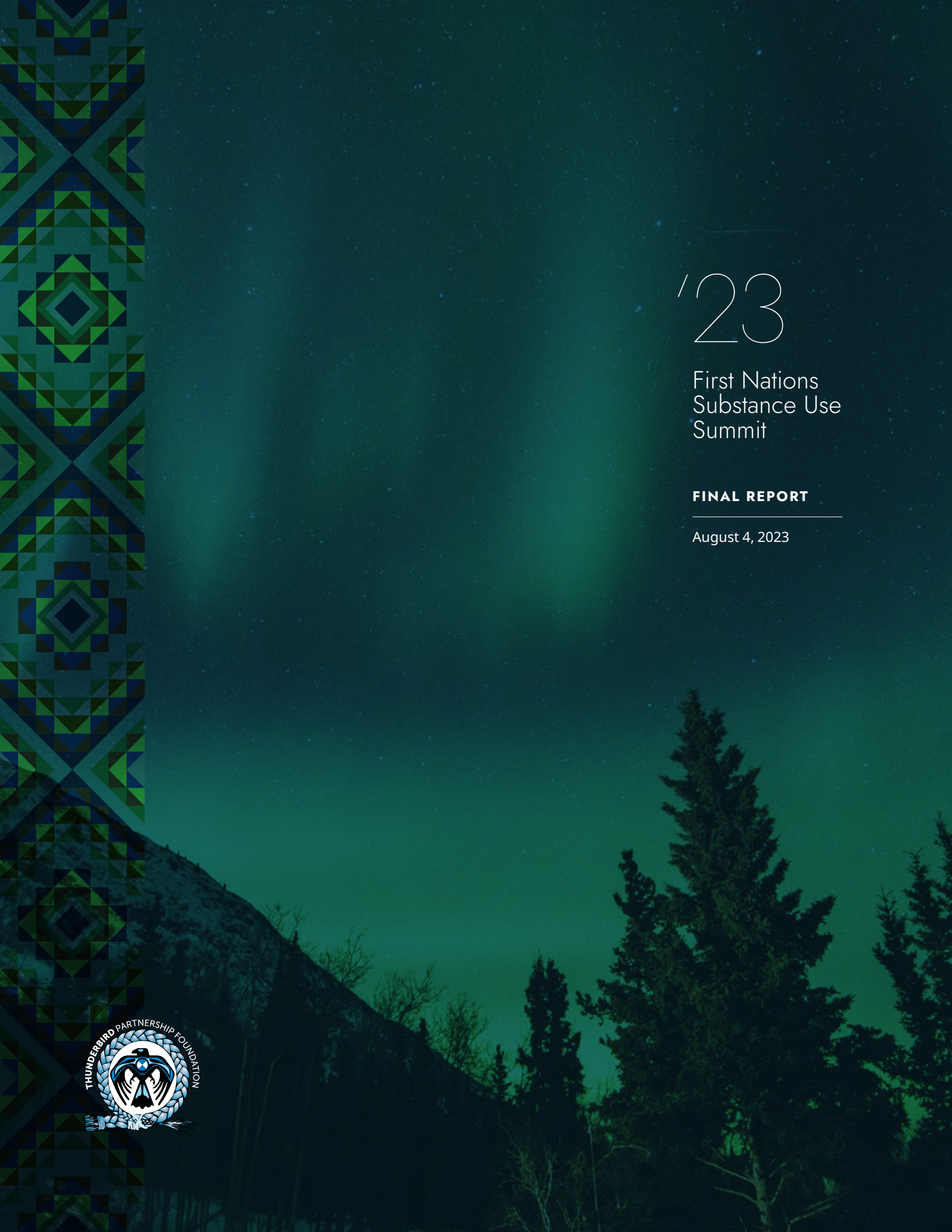

'23 First Nations Substance Use Summit

FINAL REPORT

August 4, 2023

THUNDERBIRD PARTNERSHIP FOUNDATION

Acknowledgments

The Thunderbird Partnership Foundation would like to express sincere appreciation to First Peoples Wellness Circle for their valuable partnership in hosting the First Nations Substance Use Summit (2023).

We would also like to acknowledge the Canadian Research Initiative in Substance Misuse (CRISM) Prairie Node for their financial support of the Summit, and Bourget Consulting for their work in preparing this report.

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The Thunderbird Partnership Foundation is a leading culturally centred voice in Canada on Indigenous substance use and mental wellness research, advocating for partnerships that involve integrated and wholistic approaches to healing and wellness for First Nations. Thunderbird promotes research and collaboration to empower Hope, Belonging, Meaning, and Purpose within First Nations communities. Thunderbird's mandate is to implement 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 non-profit organization and a division of the National Native Addictions Partnership Foundation Inc.

Executive Summary

Introduction

Thunderbird Partnership Foundation held a First Nations Substance Use Summit on March 28-30, 2023, in Toronto, Ontario. The primary objectives of the presentations and discussion groups were to inform core competencies for the workforce supporting addictions services in First Nations communities, provide information to develop a standardized treatment curriculum for residential treatment services, and to review the feasibility of and requirements for a national mental wellness association.

Background Information

Any discussion of substance use health issues, and potential interventions among Indigenous peoples must occur in the context of a thorough understanding of the effects of colonization, including persistent racism and discrimination, the Indian Residential School (IRS) Experience, and the Sixties Scoop. Colonization and its effects have left an ongoing legacy of trauma, loss and grief – also known as historical intergenerational trauma, which continues to have significant effects on the health and well-being of Indigenous peoples and is the root cause of substance use issues. Despite this, Indigenous peoples remain resilient, and a healing cultural revitalization is well underway in many First Nations across Turtle Island.

Toxic Drug Poisoning

Formerly, language around drug use was based on shame, stigma and blame. The language has now changed: people no longer talk about overdoses but rather toxic drug poisoning because the drugs are so unregulated. This ensures that users are not blamed for being poisoned by a toxic drug supply. The opioids in circulation now are much stronger than they were previously, i.e., fentanyl compared to heroin, and they are often adulterated with other substances such as xylazine (sometimes called tranq) etc., exacerbating the toxic drug crisis. In addition, people may be taking multiple substances, which makes it more challenging to reverse the effects.

Data on First Nations Drug Use

This is the fourth wave of the overdose crisis: the first wave involved deaths from prescribed opioids, the second from heroin use, the third from fentanyl and other synthetic opioids and, now the fourth, which involves the increased use of stimulants, particularly methamphetamine. The crisis is national in scope and toxic drug use is disproportionately affecting First Nations peoples. Data from Ontario and British Columbia showed similar findings, with deaths and hospitalizations due to toxic drug poisoning having rapidly increased among First Nations people.

Cannabis differs from the other substances discussed as it is legal in Canada for adults, and has both beneficial and harmful effects. There are both medical uses and health risks associated with using cannabis. Cannabis is one of the first substances used by many Indigenous youth and they are noted to be disproportionately more affected by harms of its use than non-Indigenous youth. More research is needed on both the benefits and harms of cannabis use among First Nations peoples.

Thunderbird conducted a series of consultations on cannabis use prior to and since legalization. Based on those consultations and on foundational documents relating to First Nations wellness, Thunderbird has developed cannabis education and dialogue tools for First Nations. The key learning objectives are:

- To develop skills to facilitate conversations with First Nations youth on cannabis
- To gain current scientific knowledge on cannabis
- To understand harm reduction practices
- To use a wholistic approach to wellness inclusive of individuals, peers, family and community, in dialogue with youth.

The training provides all the tools needed to set up a seven session Let's Talk Cannabis Group with Indigenous youth ages 13-17. Training is available both virtually and in-person. As with other Thunderbird trainings, this training is certified by The Indigenous Certificate Board of Canada (ICBOC) and the Canadian Council of Professional Certification (CCPC) Global.

Key Themes and Concepts

Culture as Foundation

Several presenters spoke about culture as being foundational to the health and wellness of First Nations peoples, and as the key factor in preventing and treating substance use disorders. Culture needs to be the foundation of the work, and a First Nations worldview – involving kindness and compassion – must guide the approach to supporting people who use drugs. Culture includes language, which has the power to change the molecular structure of peoples' bodies: the sounds of the language have the power to heal people. Traditional stories also have a medicinal element. Ceremony is a big part of recovery, and it reduces the shame and guilt that come with substance use. Land-based activities are very important in the healing process. Access to Elders has also been linked to a decrease in toxic drug use.

As crisis levels escalate, the need for such cultural ceremonies and practices is increasing, along with the need for acceptance and inclusion. For example, people should not be excluded from ceremony if they are under the influence of a substance, as long as they are able to demonstrate respect. At the same time, it is also important that cultural services, ceremonies and practices be of the highest quality. Teachings and ceremonies must be true to a full understanding of traditional ways, and mentoring is required to ensure that those passing along cultural teachings and practices have this understanding.

The Importance of Harm Reduction from an Indigenous Lens

Colonized thinking around drug use leads to stigma. Abstinence, zero tolerance and removing people from community is not connected to culture and First Nations worldviews, and it will not solve problematic drug use issues. Harm reduction is about protecting the sacred breath of life (saving lives), reducing future harms, and keeping individuals, families, and communities safe. Indigenous harm reduction is uniquely grounded in Indigenous cultures and is about addressing the traumatic legacy of colonization. Indigenous harm reduction is a way of life, it is love, non-judgement, and non-interference. It is decolonized, wholistic, trauma-informed, and deeply rooted in Indigenous Knowledge and worldviews.

Strengths and Wise Practices

Several presenters at the Summit provided examples of strengths and wise practices, including national, regional and community-based strategies as they relate to addressing substance use among First Nations peoples. These include:

- *Addictions Management Information System* (AMIS), a screening and a case management system used by treatment centres with the National Native Alcohol and Drug Abuse Program (NNADAP) and/or National Youth Solvent Abuse Program (NYSAP).
- *Wharerātā Declaration: Indigenous Youth Leadership and Priorities* on mental health and addictions systems to meet the wholistic needs of Indigenous peoples.
- *Walking alongside First Nations in BC in Response to the Toxic Drug Emergency: from Surviving to Wellness*, documenting the First Nations Health Authority of British Columbia's response to the drug crisis.
- *Improving Access to Medication Assisted Treatment for Indigenous Communities* – a description of the Meti-Phi program in Ontario which supports delivery of high-quality care for those using substance.
- *First Indigenous-Led Rapid Access to Addictions Medicine Clinic in Winnipeg* – a description of how the Aboriginal Health & Wellness Center of Winnipeg (AHWC) provides trauma-informed and healing-informed care, focuses on harm-reduction, and blends traditional and western approaches.
- *Spruce Bough Managed Alcohol Programs* – an overview of a supportive housing program for alcohol treatment in the Northwest Territories involving a full continuum of care.
- *Mobile Outreach and Harm Reduction* – an Alberta day treatment program initiative.
- *Peacemaking, Healing to Wellness and Cultural Approaches to Addressing Community Disorder* – an overview of Peacemaking and Healing to Wellness courts in Michigan, focused on Indigenous cultural ways and restorative justice.

Concerns and Barriers

Conference participants identified a number of concerns and barriers to effectively addressing the substance use crisis in First Nations communities. These included the following:

- Stigma and discrimination
- Effects of intergenerational trauma
- Lack of adequate resources and political will to address the crisis
- Insufficient focus on Indigenous approaches to harm reduction
- Jurisdictional divides
- Lack of understanding of Indigenous culture among non-Indigenous service providers
- Lack of support for paraprofessionals
- Lack of access to cultural programs for youth
- Lack of education about the harms of toxic drug use
- Lack of safe supply programs for stimulants.

Core Competencies for the First Nations Addictions Workforce

There is a need to develop standardized core competencies and scopes of practice with culture as the foundation while ensuring continuous professional development and support. Competencies highlight what is needed for a First Nations mental wellness and addictions workforce, including those who work in communities and those who work in residential treatment centres. An extensive list of recommended core competencies was produced. It includes:

- Common themes that apply across all competencies
- Specific required competencies, including:
  - understanding culture as foundational
  - Indigenous harm reduction approaches
  - competencies required in relation to all substances
  - competencies related to specific substances
  - an understanding of trauma-informed care, adoption of a public health approach to substance use
  - data related knowledge and skills
  - ability to engage with youth and support their priorities
  - understanding of and ability to deal with the connection between mental health issues and substance use
  - proficiency in delivering virtual treatment and pathways to care.

Supports required to build competency capacity were also discussed, including creating opportunities to share wise and best practices, and training and professional development opportunities.

A Standardized Treatment Curriculum for Treatment Centres Serving First Nations

The goal of this session was to identify a standardized curriculum and core competencies for treatment centres serving First Nations. Proposed core competencies in the previous section are relevant here also, as the curriculum will need to be reflective of knowledge, skills, and behaviour expected through the competencies, and competencies will need to reflect knowledge, skills, and behaviour needed to deliver the standardized curriculum content.

Curriculum Content

The proposed curriculum content includes:

- Culture as the foundation of wellness
- Stigma and discrimination
- Harm reduction
- Pharmacology
- Toxic drug use and deaths
- Assessment
- Treatment planning and monitoring
- Detox and withdrawal management
- Land based service delivery
- Complex needs
- Continuing care and partnerships
- Public health approach to substance use.

National Virtual Treatment Program

There was also a discussion about a National Virtual Treatment Program, which will support culturally based eMental health programming for Indigenous-led substance use treatment centres aiming to provide alternative substance use and addiction services. The program will support delivery of the National Standardized Addictions Curriculum through self-guided programming virtually and for purposes of pre-treatment, brief intervention, and aftercare support.

Connecting information from the National Virtual Treatment Program project and the work to develop a National Standardized Addictions Curriculum will be necessary as both projects develop.

Development of a National Mental Wellness Workforce Association

The history and process for creating a National Workforce Association was shared by Marion Crowe, CEO, First Nations Health Managers Association (FNHMA). She provided details on what occurred leading up to the establishment of the FNHMA, with information that will be very helpful in setting up a National Mental Wellness Workforce Association.

Key Takeaways

Key takeaways from the presentation included:

- The importance of conducting a situational analysis and needs assessment to identify core competencies and skills of the mental wellness workforce.
- Consensus on essential competencies and skills of workers – a competency framework.
- Developing standards, ethical guidelines, and best practices.
- Creating a mentorship and job exchange program.
- Developing a certification process based on a defined curriculum and learning modules.
- Creating a worker network to support and share information.

Recommendations for Developing a National Association

- Get support from political leadership. Recognize that change can be challenging. Identify the most important priorities and be prepared to put in the time required for change management and acceptance of change.
- Determine credentialing, which can and should recognize years of lived experience in the field. This may require a couple of pathways to certification.
- Ensure influencers are part of initial conversations about creating the association.
- Engage with potential membership and explain the benefits they will receive through a National Association. Since there are membership fees, people must understand what they are receiving when joining. One of the benefits of having a National Association is that it gives Indigenous people equitable spaces and voices at a variety of tables and venues. Belonging to a National Association and having the credentialling also empowers people to act on all of their Indigenous Knowledge and wisdom.
- Create partnerships – Articulation Agreements – with the academic world to review and approve the curriculum. This will ensure workers' credentials are recognized if they want to pursue higher education, such as a university degree, so they can walk in two worlds if they wish. This is important for continued professional development.
- Contract with an association management company that works with the best of the best to provide guidance on the incorporation of an association, establishing by-laws and registering the association – all the administrative steps.

Standard's Council Canada (SCC)

SCC is not an Indigenous organization, but it is leading a Mental Health, Substance Use Health (MHSUH) standardization collaboration, which is engaging a diverse range of key partners including Indigenous partners, to inform the work on current and future standards that will contribute to a MHSUH Standardization Collaboration Roadmap. Mahihkan Management, has contracted with Debbie and Susan Miller (Blue Heron Women), to work with the SCC to deliver a series of engagements and touchpoints to better understand the mental health and substance use health needs of First Nation, Métis and Inuit peoples in Canada.

This work is very similar to the work Thunderbird and First Peoples Wellness Circle are undertaking in the development of a professional association with standard competencies, certification, and operating standards. Synergies between the two initiatives will need to be reviewed, including how the SCC movement would relate to an association of mental wellness workers across the country.

Youth – E-Mental Health App

These discussions revolved around the need for electronic mental health (e-MH) interventions, particularly for youth, to address healthcare disparities, including stigma-related barriers and access to mental health services, and youth feedback on a preliminary app.

The conference workshop followed some preliminary engagement with youth about an e-mental health app. The purpose of the workshop was to obtain a vision on how to connect with youth through the development of an app. Several identified wise practices were shared with the youth. In general, they agreed with the proposed wise practices, many of which relate to ensuring culture is foundational.

There was also a presentation highlighting the proposed functionalities and features of the app. Youth put forward numerous ideas, such as a youth-focused podcast, wellness tracking, user-created content, personalization, guided activities, and a platform for First Nation Youth Communities' interaction. Youth found the current app's content too plain and long, not interactive enough and too text heavy. The app could be improved by personalizing the user experience, including wellness tracking, allowing user-created content, and increasing cultural and age-relevant content. The youth expressed a desire for a supportive, non-judgmental online space where they can connect, discuss, and feel proud of their successes. More consultations are planned.

Introduction

Thunderbird Partnership Foundation began its journey in 2000 as the National Native Addictions Partnership Foundation (NNAPF), created after a review of the National Native Alcohol and Drug Abuse Program. The organization was established to address the need for culturally grounded training resources, relevant research and advocacy efforts to support First Nations treatment centres and community wellness workers. It was rebranded as the Thunderbird Partnership Foundation in 2015 when the First Peoples Wellness Circle joined the organization, reflecting an expanded mental wellness focus.

Thunderbird Partnership Foundation held a First Nations Substance Use Summit on March 28-30, 2023, in Toronto, Ontario. The target audience of the Summit included Thunderbird Partnership Foundation's core stakeholders – treatment centres and communities along with tribal councils, board of directors, the federal government, and partner organizations. The primary objectives of the presentations and discussion groups were to inform core competencies for the workforce supporting addictions services in First Nations communities, provide information to develop a standardized treatment curriculum for residential treatment services, and to review the feasibility of, and requirements for, a national mental wellness association.

The Summit provided five areas/discussion topics:

1) A standardized treatment curriculum for addictions services with the primary question:
   What is critical for addiction services for First Nations? Presentations were focussed on several key subjects:
   a. Harm reduction
   b. Withdrawal management
   c. Overdose and drug poisoning prevention
   d. Stigma and discrimination
   e. Complex needs such as cognitive impairment, psychosis, community trauma.
2) Strategies to address opioids and methamphetamines with presentations on:
   a. Decriminalization
   b. Safer supply
   c. First Nations Opioid and Methamphetamine Guidelines (Canadian Research Initiative in Substance Misuse) (CRISM)
   d. Public Health Agency of Canada (PHAC) report.
3) The post-regulation impacts of cannabis
   a. Community Cannabis Survey
   b. Cannabis hyperemesis
   c. Cannabis education and training.
4) A national mental wellness association.
5) Youth e-mental health standards and apps.

Background Information

Effects of Colonization

Any discussion of substance use issues, and potential interventions among Indigenous peoples must occur in the context of a thorough understanding of the effects of colonization, including persistent racism and discrimination, the Indian Residential School (IRS) experience, the Sixties Scoop, and the over-criminalization of Indigenous people within the justice system. These effects of colonization have left an ongoing legacy of trauma, loss, and grief, which in turn continues to have significant effects on the health and well-being of Indigenous peoples.

Traumatic events can be personal (car accident or rape) or collective (war, natural disasters, or genocide), and the responses to such events are not identical. In the latter instance, there is now considerable evidence demonstrating that the effects of trauma experiences are often transmitted across generations, affecting the descendants of those who were victimized.[1] Regarding Indigenous people in Canada, there are numerous health and mental health effects related to the loss of culture and language, and the loss of Indigenous identity.[2] As stated by psychologist, Dr. Chris Mushquash, the removal of children from thriving communities with strong culture caused significant trauma which was compounded by the introduction of problematic substances and activities. It became natural to self-medicate with substances and doing things like gambling when culturally based approaches to healing, including ceremonies, had been taken away.[3]

Given the prolonged and profound history of multiple traumas in Indigenous peoples in Canada, some scholars have proposed that *historic intergenerational trauma* is a more meaningful and valid concept than Post-traumatic Stress Disorder (PTSD) for understanding trauma as it presents at the individual, family and community level in Indigenous communities.[4]

Considering the significant role that trauma plays in the lives of Indigenous peoples, it is important to identify how the mechanisms by which the cycle of trauma and stress repeats itself across generations, in order to intervene and stop the intergenerational cycle.[5] The Indian Residential School experience is particularly relevant in this regard. The literature has shown consistent connections between a history of familial Indian Residential School attendance and various types of psychological distress.[6] As noted by Dr. Chris Musquash in his conference presentation, research shows those with a parent or grandparent who attended residential school are more likely to come into contact with child welfare while those whose parents or grandparents had not attended residential school are no more likely than non-Indigenous children to come into contact with child welfare.[7] Additionally, people from families where multiple generations attended Indian Residential Schools report more distress compared to those where only one generation attended, supporting the notion of the cumulative nature of historical trauma.[8]

1 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health:* pp. 6-47; Bombay, A., Matheson, K. & Anisman, H. (2014) The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry.* 51(3) 320–338; Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health; Söchting, I., Corrado, R., Cohen, I.M., Ley, R.G. & Brasfield, C. (July/August 2007) Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *BC Medical Journal*. 49:6.

2 Ibid.

3 Musquash, C. (March 2023) Presentation on Trauma and drug-related psychosis at First Nations Substance Use Summit.

4 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health:* pp. 6-47; Bombay, A., Matheson, K. & Anisman, H. (2014) The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry.* 51(3) 320–338; Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health; Söchting, I., Corrado, R., Cohen, I.M., Ley, R.G. & Brasfield, C. (July/August 2007) Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *BC Medical Journal*. 49:6.

5 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health:* pp. 6-47.

6 Bombay, A., Matheson, K. & Anisman, H. (2014) The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry.* 51(3) 320–338.

7 Musquash, C. (March 2023) Presentation on Trauma and drug-related psychosis at First Nations Substance Use Summit.

8 Bombay, A., Matheson, K. & Anisman, H. (2014) The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry.* 51(3) 320–338.

The effects seem to carry forward in two ways: by influencing the frequency of exposure to new stressors; and by increasing the effects of present stressors due to increased reactions to the stress by the individual.[9]

There is growing evidence that children are affected by parental trauma exposures occurring before their birth, and possibly even before their conception.[10] This appears logical, as exposure to severe trauma and experiencing the accompanying post-traumatic effects would naturally impact the capacity of individuals to parent their children. Poor parenting styles, for instance, have significant effects on early development, and chronic child neglect or abuse manifests in a multitude of psychological, physical, and behavioral problems, including difficulties with emotional regulation, emotional reactivity, hyper-vigilance, and developmental delays, all of which can persist into adulthood.[11]

Additionally, a more recent claim supported by increasing literature is that the effects of the experience of trauma may also be passed along through biological mechanisms.[12] For example, being exposed to stressful events may result in epigenetic changes that suppress certain genes; these changes can potentially be transmitted from one generation to the next, which increases stress levels in the children of survivors.[13]

9 Ibid.

10 Yehuda, R. & Lehrner, A. (2018) Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry.* 17: 243-247.

11 Aguiar W. & Halseth, R. (2015) *Aboriginal Peoples and Historic Trauma: The Processes of Intergenerational Transmission.* Prince George: BC. National Collaborating Centre for Aboriginal Health.

12 Yehuda, R. & Lehrner, A. (2018) Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry.* 17: 243-247.

13 McGowan & Szyf, 2010 in Bombay et al, 2014.

Health and Mental Health Issues Among Indigenous Peoples

Overall, Indigenous peoples in Canada suffer from more health problems than non-Indigenous Canadians. These include chronic physical health problems such as diabetes, arthritis/rheumatism, high blood pressure, and heart disease, as well as lower life expectancies.[14] Mental health problems such as depression, anxiety, and substance use disorders are also more common among Indigenous people compared to the general population.[15]

Social Determinants of Health

Compared to non-Indigenous Canadians, First Nations people are more affected by social determinants of health such as education and employment (i.e., they have lower educational and employment levels), poverty, and inadequate housing.[16] Housing on First Nations reserves is often inadequate, poorly maintained, and overcrowded.[17]

Adverse Childhood Experiences

More Indigenous children grow up in single parent families, and Indigenous women are more likely to experience both spousal and non-spousal violence than non-Indigenous women.[18] First Nations peoples encounter high levels of adverse childhood experiences.[19] Adverse Childhood Experiences (ACEs) fall into three general areas:

- Abuse including verbal, physical, and sexual abuse.
- Neglect including emotional and physical neglect.
- General household difficulties or challenges including having someone who is experiencing mental illness in the home, the presence of domestic violence in the home, the presence of problematic drug or alcohol use in the home, having a parent who is incarcerated, parental separation, or divorce.[20]

Incidences of childhood sexual and physical abuse are much higher in Indigenous communities compared to all other ethnic groups.[21] As noted by conference participants, sexual abuse is known to be associated with substance use, and this needs to be incorporated into treatment guidelines.[22] The more Adverse Childhood Experiences (ACEs), the worse the outcomes, and an accumulation of ACEs is associated with a significant burden of chronic health and mental health problems, including substance use in adulthood.[23]

14 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health*: pp. 6-47.

15 Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health; Söchting, I., Corrado, R., Cohen, I.M., Ley, R.G. & Brasfield, C. (July/August 2007) Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? BC Medical Journal. 49:6.

16 Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health.

17 Burke, S. (November 2018) Supporting indigenous social workers in front-line practice. *Canadian Social Work Review.* 35:1.

18 Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health.

19 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health:* pp. 6-47.

20 Musquash, C. (March 2023) Presentation on Trauma and drug-related psychosis at First Nations Substance Use Summit.

21 Söchting, I., Corrado, R., Cohen, I.M., Ley, R.G. & Brasfield, C. (July/August 2007) Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *BC Medical Journal*. 49:6.

22 Youth and Elder Reflections (March 2023) First Nations Substance Use Summit.

23 *https://www.cdc.gov/vitalsigns/aces/*

Stressful Experiences in Adulthood

Indigenous people are much more likely to experience stressful experiences in adulthood compared to the population at large, including poverty and unemployment, violence, homicide, assault, and witnessing traumatic events.[24] Experiences of racism and discrimination are common and serve as ongoing stressors in the lives of Indigenous people.[25]

Deaths, Injuries, Self-Harm and Suicide

Compared to non-Indigenous people, Indigenous people are more likely to experience intentional or unintentional injuries, including injuries from motor vehicle accidents.[26] Possible causes for the latter include poorer road conditions on reserves, vehicle maintenance issues, driving behaviours, number of car occupants, alcohol use, and living in areas that require frequent highway traveling to access goods and services.[27] Indigenous communities are also disproportionately affected by the rates of deaths due to injuries in young people, which are three to four times higher than the national average.[28]

In addition, despite representing a fraction of the population, the suicide rate among Indigenous youth aged 15-24 is five to six times the rate seen in the general Canadian population.[29] Suicide and self-inflicted injury are the leading causes of death among First Nation youth aged 15-24, whereas in the general youth population it is accidental death.[30] These issues are made worse in remote, isolated First Nations communities, with many having deep-rooted social problems including high rates of poverty and unemployment, social disorder, substance use, chronic health problems, and family violence.[31]

24 Bombay, A., Matheson, K. & Anisman, H. (November 2009) Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health:* pp. 6-47.

25 Ibid.

26 Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health.

27 Ibid.

28 Bellamy, S. & Hardy, C. (2015) *Post-traumatic Stress Disorder in Aboriginal People in Canada: Review of Risk Factors, the Current State of Knowledge and Directions for Future Research.* Prince George: BC. National Collaborating Centre for Aboriginal Health.

29 *https://www.suicideinfo.ca/resource/mental-health-and-suicide-in-indigenous-communities-in-canada/*

30 Ibid.

31 Lithopoulus, S. & Ruddell, R. (2011) Policing isolated Aboriginal communities: perspectives of Canadian officers. *Policing: An International Journal of Police Strategies & Management* 34:3, pp. 434-453.

Workplace Wellness Issues

The effects of historic intergenerational trauma manifest themselves in the workplace and among workers on First Nations in many ways. One of these is a heightened risk of experiencing secondary, or vicarious trauma that arises from the nature of the work being done. Many service providers in First Nation communities are members of the communities in which they work.[32] So, work life and personal life are not always easily separable.[33] In some cases, a worker may be the only person in their role in the community, meaning they may have to act in their professional capacity in traumas and critical incidents involving their own family members.[34] Workers often face very high expectations from community members in their roles, as well as a lack of boundaries, both of which are additional sources of ongoing stress.[35]

If communities are affected by historic and intergenerational trauma, as many are, then this trauma will also be affecting many of the workers themselves. Critical incidents in a community, for example, affect workers both professionally and personally.[36] In addition, the trauma, grief, and loss that staff see regularly in their roles often result in excessive workloads, pressure, lack of support, and stress, leading to burnout and high rates of staff turnover.[37] In many cases, staff are experiencing trauma both vicariously, and directly, i.e., a therapist may have experienced the same trauma of the client he or she is counselling.[38]

A related issue is the lack of adequate supports to help workers maintain a balance between their personal and professional lives, which can result in a tremendous human cost, placing these workers at high risk for secondary trauma and burnout.[39] In addition, in many communities there may be few or no people available for a worker to turn to for support, leaving them isolated and more at risk for secondary trauma.[40] Exposure to lateral violence, another legacy of colonization, is also not uncommon. This occurs when people who have been oppressed for a long time feel so powerless that rather than fighting back against their oppressors, they unleash their fear, anger, and frustration against their own community members. This can represent a significant source of stress for Indigenous workers.[41]

32 Deroy, S. & Schütze, H. (2019) Factors supporting retention of aboriginal health and wellbeing staff in Aboriginal health services: a comprehensive review of the literature. *International Journal for Equity in Health*. 18:70; Goodleaf, S. & Gabriel, W. (2009) The frontline of revitalization: Influences impacting aboriginal helpers. *First Peoples Child and Family Review.* 4:2 pp. 18-29.

33 Ibid.

34 Goodleaf, S. & Gabriel, W. (2009) The frontline of revitalization: Influences impacting aboriginal helpers. *First Peoples Child and Family Review.* 4:2 pp. 18-29.

35 Brown, J. & Fraehlich, C. (2011) Aboriginal Family Services Agencies in High Poverty Urban Neighborhoods: Challenges Experienced by Local Staff. *First Peoples Child and Family Review.* 6:1, pp. 10-27.

36 Brown, J. & Fraehlich, C. (2011) Aboriginal Family Services Agencies in High Poverty Urban Neighborhoods: Challenges Experienced by Local Staff. *First Peoples Child and Family Review.* 6:1, pp. 10-27.

37 Deroy, S. & Schütze, H. (2019) Factors supporting retention of aboriginal health and wellbeing staff in Aboriginal health services: a comprehensive review of the literature. *International Journal for Equity in Health.* 18:70.

38 Goodleaf, S. & Gabriel, W. (2009) The frontline of revitalization: Influences impacting aboriginal helpers. *First Peoples Child and Family Review.* 4:2 pp. 18-29.

39 Ibid.

40 Ibid.

41 Ibid.

Remote and Rural First Nation Communities

All the factors identified above are magnified for workers in remote First Nation communities, where workers are expected to act simultaneously in many roles. In such communities, workers practice in a very personal context with limited privacy, few if any colleagues, a lack of adequate supervision, and a sense of professional isolation.[42] There is also a frustration associated with bringing clients along in the helping process to a point where they are ready for other services, only to find that such services are inadequate or not available.[43] Other challenges include working proactively in the context of a large workload of crisis situations, lack of resources, poverty, family violence, rotating staff, and lack of access to training.[44]

In addition, in remote communities everyone often knows everyone else, which presents challenges related to maintaining confidentiality and client privacy. For workers who may be related to other community members and who may be asked to share information informally, this can be a source of ongoing stress.[45]

Due to the lack of professionals in many remote communities, workers often over-extend themselves, and work issues either follow staff physically through client encounters in public, or psychologically through worry and concern for clients.[46] The traumatic experiences of clients are often haunting and overwhelming for workers to cope with, and this can develop into secondary trauma.[47]

Mental Health and Addictions Workers

Indigenous mental health and addictions workers may be particularly vulnerable to secondary trauma due to their personal and frequent exposure to the traumatic experiences of clients. This is especially the case when the discussions involve violence and physical abuse, which can be linked to the post-traumatic effect of the residential school legacy.[48]

Strengths

Despite the many challenges caused by racism, discrimination, loss of culture, and intergenerational trauma, Indigenous peoples remain resilient, and a healing cultural revitalization is well underway in many First Nations across Turtle Island. This involves reconnecting people to culture and language, to the land, and to all their relations. This is reflected in many areas, for example, the development and implementation of the First Nations Mental Wellness Continuum (FNMWC), the content in the Summit presentations, and the numerous strengths and wise practices identified by its participants.

42 O'Neill, L.K. (2010a) Mental health support in northern communities: reviewing issues on isolated practice and secondary trauma. *Rural and Remote Health* 10: 1369.
43 Ibid.
44 Ibid.
45 O'Neill, L. K. (2010b) Northern Helping Practitioners and the Phenomenon of Secondary Trauma. *Canadian Journal of Counselling*. 44:2, pp. 130-149.
46 O'Neill, L.K. (2010a) Mental health support in northern communities: reviewing issues on isolated practice and secondary trauma. *Rural and Remote Health* 10: 1369.
47 Ibid.
48 Thunderbird Partnership Foundation, n.d.

Substance Use Health Issues among First Nations Peoples

Substance use continues to constitute a crisis among First Nations peoples, and several presenters shared data about current substance use issues. Information on opioid and methamphetamine use, and on overdose deaths was provided by several presenters, including Dr. Eleanor Boyle, Thunderbird Partnership Foundation; Bernadette De Gonzague, Dr. Tara Gome, and Sacha Bragg, Chiefs of Ontario; Dr. Paxton Bach, Co-Medical Director, B.C. Centre on Substance Use; and Jolene Pagurut BSc Nursing Harm Reduction Nursing Consultant.

Background Information on Toxic Drug Poisoning

Opioids and Naloxone

Nursing Practice Consultant, Jolene Pagurut, BScN RN pointed out that language around drug use is based in shame, stigma and blame. The language has now been changed: people no longer talk about overdoses but rather toxic drug poisoning because the drugs are so unregulated. This ensures users are not blamed for being poisoned by a toxic drug supply. There are options for safer supply, but the access to them is not equitable.

Heroin is about ten times stronger than morphine, fentanyl is stronger and carfentanyl is stronger still. Carfentanyl is intended for large animal use but is turning up in human drug poisonings. Opioids now are much stronger than they were previously, for example, fentanyl compared to heroin, and they are often mixed with other substances such as xylazine (sometimes referred to as 'tranq', a drug used for sedation in animals). Prohibition equals potency – when access to safe drugs is disrupted, more toxic street drugs fill the gap. In addition, people may be taking multiple substances, which makes it more challenging to reverse the effects.

Opioids work by binding to opioid receptors in the brain and gut. They cause euphoria and control pain. The more receptors that are blocked, the more effect the drug has. It slows down the muscles and the heart rate, making people less alert, sleepy, drowsy, and pale. Toxic opioid poisoning signs and symptoms include blue lips and nails, dizziness and confusion, inability to wake up, snoring, gurgling, slow breathing or no breathing.

Naloxone is an effective antidote to toxic opioid poisoning, although there are administration guidelines that need to be followed. *These may be found in the Appendix to this report.*

Data on Opioid and Methamphetamine Use

National Findings

Dr. Paxton Bach spoke about the fourth wave of the overdose crisis, noting the first wave involved deaths from prescribed opioids, the second from heroin use, the third from fentanyl and other synthetic opioids and, now the fourth, which involves increased use of stimulants, particularly crystal meth (a form of methamphetamine). He highlighted the fact that the opioid crisis is national in scope, although deaths per 100,000 are highest in the West, specifically in British Columbia, Alberta and Saskatchewan. One of the most concerning issues is the increased toxicity of the drug supply, which constitutes a public health emergency.

Dr. Boyle shared the results of two national surveys on opioids and methamphetamine conducted by Thunderbird Partnership Foundation. One was for youth aged 12 to 17 (with parental consent) and one was for adults 18 and older. The vast majority of respondents (90%) were First Nations and 75% were living in community; close to half reported food insecurity. Of the adult population, 28% were classified as having harmful opioid use, with younger age groups having a higher risk of harmful use. Male and other non-female genders have increased risk, as do people living on reserve, living in households with more than seven people, who are food insecure, and those with trauma-related experiences. The sample size was smaller for responses to questions about methamphetamine use but showed characteristics similar to the opioid survey response, except living off reserve or the household number did not make a difference.[49]

Ontario Findings

In 2012/13, Ontario Chiefs were raising concerns about a public health crisis, and as a result mandated research related to opioid use among First Nations people. As of 2021-2023, Chiefs of Ontario (COO) and the Ontario Drug Policy Research Network (ODPRN) are continuing to explore trends in the ongoing crisis, including pathways through healthcare use among people who use opioids, and treatment outcomes among First Nations.

Key findings of two completed studies were:

- Prescription opioid use for pain has decreased.
- The rate of Opioid Agonist Therapy (OAT) use increased and was slightly higher among females compared to males. Most recipients were between the ages of 25-44, and use was higher among First Nations people living within First Nations communities.
- Hospital visits for opioid related poisoning increased between 2009-2019 and occurred at a higher rate among males than females. Visits were highest among those between the ages of 25-44. Poisonings were higher among First Nations people living outside of First Nations communities.
- Deaths due to drug poisoning have rapidly increased among First Nations, more with males than females, and most occurring among people aged 25 to 44. They were the highest rate for people living outside community.
- The COVID-19 pandemic worsened the overdose crisis, and drug poisoning deaths more than doubled in the first ten months of the pandemic.
- The toxic drug supply has caused the increase in opioid related deaths: 90% of deaths were fentanyl-related, with multiple substances frequently contributing to deaths (e.g., cocaine, methamphetamines, benzodiazepines).

British Columbia Findings

Dr. Bach informed conference attendees that First Nations communities in British Columbia are being disproportionately affected by substance use related harms. Despite representing only 3.3% of the population in the province, almost 15% of toxic drug deaths occurred among First Nations people in 2020.

49 Additional general information regarding the surveys is available at *https://thunderbirdpf.org/surveys-can-help-support-your-community/* and specific results from the FNOM survey can be accessed at *https://thunderbirdpf.org/?resources=annual-report-2023#6*

Cannabis

Four presenters provided information about cannabis use and its effects. They included:

> *Dr. Heba Hassan and Dr. Eleanor Boyle, Thunderbird Partnership Foundation; Mary Deleary, Thunderbird Partnership Foundation; Dr. Shelly Turner, Ekosi Health; and Dr. Marco Sivilotti, Queen's University and Medical Consultant, Ontario Poison Centre.*

Cannabis differs from the other substances discussed, as it is legal in Canada for adults, and has both beneficial and harmful effects. There are both medical uses and health risks associated with using cannabis.[50] While there are non-intoxicating cannabinoids and other chemicals in cannabis, THC is mostly responsible for the way the brain and body respond to cannabis.

While cannabis can be used for medical purposes, there are short- and long-term physical and mental health effects that may be harmful in certain situations. These can include cognitive and physical impairments; motor-vehicle accidents; brain development and chronic functioning challenges; dependence and psychosis; heart and lung problems; interactions with other medications; increased heart rate and blood pressure, which may be a concern for individuals with pre-existing conditions; and poorer pregnancy outcomes.

Cannabis is one of the first substances used by many Indigenous youth and they are disproportionately more affected by harms of its use than non-Indigenous youth.[51] Another lesser-known effect of cannabis use is Cannabinoid Hyperemesis Syndrome, a rare form of cannabinoid toxicity that develops in chronic smokers. It is characterized by "cyclic episodes of debilitating nausea and vomiting. Symptoms stop after cessation of cannabis use" (Sirius J: High Times [2014 Dec 22]). This is often under-diagnosed. It can happen at any age and can be resolved if the individual is able to stop using for a long period of time.[52]

In addition to the documented harms, there may also be some benefits to cannabis use. These include:[53]

- Traditional uses for healing and spiritual purposes.
- Economic opportunities for Indigenous communities through cannabis production and sales.
- Its role in reducing opioids and other toxic substances and reducing overdose deaths and improving quality of life.
- Improving quality of life for those living with chronic pain.
- Reducing benzodiazepine use for sleep and anxiety.
- Using a combination of CBD and THC appears to be most beneficial in dealing with anxiety, depression, sleep disorders, chronic pain, and arthritis.

Thunderbird Partnership Foundation has conducted three cycles of surveys of cannabis use among First Nations people – the first was with youth and adults prior to legalization, while the second two were longer studies of both youth and adults post legalization. Thunderbird has an Addictions Management Information System which includes a Drug Use Screening Inventory (DUSI). This was modified in 2020, and results from the third round of surveys since then show an increase in cannabis use, although the exact reason for this is unclear.

The implementation process is extensive to ensure both youth and parents know what the purpose, process and outcomes of the survey will be. The research is both quantitative and qualitative, and outcomes allow Thunderbird to design programs for health promotion for delivery to communities. Thunderbird will also facilitate helping to implement the study in communities.

50 Dr. Heba Hassan; Dr. Eleanor Boyle (March 2023) Presentation on Cannabis at First Nations Substance Use Summit & Dr. Shelly Turner, Ekosi Health. Presentation on Cannabis Use and Impacts at First Nations Substance Use Summit.

51 Ibid.

52 Dr. Marco Sivilotti, Queen's University and Medical Consultant, Ontario Poison Centre (March 2023) Presentation on Cannabinoid Hyperemesis Syndrome at First Nations Substance Use Summit.

53 Dr. Shelly Turner, Ekosi Health. Presentation on Cannabis Use and Impacts at First Nations Substance Use Summit.

Thunderbird has also developed cannabis education and dialogue tools for First Nations, based on:

- *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations in Canada (HOS)*, which promotes a continuum of care with essential supporting elements including: community development, prevention, promotion, secondary risk reduction, early intervention, treatment, and specialized treatment; and promotes culture-based defined principles with Indigenous culture as central to all aspects of care in addressing substance use and mental health.
- The *First Nations Mental Wellness Continuum (FNMWC) Framework*, which is rooted in Indigenous Knowledge and culture-based practice builds upon the Honouring Our Strengths Renewal Framework to identify core outcomes that guide all components of mental wellness. The FNMWC has key themes that underpin a population approach to addressing key needs across the life span with essential services.
- The *Indigenous Wellness Framework*, was developed simultaneously with the FNMWC and shows the four essential components of mental wellness among First Nations – Hope, Belonging, Meaning, and Purpose and is the backbone to the Native Wellness Assessment™.

Across regions and through focus group discussions, Thunderbird Partnership Foundation gathered and summarized community strengths, priorities and recommendations related to cannabis which align with the five key themes of the FNMWC:

- Culture as Foundation
- Community Development, Ownership and Capacity Building
- Quality Care System and Competent Service Delivery
- Collaboration with Partners
- Enhanced Flexible Funding.

The foundational documents and consultations resulted in the development of *Let's Talk Cannabis – Dialogue Tools and Curriculum Development* for cannabis education, awareness, and policies in First Nation communities. It provides opportunities to explore the risks and benefits of cannabis legalization, harm reduction strategies and the potential impacts on First Nation communities. It supports interested facilitators from across Canada in providing cannabis education training within their communities and tailored to their unique community needs. The key learning objectives are:

- To develop skills to facilitate conversations with First Nations youth on cannabis
- To gain current scientific knowledge on cannabis
- To understand harm reduction practices
- To utilize a wholistic approach to wellness inclusive of individuals, peers, family and community, in dialogue with youth.

The training provides all the tools needed to set up a seven session Let's Talk Cannabis Group with Indigenous Youth ages 13-17. Trainers will be supported by the Community of Practice in the Let's Talk Cannabis Hub to network with others who are delivering the Let's Talk Cannabis Program in their communities and will also be able to order workbooks from there. Training is available both virtually and in-person. As with other Thunderbird trainings, this training is certified by The Indigenous Certificate Board of Canada (ICBOC) and the Canadian Council of Professional Certification (CCPC) Global.

Key Themes and Concepts

Culture as Foundation

Several presenters spoke about culture as being foundational to the health and wellness of First Nations peoples, and as the key factor in preventing and treating substance use disorders.

In her presentation on *First Nations Harm Reduction, Opioid and Methamphetamine Guidelines*, Dr. Carol Hopkins, CEO of the Thunderbird Partnership Foundation, stated culture needs to be the foundation of the work and a First Nations worldview – involving kindness and compassion – needs to guide the approach to supporting people who use drugs. Findings from Thunderbird's First Nations Opioid and Methamphetamine survey also support the concept of culture as foundation. When asked what treatments should be strengthened or made available in-community, 90% of the survey respondents said they wanted access to ceremony, 89% said they wanted sharing circles, 87% desired family programming, and 87% wanted life skills programming.

Presenters Elder Leona Stevens and Elder Wes Whetung – *Culture as a Core Competency of Mental Wellness* – noted that culture is healing in itself, and in First Nations culture the principle of respect is always emphasized. It becomes part of who people are, how they relate to others, and how they do their work. Therefore, respect needs to be ingrained in all aspects of addictions work. They also said that culture is more accessible now than ever before, for example, people can participate in ceremony and get their spirit names. As crisis levels escalate, the need for such cultural ceremonies and practices is increasing, along with the need for acceptance and inclusion. For example, people should not be excluded from ceremony if they are under the influence of a substance, so long as they are able to demonstrate respect.

At the same time, it is also important that cultural services, ceremonies, and practices be of the highest quality. Teachings and ceremonies must be true to a full understanding of traditional ways, and mentoring is required so those passing on cultural teachings and practices have this understanding.

Similar themes emerged from the presentation on *Culture and Substance Abuse* by Elders Jo-Ann and Jerry Saddleback. Culture is a process, not a product, and kindness and compassion are the goals. Being an Elder is a calling which first and foremost involves love for all. In addition, only validated Elders with several generations in front of them have the right to name and do certain ceremonies.

It is never too late to instill culture. Culture is healing for all age groups, even adults who have not been exposed to it before. Culture includes language, which has the power to change the molecular structure of peoples' bodies: the sound of the language has the power to heal people. Traditional stories also have a medicinal element – the old people believed that stories are the ingredients of how a child is raised. That is how people knew who they were, and the stories would grow their memory bank. Names are important and people should say their names loudly and often. Names come with colours, deity, and songs, all of which are urgently needed for healing. Ceremony is a big part of recovery, and it reduces the shame and guilt that come with substance use. Elders are important in helping to teach people how to pray for themselves, and how to use tobacco and pipe. The key takeaway is that each person is sacred, and learning to identify as a sacred being is harm reduction in itself. This creates a voice that says: it's not okay to destroy myself – because I matter, I am a sacred being, and I can help to preserve my life.

The presentation on *Models of Care Between Traditional Indigenous and Mainstream Health Care Practices* by Dr. David Tu and Elder Sandy Lambert touched on similar themes. They work at Kilala Lelum, which is an Indigenous health and healing co-operative located in the Downtown Eastside (Vancouver). They shared research findings on 'becoming a medicine house' that demonstrate connection to culture is healing. They provided the example that contact with Elders when dealing with opioid use is beneficial: after six months of care in a medicine house and connection with an Elder, there was a 40% drop in illicit opioid use and a decrease in the number of emergency room visits by 15-18%. Additionally, qualitative research has shown that connecting to Indigenous spirituality, ceremonies and medicines inspires healthier living, more positive attitudes and hope for the future, and a sense of Belonging. It gives people tools to promote mental and emotional wellbeing, empowers them to make positive changes including continued sobriety, and supports them in creating better circumstances for their children and grandchildren.

Youth and Elder Reflections, which occurred during the opening and closing of the conference also emphasized the importance of culture. The strength of First Nations people lies in their traditional practices such as the healing practice of the round dance, and their connections with each other, community, and the land. Land-based activities in particular, are very important in the healing process.

The Importance of Harm Reduction from an Indigenous Lens

As stated by Dr. Carol Hopkins in her presentation, *First Nations Harm Reduction, Opioid and Methamphetamine Guidelines*, harm reduction is not fully understood and is sometimes viewed as enabling people in their addiction. However, harm reduction is about protecting the sacred breath of life (saving lives), reducing future harms, and keeping individuals, families, and communities safe. Harm reduction focuses on a vision for the future, and First Nations people are great visioners. Reducing the harms of drug use increases the odds that someone who uses drugs is going to be alive tomorrow and have the time to get to that *good place* of readiness for making a change.

Colonized thinking around drug use leads to stigma. Abstinence, zero tolerance, and removing people from community are not connected to culture and First Nations worldviews. These are not solutions. Culture needs to be the foundation of harm reduction, and a First Nations worldview must guide the approach to supporting those who use drugs. Starting from a place of culture does not necessarily need to include cultural practices at first (e.g., sweat lodges and smudges), but it involves meeting people where they are at with kindness and compassion.

In the discussion following the presentation, participants emphasized that healing through harm reduction approaches is a process – it takes time to get to a mental, emotional, social, and spiritual place where one can make a meaningful decision to change their relationship with drugs. It takes time, it takes resources, and it takes being in a relationship with the right people. It is also important to make use of existing community strengths, and to build from a place of community development, ownership, and capacity building.

Some of the principles for developing harm reduction approaches from an Indigenous lens include:

- Making a commitment to building and maintaining innovations.
- Changing the belief that First Nation communities are bad, toxic, and cause us harm – First Nation communities have many strengths and trusting relationships must be built among community members.
- Supporting First Nations government by creating good connections with chiefs and councils, to facilitate their work so that they can be involved, know how to help, and who to go to for that help.
- Placing culture and language at the centre of the work – both are powerful medicines.
- Ensuring that community-based models are at the centre of the work: this will result in a circle of supports such as land-based programming, rapid access to additional medicine, social programming, family-based supports, clinical care, counselling mental health supports, cultural counseling and practices, referral to other resources (training mentorships), a 24-hour crisis line/chat, and outreach.
- Paying attention to the physical needs of addiction – food, water, shower, physical safety, and medicines for other (associated) ailments.
- Gaining support for community development and the ability to support trauma-informed care.
- Improving participation and collaboration among service sectors to provide the highest quality of care.
- Developing a barrier-free service model to ensure access to supports and provide options for those seeking assistance to access tools like messaging and virtual care.
- Advocating for and developing primary care renumeration models regarding substance use care.
- Implementing different funding models for engaging doctors and nurse practitioners, so that their services are appropriate to the needs and in collaboration with the community.
- Ensuring access to pharmaceuticals in communities (i.e., naloxone)
- Overcoming the barrier of racism and accessing equitable funding – i.e., the First Nations addictions workforce is paid 47% less than the publicly funded workforce, even given the same accreditations.
- Securing on-going funding for long term sustainability, as most of the funding is for three years and is research-based.

Elders Jeanette Armstrong and Marlow Sam presented on *Harm Reduction and Culture* and echoed many of the themes described above. Primarily, they focused on the healing power of language and ceremony in harm reduction. Language and ceremony are vital parts of the healing journey and can be powerful tools in substance use programs. Principles such as land-based healing and meeting people where they are at can help organizations de-institutionalize while balancing harm reduction and culture. Integrating culture into substance use programs is highly beneficial, even with limited resources or experience.

Mae Katt, a primary health care nurse practitioner, spoke about *Healing beyond Trauma*. The purpose of harm reduction is to lower the risk for people who use drugs, and the best definition of harm reduction, as mentioned by Dr. Hopkins, is kindness and compassion. In alignment with the theme of culture as healing, she emphasized the importance of connection to the land, to self, to family and to spirit. All of these create a sense of Belonging.

Mae Katt shared an Indigenous healing model developed by Elder Dr. Ed Connors, which involves the following steps for clients and helpers:

1. Denial and shock: Just being there (presence).
2. Forgive: Give people space to express their guilt. Forgive yourself.
3. Acceptance: Claim your identity.
4. Reconciliation: Healing happens when you forgive.

Five healing protocols from survivors are similar:

1. Reconciliation
2. Reclamation
3. Truth
4. Develop parenting skills
5. When trauma re-occurs, we need to restart the healing process

We all need connection. For young people, this means creating an atmosphere where they will feel a sense of Belonging. Being on the land, in the water, and around the fire all create this feeling of connection and Belonging. Land-based healing options are a high priority. Parenting programs are also needed.

For service providers, kindness and compassion are the biggest drivers to help in recovery. A key skill is listening – which in itself is a health benefit. Service providers must also be willing to learn from the communities they serve. Nurse practitioners can prescribe drugs to replace opioids, but medication alone is not sufficient for healing. Communities need to develop a full circle and continuum of care. In terms of interventions, Mae Katt talked about NAN Hope: The Nishnawbe Aski Nation Mental Health and Addictions Support Access Program that provides services to 49 First Nations communities in the Nishnawbe Aski region (*www.nanhope.ca*).

Similar themes emerged from the presentation on *Indigenous Harm Reduction Resources: Overview of Key Findings and Recommendations* by Trevor Stratton, Indigenous Leadership Policy Manager, Communities and Alliances Network. This presentation was about the development of a policy brief for governments and organizations so they can meaningfully incorporate Indigenous approaches to harm reduction into their work. It involved a very extensive consultation process with Elders, Indigenous Knowledge Keepers, people with lived experience and other key stakeholders. The policy brief has four main sections:

- Indigenous Harm Reduction
- Challenges to Indigenous Harm Reduction
- Recommendations for Indigenous Harm Reduction Policy and Practice
- Promising Practices in Indigenous Harm Reduction (case studies).

The presenter noted that people speak of abstinence and harm reduction as if they are two different things, but abstinence can be part of harm reduction. Harm reduction is about helping people set their own health goals, and achieve them. If their goal is abstinence, then we walk with them on that path. There is still not full acceptance that harm reduction is a good approach, and more conversations are needed around this.

The policy brief acknowledges the importance of mainstream harm reduction, which involves a range of policies, programs and practices proven to reduce the harms that may be associated with substance use. These include safe consumption sites, needle exchanges, opioid substitution programs, wet shelters (where people dependent on alcohol have a safe place to stay and drink under supervision), education and outreach, and naloxone distribution.

However, while harm reduction is needed and is often lifesaving, it is too narrowly focused on technological and behavioral interventions, i.e., about individual choices, not social and systemic changes. Nor does main stream harm reduction address the need to disrupt the colonial system and the structures that put people at risk of substance use in the first place.

Indigenous harm reduction is uniquely grounded in Indigenous cultures and is about reducing the harms of colonization. It is a way of life, it is love, non-judgement, and non-interference; it is deeply rooted in Indigenous Knowledge and worldviews and combines that with the best of what the Western world can offer while reducing harm from colonization. It has the following characteristics:

1. It is decolonizing, centring power and control where it has been removed due to colonization. It supports policies and practices that are community-based and peer-led. It is trauma informed. It is distinctions-based and culturally safe, and it is reflexive to ensure colonial systems are not repeated.
2. It is indigenizing, supporting policies, practices and programs that are culturally grounded in traditional knowledge, teachings, ceremonies, and languages (where appropriate). It is strengths-based, and it is Indigenous-led.
3. It is wholistic, inclusive, innovative and evidence based.

Recommendations for Indigenous Harm Reduction Policy and Practice include:

- Indigenous community-based leadership, which will involve asking people with lived experience what they want and about their experiences.
- Peer-leadership, engagement, and support, helping people to release their own capacity and use their voices.
- A multi-level and multi-sectoral approach: interventions must be part of a wholistic and intersectoral package of policies and programs that treat the whole person in the context of their families, communities, and Nations.
- Diverse and inclusive: policy, funding, and practice must recognize and support the unique needs of each individual, community, and Nation.
- Evidence and evaluation: Program evaluations must consider different kinds of evidence and must honour and acknowledge that Indigenous communities know what is best for Indigenous communities.
- Adequate and sustained funding: federal, provincial and territorial governments must provide adequate and sustained funding for Indigenous harm reduction that is mid-to long-term in vision, and wholistic or multi-sectoral in scope. Include peer-led and culturally grounded initiatives.

The session *Indigenous Harm Reduction, Good Medicine,* led by Audra Stonefish, Cultural Harm Reduction Outreach Supervisor for Chippewas of the Thames First Nation located in southwestern Ontario, focused on the importance of innovation and collaboration in supporting those with addictions. The discussion revolved around the availability of support across nations, and the potential of volunteer-led programs through partnerships. Workforce support, partnerships and collaboration, and innovative cultural harm reduction activities were emphasized. Possible solutions include pooling funds for cultural harm reduction activities and partnering with other organizations to expand the services' scope. Key points include:

- Being innovative is crucial when supporting individuals with addictions.
- Programs can serve multiple communities by pooling funds together to plan and initiate cultural harm reduction activities.
- Volunteer-led programs through partnerships can expand the scope of services provided.

Strengths and Wise Practices

Several presenters provided examples of strengths and wise practices, including national, regional, and community-based strategies as they relate to addressing substance use among First Nations peoples.

National Strategies

***AMIS: Community-based addiction services*, Bernalda Robinson and Shawna Olson, Thunderbird Partnership Foundation.**

The Addictions Management Information System (AMIS) database collects reliable evidence of stories, experiences, and strengths. AMIS can gather a lot of culturally based information. It supports accreditation and certification, as well as research and funding initiatives. However, the community decides who has access to the data.

AMIS is a screening and a case management system used by treatment centres that are part of the National Native Alcohol and Drug Abuse Program (NNADAP) and/or National Youth Solvent Abuse Program (NYSAP). AMIS is now being expanded for First Nations community-based substance use and addictions programs, such as a day program, an outpatient program, or a residential program, and a land-based program with or without a community-based clinical program.

AMIS:

- Collects culture-based evidence that can be used to inform client care.
- Demonstrates the strengths of the National Native Alcohol and Drug Abuse Program (NNADAP) and/or National Youth Solvent Abuse Program (NYSAP).
- Offers various reports that can be used to support funding requirements.
- Supports research initiatives.
- Provides the evidence to support ongoing/ enhanced funding for NNADAP and NYSAP and community-based programs across Canada.

AMIS Outcome Measures:

1. Drug Use Screening Inventory (DUSI): Assesses addictions and mental health and contains a trauma scale that is specific to First Nations context and experience.
2. The Native Wellness Assessment™: Measures the impact of culture to Hope, Belonging, Meaning, and Purpose. Also measures the connection to culture to clearly demonstrate the difference culture makes in mental wellness.

Advantages of using AMIS:

- A national database on First Nations drug and alcohol use and culturally based treatment services across Canada.
- A secure database that prevents unauthorized access to the data and protects the data from corruption and deletion.
- Improves the integrity of the data through automatic data checks that occur during data entry.
- Automatically generated annual reports are created to help treatment centres and communities tell their own story, monitor trends, and meet outcome connection and funding criteria.
- The electronic record makes data/information more available to service providers.
- Software, training, and ongoing support is free.

Currently, 26 treatment centres are using the database, and there is an expansion/pilot project underway to 50 First Nations communities. Virtual services are also an option.

***Wharerātā Declaration: Indigenous Youth Leadership and Priorities*, Misko Kicknosway, Program Facilitator at *Level* – a Canadian Justice Education Charity, and Olivia Olson, Community Youth Leader.**

The Wharerātā Declaration was born out of the International Initiative for Mental Health Leadership (IIMHL), an international collaborative of eight countries (Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, Sweden and USA) that focuses on improving mental health, addiction and disability services and aims to provide better services to consumers and families. The Wharerātā Declaration was prepared by the Indigenous Leadership Group, assembled, and supported by the IIMHL in February 2009.

The word Wharerātā is Maori in origin. Whare translates to 'house', and Rata translates to 'a tree with bright red flowers and a large canopy'. Whare rata is 'a house of wisdom and understanding, a house of shelter and protection'. The Declaration was written to document a vision of the near future in which mental health and addictions systems meet the wholistic needs of Indigenous peoples. It covers what is unique about Indigenous peoples, a systems approach to mental health and addictions which values partnership and collaboration between Indigenous and mainstream providers, cultural competence of mainstream mental health providers, and finally a declaration on the unique aspects of Indigenous leadership.

The Declaration articulates five themes for balancing Indigenous and mainstream approaches to develop Indigenous mental health leaders. These themes revolve around the following:

1. Indigeneity
2. Best practice
3. Best evidence
4. Informed, credible, strategic, connected, sustainable leadership
5. Influential and networked leadership.

There was a feeling among the Indigenous youth present that there needed to be more focus on youth voices and that the Declaration did not adequately reflect youth voices. Subsequently, in Fall 2022 at an IIMHL conference in Washington, a group of six youth shared their thoughts and experiences with those in Washington on what effective leadership looks like, and youth from the National Indian Education Association also shared their feedback. This led to further discussions about youth leadership, and particularly in relation to mental health and addictions. The group of six has since continued to solicit feedback from various groups about the concept of Indigenous youth leadership.

To date, identified leadership priorities are:

- Access: the ability to connect with others and resources.
- Connection: relationships between one another, a thing, or an idea.
- Education: the process of receiving or giving instructions.
- Growth: to increase in an area or as a whole.
- Reconciliation: to acknowledge and to set aside the differences and be one.

Leadership qualities include:

- Acceptance: recognizing a situation, process or condition without attempting to change it or protest it
- Culture: the social behaviour institutions and norms found in human society as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in that group
- Community: a social unit with commonality (place, norms, values, customs, or identity)
- Purpose: the reason for which something is done or created or for which something exists

The presenters then asked for feedback, focused on two questions:

- What role do traditional practices contribute to your community?
- How are they incorporated into mental health services?

Responses from the Zoom chat and table report back included the following.

Things are beginning to return to normal after the pandemic. Ceremonies are starting again, and they remind people across the lifespan from children to Elders what our teachings and our way of life are. This contributes to mental health by reminding us of the ways the Creator gave to us to live, and will help with mental health by giving us pride, something to look forward to, and teachings to learn to share with the future. Agencies are also bringing in cultural practices such as land-based healing, basket making and ceremony. However, there is still shame among some when it comes to engaging in traditional practices, which is an important part of programming. There can also be divisions based on Christian and traditional belief systems and this can impact families and their ability to interact with each other.

Participants noted it is important to take a Two-eyed-seeing approach, but at the same time, traditional practices are imperative to mental health and addictions. When those who have been seeking help through different programs are asked what is different about land-based healing they say that Western practices just do not work. When working with a Western therapist, they feel obligated to answer the questions that they are asked, and some people are not ready to answer questions about childhood trauma, etc. Land-based programs offer a chance to engage in therapy while participating in traditional activities such as berry picking. Participants are more comfortable and more likely to open up in that environment. Participants also start to guide their own healing in such settings. For example, they may ask to smudge and talk.

Communities could be more proactive in dealing with mental health and support is not always available. This could be due to a number of issues including limited funding. Communities in crisis often tend to have volunteers that come forward to provide information and services, including information about ceremonial practices to people in crisis. Usually that comes through formal programs and service offerings but sometimes it comes through community gifts.

Regional Strategies

***Walking alongside First Nations in BC in the Response to the Toxic Drug Emergency: from Surviving to Wellness*, Duanna Johnston-Virgo and Jodie Millwood, First Nations Health Authority, British Columbia.**

The First Nations Health Authority (FNHA) has five regions, with 26 cultural groups, 34 languages, more than 200 First Nations or bands, and 41 communities which are rural or remote.

FNHA's philosophy is focused on wellness, centred on individuals and a balanced lifestyle.

The FNHA is the result of a unique partnership in BC: a 2018 tri-partite agreement to improve health and mental wellness of First Nations people. It involves flexible multiyear funding to support mental health and wellness; First Nations led approaches including planning and partnerships; flexible reporting requirements that include oral reporting of what communities are doing with their funding; identified strengths-based indicators; and an informed ten-year strategy on the social determinants of health.

FNHA has ten funded treatment centres, one currently operating day programs, two recovery houses (in Round Lake and the Williams Lake area), and two new treatment centres under development. There is one universal application, and travel costs are covered by FNHA benefits. A key focus is supporting healing and addressing root causes of trauma. Further to that, there are 147 land-based healing initiatives, traditional wellness teams, and supports for First Nations people affected by the Indian residential school system.

FNHA has played an important role in the toxic drug supply emergency in BC. In 2016, when BC declared a state of emergency, a response was needed. Since 2016, at least 1609 First Nations people have died of toxic drug poisoning and that includes 373 people in 2022 alone. First Nations people are dying at five times the rate of other BC residents, while for First Nations women, the death rate is 11.2 times higher than non-First Nations women.

In response to the poisoned drug supply, FNHA changed its language to reflect what they do and how they respond, i.e., they are not focused solely on detoxing treatments but more on a wholistic approach to wellness. Harm reduction is key, and the goal is to meet people where they are at, and to keep them alive to take their journey. Their approach includes people who are regularly involved in substance use as well as people who use drugs sometimes, for fun or for pain management. There are 15 internal FNHA teams active in the emergency response, there is a senior overdose response team, and there are social media campaigns to share information across the province.

FNHA has an *all paths lead to wellness* circle image, which encompasses four key objectives:

1. Prevent people who overdose from dying;
2. Keep people safe when using substances;
3. Create an accessible range of treatment options; and
4. Support them on their healing journeys.

Promoting a shift in policy has been a major aim of FNHA in BC focusing on decriminalization and safe supply, harm reduction, and nurse prescribing. The decriminalization approach is critical: it makes it safer for people to access safe use sites and other programs, and not to fear the threat of being stopped and arrested because they need drugs.

When a toxic drug supply comes into a community, FNHA has an emergency response capacity focused on what can be done in the moment. This includes working with communities to see what resources they have, providing harm reduction supplies, and using an established network of people who use drugs to help keep others alive. Eliminating stigma and ensuring that people feel safe is critical in saving lives.

***Improving Access to Medication Assisted Treatment for Indigenous Communities*, Dr. M. Kahan and Ann Marie Corrado, Ontario**

The program, called Meta-Phi, supports delivery of high-quality care across Ontario for those who use substances. They do so through advocacy, education, networking, and guideline development, as well as operating Rapid Access Addiction Medicine (RAAM) clinics for all people who use substances.

RAAM clinics are accessible to anyone without an appointment or referral. They provide pharmacotherapy, brief counselling, and referrals to community services. There are more than 55 RAAM clinics across Ontario. Some services they provide are treatments for alcohol and opioid withdrawal, and information about and connections to after care.

The clinics are open to both referrals and walk-ins three mornings per week. On the first visit, patients are assessed by an addiction physician, who discusses treatment goals and plans, which includes psychotherapy and pharmacotherapy. Patients can also meet with a nurse, social worker and/or an addiction worker based on what they need. RAAM clinics will work with family physicians to ensure they are able to help with the pharmacological treatment for addiction. They also connect patients to mental health and addictions community-based services.

Meta-Phi is willing to coordinate and work with Thunderbird to find ways to make treatments available to Indigenous communities.

***First Indigenous-Led Rapid Access to Addictions Medicine Clinic in Winnipeg*, Charlene Hallett, Aboriginal Health and Wellness Centre.**

The Aboriginal Health and Wellness Centre of Winnipeg (AHWC) was established in 1994, has 13 programs, 80+ employees, and is the only Indigenous community health agency of its kind in Manitoba. It provides trauma-informed and healing-informed care, focuses on harm reduction, and blends Indigenous and Western approaches.

Rapid Access to Additions Medicine Clinics (RAAM) are low-barrier drop-in clinics for people looking to get help with substance use and additions, offering medical assistance for people who have substance use related health issues. The purpose of the clinic is grounded in the Truth and Reconciliation Commission calls to action, including the calls to justice where clan grandmothers, community members, and constituents all called for a *rerooting of Indigenous culture into solutions*. Their approach is about life promotion and harm reduction, not simply suicide or addictions prevention. Harm reduction reduces the negative impacts associated with drug use/policies/laws/attitudes – it is grounded in justice and human rights, and focuses on positive change without judgement, coercion, or discrimination. Harm reduction does not require someone to stop using substances. Elements and concepts of harm reduction have been implemented in every aspect of clinic design and creation.

***Spruce Bough Managed Alcohol Program*, Renee Sanderson and Jayson Quesada, Yellowknife Women's Society, Northwest Territories.**

The Spruce Bough Managed Alcohol Program takes a housing first approach (providing personal and private space with access to common rooms). Supportive housing includes access to comprehensive wellness and support services (for example, required care services such as nurses, personal support workers, counselors, various outreach services, transportation, primary and treatment care services, land-based and cultural services), one of which is a Managed Alcohol Program which has been operating since spring of 2020. There is a full continuum of care supporting all needs – physical, emotional (complex trauma), mental (teaching and education), and spiritual (land-based).

Medical support staff offer managed alcohol doses based on individual needs (medical based on withdrawal or other considerations), for example, they serve beer, wine, and vodka, which are administered at intervals. Clients are informed that this is optional, and they do not have to take doses if they prefer not to. The Northwest Territories government pays for the alcohol, while the accommodation and food costs are covered by the individuals. People may stay at the house as long as needed.

Community-based Strategies

Mobile Outreach and Harm Reduction, Dr Terri-Lynn Fox, Blood Tribe First Nation, Alberta.

This initiative includes a Day Treatment Program (DTP) for those who cannot attend a residential treatment program, who may have mixed feelings about their decision to attend a treatment program, or those who are already on their recovery journey looking for ongoing support. It has been in operation for several years, with more than 1300 participants and 60+ graduates.

The DTP provides education, awareness, and support to those who suffer with illicit substance use and/or alcohol use disorders. The goal is for clients to learn skills to cope in a healthy and logical manner with drug/alcohol related urges and thoughts. It seeks to decolonize harm reduction by grounding the work in culture and cultural ways of doing and knowing. Elders and Knowledge Keepers are routinely engaged with the DTP.

The program is part of a research initiative which involved data collection and is moving to phase two of a study following phase one. It includes a survey with specific questions to provide an opportunity for more robust quantitative data, and to identify baseline factors and quality of life. The preliminary phase two study started with about 20 DTP participants.

The program was one of 13 to be nationally recognized for innovations in addictions care and aftercare. The connection with culture and Elders has been tremendously positive in the client journey and has fostered long term relationships that improve client outcomes. The program is currently in the process of developing a best practices manual that is guided by staff as well as Elders.

Key findings to date are:

- There are significant linkages between quality of life and culture, and quality of life and subsequent substance use.
- The younger a participant is the less likely they are to have a connection with culture and the more likely they are to use substances.
- Targeting youth populations with culture and Elder engagement acts as a harm reduction strategy for an upstream approach.
- Grounding work in culture has significant benefits for client interactions.

***Peacemaking, Healing to Wellness and Cultural Approaches to Addressing Community Disorder*, JoAnne Cook (Chief Appellate Court Judge, Grand Traverse Band, in-person) and Matt Lesky (Little Traverse Bay Bands of Odawa Indians Government, virtual).**

Matthew Lesky is an attorney licensed in the state of Michigan, and a court administrator for the Little Traverse Bay Band of Odawa Indians. He has been a member of the Tribal Court, Drug Court Program since 2009, first as a prosecutor and then as a defense attorney. He now serves as a court administrator of the Family Preservation Court, focusing on preventing the removal of children from their families, and providing services to reunify families where removal has occurred.

JoAnne Cook is a member of the Grand Traverse Band of Ottawa Chippawa Indians, located in Michigan, where she serves as Chief Appellate Judge. She is involved in Peacemaking Courts and Healing to Wellness Courts.

The concept of Peacemaking Courts originated in a gathering in the West in the 1990's, where discussions were held about traditional ways to resolve disputes, and how to re-integrate these into Indigenous communities. JoAnne shared that restorative justice has always been her passion, and her objective for peacemaking was to re-establish Anishinaabe culture and traditions. The process started by talking with community members including Elders, youth, and Christians who have incorporated Indigenous traditions and language into their churches and asking them how restorative justice could help to change lives.

The Peacemaking Court started with youth – engaging first-time offenders and their families – and moved on to family custody cases. Currently, any charges where both parties agree to go to peacemaking can be brought to the court. There remains a strong focus on engaging with youth. Attorneys are not allowed to participate in peacemaking. Most offenses involve property crimes done under the influence as well as some felony level misdemeanors.

Peacemaking involves a 'sentencing circle' – people in a circle, with a blanket, a candle, and a speaking rock (similar to a talking stick). Peacemaking is about speaking from the heart, speaking truth to each other, reflecting, and ensuring that all parties have a voice. It is also strengths-based and emphasizes that everyone has gifts, even if they have made mistakes.

In addition to the court, there is a peacemaker who works in the community, supporting individuals and families, and peacemaking has been used to resolve human resources disputes and in schools to help students deal with issues and conflicts.

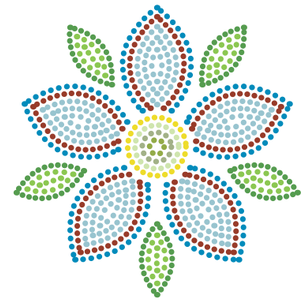
The idea of peacemaking is growing and taking hold elsewhere as well – each of the tribes in the United States either has a peacemaking initiative or is seeking it out; some law schools are now teaching peacemaking; there have been research articles written about it; some non-Indigenous courts are adopting some of the principles; and other countries are also showing interest in learning the concepts.

Matt Lesky spoke about how the system is very different in Michigan compared to Canada, so people attending the conference would have to think about how his presentation and comments could be applied to the work they are doing. The development of a Healing to Wellness Court started in 2008 when the Tribal Council, judiciary and executive branch decided that existing services were not addressing the problems – people were frequently in court and not getting better. The Healing to Wellness program came about because communities were losing a lot of their people to alcohol and then drugs. The Council requested and received a grant to set up a Healing to Wellness Court.

It is a specialty court model – not adversarial. People are ordered to attend court once a week and the judge has direct interaction with clients. It serves as an alternative to incarceration. Some clients have avoided up to 70 years in prison, and there has been little indication of further involvement with law enforcement. The program uses a high risk, high need assessment called a Limited Liability Company (LLC Michigan) which includes indicators on social history and crime such as: Driving Under the Influence (DUI), possession, and domestic violence. Programing is geared to those who are high risk, high need and who may influence lower risk individuals. There is also a 'Wellbriety' weekly program that lasts 18 months and incorporates the Seven Grandfather teachings and other Anishinaabe teachings.

There are cultural resource advisors whose sole role is to figure out how to integrate clients back into community via cultural activities, for example: sugarbush, sweats, sweetgrass, finding name and clan, etc. This is an interwoven approach to justice, a concept that permeates all aspects of programing. Clients and staff all sit in a circle and clients are integrated into the program to support each other and graduates.

The key factor of both initiatives is that they are based on – and lead with – culture. Decolonizing language and working within a cultural framework is healing and has shown great success.



Concerns and Barriers

Conference participants identified a number of concerns and barriers to effectively addressing the substance use crisis in First Nations communities.

Stigma and Discrimination

Stigma and discrimination were discussed by two presenters: Tahl East, Wellness Programs Director, Tribal Health Educator in Harm Reduction; and Mary Deleary, Training and Education Manager, Thunderbird Partnership Foundation, who talked about combating stigma in the context of decolonization and reconnection to culture.

Tahl East is a Harm Reduction Specialist, Substance Use Specialist, and a Manager of Wellness and Healing programs. She is a recovered crack/cocaine addict with lived experience.

She noted that 100% of participants will know and love someone who uses substances. Many of these people want help for misuse but do not receive it. Stigma and discrimination against people who use substances is still very much a problem. Discrimination is when someone treats you in a negative way because of your substance use – it is an act or behaviour. People who use substances get lost behind the stigmatizing language. Negative and harmful words leave people feeling worthless. These negative feelings create barriers to seeking help, to supporting those who seek help.

Mary Deleary expanded on some of these points, emphasizing that the foundation of stigma is racism. She explained there are several types of stigmas:

- Cultural stigma, which makes people feel alienated and discriminated against both in their own cultural group and in wider society.
- Public stigma, which are negative and discriminatory attitudes that others have about their dealing with mental illness or substance use.
- Self-stigma, which is internalized shame and negative attitudes, that people with mental illness or substance use have about their own condition. This has built up over 500 years – it is intergenerational.
- Institutional stigma, which upholds all other forms of stigma, limits opportunities, and has limiting policies.

Tahl East said the solution to the issues of stigma and discrimination is to rethink new ways and strategies to address substance use, to ensure language and thoughts as a service provider are non-stigmatizing, and to support people who use substances with empathy, compassion and understanding. Treatment must be offered from a harm reduction perspective. This includes not having rules or restrictions on drug use before providing help and including people struggling with substance use in ceremony and traditions.

These ideas were supported by Mary Deleary, who discussed the concept of culture as foundational in recovery. People need to reconnect to their original way of being, the way they were created – this helps them to regain hope. Addictions are a symptom of what is missing, which includes language, culture, Elders, land, and traditional medicines.

During the follow-up discussion, people offered additional thoughts in relation to stigma and discrimination. These included the need to recognize that the matriarchal structure is gone through colonial practices. There is not the same level of respect for women as before, when there was respect for grandmothers, especially those in leadership. Also, racism experienced in workplace settings can be credited to stigma – people may have to take cultural sensitivity trainings, but they often do not work because of how internalized their biases are. Sometimes people must experience what they are inflicting on others to allow them to understand the effects. The question was posed: How do we generate a program or other intervention that will allow people to experience these feelings (humanely)?

Effects of Intergenerational Trauma

Several presenters talked about the intergenerational trauma experienced by First Nations people as a direct contributor to and cause of substance use disorders – it creates the demand. Healing this trauma is of the highest priority in dealing with the substance use crisis, and until we start focusing on demand reduction, the problem will persist. Demand reduction requires addressing the issues that contribute to people's use of fentanyl, methamphetamine, or any other substances. This includes attending to social determinants of health such as education, employment, housing, living wages and food security as well as focusing on cultural identity, and mental, social, and spiritual well-being.

Lack of Adequate Resources and Political Will

An appropriate response to the toxic drug poisoning crisis must relate to the scale of the damage. As an example, more money was spent on COVID-19 in BC than on the opioid crisis in 2020 even though more people died of toxic drug poisoning, showing a lack of political will to address the issue.

Funding is often project based and time limited, with expectations to make significant changes in a short amount of time. Then the funding stops. This is an unrealistic approach.

Funding must be adequate to ensure equitable service delivery and standards of care for First Nations service providers, and to provide people with the right services at the right time. The lack of resources and funding to fully address issues related to the drug crisis has resulted in addictions workers using their own salaries to buy food for their clients, to pay for transportation for people traveling outside of the community to get harm reduction kits, etc. Limited funding also contributes to burnout and a loss of valuable human resources.

Insufficient Focus on Indigenous Approaches to Harm Reduction

There is also a lack of sustainable and adequate funding for programs and projects based on Indigenous harm reduction. While some Western approaches can be effective, they can include unrealistic expectations of abstinence and zero tolerance for drug use. These expectations have spilled over into some Indigenous approaches but are a result of colonization. Indigenous harm reduction is uniquely grounded in Indigenous cultures and in addressing the traumatic legacy of colonization. Support is needed to continue to move away from colonial thinking and toward honouring and using Indigenous ways of knowing. More conversations are needed about harm reduction and how difficult this concept can be for parents and communities. Over-focusing on abstinence and zero tolerance creates stigma and impedes the capacity to heal.

Jurisdictional Divides

There continue to be too many jurisdictional divides between provincial, territorial, and federal governments in terms of who is responsible for funding various services for First Nations peoples, and the different levels of government do not always work collaboratively. This negatively effects the ability of communities to provide required services and supports to their people struggling with addictions.

Lack of Understanding of Indigenous Culture Among Non-Indigenous Service Providers

Indigenous care providers have a double workload trying to teach non-Indigenous care providers how to appropriately work with Indigenous people as well as doing their own jobs. Education for non-Indigenous partners is needed to reduce this workload.

Lack of Support for Paraprofessionals

We must open our minds when considering who has the expertise to deliver programs and services to ensure those with lived experience can be trained and employed within their own communities and that this training should move beyond formal Western education.

Oftentimes, valuable programs and services are provided by paraprofessionals, who may have extensive lived experience or some training in a professional field but are not fully qualified or licensed. These individuals may not receive any compensation for their time and effort. It is imperative to advocate to government to support the development of core competencies that are not linked solely to formal education and to ensure that programs and services delivered by paraprofessionals can be covered by the Non-Insured Health Benefits Program of Indigenous Services Canada.

Lack of Access to Cultural Programs for Youth

Youth participants said they wish there were more cultural programs to keep young people occupied and off the streets. Youth also need more opportunities to feel heard and engaged. Many are feeling stuck, or isolated, or suicidal. Church influences may impede access to traditional culture and perpetuate ongoing stigma from colonization. More education is needed about what cultural resources are available and how to access them, so that youth can connect with their cultural identity.

Lack of Education About the Harms of Drug Use

More education is needed about the harms of drug use for youth (and community in general). Many people are unaware of how toxic and dangerous the current drug supply is. This should also include education about cannabis use and how heavy use and/or use of products with high THC levels can affect individuals, particularly youth.

Lack of Safe Supply Programs for Stimulants

Safe supply programs for stimulants are challenging because there is no comparable prescription drug (e.g., naloxone) that can be administered.

Core Competencies for the First Nations Addictions Workforce

There is a need to develop standardized core competencies and scopes of practice with culture as the foundation while ensuring continuous development and support. Competencies highlight what is needed for a First Nations mental wellness and addictions workforce, including those who work in communities and those who work in residential treatment centres.

Participants of the First Nations Substance Use Summit were asked to provide feedback on specific areas and on what is needed for a First Nations mental wellness workforce. Common themes as well as supports needed for capacity building were provided from this feedback, as well as from a review of Summit presentations and discussions. The results are shown below.

Common Themes Across Competencies

Common themes that apply across all competencies are:

- The ability to support a coordinated care approach, for example:
  - Ability to develop and foster partnerships with relevant organizations and services to support client wellness.
  - Ability to offer low barrier supports, programs, and initiatives.
  - Ability to refer/ connect clients with relevant services and supports across the continuum of essential services.
- Creativity – the ability to *think outside of the box* to support client needs.
- The importance of acting with compassion, empathy, kindness, and respect; skills in applying emotional intelligence principles; and active listening skills.
- The ability to support community needs including those of specific populations and across the lifespan.

Specific Required Competencies

Understanding Culture as Foundation

Workers need to have a deep understanding of Indigenous cultures and how to help people access cultural programming. Everyone who provides services to Indigenous community members must be knowledgeable about Indigenous history, worldviews, and cultural teachings. Cultural practices and languages must be incorporated into healing programs. Even with limited resources, workers must introduce cultural elements into substance use programming based on principles that resonate with the community and reflect their connection to the land. All activities and approaches should support an Indigenous culture as foundation approach, and workers must have the ability to support and facilitate this process.

Worker Competencies:

1. Cultural Competence and Cultural Safety: Ability to acknowledge, respect, honour and interact effectively with people of different cultures, values and socio-economic backgrounds, particularly within Inuit and First Nation communities/ societies; demonstrates a willingness to embrace cultural differences and practices; demonstrates a commitment to continued learning of Indigenous and First Nation's culture and knowledge while ensuring a positive cross-cultural work environment; practices critical reflection and humility by addressing their own perceptions and bias and contributes to building a work environment which is safe, inclusive and respectful; demonstrates and supports the cultural development and learning of Inuit and First Nation clients while respecting and recognizing the diversity within the community.
2. Knowledge of and ability to apply the core concepts of the Indigenous Wellness Framework – the backbone to the Native Wellness Assessment ™ – and the First Nations Mental Wellness Continuum, and to apply strategies from the Honouring Our Strengths Renewal Framework.
3. Understand the relevance of, and ability to plan and facilitate activities and events grounded in culture, including land-based activities. Ability to engage cultural supports in activities (e.g., cultural practitioners, Elders, Knowledge Keepers) relevant to clients, community, region, and situation.
4. Managers/ supervisors/ executive directors: Ability to support staff through culture-based healing approaches (staff wellness).

Harm Reduction

Indigenous harm reduction requires specific skills and abilities. Centring abstinence and zero tolerance creates stigma. More education is needed for workers in this field.

Worker Competencies:

1. Understand the importance and benefits of harm reduction, understand: "what is harm reduction?", and connections to stigma.
2. Knowledge, skills, and behaviours in facilitating culture as foundation in harm reduction, including but not limited to land-based approaches.
3. Ability to translate harm reduction principles into relatable concepts.
4. Understanding the different harm reduction supports required by people who are using different types of drugs, e.g., those who are addicted to opioids and those who are addicted to methamphetamines will need different harm reduction approaches.
5. Ability to apply harm reduction principles to different job roles and responsibilities.
6. Skills in health promotion and prevention, skills to provide support throughout the continuum of essential services.
7. Skills in toxic drug poisoning prevention and response (e.g., safe supply/ safe consumption/ safe use; naloxone administration or first response in a medical emergency), including prevention of infectious diseases.

Worker Competencies Required in Relation to All Substances

(<u>For this discussion</u>: opioids, methamphetamines, cannabis, and alcohol)

1. Understand the different substances and addictions (pharmacological and neuropsychological understanding) including but not limited to opioids, methamphetamines, cannabis, and alcohol. This includes the effects of mixing various substances.
2. Understand the effects of different substances on the whole person and the ability to support someone who uses wholistically (spiritually, mentally, emotionally, physically), throughout the continuum of essential services, using culture as foundation, and considering family and community needs.
    - Knowledge and skills to support withdrawal from different substances using medical and cultural approaches.
    - Knowledge and skills to support access to safe supply and harm reduction resources.
    - Understand the effect of different substances on individuals, families, and communities.
    - Understand the effects of different substances when used during pregnancy.
    - Knowledge of traditional healing approaches.
3. Understand the connection between sexual abuse and substance use, as well as the impact of drug use on sexual behavior and sexual abuse.
4. Understand the effects of substance use on cognitive abilities and behavior.
5. Dedication to ongoing learning and understanding of different substances and their changing environment.
6. Substance-specific competencies need to be informed by program assessment, people with lived and living experience, and from a culture as foundation perspective.

Competencies Needed in Relation to Specific Substances

Opioids

1. Understand the implication of co-use with other substances, e.g., benzodiazepines.
2. Knowledge of opioid agonist therapy (OAT), its use, and how it can be led by culture as foundation.
3. Ability to support different harm reduction strategies, including administration of naloxone.

Methamphetamines

1. Understand the effects of methamphetamines on the whole person.
2. Understand the implication of co-use with other substances, e.g., opioids / benzodiazepines.
3. Ability to support someone who uses methamphetamines wholistically, including provision of supports for safe sexual behaviour.

Cannabis

1. Understand the effects of short- and long-term use of cannabis on the whole person.
2. Understand the effects of cannabis use across the lifespan, especially among youth.
3. Understand the potential uses of cannabis for harm reduction of other substances.
4. Understand policy/ legislation changes and the influence on treatment and recovery, this includes knowing where to find post-legislation cannabis data (e.g., detrimental effects of use including hyperemesis, cannabis induced psychosis, etc.) and understanding local area bylaws.

Alcohol

1. Understand the effects of alcohol use on the whole person.
2. Understand the effects of alcohol use across the lifespan.
3. Understand the implication of co-use with other substances, e.g., opioids / benzodiazepines, stimulants.
4. Ability to support different harm reduction strategies.

Trauma-Informed Care

1. Understand different types of trauma.
2. Understand historical and ongoing colonial legacies specific to Indigenous Peoples of Canada.
3. Understand the connection between trauma and substance use.
4. Knowledge and skills in trauma informed approaches to care.
5. Ability to develop and maintain a wellness plan to prevent burnout, compassion fatigue, and protect against vicarious trauma.

Public Health Approach to Substance Use Health

1. Knowledge and skills to support beyond the individual, including family and community.
2. Ability to acknowledge system change needs and ability to support clients and community wholistically (throughout the social determinants of health, through evidence informed policy development and engagement with leadership, through commitment to social justice and equity, etc.).

Additional Competencies

Data

1. Knowledge and skills in data stewardship.
2. Ability to apply data to all of the above competencies to better understand and support community needs.

Youth

1. Ability to effectively engage with youth.
2. Ability to identify and support youth priorities.

Mental Health

1. Knowledge of different mental illnesses and connection to substance use and addiction.
2. Ability to support complex mental health and complex trauma needs.

Virtual Services

1. Proficiency in delivering virtual treatment, including competent use of technology.
2. Understand service navigation/ pathways to care, i.e., how clients can receive support and go back to their community supported.

Supports Needed to Build Capacity in the Above Listed Competencies

1. Spaces and opportunities to share wise and best practices, network (e.g., through a professional association, or events similar to the First Nations Substance Use Summit).
2. Training and professional development opportunities on all the above topics.
3. Ongoing advocacy work by Thunderbird (e.g., Workforce Wellness Project, Harm Reduction Campaign).

A Standardized Treatment Curriculum for Treatment Centres Serving First Nations

The goal is to develop a standardized curriculum and core competencies for treatment centres serving First Nations. Proposed core competencies in the previous section are relevant here also, as the curriculum will need to be reflective of knowledge, skills, and behaviour expected through the competencies. Competencies should reflect knowledge, skills, and behaviour needed to deliver the standardized curriculum content. The National Standardized Addictions Curriculum outline used to guide the First Nations Substance Use Summit (Mar 28-30, 2023) is presented below.

Proposed Curriculum Content

General/Foundational

Culture as the Foundation of Wellness

- Competency reflection: fundamental to First Nations mental wellness workforce competencies.

Stigma and Discrimination

- Competency reflection: important aspect of competency in harm reduction.

Harm Reduction

- Competency reflection: foundational competency needed for a First Nations mental wellness workforce.

Pharmacology

- Competency reflection: Knowledge of pharmacological and neuropsychological effects across different substances and addiction needed.

Toxic Drug Use and Deaths

- Competency reflection: knowledge, skills, and capacity to prevent and respond to toxic drug use needed across opioids, methamphetamines, alcohol, and cannabis.

Assessment

Native Wellness Assessment, Drug Use Screening Inventory to Substance Use and Mental Health and Trauma for Adults and Youth

- Competency reflection: Access to and data stewardship expressed as an important skill and resource to guide service planning and implementation.

Treatment Planning and Monitoring

- Competency reflection: knowledge, skills, and capacity (human resources and funding) to support a coordinated approach to treatment planning and pre-treatment care.

Detox and Withdrawal Management

- Competency reflection: knowledge, skills, and capacity (human resources and funding) in withdrawal management needed across opioids, methamphetamines, alcohol, cannabis.

Land Based Service Delivery

- Competency reflection: expressed as an important aspect of First Nations mental wellness and addictions services.

Complex Needs

- Competency reflection: Additional competency in mental health suggested which includes knowledge and skills to support complex mental health and complex trauma needs.

Continuing Care and Partnerships

- Competency reflection: knowledge, skills, and access to resources needed to develop processes and partnerships to best support coordinated and continued care.

Public Health Approach to Substance Use

- Competency reflection: knowledge and skills to support beyond the individual, including family and community. Ability to acknowledge system change needs and ability to support clients and community wholistically (throughout the social determinants of health, through evidence informed policy development and engagement with leadership, through commitment to social justice and equity, etc.).

National Virtual Treatment Program

The goal of the National Virtual Treatment Program is to support culturally based eMental health programming for Indigenous-led substance use treatment centres aiming to provide alternative substance use and addiction services. The program will support delivery of the national standardized addictions curriculum through self-guided virtual programming and for pre-treatment, brief intervention, and aftercare support.

Connecting information from the National Virtual Treatment Program project and the work to develop a national standardized addictions curriculum will be necessary as both projects develop.

Preliminary results from the content consultation and needs assessment for virtual treatment in First Nations communities is presented below (six different treatment centres; eight interviewees, 2022). This review will help to inform virtual treatment programming content creation for the website (end deliverable), and overall structure for the program.

Initial feedback primarily focused on structure, policies, and procedures needed to support virtual addictions treatment delivery – these pieces will be considered when determining knowledge and skills needed by staff delivering virtual addictions treatment programming, contribute to the national professional association core competencies, and provide structure to curriculum content delivered virtually from the national standardized addictions curriculum.

Identified strengths of virtual treatment are:

- Depth and breadth.
- Greater access to treatment.
- Broad range of participants beyond the immediate community and those that are unable to participate in-person, e.g., those who are incarcerated, those parenting young children, those living in different regions of Canada.
- Access to resources during the pandemic.
- Encouraged adoption of technology/ updating resources within treatment centres.

Barriers associated with virtual treatment include:

- Safety concerns, e.g., how to respond to emergencies of safety-related situations from a virtual environment.
- Privacy concerns
  - Ensure clients have camera on (to confirm identity), use of headphones, participating in call in a private area (not in public or around others) if able.
- Attrition and engagement
  - Active participation – centres interviewed developed flexible programming with shorter intervals to support engagement.
- Technology literacy of staff and participants.
- Resources to develop virtual content (human resources, time)
- Environment, i.e., not being able to meet and support people in their environment.
- Integrating 'deeper' content into treatment, e.g., ensuring content does not trigger or cause additional trauma without being able to provide relevant supports.

Resources Required (what is needed to keep going/re-start)**:**

- Not all centres continued virtual programming – resumed in-person programming required capacity previously used to support virtual programming.
- For those that want to implement long-term:
  - More staff, including staff dedicated to supporting virtual programming.
  - More funding and related advocacy.
  - More technology expertise/ resources.
  - Increased capacity to monitor outcomes, e.g., use of AMIS and other ways to monitor change.

Indigenous-Focused Needs:

- All centres noted that consultation with community and Elders occurred prior to sharing culture in a virtual space.
- Examples of ways culture was shared in a virtual space:
  - Mailing craft and art kits
  - Virtual smudging
  - Tea with Elders
- Ensure teachings shared are credited to appropriate Elders, communities, and Nation(s).
- Develop programming from an Indigenous lens/ culture as foundation.

Development of a National Mental Wellness Workforce Association

Creating a National Workforce Association,

Marion Crowe, CEO, First Nations Health Managers Association

History

The First Nations Health Managers Association (FNHMA) was established in 2010. The vision is that First Nations Health Managers are leaders who honour, maintain, and uphold inherent ways of knowing while balancing management principles to bring excellence to their communities and health programs.

The Assembly of First Nations (AFN) and the First Nations and Inuit Health Branch of Health Canada committed in 2006 to coordinating the development of a First Nations Health Managers Continuing Competency Framework. A First Nations Health Managers Advisory Committee was set up in 2006 to guide the work. There were two objectives to the work of the Advisory Committee: create a framework for the work of a health director – in essence the job description; and to investigate what a national association could be.

The initial task was to conduct a situational analysis and needs assessment (2007/2008). It took three years to complete the work, which included cross-country consultations and an extensive review of competencies and skills of health directors.

Key findings included consensus on essential skills for First Nations health managers, namely:

- Communications, accountability, fiscal and human resources management.
- A connection to the community and understanding its culture and values is essential.
- The importance of speaking the local language was emphasized.
- An awareness of First Nations history, recognizing the impact of colonization and residential schools is crucial.

Recommendations from the situational analysis/needs assessment which were reviewed and validated in 2008 were:

- Support the development of standards, ethical guidelines, and best practices, similar to a professional organization.
- Create a mentorship and job exchange program.
- Develop a certification process for health managers using existing curriculum and modules.
- Create a Health Director Network to support and share information.

The Advisory Committee then recommended moving forward with the creation of a national association. This was supported by a resolution from AFN in 2009, which was followed by another resolution in 2015 that stated when hiring health leaders, look for the credential 'certified First Nation Health Manager.'

The next step was to conduct an environmental scan of what was being taught in colleges and universities in relation to required health manager skills and competencies: about 60% of the competencies identified by the Advisory Committee were being taught. What was missing was the cultural support and how it actually works, which led the Advisory Committee to decide to develop their own curriculum. So, they developed a Certified Health Manager Program. This program includes anyone managing health services: addiction, treatment, etc.

The Competency Framework

The competency framework is represented in the form of a medicine wheel, with culture at the centre. The other areas of the wheel include:

- Planning and Communication (black);
- Leadership and Governance, Professionalism, and Advocacy Partnerships and Relationships (white);
- Human Resources Management, and Financial Management and Accountability (yellow); and
- Health Services Delivery, and Quality Improvement and Assurance (red).

Framework Components

- Domain: A broad category that explains a particular field of knowledge.
- Core Competency: An observable and/or measurable knowledge, skill or behaviour that contributes to successful job performance.
- Competency Indicators

Benefits of a Competency Framework

- Outlines the complexity of a worker's role.
- Is a valuable tool for recruitment and retention.
- Is a process to assess knowledge and abilities and can identify further training needs.
- Can be used by educational institutions to influence curriculum development.
- It is important to note that the Framework should not be mandatory, i.e., not used to judge the merits of a particular worker.

Recommendations:

1. Get support from political leadership. Recognize that change can be challenging. Know which items to take ownership of and be prepared to put in the time required for change management and acceptance of change.
2. Create a national association and determine credentialing, which can and should recognize years of lived experience in the field. This may require a couple of pathways to certification.
3. Ensure influencers are part of initial conversations about creating the national association.
4. Engage with potential membership and explain the benefits they will be receiving through a national association, as there are membership fees, so they must understand what they are receiving in return. One of the benefits of having a national association is that it gives Indigenous people equitable spaces and voices at a variety of tables and venues. Belonging to a national association and having the credentialling also empowers people to act on all their Indigenous Knowledge and wisdom.
5. Create partnerships – articulation agreements – with the academic world to review and approve the curriculum. That will ensure workers' credentials are recognized if they want to pursue more higher education, such as a university degree, so they can walk in two worlds if they want to. This is important for continued professional development.
6. Contract with an association management company that works with the best of the best to provide guidance on the incorporation of an association, establishing by-laws and registering the association – all of the administrative steps.

National Standards Collaborative in Mental Health and Substance Use Health,

Debbie and Susan Miller, Mahihkan VGN/ Management

Standard's Council Canada (SCC) is Canada's voice on standards and accreditation on the national and international stage. SCC is not an Indigenous organization, but it is leading a Mental Health, Substance Use Health (MHSUH) standardization collaboration, engaging a diverse range of key stakeholders, including Indigenous partners, to inform the work on current and future standards that will contribute to a MHSUH standardization collaboration roadmap.

The SCC and MHSUH recognize the effects of colonization and the importance of culturally informed health care for First Nations, including land-based interventions. Further to that, the SCC has retained Mahihkan Management, using the services of Debbie and Susan Miller (Blue Heron Women) to deliver a series of engagements and touchpoints to better understand the mental health and substance use health needs of Indigenous peoples in Canada.

The presenters noted that Indigenous people have different needs than non-Indigenous people due to the history of colonialism, and this requires an understanding of what has and has not worked in terms of mental health and substance use health services and supports. The purpose of the presentation was to request feedback of conference participants, to ensure that the presenters are asking the right questions when they move forward with Indigenous engagement sessions. Anyone who would like to have their voice heard can go to the website *www.scc.ca*. They can also contact SCC directly at *health.sante@scc.ca*. The presenters, Blue Heron Women, can be contacted at *blueheron62@gmail.com* and more information about engagement sessions can be found at *events1@mahihkan.ca*.

The engagement process will be virtual, and it will involve two 2-hour virtual introduction sessions. Regional sessions (a 3-hour meeting), will provide an opportunity to reflect on six themes involving three priority areas with sub-themes:

- Primary Health Services Integration
  - Integration of MHSUH in primary care settings
  - Digital MHSUH
- Children and Youth
  - Access to integrated community-based services for youth
- People with Complex Needs
  - Integrated MHSUH services for people with complex needs
  - Substance use treatment centres
  - Substance use workforce

The sessions will be followed by two virtual wrap-up meetings, focusing on the question: 'Did we hear what you said?'

There will also be twenty interviews with First Nations, Métis and Inuit persons with lived/ living experience, and participants invited to express interest in being interviewed. Following the 'did we hear what you said' stage there will be a final report on MHSUH to SCC, which may inform the cycle again.

Participants asked about youth perspectives and the presenters confirmed that they need to make connections with young people and introduce youth voice as a major part of the engagement process.

Implications for the Development of a National First Nations Mental Wellness Association

This work is very similar to the work Thunderbird and FPWC are undertaking to develop a professional association with standard competencies, certification, and operating standards. Synergies between the two initiatives will need to be reviewed, including how the SCC movement would relate to an association of mental wellness workers across the country. It will be important to ensure that building blocks are in place so the two are working together and not separately. There will also need to be consideration of how a potential Indigenous accreditation board would align with the professional association and the work that the SCC is doing.

Youth and E-Mental Health Apps

eMental Health: Standards for Developing Digital Resources for First Nations Youth,

Dr. Ed Connors, Kahnawake First Nation, Chris Heffley, Creative Lead, Thunderbird Partnership Foundation, Jordan Davis, Full Stack Developer, Thunderbird Partnership Foundation.

Background

The COVID-19 pandemic increased the burden of mental health issues among Indigenous youth. Electronic mental health (e-MH) interventions may be effective in addressing healthcare disparities, including stigma-related barriers and access to mental health services for youth.

This workshop followed preliminary investigations with youth about an e-mental health app. Community-based participatory research was carried out during youth sessions at two events:

1. Youth led Life Promotion Workshop, Whitehorse, Yukon.
2. First Nations Substance Use Summit, Toronto, Ontario organized by Thunderbird in March 2023.

Five youth attended the pre-workshop event to review and give feedback on the guide to assessing e-Mental Health standards. Thirteen youth from across Canada attended the Substance Use Summit. Elder Dr. Ed Connors was contracted to facilitate both discussions.

The guide for the assessment of e-mental health interventions for Indigenous youth was introduced along with four standards: 1) clinical evidence standards; 2) clinical safety standards; 3) usability and accessibility standards; and 4) cultural safety, social responsibility, and equity standards.

The following questions informed the review of the standards for e-MH interventions:

1. Does the e-MH intervention represent Indigenous culture in a 'one size fits all approach', or is it culturally matched to the specific target group/community of interest?
2. Is culturally relevant language included in the e-MH intervention?
3. Is culturally relevant multimedia (e.g., images, videos, auditory components, other aesthetic components) included in the e-MH intervention?
4. Were Indigenous media experts (e.g., Indigenous-owned film crews, Indigenous actors, Indigenous artists, Indigenous graphic designers) included during the e-MH intervention development process?
5. Is e-MH intervention content familiar/relatable? Scene locations (e.g., rural reservations), storyline characters (e.g., trusted parent, peer, or adult)
6. Are cultural values included in the e-MH intervention?
7. Are cultural norms included in the e-MH intervention?
8. Are Indigenous frameworks (e.g., Two-eyed seeing) included in the e-MH intervention?
9. Was culture incorporated into the research design process?

Indigenous youth recognized that these questions are relevant to their wellness, and that their engagement in the development of any new e-MH app will require wholistic healing teachings, language restoration, and land-based activities. They agreed that cultural connection and a user-friendly app would be valuable for Indigenous youth and their communities. Dr. Connors was planning further connection with youth at the Canadian Association for Suicide Prevention conference on May 10-12, 2023, in Halifax.

Purpose of the Workshop

The purpose of this workshop was to create a vision on how to connect with youth through the development of an e-mental health app. We are becoming connected without borders, and technology is a method to communicate with one another. Through relationships youth have the potential to guide us and find ways to use technology.

The COVID-19 pandemic disconnected people from one another. The app could be a doorway to connection / reconnection. The challenge is how to get to the next stage. How do we create this app so that it will reach our youth? There are many differences and teachings. The challenge is to create apps that are specific to our communities and regions.

Wise Practices

In the development and application of e-health interventions, a number of wise practices have been identified. Some may be found on the Wise Practices website for youth and community (*https://wisepractices.ca/*).

The Mental Health Commission has also developed a set of criteria for assessing cultural safety, social responsibility, and equity, as shown below.

- **4a – Q1:** Does the e-MH intervention represent Indigenous culture in a "one size fits all approach", or is it culturally matched to the specific target group/community of interest?
- **4a – Q2:** Is culturally relevant language included in the e-MH intervention?
- **4a – Q3:** Are culturally relevant multimedia (e.g., images, videos, auditory components, other aesthetic components) included in the e-MH intervention?
- **4a – Q4:** Were Indigenous media experts (e.g., Indigenous-owned film crews, Indigenous actors, Indigenous artists, Indigenous graphic designers) included during the e-MH intervention development process?
- **4a – Q5:** Is e-MH intervention content familiar/relatable?
- **4a – Q6:** Are cultural values included in the e-MH intervention?
- **4a – Q7:** Are cultural norms included in the e-MH intervention?
- **4a – Q8:** Are Indigenous frameworks (e.g., Two-eyed seeing) included in the e-MH intervention?
- **4a – Q9:** Was culture incorporated into the research design process?

Research questions:

- What are the standards to guide us to develop an app for youth?
- What are the limitations of an e-mental health app?
- What are the unintended consequences?
- How are your families and communities going to benefit from it?

Further questions:

- How do we use technology in a good way?
- How do we enable youth to have access?
- How do we share information with youth?
- How do we promote life in an e-mental health app?

The Importance of Culture

Participants were asked: What role do traditional healing practices and traditions play in community and how are they incorporated in mental health services?

Responses included:

- Challenges are faced when people feel shame practicing traditions because of the uncertainty and the unknown.
  - A Two-eyed seeing approach acts as a bridge for incorporating culture and this is especially true for clinical practices where it can be beneficial to community and client outcomes.
- Communities in crisis tend to have volunteers come forward to offer their ceremonial practices to those in crisis in the community.
  - Family clans
  - The division between traditional and Christian families needs to be bridged and there is a greater need for family-based programming.
- There are not always immediate effects of incorporating culture however the long-term effects are undeniable.
- Traditional practices, especially land-based services, are imperative for addictions and mental health.
- Revitalization of culture in community – clinical programming and education with links to land-based programming
  - Use of evidence based cultural activities such as drumming.
  - Culturally based programming is the basis/ foundation of all services in community.
  - Culture is used to heal and rejuvenate the community.
- Connection of generations (youth to Elder) gives strength to intergenerational approaches.
- Communities can be proactive or reactive, this varies.

Creating a First Nations Youth Mental Wellness Digital App, Elder Dr. Ed Connors

The presentation highlighted the proposed functionalities and features of the app, such as requests for sacred medicines, youth-focused information packages, First Nation language translation, mental wellness activities, and helpline communication.

Youth Feedback

The youth suggested numerous ideas for the app, including a youth-focused podcast, wellness tracking, user-created content, personalization, guided activities, and a platform for First Nation youth communities' interaction. Youth found the Thunderbird Wellness app content too plain and long, leading to disinterest, and identified a lack of relatable and relevant content as a key concern.

Youth identified the value of information on opioids and substance use but suggested that the app content should directly speak to their realities and experiences. They also expressed the importance of making the app a supportive online environment where successes can be celebrated without judgment.

The app could be improved by personalizing the user experience, including wellness tracking, allowing user-created content, and increasing cultural and age-relevant content. The youth expressed a desire for a supportive, non-judgmental online space where they can connect, discuss, and feel proud of their successes. The app could also benefit from more interactive features and less text-heavy, more concise information.

Generally, the youth and Elder were able to imagine aspects of what an eMental health app might look like if developed specifically for youth in their cultural territory. They recognized the value of developing culturally specific apps and could imagine what that would look like, sound like and how it could provide opportunities for language restoration. However, they were only beginning to think through aspects of app design and development.

They could see how regional apps could serve to support youth to connect with other like-minded youth in their territory (networking) and how a national app might connect them with Indigenous youth from across Turtle Island. However, they also began thinking of separate youth audiences ages 6-12, 13 -19 and 19-29.

They agreed having Elders offer wholistic teachings from the land will help youth learn to think wholistically and apply teachings to their unique wellness needs.

Overall, these participants felt that the standards pertaining to culture, mental wellness and Indigenous youth are adequate.

Next Steps

- Integrate the feedback from the youth into the next phase of app development.
- Ensure the app provides a supportive environment that celebrates individual successes and fosters open discussions.
- Improve user engagement by making content more engaging, digestible, and culturally relevant.
- Explore gamification elements to motivate regular use and engagement.
- We could get more feedback and from Indigenous youth who are more informed about app design and development. There was at least one youth in this group with this experience and knowledge. Our youth from the Indigenous youth life promotion toolkit project have these abilities. Elder Dr. Connors was planning a more in-depth discussion with them at the Canadian Association for Suicide Prevention event in Halifax.

Appendix: Administering Naloxone

***Administering Naloxone*, Jolene Pagurut, Nursing Practice Consultant**

Key Points

A harm reduction approach in administering naloxone is very important.

Get naloxone where it needs to be. Kits are available through Thunderbird and most pharmacies across Canada without prescription.

Individuals need to feel safe in accessing help when needed. Training and understanding every step including aftercare are as important as having kits available.

Administration

Naloxone can be given in a few ways but not orally. It can be injected intramuscularly or given intranasally (which is called Narcan). The injectable approach uses less product: Our muscles are like a big roast with a lot of blood in it; if the needle is put in gently, it will find a vessel and get the medication through the body very quickly. Therefore, it requires only a small amount (.4mg/ml). The nasal spray may affect people with allergies or nose infections and can harm healthy tissue in the nose. It is 4 mg, so much stronger than intermuscular. However, it does not seem as strong, and as a result sometimes people give doses too close together. Administering the injectable takes a bit of skill versus nasal Narcan so people are more inclined to use the latter.

Toxic Opioid Poisoning Signs and Symptoms

Toxic opioid poisoning signs and symptoms (i.e., from codeine, morphine, hydromorphone, etc.) include blue lips and nails, dizziness and confusion, snoring, slow breathing, gurgling, or no breathing, and the person is hard to wake up.

Good Samaritan Drug Overdose Act

This became law in Canada in 2017. It protects people who call 911 or who are experiencing toxic drug poisoning for themselves or another person. People may not call because they are afraid of losing their house, their children, etc. The Act protects them if they are on parole, pretrial release, probation orders, or under simple possession conditional sentences. However, the Act does not protect against – and police will follow up on – outstanding warrants, production and trafficking of controlled substances or other crimes which are not outlined within the Act. Overall, the Act lets people know it is safe to call for help.

Contacting First Responders

If calling 911, tell them the person is not responsive and not breathing, and give the address. If you know Google Maps does not work for the location, give specific instructions. GPS coordinates can be added to your kits or information regarding addresses. If possible, send someone to direct first responders when they arrive. Make sure there is someone at the front door to greet them.

Maintain a calm environment when there is more than one responder: everyone wants to help, and everyone is scared; at most 4-6 people are needed to assist. There should be someone doing rescue breaths and CPR, someone drawing up the medication and giving it, and an extra person who can read out the administration steps and do the timing of when to give the naloxone, as well as someone on speaker phone with 911, and someone to maintain crowd control in the building.

Procedures

Utilize **SAVE ME** steps: stimulate, airway, ventilate, evaluate, medicate, evaluate again (these steps are inside the kits).

Stimulate: say the person's name, do not shout it. Be gentle, the person may be very scared. Always say what you are doing before you do it, ask them. If there is no response, shout their name and tell them you are getting ready to give them Narcan. If you don't get a response check for pain: do trapezius (muscle between neck and shoulders) squeeze, nail bed pressure (you can use a pen or tip of naloxone, press something firm onto their nail bed, close to the cuticle, on their finger next to their thumb. Pain wakes a person up). Do not kick, punch, slap or throw the person in the shower. Intervenors are no longer doing a sternal rub on the chest, because it is hard to differentiate whether a person is having a heart attack or drug poisoning.

The recovery position is important if you need to leave the person. Tuck their hand under their cheek and bring their knee up toward their chest. Make sure their airway is open by tilting their head and lifting their chin.

Airway: Check their breathing: is it absent, slow, snored, gurgled? 16-20 breaths per minute is normal, but with opioids there may be less than 10 breaths per minute. Remove anything visible in the mouth (chewing tobacco, gum, vomit etc.) Head-tilt-chin-lift (often they start breathing because the tongue isn't in the way anymore) or jaw thrust.

Ventilation: This is crucial to prevent brain damage and death. Use the face shield in the kit to protect, give the person rescue breaths, plug nose, do two full breaths. The chest should rise and fall with each ventilation, and continue giving one breath every 5 seconds until they are breathing adequately on their own.

Evaluate: If they start breathing normally, roll them into the recovery position on their side until help comes. If they stop breathing, roll them on their back, and give rescue breaths. Any time the person does not have a pulse, start CPR with rescue breathing and compressions.

Medicate: Nasal naloxone comes in a kit, with gloves, a face shield, a peel open package, and a concentrated dose. Support the person to keep their airway open, place the dosing package into their nose and put your thumb on the plunger, with a finger on either side of the device, depress the plunger the entire way, and tell the person you are giving them naloxone. They will feel a slight pinch.

Evaluate again: Continue going through the SAVE ME steps. As soon as they start breathing normally with 10 breaths per minute stop giving naloxone, even if they are still unresponsive. If they are still not breathing normally after 3-5 minutes after giving naloxone give another dose. After giving naloxone evaluate them to see if they are getting better.

Aftercare

This is very important. When the person wakes up is not the time for a lecture. Let them know what happened, they may be unaware of anything, tell them what you did to try to help them, let them know naloxone will wear off in 20-90 minutes, keep them as calm and comfortable as possible. They may want you to talk or be quiet, they may also be thirsty but do not give them too much water until they are more awake. If they feel the urgent need to use substances, they want to feel less sick, use a tiny test dose. Support them with their mental, emotional, spiritual, and cultural wellness and connect them to supports.

When help arrives tell them how long the person was unresponsive and any medical conditions you know of, if they have allergies or are taking other medications, substances used if known, how much naloxone was given, what route (nasal or intermuscular) the time and route of doses.

Aftercare for the Responder

Have policies in place for toxic drug poisoning prevention, having a kit there is not good enough, you need to think about what you are doing to prevent drug poisoning and reduce stigma. There should be a policy regarding how many people respond and what happens afterward: a plan to debrief, staff support. When you respond you feel like a superhero if the person survives, but sometimes it is so terrible you keep thinking about it at work. Give yourself the kindness and compassion you show to others. Self-care does not replace community care, we need to check back in with each other, and ask each other how we are feeling.

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