Building Sustainable Equity in First Nations Addictions Treatment Programs

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THUNDERBIRD
PARTNERSHIP FOUNDATION

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Summary of Recommendations

1. Conduct a comprehensive review of the current funding formula to inform the modernization of a new formula based on new criteria, recognizing the need for increased funding.

2. Implement guidelines for fair and equitable salaries for addictions workers of the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP), commensurate with those paid to mainstream and provincial counterparts.

3. Strengthen system continuity and coordination to ensure services and programming are better integrated between the federal, provincial, and territorial governments, ensuring that all First Nations peoples have access to services in accordance with the principles of the Canada Health Act.

4. Increase federal government transparency and communication in funding structures to assess whether funding is sufficient and increase accountability to First Nations peoples.

5. Place measurable conditions on mental health transfers to the provinces and territories so that the federal government is accountable for the funding they transfer.

Introduction

For First Nations, Inuit, and Métis people residing in Canada, substantial disparities in health and healthcare access persist, despite the focus on Indigenous reconciliation over the past number of years (Allan & Smylie, 2015). It is widely recognized that these communities experience inequitable access to healthcare as well as a disproportionate burden of harm related to substance use that has been exacerbated by the pandemic. The Chiefs of Ontario and the Ontario Drug Policy Research Network (2021) found that during the first year of the pandemic, First Nations people experienced a 132% increase in the number of opioid poisoning-related deaths relative to a 68% increase for non-First Nations during this period. This problematic use of substances, including alcohol, tobacco, opioids, and other prescription and illicit drugs, has consistently been identified as a priority health concern by First Nations communities. The overuse of these substances, in addition to the burnout of staff who are involved in prevention and treatment, have unquestionably worsened due to the conditions that the COVID-19 pandemic has imposed.

Further, the number of First Nations people who specifically identify their trauma and associated substance abuse issues as being linked to Indian Residential Schools, Day Schools, Missing and Murdered Indigenous Women and Girls, and child welfare experience has also increased (Honouring Our Strengths, 2011; Lee et al., 2021). At least 41% of First Nations adults who reported using opioids in a harmful way or methamphetamine identified their experience with trauma, and grief and loss as contributing to their current use of these drugs (Thunderbird, 2022). There is broad recognition among First Nations communities, First Nations organizations, academics, and health professionals of the need for strong health promotion, prevention, early identification, and intervention services to address the social determinants of health within the context of community development for First Nations communities and especially for the rapidly growing First Nations youth population.

The primary federal programs to both treat and prevent these problems among First Nations and Inuit communities are the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP). Both are national networks of Indigenous-specific addiction programs that have been in place for decades. Despite the strengths inherent within NNADAP and NYSAP, including the provision of culturally relevant services, previous reviews of this program (1998 NNADAP General Review) have noted their shortcomings. The programs contend with significant challenges associated with employment and retention, including high workloads, stressful working conditions, and salaries that are not on par with those for similar positions elsewhere in the country. These obstacles are rooted in an outdated modified Berger funding formula, which is used by the federal government and grossly underestimates the resources required to effectively deliver programming. The formula ultimately determines how much is invested in these programs and facilities, which signals the amount of funds available to pay staff and support operations. The inability to meet capital and operational expenses for basic utilities has also significantly impacted conditions of work, further exacerbating this challenge. Further, the federal government's level of program funding has not kept up with the Government of Canada's evolving position towards reconciliation over the last 30 years.

Without reform to the foundational policy and funding assumptions underlying these programs that were developed and continue to persist as relics of a colonial government, there is concern that the ability of communities to deliver these programs will be irretrievably compromised – at a time when they are needed most. While the primary focus of this paper is to encourage and justify the need for a systemic review with the objective to increase resources under the NNADAP and NYSAP programs, the principal arguments extend to the other mental wellness programs, such as the Indian Residential Schools Resolution Health Support Program, Mental Wellness Teams, and others focused on suicide prevention and MMIWG2+.

Background

The National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP)

NNADAP was established as an alternative to mainstream addiction services based upon the recognition that culturally relevant programming, grounded in a First Nations worldview, is essential for many First Nations people to heal from substance use and other related problems. The program is an example of a First Nations and Inuit Health Branch (FNIHB) program largely controlled by First Nations and Inuit communities and organizations. The goal of NNADAP is to support First Nations and Inuit people and their communities in establishing and operating programs aimed at arresting and offsetting high levels of alcohol, drug, and solvent misuse among their target population. The treatment centers are largely located on First Nations lands but serve First Nations and Inuit populations no matter where they reside.

The foundation of this program is built on community and culture-based practice, and an understanding that cultural-based healing practices are important in both community and treatment centre settings. The NNADAP program was created in 1982 with one-time funding, and then subsequently received permanent, federal funding in 1992. **This funding model, which is an out-of-date approach that is insufficient, has not been modified since despite overwhelming support to do so by First Nations communities and the Government of Canada's expressed effort towards Truth and Reconciliation.**

NNADAP and NYSAP includes 52 treatment centres (10 of which are for youth) across nine provinces, approximately 700 treatment beds, more than 500 alcohol and other drug abuse community-based programs and funding for approximately 730 NNADAP community workers. These facilities are governed by First Nations communities and rely primarily on the federal government for their core funding. Community-based addictions treatment falls under the jurisdiction of provinces and territories, who are constitutionally responsible for Public Health, Primary Care and Physician Services. These aspects of health care are critical for addressing opioids and methamphetamine at the community level and require cooperative effort with provinces and territories.

For those First Nations and Inuit individuals residing off-reserve, the Non-Insured Health Benefits (NIHB) program provides coverage for a range of medically necessary health benefits when these benefits are not otherwise covered through private, provincial or territorial health insurance plans or social programs. The NIHB program is cumbersome in nature due to the crawling pace at which the review and approvals processes are undertaken, creating another barrier for First Nations people to achieve positive health outcomes. Notably in British Columbia, responsibility for the design, management and governance, and delivery of First Nations health programming has been transferred to the First Nations Health Authority, pursuant to a tripartite agreement with the provincial government and the federal government. However, many provinces/territories lack an independent First Nations health authority.

Most NNADAP activities fall into the following areas: prevention, treatment, research, and development. Prevention component activities cover three key areas: (1) prevention: aimed at preventing serious alcohol and other drug abuse problems; (2) intervention: aimed at dealing with existing abuse problems at the earliest possible stage; and (3) aftercare: aimed at

preventing alcohol and drug abuse problems from reoccurring. Federal funding for NNADAP does not provide for comprehensive community-based addictions and harm reductions services nor does the funding ensure communities have capacity for physicians and nurse practitioners who can facilitate pharmacological therapy, an outreach workforce to support people who are using drugs, or mental health therapists working from culture or western-based credentials, nor does federal funding sufficiently address the inequity across the determinants of health that further exacerbate trauma, substance use and associated harms.

Health Canada and First Nations communities partnered in 1995 to develop NYSAP in response to alarming rates of volatile substance misuse amongst youth in select First Nations and Inuit populations across Canada (Dell & Hopkins, 2011). Key to this partnership was that both Indigenous culture and Western approaches to treatment and recovery informed the development of the residential treatment centers' structures, services, and program delivery.

Currently, NYSAP receives $13 million a year in federal funding. It is run through ten Youth Solvent Addictions Centres (YSAC), which are located throughout the country, providing 120 treatment beds in total. These centres follow a "continuum of care" approach that begins with pre-treatment, then treatment, and finally post-treatment care in which the families of the youths are involved. Since the program began, the treatment centres have been used at maximum capacity, with a minimum of 212 youth treated every year.

Today, NNADAP and NYSAP treatment centres apply Western therapeutic approaches, such as cognitive behavioural therapies, while increasingly strengthening the use of traditional cultural interventions (Dell et al., 2011). These programs incorporate First Nations community and history context as the foundation of care and therefore tend to be more trauma informed. **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 the NNADAP and NYSAP workforce** (Honouring Our Strengths, 2011).

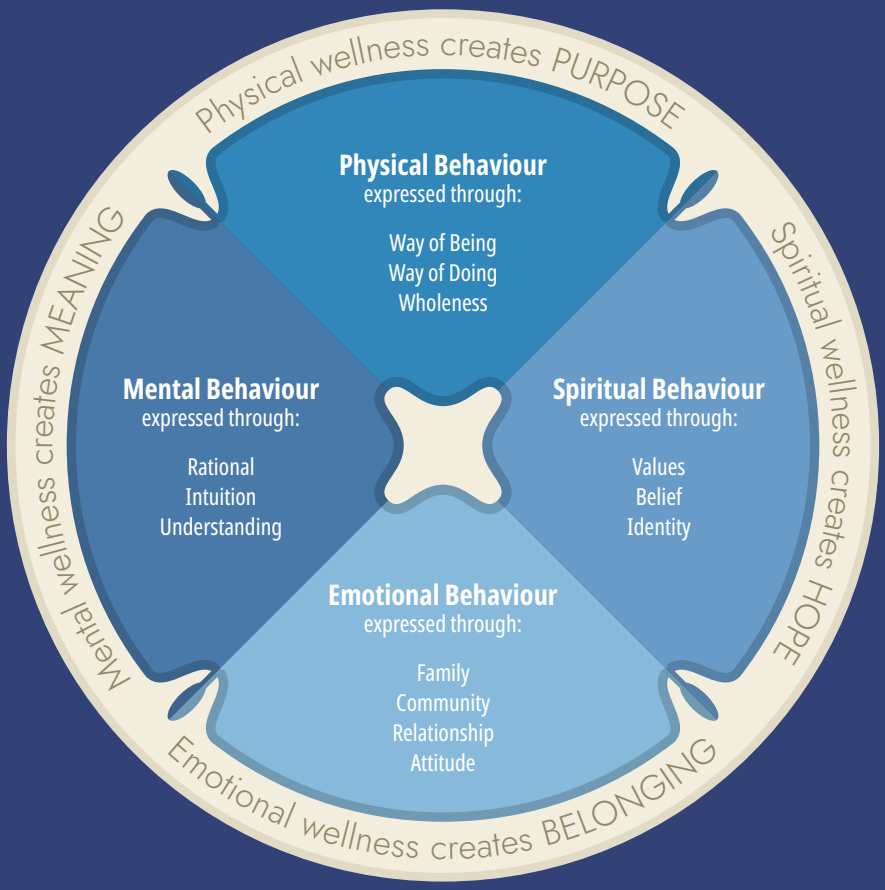
The numerous reviews of NNADAP have consistently generated a list of similar recommendations, including the need for communities, regions, and all levels of government to better coordinate services and supports to meet the needs of First Nations communities. Some of these have been addressed while others continue to be evaded, notably the strong recommendation from the 1998 review that the funding criteria be modified. Subsequent to those reviews, the Assembly of First Nations (AFN), the National Native Addiction Partnership Foundation (NNAPF), and FNIHB oversaw a comprehensive, community-driven review of substance use-related services and supports for First Nations people in Canada.

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. This evidence-based framework outlines a continuum of care to guide the delivery, design, and coordination of integrated services at all levels of the NNADAP/NYSAP program, as well as other substance use and mental health programs that are needed by First Nations populations. NNADAP and NYSAP treatment centres have been evolving to address the emerging and changing needs of First Nations people.

Some have transitioned to family treatment programs, land-based treatment, day treatment and the inclusion of out-patient or community-based treatment. The initiative to create change where change was possible was sparked by national consensus on First Nations culture, and must be central to the way substance use and mental health issues are addressed among First Nations communities (Health Canada, 2011). Although the federal government participated in the development of the framework, there was no policy change to ensure funding for the continuum of care.

Knowing that mental wellness is supported by factors such as culture, language, Elders, families and creation, Indigenous Services Canada, Thunderbird Partnership Foundation, the AFN and First Peoples Wellness Circle developed the First Nations Mental Wellness Continuum Framework in 2015 with the overarching goal to improve mental wellness outcomes for First Nations. This framework illustrates how First Nations seek to achieve whole health, which includes physical, mental, emotional, spiritual, social, and economic well-being and the type of knowledge and expertise that NNADAP and NYSAP workers require to work with these communities (Indigenous Services Canada and Thunderbird Partnership Foundation, 2015). Figure 1 is a simplified and focused Indigenous Wellness Framework Wheel (The comprehensive First Nations Mental Wellness Continuum Model can be found in Appendix A).

Figure 1: Indigenous Wellness Framework



NNADAP and NYSAP are provided with some base funding through the FNIHB program in accordance with the Berger formula that was developed in 1982, which was a much different era for Indigenous Truth and Reconciliation. The formula adjusts to population based on the distribution of people across each region in terms of remoteness and size of community (Statistics Canada, 2020). About $100 million, or 8.0%, of core/on-going program funding in 2018-19 was identified as being allocated using this Formula (Office of the Parliamentary Budget Officer, 2021). The federal government makes funding for these services and programs contingent on whether certain terms and conditions are met, such as provider qualification, standardized activities to achieve an established set of objectives, a baseline for bed utilization rates and non-operational days, and accreditation.

Accreditation as a Condition of Funding

Accreditation of treatment programs is voluntary among NNADAP treatment centers and is a significant undertaking that demonstrates the quality of residential treatment. NNADAP has been engaged in accreditation since 1998 when it partnered with Canadian Council for Health Services Accreditation, now Accreditation Canada, to review accreditation standards for health care services and to enhance the standards of excellence with a focus on patient safety, and continuous quality improvement. Accreditation became optional for NNADAP treatment programs in 1998 and mandatory for the Youth Solvent Abuse Treatment Programs in 1995. The Canadian Executive Council on Addictions (CECA) undertook a study of the status of accreditation among residential treatment programs in Canada, including NNADAP and NYSAP. Concerns for the quality of treatment programs that are publicly funded but not accredited was a primary objective of the study undertaken by CECA. One of the findings of this study indicated that there are more accredited treatment centers among NNADAP and NYSAP, 85% accredited, than there are among mainstream Canada, 62% accredited.

For Ontario, it was reported that less than one quarter of mainstream treatment centers are accredited (CECA, 2014). Accreditation standards used by NNADAP and NYSAP treatment centers are the same standards Accreditation Canada used for all health care services. Standards of excellence for governance, human resource management, information management, health & safety, are common across all health care services that are accredited by Accreditation Canada. The client services section of standards is specific to the service, and in this case, the standards for substance use services used by NNADAP and NYSAP are equal to standards used in mainstream substance use services.

The Challenges These Communities Face

While it is acknowledged that permanent funding exists, it is considered "deficit funding" as it has failed to meet the demands on these services from decades ago, let alone with today's realities. This is because the funding formula has not since been evaluated or reformulated in decades and has engendered a lack of wage parity between addictions staff in First Nations communities, and mainstream workers in the province (Ontario Regional Addictions Partnership Committee, 2013). First Nations addictions workers earn nearly 45% less than their provincial counterparts. The amount of funding provided simply does not enable communities to provide adequate wages for their staff and is not commensurate with their skill or experience, particularly given the complexity of services that need to be provided and some of the other circumstances and infrastructure challenges faced by these facilities.

NNADAP and NYSAP have had increases in their funding through the National Anti-Drug Strategy (NADS) and other programs, however, it has tended to only be short-term, and in some cases directed at particular initiatives identified by the federal government. Despite increases in mental wellness funding over the last years, the funding streams and allotments are temporary in nature and are not considered core funding and cannot be used for salary enhancements for addictions staff in First Nations communities.

There are increased demands for these types of prevention and treatment services in First Nations communities which is attributed to the legacies of colonization and systemic violence.

First Nations in Canada report higher rates of substance-related hospitalizations and overdoses than the general population (Russell, 2016).

Rates of mental health disorders are especially high in First Nations communities and, in particular, amongst those struggling with substance use disorders. It is now well recognized that this reflects the impact of policies implemented to assimilate Indigenous peoples, including loss of land and language, grief, and chronic trauma. These have had a devastating, intergenerational impact on First Nations communities, dissolved cultural continuity and unfavorably shaped their health outcomes. First Nations peoples also experience ongoing stressors, including large socioeconomic disparities, discrimination, racism, and oppression.

Tragically, resulting mental health, substance use and violence issues among First Nations communities can manifest themselves in a vicious cycle of stress and trauma (Ninomiya et al., 2020). The complexity of symptoms that accompany intergenerational trauma and substance use disorders represents major challenges in the treatment of both disorders. Intergenerational trauma and incidences of poor mental health have also spawned other challenges for Indigenous people, as they face a higher prevalence of physical chronic conditions — such as hypertension, obesity, diabetes, and arthritis.

Data From the National Addiction Information Management System

Data from the system indicated that 75.5% of clients complete their addictions treatment program, and:

- The majority of clients (82.2%) entering treatment use more than one substance, of which 90.3% are addicted to alcohol, followed by cannabis, cocaine, and opioids
- 71.2% of clients terminate use of alcohol post-treatment, 67.4% terminate use of cannabis, 81.8% terminate use of cocaine and 72% discontinue misuse of opioids
- Of those who did use post-treatment, 94.9% use less than pre-treatment use
- Post-treatment supports most used are cultural /social 71.4% and cultural spiritual 72.2%
- 90% of post-treatment clients report they have more control over their life, improved positive relationships, can ask for help when needed, have a sense of purpose
- 33.6% of opioid using clients have diagnosed or suspected mental health disorder. 28.2% of non-opioid using clients have a diagnosis/ suspected mental health disorder

Regarding mental health and addictions, rural and remote communities generally bear a disproportionate burden of disease while simultaneously having limited or less consistent access to health services, particularly when it comes to specialist care. (Schiff & Moller, 2021). This is exacerbated in northern communities as residents are more likely to experience increased instances of housing instability and poverty (Schiff & Moller, 2021). Through the implementation of the First Nations Opioid and Methamphetamine survey, First Nations communities have reported that context for declaring a state of emergency is due to the alarming rates of violence in the community brought on by gangs coming into the community who then incite gun violence, murders, human trafficking, and the recruitment of children and youth as

drug mules (Thunderbird 2021). These communities lack resource capacity to respond and increase community safety and the highly qualified workforce recruited for mental health and addiction services leave the high stress work environment for higher paying and less stressful work environments.

Where mainstream mental health and addiction services have been available, there has been apprehension to utilize them due to the distrust sown through colonial violence. The cultural beliefs and healing traditions of First Nations are often excluded from mainstream substance use treatment services or social services. Because of this, First Nations are more likely to withdraw from addiction treatment as they do not feel culturally safe (Maina et al., 2020). Therefore, adequate services for First Nations communities implies incorporating culturally safe approaches and programs to ensure the best possible quality of care that will be intentionally sought out. Culture based interventions facilitated on the land demonstrate a 14% increase in mental wellness (Thunderbird 2021).

Building Equity, Retention and Capacity in Treatment Centres

The Thunderbird Partnership Foundation and its allies have been raising the alarm on the issues of fair wage compensation commensurate with the level and complexity of work, and the lack of equity and capacity within addictions treatment due to issues of staff retention and loss of critical knowledge for years. Time is of the essence to make meaningful changes to better support NNADAP and NYSAP and strengthen community, regional and national responses to substance use and associated mental health issues among First Nations people in Canada. To do so, Thunderbird Partnership Foundation and its allies highlight three critical areas where federal support is required.

1. "Right Pay for the Job": Competitive Wages for First Nations Mental Health and Addiction Services

Salaries paid to staff in the NNADAP and NYSAP programs are **at least 47% lower** than the national average for the same positions (Thunderbird Partnership Foundation, 2018). This lack of competitive compensation between NNADAP and NYSAP workers and mainstream workers over the decades has created pervasive challenges in recruitment and retention of qualified and dedicated staff. For example, a 2015 report highlighted a 50% staff turnover rate at a treatment centre for youth with inhalant addictions (Indigenous Services Canada, 2015; Thunderbird Partnership Foundation, 2015). In turn, this has had not only an impact on staff wellness and burnout, but also an impact on the effectiveness of treatment and resulting health outcomes of First Nations peoples overall (Thunderbird Partnership Foundation, 2018). For example, in treatment centres with an increased number of certified NNADAP and NYSAP staff the rate of client completion of treatment improved from 66% in 2005 to 75% in 2012 (Thunderbird Partnership Foundation, 2018).

Noting the seriousness of this challenge, the Ontario Regional Addictions Partnership Committee (ORPAC) drafted the following proposed NNADAP wage ranges for 2009 and 2014 (See Table 1) based on job descriptions and comparing them to similar off-reserve job descriptions and wage levels as NNADAP wages at the time ranged below national standards from $20,001 to $50,000 (Chiefs of Ontario, 2014; Thunderbird Partnership Foundation, 2018).

Building off of this previous work, the below table further proposes what those wage ranges should look like in 2022. Of importance is that the 2022 salary range for NNADAP workers below is based on a 2% annual increase since 2014, without taking into consideration that inflation has not kept pace with cost-of-living increases, that both addictions workers, mainstream and First Nations, tend to be underpaid and specifically for NNADAP and NYSAP workers the level of complexity of the work and the changing educational and skills requirements of some of these positions.

As retention of these workers has been a substantial and reported struggle for decades, there is a significant lack of value for those who continue to meet standards of excellence for accreditation, have a high-rate of certification in addiction core competency, possess comprehensive culture-based knowledge, are trained in trauma-informed approaches, and demonstrated high quality outcomes for the First Nations they serve. This lack of value is clearly demonstrated through inadequate compensation that fails to reflect these qualities and pay at the upper range of the mainstream national wage scale (Thunderbird Partnership Foundation, 2018).

Further information about the type of knowledge and skills required are unpacked in the sections below.

Table 1: Proposed NNADAP Wages Compared to Off-Reserve Job Descriptions and Wages - Ontario

NNADAP Position	Salary Level in 2009	Proposed NNADAP Salary Level in 2014 (3%/yr increase)	Proposed NNADAP Salary Level in 2022 (2%/yr increase)*	National Salary Range (2022)
Secretary / Receptionist	$26,000 - $32,000	$30,141 - $37,097	$35,315 - $43,465	$33,047 - $44,138 **Median: $35,976**
Prevention Worker	$32,018 - $41,284	$37,118 - $47,859	$43,490 - $56,074	$36,467 - $64,396 **Median: $42,900**
Intake Worker	$32,018 - $41,284	$37,118 - $47,859	$43,490 - $56,074	$39,254 - $70,980 **Median: $52,116**
Addictions Counsellor	$35,437 - $47,130	$41,081 - $54,637	$48,133 - $64,016	$44,753 - $76,567 **Median: $60,000**
Case Manager	$40,637 - $52,130	$47,109 - $60,433	$55,196 - $70,807	$47,366 - $72,674 **Median: $60,565**
Supervisor / Director / Administrator	$60,000 - $80,000	$69,556 - $92,742	$81,496 - $108,662	$54,700 - $114,446 **Median: $80,000**

(Source: Chiefs of Ontario. (2014). Building Capacity in NNADAP *with updated calculations on proposed salaries for 2022)

Over the years there have been significant advancements in the organizational accreditation with standards of excellence of NNADAP and NYSAP programs along with ongoing certification of treatment and community workers in addictions specialization within these programs (Chiefs of Ontario, 2014). More NNADAP and NYSAP staff have taken the initiative to increase their professional competency by meeting core competencies for Addictions Counsellor Certification, in addition to post-secondary education.

However, wages for qualified NNADAP and NYSAP staff to this day do not even approach provincial standard wages for qualified addictions workers with the same education, skills, and hours of work. For example, the median addictions counsellor salary in Canada is $60,000 per year (Talent.com, 2022). In a recent summer of 2021 NNADAP Addictions Counsellor job posting salary range was between $49,000 to $54,000 per year (Saugeen First Nation, 2021). This posting was at the lower range of the national pay grid even though the job required at least 2 years of experience, educational certification as well as specific skills and knowledge of First Nations communities and their culture.

While the Government of Canada may indicate that wages are up to communities to establish, the reality is that there is not sufficient funding within the existing envelope and formula to allow for wages to be at parity with provincial standard wages for qualified workers. Nor does community-based funding provide enough resources for the expanded workforce required to provide community-based addictions treatment for the deadly cocktail of opioids, methamphetamine, benzodiazepines, and alcohol.

"Staffing continues to be a challenge in the region and although we have diversified our funding beyond NNADAP funding, we continue to find it challenging to provide adequate pay to remain competitive with others in the region."

Mark Amy Treatment Centre, Wood Buffalo Wellness Society, Alberta (2019)

In the NNADAP review of 2007-2011, a national meeting was held to synthesize regional reports. At the national meeting, representatives from Alberta region reported the inability to retain their addictions workforce due to competition with the food service industry, where McDonalds paid the same wages as their addictions counsellor wages with far less stress. In Manitoba, it was verbally reported that the addictions workforce experienced low self-esteem due to the undervaluing of their work as evidenced by the low wages for critically important and life saving work.

Recently in a national meeting of NNADAP and NYSAP treatment centers, representatives from Saskatchewan reported a significant loss of their workforce to tree-planting jobs. Funding for salaries is often too limited to retain highly qualified staff and a more competitive salary grid linked to experience, training, population size in the community, remoteness and environmental risk is required for both NNADAP and NYSAP (Thunderbird Partnership Foundation, 2018). For treatment of opioids and methamphetamine, a more comprehensive budget is required for services within First Nation communities. The expectation that an impoverished population in rural and remote Canada can support transportation costs to urban centers to access harm reduction and treatment services does not address the impact and harms of substance use that remain in the community. A population with high rates of unresolved and intergenerational trauma cannot endure culturally unsafe services nor should they be expected to endure stigma, discrimination, and racism when services are not governed by First Nations. The disproportionate rates of opioid poisoning deaths among First Nations people in Canada are the evidence of lack of available and accessible services.

If circumstances don't change now, the high stress of the job due to difficulties and complexities of working with First Nations people caused by colonization, intergenerational trauma and the complete negligence of addressing funding frustrations will continue to lead to high turnover rates of NNADAP and NSYAP staff taking their certification, knowledge and expertise for more competitive wages (Chiefs of Ontario, 2014).

2. "Right Number of People with the Right Skills": Capacity to Address Complex Mental Health and Addictions Challenges Experienced by First Nations People

Without competitive wages provided from a funding model that considers experience, training, population size in the community, remoteness, and environmental risk for both NNADAP and NYSAP, retention of highly qualified staff will continue to be an issue within these services, which will in turn contribute to the lack of capacity to adequately address mental health and addiction within communities (Thunderbird Partnership Foundation, 2018; Chiefs of Ontario, 2014). **Continuity and access to care is vital as 75% to 100% of those seeking treatment for substance abuse have concurrent mental health issues** (Thunderbird Partnership Foundation, 2018). Indigenous communities overall have poorer mental health outcomes, including anxiety, depression, and suicide, compared to non-Indigenous peoples in Canada with suicide rates 3 times higher among First Nations, 9 times higher among Inuit, and 2 times higher among Metis people (Graham et al., 2021). In the year prior to the pandemic, 20% of First Nations adults entering NNADAP treatment for addictions indicated they had attempted suicide, while 28% of youth

entering NYSAP treatment for addictions indicate attempting suicide.

In 2013, at least 23% of NNADAP and NYSAP centres experienced staff vacancies with more than one vacancy at one time. For example, four treatment centres experienced 4, 5, 7, and 11 vacancies at one time (Chiefs of Ontario, 2014). This is still the case today, where centres have voiced their concerns regarding the lack of a dedicated counselor on staff, the lack of resources overall and the temporality of their services due to retention issues and funding.

NNADAP and NYSAP programs likewise struggle to retain adequate staff to provide culturally-based and trauma-informed approaches to appropriately address the needs of communities. In a 2013 survey of NNADAP and NYSAP treatment centres, staff vacancies were more widespread among certified than non-certified positions and roles. In individual treatment centres, the length of the vacancies stretched over several weeks or months, presumably throughout the length of the treatment cycle, and in roles that are directly involved in treatment. The average length of combined vacancies, which occurred in 2013 among as many as 18 treatment centers was 11.72 weeks. Other vacancy highlights of note during 2012-13 were that at least one vacancy occurred in 60% of treatment centres, and four facilities had four, five, seven and 11 vacancies respectively, each causing a disruption in service.

"...we didn't have a consistent counsellor every day of the week or you know, they didn't have regular appointments. She did have a few and then they kind of tapered off after, um, after she was recommending them to come into town. She [counsellor] still comes and we would like her to come more often than not, but it has to do with their funding and having somebody, and resources, to be able to come out. I think the mental health system and team is spread pretty thin"

Health Service Provider, Regional Municipality of Wood Buffalo (RMWB) (2021)

"It's temporary services ... Once you've finally engaged the people into a program, then it's gone the next day, you know. It's not enough personnel to cover how many people need to be seen here. Then at the same time, it's not even enough time to engage the people to get to know them, because they only pop in once a week. And how do you build a relationship with a community one day in a week. I've been here for eight years and I'm still doing it... Their [mental health therapist] workday starts at 8:30am, they get here by 10:30am, they leave by 2:00pm and we have 400 people out here that want to see this one person"

Health Service Provider, Regional Municipality of Wood Buffalo (RMWB) (2021)

In many communities, it is usually only one NNADAP / NYSAP worker who provides this broad range of services and supports, which may include but not limited to crisis intervention, assessment and referral for withdrawal management and residential treatment, referrals to mental health and other health and social service programming, treatment planning, supportive and therapeutic counselling and therapy, educational presentations and workshops, suicide education, prevention and intervention work, smoking cessation, sexual abuse, and substance use education (Thunderbird Partnership Foundation, 2018). For example, Pikangikum First Nation, one of the largest settlements on Ojibew people in the north, was known as the "suicide capital of the world," drawing international attention to the high level of mental health challenges, particularly youth suicide and only had 1.5 staff employed on their NNADAP program (Pikangikum First Nation, 2014; Talaga, 2017).

3. "Right Place, Right Tools": The Expertise Supported by Culturally-Informed and Trauma-Informed Services in First Nations Communities

Over the years there has been an increasing demand placed on the NNADAP and NYSAP workforce with the emerging evidence and awareness of the impacts of intergenerational trauma caused by systemic colonialism instituted in Canada that have lasting multi-generational effects. The continued loss of land, culture and language, grief, chronic trauma, forced assimilation, marginalization, and racist policies have direct links to mental health and substance use among First Nations people that in turn, contributes to further stress and trauma (Ninomiya et al., 2020). Therefore, it is key for all NNADAP and NYSAP programs to have the capacity to deliver services that are holistic and provide culturally-based interventions within the community. First Nations people's health, physical, spiritual, emotional, and mental well-being rely on their foundational relationships with their land, community, family, culture, ceremony, and language to support such an approach to health and wellness (Cardinal & Pepler, 2021; Lines et al., 2019).

Increasing demand is also due to the scarcity of any mental health and medical services available in northern communities; if there are any services at all, they are overloaded as well as hundreds of kilometers away from the communities that need them the most (Talaga, 2017). For example, in Ontario, Indigenous leaders have worked with the federal government to provide emergency measures, which included flying in mental health care workers, but these experts would leave once the immediate crisis was over. There would also be similar experiences with mental health care programs that would start and not too long after would end due to lack of funding or a change in programs (Talaga, 2017). This is a pervasive issue not only in Ontario but across all provinces as exemplified by a lived experience below from a health services provider in Alberta.

"Specifically, for mental health we had to get creative with some of our service providers with the trauma counselling, relying on the holistic approach in taking more of a cultural, spiritual route for mental health and healing"

Health Service Provider, Regional Municipality of Wood Buffalo (RMWB) (2021)

With the lack of services directly in First Nations communities, there has also been a focus on how telemedicine can bridge the gap between rural and remote communities and urban centres as a pathway to equity and expanded access to mental health and addictions services (Schiff & Møller, 2021). However, the efficacy of such technologies and services are related to a myriad of factors including user acceptance, patient, and practitioner technology literacy, and internet viability and affordability (Schiff & Møller, 2021). Internet infrastructure and connectivity is a significant barrier to digital capabilities in many First Nations and remote communities. In 2016, the Canadian telecommunications regulator, Canadian Radio-Television and Telecommunications Commission (CRTC), established a speed target of 50 Mbps download and 10 Mbps upload for all of Canada, including individuals in remote communities. However, only 31.3% of First Nations on reserve have access to such 50/10 target speeds (Internet Society, 2020).

Even with increased access to in-person or virtual care services for mental health and addictions support, the development and implementation of the right tools to address the mental health and wellness of First Nations is essential to support workers in their role as well as the communities they care for. As noted above, Indigenous Services Canada and Thunderbird Partnership Foundation have developed a First Nations Mental Wellness

Continuum Framework as a tool to provide guidance to communities to adapt, optimize, and realign their mental wellness programs and services based on their own priorities (Indigenous Services Canada and Thunderbird Partnership Foundation, 2015). Yet, broad Canadian mental health policies and policy guidelines seem to be limited in terms of how to implement trauma-informed approaches with Indigenous communities (Lee et al., 2021). For example, the Mental Health Commission of Canada describes the importance to "... recognize that in order to effect change, healing from this historical trauma must occur. They have established initiatives at the national, regional and community levels to address gaps and fragmentation in the continuum of mental wellness services, while recognizing communities as their own best resource and drawing on traditional and cultural knowledge" but no trauma-informed services were noted within the document. Similarly, the Canadian Mental Health Association drew attention to the establishing policies and programs in collaboration with Indigenous people to ensure their knowledge base is honored without specific examples of programs and services to do so (Lee et al., 2021).

For NNADAP and NYSAP workers to meet the needs of First Nations communities and provide culturally relevant and trauma-informed services, sustainable, and long-term funding and equitable access to resources is critical (Fitzpatrick et al., 2021).

"We are losing resources, but I could speak on behalf of the health centre because I was here at the time. There was no programming here. It was a lack of programming in the health centre in general, not much direction. So, our NNADAP programme was lacking. There was no pre- and post-natal. We had no public health. We had no home care services. We had no services. All we have here is a building planted on the reserves.

Health Service Provider, Regional Municipality of Wood Buffalo (RMWB) (2021)

"From the healing and recovery perspective as well as for individuals, whether that's trauma from their past, growing up, environmental impacts, social impacts, the consistency on the level of supports that are coming in is very important"

Health Service Provider, Regional Municipality of Wood Buffalo (RMWB) (2021)

Recommendations

Based on the ongoing need for more robust mental health and addictions services for prevention and treatment that adequately compensate the staff in these communities, Thunderbird Partnership Foundation and its allies recommend the following.

1. Conduct a comprehensive review of the current funding formula to inform the modernization of a new formula based on new criteria, recognizing the need for increased funding.

The Prime Minister's most recent mandate letter to the Minister of Indigenous Services directs the Minister to "co-develop and invest in a distinctions based Mental Health and Wellness Strategy to meet the needs of First Nations, Inuit and the Métis Nation, including culturally appropriate wraparound services for addictions and trauma, suicide and life promotion and the building of treatment centres".

The funding that has been provided by the federal government over the last two years and to maintain trauma-informed, culturally-appropriate, Indigenous-led services to improve mental wellness is acknowledged and welcomed. However, the successful implementation requires that funding and conditions for its expenditure align with the actual needs of communities, including the salary pressures and infrastructure standards, outlined above.

That is why it's critical that thorough review and audit be undertaken on the framework of funding these urgent services and programs. Such a review will result in the modernization of a new formula that is more reflective of the current needs of communities, and takes into account the intergenerational trauma and social determinants of health.

The federal government has shown that it is amenable to updating funding formulas for health-based services and programming. In 2019, Indigenous Services Canada announced a new, co-developed policy and funding approach that will better support the needs of First Nations students on-reserve that included the implementation of a series of new formula-based regional funding models for elementary and secondary education. Indigenous Services Canada's openness to consider different pedagogies that adopted a cultural and community centred approach should be mirrored for mental health and addictions services and programming.

2. Implement guidelines for fair and equitable salaries for addictions workers of the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP), commensurate with those paid to mainstream and provincial counterparts.

Throughout the existence of these two programs, the federal government has kept apprised of how inadequately funded the First Nations addictions workforce and treatment centers are by undertaking periodic reviews of their salaries. This awareness should result in some form of action. There is great need for the development of a more competitive, standardized, and equitable salary grid linked to experience and training, the population size of the community, remoteness, exposure to physical environmental risks, and the social determinants of health, and that funding based on that grid be made available, both to NNADAP and NYSAP treatment programs and prevention programs. This should be a collaborative effort between First Nations, who possess up-to-date data on wages paid to their addictions staff, and the federal government, who would have data on wages of their provincial counterparts. This will help ensure that NNADAP, NYSAP, and other First Nations mental health and addictions workers have salary parity with mainstream workers in the provincial system. NNADAP and NYSAP staff in First Nations communities are dealing with both a higher quantity of clients, and a higher prevalence of complex clients relative to non-Indigenous communities. Their salary should be commensurate with the challenging aspects of their job.

3. Strengthen system continuity and coordination to ensure services and programming are better integrated between the federal, provincial, and territorial governments, ensuring that all First Nations peoples have access to services in accordance with the principles of the Canada Health Act.

Due to Canada's federalism, there is a patchwork of health service coverage for First Nations peoples that is occasionally covered by the federal government, and occasionally covered by the provincial and territorial governments. Ultimately however, the national principles that govern the Canadian health insurance system through the Canada Health Act must be fulfilled, including the principles of accessibility and universality. In legislation this applies to First Nations communities in Canada, but not in practice.

National and regional organizations will help break down jurisdictional barriers that are stringently enforced by governments, hindering communities from being able to tap into provincial resources. The provinces and territories have funds for mental health programs, but do not have relationships with First Nations governments who are often seen by provinces as "federal responsibility" making the funds inaccessible. As AFN has strongly exhorted through its resolutions, provinces and territories must play a more active role in funding the delivery of health and wellbeing services under First Nations governance.

The relationships between First Nations governments, the federal government, and provincial and territorial governments must reflect the new era of reconciliation; federal, provincial, and territorial governments must respect First Nations inherent rights, Aboriginal and Treaty rights that are protected under section 35 of the Constitution Act, 1982, as well as the United Nations Declaration on the Rights of Indigenous Peoples (Assembly of First Nations, 2017; United Nations, 2008).

> *"First Nations hold the right to self-determination over healthcare for our people, and federal and provincial governments hold a responsibility to work with First Nations on healthcare,"*
>
> **- National Chief Perry Bellegarde (AFN, 2017).**

To ensure that First Nations are receiving necessary care that is also culturally safe and relevant, both levels of government must work in alignment and in close consultation with First Nations governance. For instance, provincial and territorial mental health services that incorporate First Nations trauma informed approaches are crucial as they are aligned with First Nations values and paradigms. However, these services are rarely available in rural and remote First Nations communities. Those conversations regarding increased collaboration between different levels of government and First Nations communities requires accountability of the Federal government for the health transfer funding to provinces and territories to ensure equity in mental wellness for First Nations.

Where regional administrative agreements have been established between provincial, federal and first nations governments, increased capacity to respond to inequity has been achieved, such as the First Nations Health Authority of British Columbia. In 2018, because of $40 million invested by the province, and an additional commitment of $30 million announced by the Government of Canada, the First Nations Health Council of BC had capacity to support Nation-based approaches to the planning, design and delivery of mental health and wellness services, including capital improvements to existing treatment facilities and invest in the building new treatment center facilities (FNHA, et al., 2019). Wages which ranged from $33, 000 - $44,000 annually for the addictions and mental workforce were set at a minimum salary of 75,000 annually in the new era of the BC First Nations Health Authority (FNHA, 2020). This also speaks to the fact that new compensation agreements should be devised and implemented to reflect the complex needs of First Nations communities as fee-for-service cannot adequately deliver the care that is required to address decades of poor health.

This involves the establishment of a regional planning body which would help to support cross-jurisdictional partnerships, and to provide 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. The Nishnawbe Aski Nations' Charter of Relationship Principles Governing Health System Transformation in NAN Territory (the Charter) signed in 2017 is another example of an administrative agreement (Health Canada, 2017). The Charter, which was signed with the province of Ontario and federal government, also facilitates increased equity in workforce and funding that enables NAN (a political territorial organization representing 49 First Nation communities in northern Ontario) to establish physician and nurse practitioner services for the 49 First Nations to address the opioid and methamphetamine crisis. This included a much needed telephone and virtual rapid access center for crisis counselling, health services navigation, and rapid access to addictions medicine and mental health services during the pandemic.

Inequities in service provision due to federal-provincial-territorial payment disputes have started to be recognized over the last several years. This was also demonstrated by the Canadian Human Rights Tribunal's series of legally binding orders that include applying Jordan's principle to all First Nations children living both on and off reserve and based on the needs of the child. Jordan's principle set a foundation for different levels of government to ensure that Canada's division of powers does not interfere in First Nations peoples receiving the preventive care and treatment they need and deserve.

4. Increase federal government transparency and communication in funding structures to assess whether funding is sufficient and increase accountability to First Nations peoples.

There is a degree of opaqueness and significant miscommunication regarding funding and budgetary announcements for various First Nations communities. This is not only preventing their empowerment, but hindering the ability for funding to be used for its intended, urgent purpose. This obfuscation interferes with the ability of executing good self-governance. Further, 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 communicated clearly. Awareness of the flexibility that is in existence needs to be increased so communities can take advantage of associated opportunities.

5. Place measurable conditions on mental health transfers to the provinces and territories so that the federal government is accountable for the funding they transfer.

Acknowledging that attaching conditions to any sort of health transfers is controversial, they can be an effective mechanism in guaranteeing measurable results. This would help put the onus on provinces and territories to demonstrate that they are serious about attending to equitable services in rural and remote FN communities

Ultimately, the majority of attention is on the retention of the overburdened workforce, crumbling infrastructure, and the outdated funding formula that does not adequately serve them. The state of NNADAP and NYSAP facilities and their workforce is such that without modification to the foundational funding and policy framework that defines these programs, they simply cannot deliver services that are so critically and desperately required by the communities they serve, nor will First Nation communities have the capacity to the rising deaths due to opioid poisoning, overdose, and increased harms associated with drug use.

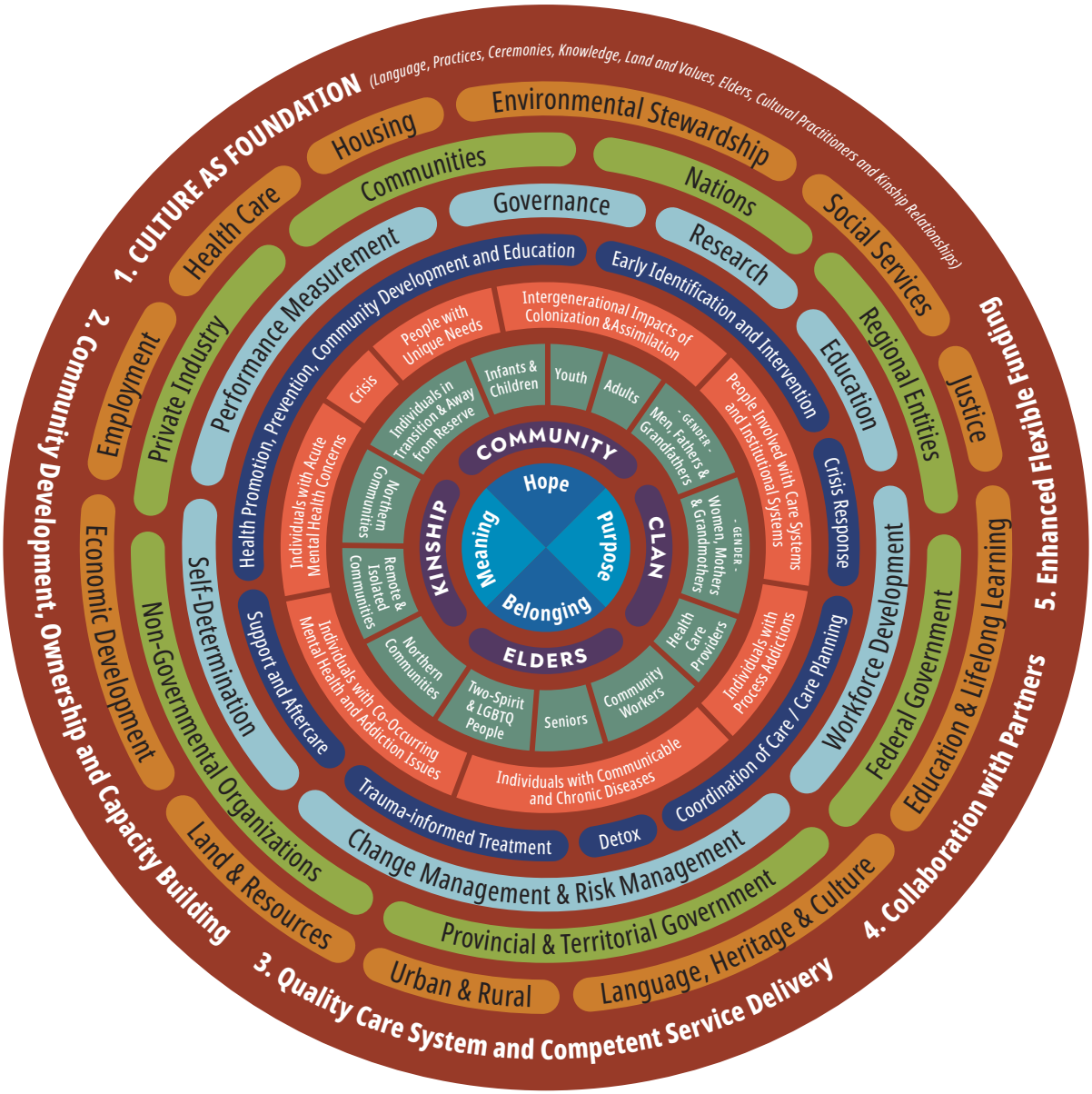
Indigenous peoples residing within Canada comprised an estimated 4.9% of the total population, but make up a significant proportion of rates for poor mental health, suicide, infant mortality, incarceration, diabetes, obesity, food insecurity, and lower life expectancy (Graham et al., 2021).

This is due to the harmful impacts of colonial actions and policies that will continue to have long-term and intergenerational effects on the health of Indigenous populations for decades to come. This complexity of client care that is needed makes it imperative that any type of funding be adapted to account for a multitude of factors beyond remoteness and population, which is expected to grow significantly in the coming decades (Statistics Canada, 2021).

If funding levels continue to be a limiting factor in resourcing and compensating staff equitably, the high stress that workers endure due to the complexities associated with working with First Nations peoples will continue to lead to high turnover rates, resulting in a shortage of resources to provide prevention and treatment services and a continuous loss of investment to recruit, onboard, and train new staff. This has and continues to exacerbate an already dire problem where intergenerational trauma persists and is left untreated, leading to even more challenges for underserved First Nations communities.

Appendix

First Nations Mental Wellness Continuum Model



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