets - up to 4 tablets at bedtime (withdrawal causes sleeplessness).

The community will be responsible to provide culture-based support for the clients that should consist of ceremony, counselling and education topics such as: coping techniques, triggers and craving, relapse prevention, and motivation enhancement. Coping techniques will assist the clients to focus on diversion such as recreation, culture, spirituality and meditation, daily living including self-care, nutrition and relaxation techniques. Triggers and relapse prevention will address the management of emotional, community and environmental triggers.

PROGRAM DURATION

Each treatment intake consists of an Initiation Phase and a Maintenance Phase that is estimated to be 12 to 24 months in duration. The program will begin on a date determined by the community and treatment team. Approximately 20 clients can be treated in each intake. As the actual numbers of people requesting treatment are unknown, subsequent treatment intakes can be implemented as soon as the leadership determines the need.

SUMMARY OF PROGRAM COSTS

The treatment team will initiate the Suboxone treatment in the community during a 3-day visit then make a follow-up community visit (1 to 3 days) over the initial two-month period to ensure that dosage is adequate, and clients are assessed for any arising concurrent disorders such as anxiety, depression and grief. A nurse is required on-site for the first 10 days to monitor clients and observe for any side effects. A maintenance phase will be required for most clients and each will be individually assessed by the treatment team.

Costs are based on professional time and personnel required to provide on-site care until clients are stabilized on the therapy (usually 10 days).

All personnel working in a community-based treatment program should complete a free 6-hour Suboxone training, with certificate, at www.suboxonecme.ca

Total cost for each Suboxone Treatment program intake is **$ 22,500**, which is about $1,000 per client to be initiated on Suboxone treatment in a First Nations community. If 12 intakes were completed to treat 240 clients, the overall cost is **$ 270,000**.

BUDGET FOR SUBOXONE TREATMENT TEAM (FOR 20 CLIENTS)

PROFESSIONAL FEES:	
Physician/Nurse Practitioner 2 @ $1250/day x 3 days	$7,500.00
Regulated Health Professional (RN/RPN)1 @ $900/day x 10 days	$9,000.00
TRAVEL & ACCOMMODATION:	
Average $2,000 /trip x 3 people	$6,000.
TOTAL COST PER 20 CLIENTS	**$ 22,500.00**
TOTAL COST FOR 12 INTAKES 12 Suboxone Treatment Intakes (max 240 clients) @ $ 22,500/intake x 12 visits	**$ 270,000.00**

APPENDIX H: REFERENCES

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