Feasibility Study for CLFN Addictions Treatment Services Continuum Through Community Leadership and Better Coordination

for

Constance Lake First Nation and the Jane Mattinas Health Centre

Final Report

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Submitted by:

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Executive Summary

Substance abuse has been recognized as one of the most serious problems facing First Nation communities. While some First Nations abstain from alcohol altogether, there are others whose members have heavier drinking patterns than the general population. Alcohol and substance abuse have been directly linked to suicide and community violence.

Recently, the most prominent method of addressing substance abuse in First Nation communities has been focused almost entirely on the individual and involved sending individuals to distant in-patient treatment centres. Although some First Nation communities offer residential treatment services, these facilities typically experience long wait lists that delay treatment. In addition, most treatment facilities are commonly located in unfamiliar urban centres. After four to eight weeks of treatment, individuals return to their home community to resume their life as it was prior to treatment. Consequently, relapse has been common, at rates of 35% to 85% within 90 days of completion.

Conclusions

Based on the information and findings about addictions and responses to it from five sources, it was concluded that:

- The number of residents in the NAN territory who were abusing drugs was estimated to be:
  - 2,650 - 3,200 adults and 1,000 - 3,600 youth abusing prescription drugs.
  - 2,400 - 5,000 adults and 1,000 - 2,500 youth abusing other substances.

- The need for substance abuse treatment programs in northwestern Ontario is significant and urgent.

- The need for effective prescription drug detox and treatment programs in northwestern Ontario is critical and growing.

- There is a critical need for local resources for programs for pre-treatment and long-term aftercare supports for those attending detox and treatment programs.

- Estimates of demand (kept on a waiting list) for addictions treatment programs were:
  - 185 adults and 78 youth in Matawa First Nations member communities, and
  - 500 - 1000 adults and 200 - 400 youth in the NAN territory.
- Demand for treatment programs is great, but it underestimates the real need.

Differences between need and demand were attributed to:

- Long waiting times from application to enrollment in residential addiction treatment programs lead to personal discouragement and pressures on communities to fill the support gaps.
- Due to the distance that must be traveled from home to treatment for most residents of northwestern Ontario, many never apply for admission.

A limited supply of treatment options exists:

- There was no residential addictions treatment centre that could efficiently serve the 15 First Nations immediately surrounding and accessible to Constance Lake by road; fly-in centres required a six-hour drive to Thunder Bay airport.
- The alternatives to residential treatment programs generally relied on referrals to local resources and many communities had resource challenges.
- Most residents of Constance Lake First Nation, other Matawa First Nations Communities, and other NAN communities did not have a reasonably proximate addiction treatment option that was
  - based on cultural and other relevant principles of treatment
  - with structural attributes that would effectively meet the needs of their most underserved community members.

This last conclusion was based on:

- Funding and other limits that make it difficult to treat the whole person and providing sufficient programming to go beyond the addiction treatment and restore individuals and families to functioning better in their home communities.

- Community partnerships and involvement were limited due to large catchment areas (many communities) and inconsistent local capacity.
- There was limited continuity between detox, treatment and aftercare programs for some clients and limited supply of detox and aftercare.
- Few programs had the capacity for effectively meeting the detox and treatment needs of prescription drug and poly-substance addicts or those with additional mental health challenges. Some experts thought that these needs were dominant and on the rise.
- Family unit healing was emphasized in only one non-residential program and one residential program.
- Youth and women were harder to place in safe environments.
- Treatment programs typically provided short-term aftercare, but many addicts needed longer-term transitional support in their home communities and some even needed lifetime support to remain clear.

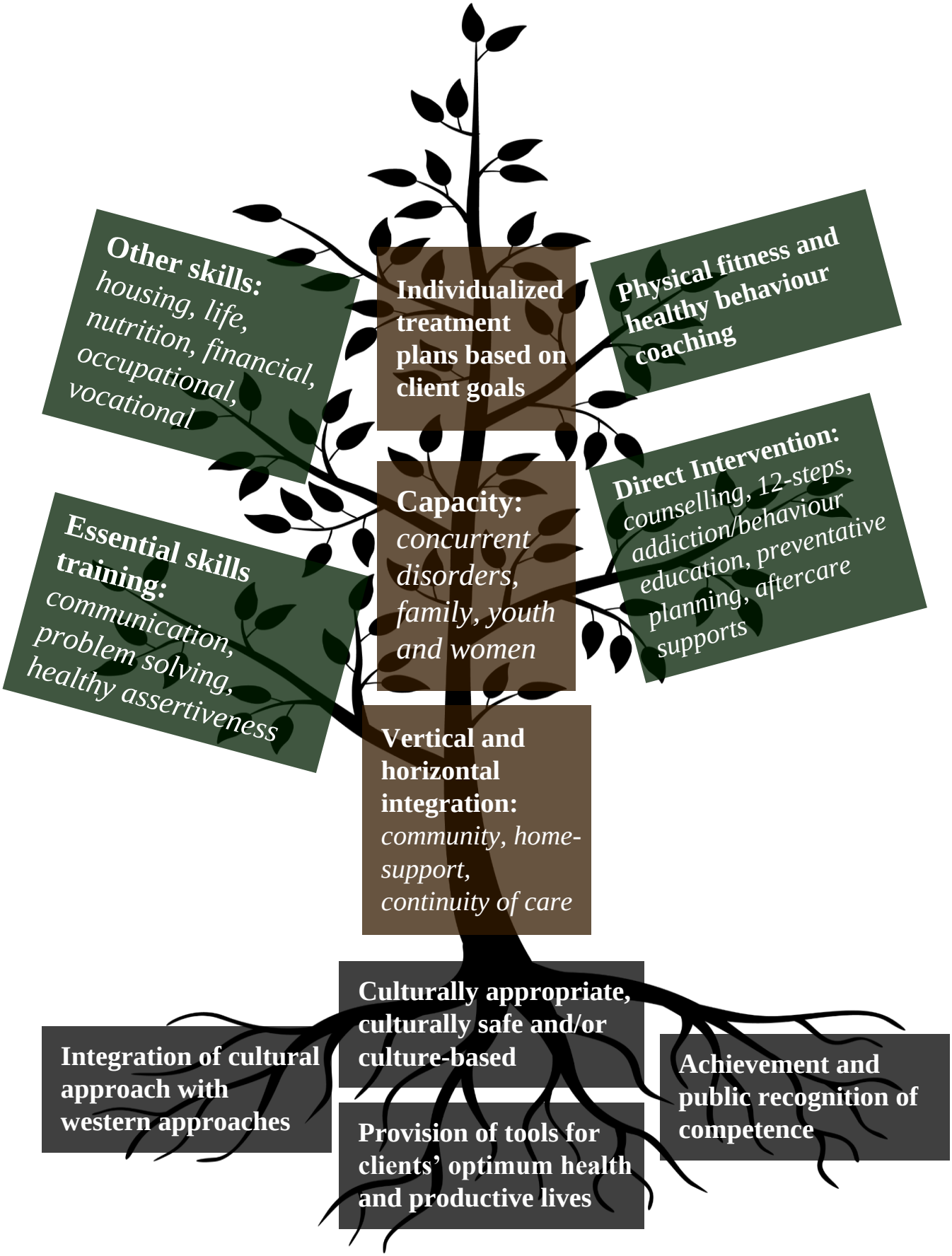
Proposed Model

Using the multiple sources of recommendations for an ideal addictions treatment program and/or best practices as well as research results that support aspects of a variety of treatment programs, a set of characteristics of a program model has been constructed. It would be unrealistic to expect a new program to achieve all of these characteristics at the outset; nevertheless all aspects come with recommendations or positive evaluations.

Three types of recommendations/ valued aspects were put forward:

1. Principles
2. Structure of the program, internally and in relation to the clients' local communities
3. Program offerings/activities

The recommendations came from a variety of sources. The most important was the Constance Lake First Nation's community vision as presented by Chief Arthur Moore (Moore, 2010). For this needs assessment, health directors and program providers from nine communities within the Matawa First Nations added their views in a meeting, as did 49 health directors from NAN communities through interviews. A report done for the Chiefs of Ontario and FHNIB also included recommendations (COO and FHNIB, 2008). Best practices were gleaned from interviews with representatives of existing programs and from the research literature.


Other skills: housing, life, nutrition, financial, occupational, vocational
Individualized treatment plans based on client goals
Physical fitness and healthy behaviour coaching
Direct Intervention: counselling, 12-steps, addiction/behaviour education, preventative planning, aftercare supports
Capacity: concurrent disorders, family, youth and women
Essential skills training: communication, problem solving, healthy assertiveness
Vertical and horizontal integration: community, home-support, continuity of care
Culturally appropriate, culturally safe and/or culture-based
Integration of cultural approach with western approaches
Achievement and public recognition of competence
Provision of tools for clients' optimum health and productive lives

The visual model on the previous page matched the three parts of the model to three parts of a tree. The roots are the Program Principles, the trunk of the tree is the Program Structure, and the branches are ever growing and evolving to represent the Program Activities. Together these three parts of the tree and model make-up the whole -- a strong foundation on which to operate a successful treatment centre.

Opportunities for Service Integration

There is a wealth of opportunities for Service Integration to be explored in developing the business case for a treatment facility in Constance Lake First Nation. Federal, Provincial and First Nations governments have all indicated that mental health and addictions is a priority in moving forward.

Constance Lake offers a number of internal resources for service integration including a methadone clinic and the Jane Mattinas health centre. They also have well developed relationship with the Notre Dame hospital in Hearst and have the full support of the Mattawa and Wabun Tribal Councils and a resolution passed by the NAN chiefs. There is great potential for the development of partnerships with organizations external to the community including the NELHIN, NNADAP treatment centre networking groups, and the Chiefs of Ontario. As treatment is an area of high need, there is great interest among potential partner groups in helping Constance Lake in developing a successful treatment model.

Prescription drug abuse is an area that is increasingly garnering attention and as such Constance Lake's proposal is well positioned to benefit from knowledge based resources that are currently being developed. For example, as part of the NNADAP renewal process a series of research papers and studies are being completed to better inform treatment provision on reserve. The COO is also developing resources in this area. In addition, Constance Lake has the opportunity to learn from other First Nations treatment models including Sagashtawao Treatment Centre in Moosonee.

Potential funding opportunities include Health Canada and the MOHLTC. It may be possible for Constance Lake First Nation to align with the MOHLTC's 10 year mental health and addictions strategy and the NELHINs mental health and addictions strategy to secure additional resources. Funding avenues will need to be explored further in the development of the business plan.

In order to provide an optimal plan for services integration, a number of strategies are identified in this report. These include development of a business plan steering committee as well as a technical sub steering committee among others. It is anticipated that the initiation of these advisory groups will keep the process informed from a community/tribal council level while leveraging external expertise allowing Constance Lake First Nation to benefit from existing knowledge and service resources.

The Strengths of Constance Lake First Nation for Meeting the Unmet Needs in the NAN Territory

There has been overwhelming political and local First Nation support expressed in support of the Constance Lake First Nation operating a treatment centre that services primarily the NAN territory with a strong focus on prescription drugs, as well as providing detoxification, treatment, maintenance, and aftercare services within one facility. Further Constance Lake has been a leader in initiating solutions to address the issue of increased use of prescription drugs within First Nations communities. It was the first in Canada to open a Methadone Clinic within a First Nation. Every Health Director within the Matawa First Nations Tribal Council and 76% of the NAN territory First Nation respondents stated they would definitely refer their band members to the First Nation operated and controlled facility, indicating that distance and location were either reasonable or not a concern.

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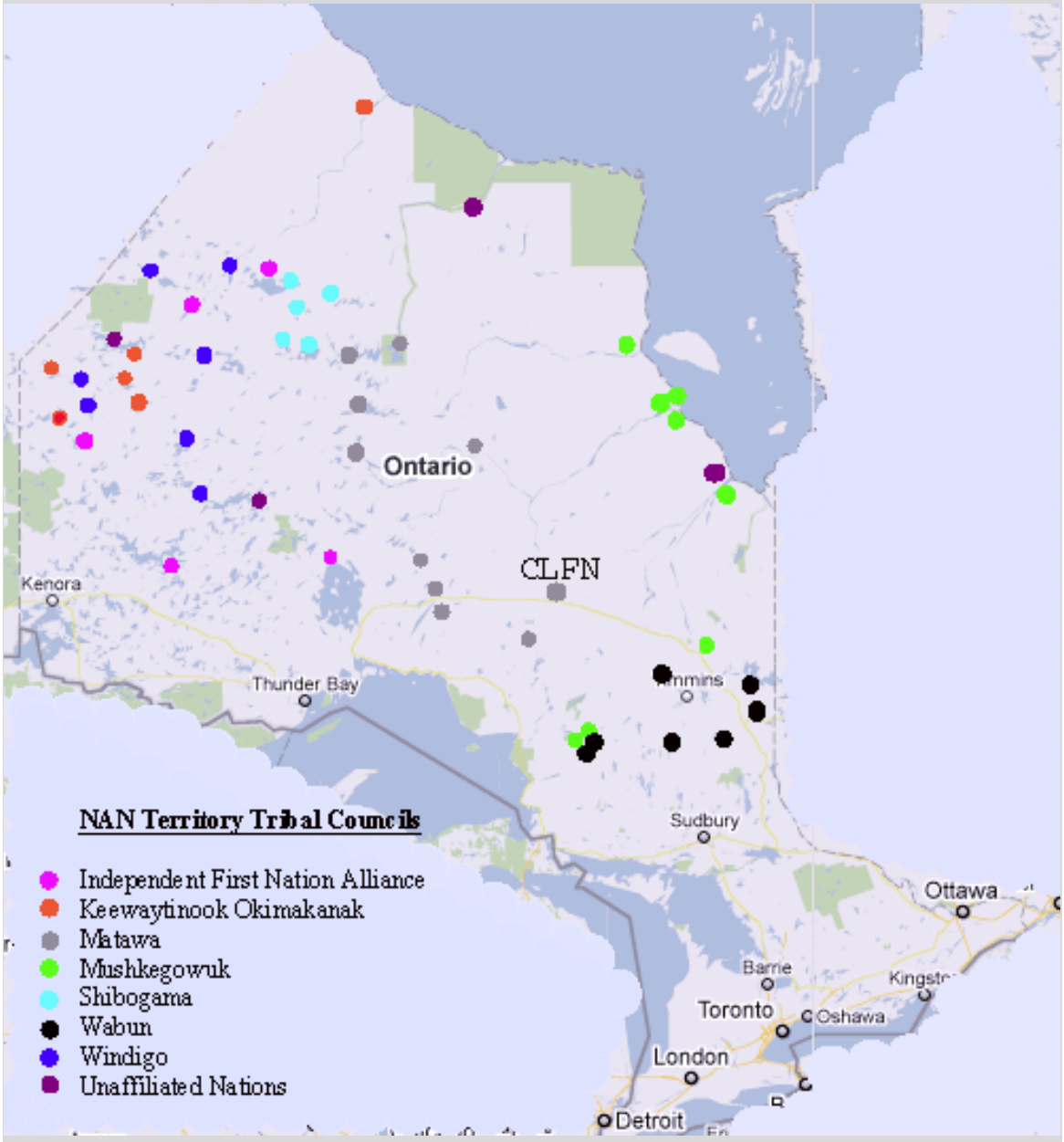
Setting the Stage for, Interpretation

Figure 1.1: Map of Nishnawabe Aski Nation First Nations by Tribal Council



1. Introduction

Substance abuse has been recognized as one of the most serious problems facing First Nation communities. While some First Nations abstain from alcohol altogether, there are others whose members have heavier drinking patterns than the general population. Alcohol and substance abuse have been directly linked to suicide and community violence (FNIGC, 2006).

Recently, the most prominent method of addressing substance abuse in First Nation communities has been focused almost entirely on the individual and involved sending individuals to distant in-patient treatment centres. Although some First Nation communities offer residential treatment services, these facilities typically experience long wait lists that delay treatment. In addition, most treatment facilities are commonly located in unfamiliar urban centres. After four to eight weeks of treatment, individuals return to their home community to resume their life as it was prior to treatment. Consequently, relapse has been common, at rates of 35% to 85% within 90 days of completion (Jiwa, Kelly and St Pierre Hanson, 2008).

1.1 Constance Lake Demographics

Constance Lake First Nation (CLFN) is one of ten First Nations included within the Matawa First Nations Tribal Council and one of the 49 communities represented by the Nishnawbe-Aski Nation (NAN) political organization. Matawa First Nations Tribal Council is one of seven NAN tribal councils and a group of unaffiliated First Nations that compose the NAN territory. The locations of the 49 communities and NAN Tribal Councils can be observed on Figure 1.1 (on previous page). Constance Lake First Nation is located on the shores of Constance Lake in northern Ontario. There are 1,470 members of Cree and Ojibway ancestry with approximately 870 living on the 7,686 acres that make up the First Nation territory.

According to the 2006 Census of Constance Lake, a fifth of residents were youth aged 15 to 24, three-fifths were single, and a quarter either had completed high school or trade school. Just over a third were employed and the average income was $12,896. Almost half of the homes required major repairs. For additional characteristics of Constance Lake, see Table 1.3 that provides percentages for all residents and also provides figures for men and women (Statistics Canada, 2010). The First Nation is growing and progressive. Economic development is happening in power generation, mining and exploration, forestry and bio-mass and internet and broadband. Community amenities are listed in Figure 1.2.

Figure 1.2: Constance Lake: Community Amenities

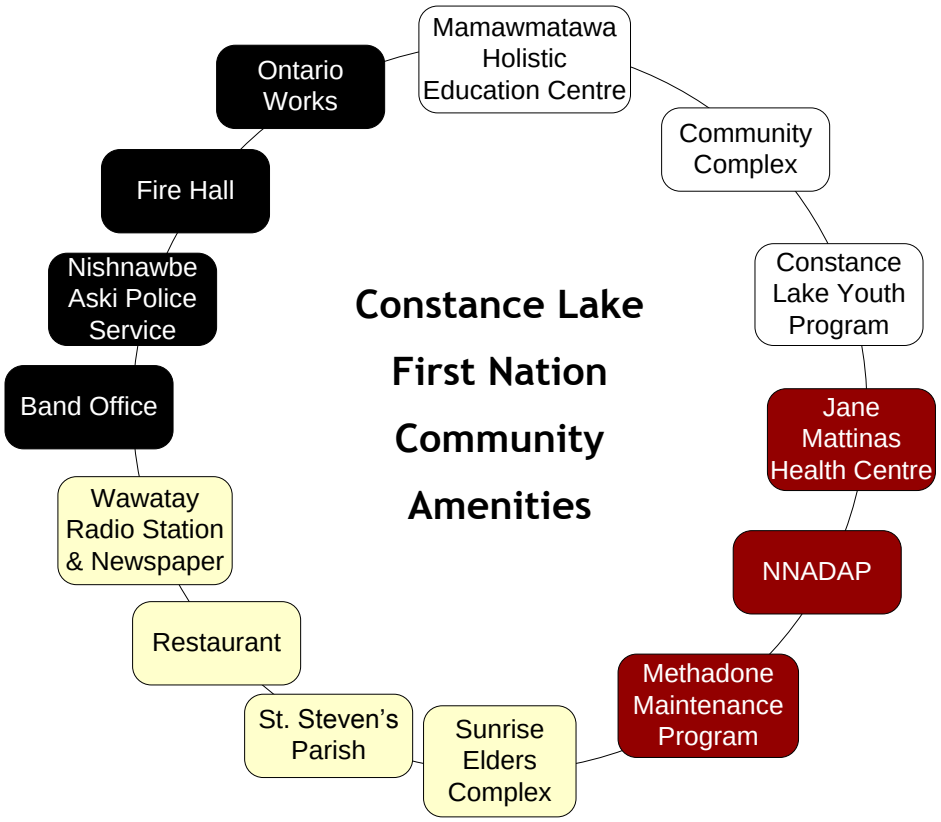


Table 1.3: Statistics Canada Census Data from 2006 Aboriginal Peoples Survey, N= 702

Describing the Respondents to the 2006 Aboriginal Peoples Survey in CLFN	Total	Breakdown within Males	Breakdown within Females
Gender			
Female	48%		
Male	52%		
First Nation	*All Aboriginal*		
Age			
Aged 15-24	19%	19%	21%
Aged 25-34	14%	15%	12%
Aged 35-44	13%	16%	10%
Aged 45-54	11%	9%	13%
Aged 55-64	6%	4%	7%

Describing the Respondents to the 2006 Aboriginal Peoples Survey in CLFN	Total	Breakdown within Males	Breakdown within Females
Marital Status			
Married	28%	27%	29%
Divorced / Widowed	9%	8%	16%
Separated	5%	6%	4%
Single	58%	62%	54%
Educational Attainment (aged 15 and over)			
Graduated High School	10%	6%	13%
Completed Trade School	16%	25%	9%
Completed College	7%	6%	11%
Completed University	2%	--	--
Labour Force Participation (aged 15 and over)			
In the Labour Force	50%	57%	40%
Employed	37%	41%	29%
Unemployed	13%	14%	10%
Not in the Labour Force	51%	43%	58%
Income Characteristics (aged 15 and over)			
Median Income	$12,896	$13,483	$11,232
Employed Income	77.6%	82.9%	66.3%
Government Assistance Income	20.9%	14.2%	30.5%
Other Income	2.1%	1.6%	2.9%
Housing Characteristics (occupied private dwellings)			
Dwellings requiring major repair	47.4%		
Mean number of persons per room	6.2		
Dwellings with more than one person per room -- as a % of total occupied private dwellings	5.3%		

1.2 Matawa First Nations

The Matawa First Nation is a NAN tribal council made up of ten Cree and Ojibway communities located in the James Bay Treaty 9 and the Robinson Superior Treaty 1850 areas (as depicted in Figure 1.1). Five out of ten of the communities are accessible by air only with the remaining five accessible by road. The tribal council represents about 8000 people, 4,297 living on- reserve and 3,911 living off reserve. The mission of the tribal council is to provide an environment of community cooperation and to advance the core strategic priorities of the communities. Five of Matawa First Nation's remote communities are located near the Ring of Fire, an area that holds some of the wealthiest mineral potential in Canada.

Matawa First Nations communities are listed below. First Nations with an asterisk beside their name are remote access, fly-in communities.

- Aroland
- Constance Lake
- Eabamatoong*
- Ginoogaming
- Long Lac 58
- Marten Falls*
- Neskantanga
- Nibinamik*
- Webequie*
- Hornepayne*

1.3 Nishnawbe-Aski Nation Demographics

Nishnawbe-Aski Nation (NAN) is a political territorial organization that represents 49 communities in Northern Ontario, one of which is Constance Lake First Nation. The territory covers 210,000 square miles and represents the whole of the James Bay Treaty No. 9 areas and the portion of Treaty No. 5 area that is in Ontario. Approximately 45,000 First Nations people live on and off reserve within these boundaries. NAN includes some of the most isolated communities in the province with approximately 30 of the 49 communities accessible by air only.

First Nations communities in the NAN territory are represented through seven regional Tribal Councils as shown in Table 1.4. A further five communities are not affiliated with a Tribal Council and are grouped under Unaffiliated Nations. A more detailed breakdown of population by First Nation is provided in Appendix D.

Table 1.4: Nishnawabe Aski Nation Tribal Councils and Representative Communities, N= 28,555

Tribal Councils	First Nation Communities	Population On-reserve
Independent Nations Alliance	Pikangikum, Muskrat Dam Lake, Kitchenuhmaykoosib Innnuwug, Lac Seul, Whitesand Lake	3,211
Keewaytinook Okimakanak Tribal Council	Poplar Hill, Deer Lake, North Spirit Lake, McDowell Lake, Keewaywin, Fort Severn	2,877
Matawa First Nations Management Inc.	Constance Lake, Eabamatoong, Long Lac No. 58, Ginoogaming, Marten Falls, Neskantaga, Webequie, Nibinamik, Aroland, Hornepayne	4,730
Mushkegowuk Tribal Council	Attawapiskat, Kashechewan, Fort Albany, Moose Cree, Taykwa Tagamou , Misainabe Cree, Chapleau Cree, Peetabeck	7,507
Shibogama First Nations Council	Wapakeka, Kasabonika Lake, Wawakapewin, Kingfisher Lake, Wunnumin	2,361
Wabun Tribal Council	Beaverhouse, Matachewan, Mattagami, Brunswick House, Chapleau Ojibway, Flying Post, Wahgoshig	582
Windigo	North Caribou Lake, Bearskin Lake, Sachigo Lake, Cat Lake, Slate Falls, Koocheching, Whitewater Lake	2,534
Unaffiliated Nations	SandyLake, Mishkeegogamang,Weenusk, Mocreebec Council of the Cree Nation	4,753
	Total Population	**28,555**

1.4 Factors Contributing to and Resulting From Addiction Patterns

Health Directors and addictions services providers from NAN communities responded to a question about causes of addictive behaviours; the results of this survey are discussed in greater detail in section 2.2. Considering individual, family and community factors as causal for current addiction patterns, family factors were most often mentioned. Family and community characteristics played a role in the response of the individual youth and adult to the temptation of altered consciousness to be obtained through substance use which gives rise to abuse and further family dysfunction. One respondent called it *killing the pain.*

Almost half of the 35 respondents (16) cited family problems/dysfunctions as an important contributor to the prevalence of addictions. These factors included marital problems, overcrowding, gambling, addicts in the family, violence and sexual abuse. Family factors that might be seen as causal for the dysfunctions included residential school issues (7 respondents), poor socio-economic prospects (5) and lack of parenting skills (3).

Community characteristics that were most important in maintaining family and individual patterns were lack of alternative activities such as recreation (7), lack of job opportunities (5), lack of support for addicts (3).

Individual situations that grew out of the above included too much time on hands/bored (8), peer pressure to experiment (6), health and balance issues (6), and easy to obtain substances (3).

The descriptions of what the addictions do to individuals, families and the community included loss of homes, children going hungry, serious health problems and safety problems. Some respondents described a negative impact on such group and interpersonal characteristics as trust, respect, and the ability to work together for solutions.

2. Methodology and Approach

To ensure that the reader has a good understanding of the weight and rigor of the data collected, this section discusses the realities of data collection in First Nations contexts, the methods utilized for this study and demographic and community substance abuse findings of the two major surveyed groups. All literature review and data collection occurred in mid-March to mid-May 2010.

2.1 Approach Collecting Data within First Nations

The principles of Ownership, Control, Access and Possession (OCAP) are paramount. To employ these methods we ensured that all data collected within Constance Lake First Nation was returned in hard and electronic copies, that the community steered and implemented the survey of residents, and that all First Nations respondents were provided the opportunity to receive a copy of the final report. Further, the draft report was designed to undergo a peer review process that includes First Nations and other key stakeholders prior to being finalized.

It was critical for CLFN to control the implementation of the resident survey in order to ensure the trust of community members and to access community events with potential survey respondents. This research was also backed by a Chiefs of Ontario resolution that supported Constance Lake First Nations efforts in establishing a treatment centre facility. While this study raised the question without presuming the conclusion that a treatment centre was in order, having this political support encouraged First Nation Health Directors to take the time for yet another survey. The political and other supports lent weight to the assumption that the research would be completed and have consequences. Without these efforts and the participation of 159 CLFN residents, as well as 35 of 49 NAN Health Directors and health service providers, this research would not have had the quality information on which this report was built.

2.2 Methodology

Triangulation of data sources and research topics was intended and implemented. When rigorous experimental designs are not possible in social research, it is common to look at information from many points of view and where there is consensus, to lend more weight to each source. This viewing information through several lenses is called triangulation. Seven sources were consulted for this needs assessment: research literature, a survey of Constance Lake First Nation residents, interviews with service providers in many First Nations, a meeting with Matawa First Nations community service providers, interviews with three resident treatment centres, peer review of this needs assessment draft report, and potential service provider partners for a service integration model.

Literature served as the first lens through which we examined best practices, needs and gaps in service provision in Canada First Nations and international Indigenous substance abuse, mental health, and suicide treatment programs. A second approach surveyed Constance Lake First Nation community members and described their demographic characteristics and health conditions, as well as their health care and addictions/crisis needs and usage. A third lens analyzed the results of one-on-one in-person and telephone interviews with NAN territory First Nations Health Directors, and NNADAP and crisis intervention workers to assess local service needs, demand, capacity for accessing and providing treatment services, and their willingness to work with a new First Nations' treatment service provider. A fourth understanding was reached when the team met with the Matawa First Nations Tribal Council Health Directors in a presentation and discussion meeting led by the Health Directors and Matawa. A fifth triangulation investigation included interviews with three key treatment centers in First Nations in the NAN territory. The final triangulation of data findings will come from input of the Peer Review panel about their assessments of this feasibility study's utility and their commitments to support a new treatment facility.

The CLFN resident survey was deployed at a variety of locations including the high school, senior's residence, and a series of community socials and feasts. Each respondent received five dollars for participating - a rate set by the First Nation. Other methods included door-to-door solicitation by CLFN health staff and approaching individuals on the street. A sample of 159 of 870 residents was obtained. Respondents were required to be at least 15 years of age and less than 64. The number of residents in this age range was estimated at 548 (based on the 2006 Census proportions applied to the base of 870 residents). Therefore, the survey reached 29% of the applicable population in CLFN. The discussion in section 2.3, below, demonstrates the similarities and differences of the surveyed population with 2006 Census data.

The data from the Matawa First Nations Tribal Council were gathered during a one-day meeting held in Thunder Bay with eight of the tribal council's health directors and from interviews with health directors (6) or case managers (3) from nine of ten communities. The one-day meeting included individual presentations prepared by each First Nation representative, a group discussion about the CLFN proposal, reactions and myths, as well as a presentation from CLFN. The result was the full support of all communities for the CLFN proposal. The extent of the consultation with these knowledgeable First Nation representatives provided a credible profile of Matawa First Nations about substance abuse issues, treatment demand, need, local capacity and support for the Constance Lake treatment facility.

A series of interviews with First Nation Health Directors, NNADAP workers or crisis workers in NAN communities were conducted for the purpose of understanding the need and demand for addiction treatment services, the perceived accessibility and effectiveness of the available services for various kinds of addictions, the obstacles to getting favourable results, and the resulting prospects for a new treatment centre in Constance Lake First Nation. Respondents were asked to respond from their own jurisdiction's point of view. Thirty-one of the 35 respondents were community representatives and the remaining had broader responsibilities. Respondents varied in their tenure in their current roles from less than one year (4 respondents) to ten or more years (4 respondents). The modal tenure was 1 to 3 years (16 of 32 respondents). Non-respondents included those: without telephone service (2), stating most band members lived off-reserve (1), had limited tenure in their positions and were not yet familiars with the issues (4), and did not return phone calls despite repeated attempts (7).

The communities were all in the north-western part of Ontario although they varied greatly in distance from Constance Lake, in size and resources, and in focus and concerns. Some small communities had few internal resources for dealing with members with addiction or substance problems, while other communities had extensive networks and resources for mounting local programs.

Finally, in-depth telephone interviews were held with three treatment centres in the NAN territory: Reverend Tommy Beardy Memorial Family Treatment Facility at Muskrat Dam, Iris Addiction Recovery Centre in Sudbury, and Sagashtawao Healing Lodge in Moosonee.T. Interviews were with intake staff (Iris) and administrative executives (Muskrat Dam and Moosonee). The intent of the interviews was to ascertain treatment needs from those delivering treatment and understand current services delivered in the north in order to identify best practices and provide an understanding of industry challenges.

2.3 Demographic Description of Surveyed CLFN Residents

The CLFN Resident Survey demographics demonstrated similarities with Statistics Canada data in that a wide-range of community members were surveyed. The distribution of men and women was about half and half as would be expected, and while the CLFN 2010 surveyed population did not include children or those above the age of 64 there was a fair distribution in the various age categories from 15 through 64. Youth aged 15 to 24 were about a third and ages 25 to 34 were another third. The CLFN survey tended to under-represent the *widowed or divorced* (2% instead of 9%) and over-represent those in relationships (44% instead of 28%). Those surveyed were more likely to have high school completed than the Census counted (21% instead of 10%) and fewer had college diplomas (3% instead of 7%).

The distribution between those employed and unemployed was similar to the Census statistic. However, partly due to the over-surveying of youth and partly due to the economic climate, fewer 2010 respondents were in the labour force (36% instead of the 2006 census finding of 50%) or employed (28% instead of 37%). The CLFN survey was more recent, and since 2006 there had been a major recession and industries, such as logging, were closed down on the First Nation. It is possible that these survey data may actually be more representative of the current situation. The potential impact of the recession and over-surveying of youth also shows in the income sources distribution with 25% of those surveyed receiving employment income instead of the previous 78%. As might be expected, 59% of survey respondents were receiving social assistance as opposed to 21% of the Census population.

Further, it has been suggested that during Census data collection in First Nations, the under-privileged population was under-surveyed in 2006, further lowering the Census government transfer percentage. This factor may also play a role in the housing data, making the Census housing conditions look better than they are in reality. *Dwellings with more than one person per room -- as a % of total occupied private dwellings* in the Census was 5.3% and the CLFN survey data was 23%. Those in relationships were over-represented in the survey; however this alone does not account for this discrepancy. The Census mean number of persons per room was 6.2 and for those surveyed it was 5.5. Dwellings requiring major repair in the Census was 47.4% and in the CLFN survey it was 28%.

Notable differences between men and women among our survey group were that our sample included younger females (aged 15-24 included 29% of males and 34% of females). Males were more likely to have some post-secondary training/education, with trades training being cited by 20% of males and 5% of females. More males than females were in the labour force (48% vs. 25%). Likewise, more females than males were receiving government transfers (63% vs. 55%).

Some CLFN 2010 resident survey findings of interest include that 70% of homes had contaminated water issues, 9% required a ramp installed, 31% required doorways and hallways be repaired, and 20% were without a proper working bathroom. High-speed Internet was in 43% of homes, 52% had a computer, and 69% had cable/satellite. Well over half (61%) had a parent/grandparent who attended residential school and half of those people (30%) reported resulting health issues and a little more than half (35%) felt negatively affected by this past trauma.

Among the highest ranked community concerns, 72% said prescription drug abuse, drug abuse in general and unemployment were equal concerns. This was a concern for more females than males (80% for all points vs. 64%).

Someone to get advice from and someone to listen when needed were among the lowest ranked supports a person had (16% and 21% *very often* respectively). More females than males reported having advice support (21% *very often* vs. 10%) and listening support (27% *very often* vs. 16%).

The highest ranked unhealthy situation was poor diet for 40% of respondents and high stress for 38%. The highest ranked healthy habits were having a good home (61%), proper/good rest (60%), and being happy/content (58%). Stress was reported by more males than any other unhealthy situation. More males than females reported having stress, (39% vs. 35%). Poor diet was reported by more females than any other unhealthy situation. More females than males reported poor diet, (43% vs. 35%). In turn, females tended to be happier, felt they have a good home and got proper rest (~66% versus 51%, 53%, and 56% of men, respectively).

Current Need, Demand, Supply, Gaps, and Issues

3. Conclusions Based on Need, Demand and Supply

Based on the information and findings about addictions and responses to it from five sources, it was concluded that:

- The number of residents in the NAN territory who were abusing drugs was estimated to be:
  - 2,650 - 3,200 adults and 1,000 - 3,600 youth abusing prescription drugs.
  - 2,400 - 5,000 adults and 1,000 - 2,500 youth abusing other substances.
- The need for substance abuse treatment programs in northwestern Ontario is significant and urgent.
- The need for effective prescription drug detox and treatment programs in northwestern Ontario is critical and growing.
- There is a critical need for local resources for programs for pre-treatment and long-term aftercare supports for those attending detox and treatment programs.
- Estimates of demand (kept on a waiting list) for addictions treatment programs were:
  - 185 adults and 78 youth in Matawa First Nations member communities, and
  - 500 - 1000 adults and 200 - 400 youth in the NAN territory.
- Demand for treatment programs is great, but it underestimates the real need.

Differences between need and demand are attributed to:

- Long waiting times from application to enrollment in residential addiction treatment programs lead to personal discouragement and pressures on communities to fill the support gaps.
- Due to the distance that must be traveled from home to treatment for most residents of northwestern Ontario, many never apply for admission.

A limited supply of treatment options exists:

- There was no residential addictions treatment centre that could efficiently serve the 15 First Nations immediately surrounding and accessible to Constance Lake by road; fly-in centres required a six-hour drive to Thunder Bay airport.

- The alternatives to residential treatment programs generally relied on referrals to local resources and many communities had resource challenges.

- Most residents of Constance Lake First Nation, other Matawa First Nations Communities, and other NAN communities did not have a reasonably proximate addiction treatment option that was
    - based on cultural and other relevant principles of treatment
    - with structural attributes that would effectively meet the needs of their most underserved community members.

This last conclusion was based on:

- Funding and other limits that make it difficult to treat the whole person and providing sufficient programming to go beyond the addiction treatment and restore individuals and families to functioning better in their home communities.
- Community partnerships and involvement limited due to large catchment areas (many communities) and inconsistent local capacity.
- There was limited continuity between detox, treatment and aftercare programs for some clients and limited supply of detox and aftercare.
- Few programs had the capacity for effectively meeting the detox and treatment needs of prescription drug and poly-substance addicts or those with additional mental health challenges. Some experts thought that these needs were dominant and on the rise.
- Family unit healing was emphasized in only one non-residential program and one residential program.
- Youth and women were harder to place in safe environments.
- Treatment programs typically provided short-term aftercare, but many addicts needed longer-term transitional support in their home communities and some even needed lifetime support to remain clear.

4. Need Is Great and Urgent

The needs for [resident] treatment programs were assessed, and through discussions, need for local program resources were reported as an additional major gap. Based on the numbers of estimated substance abusers in the communities in northwestern Ontario, there were thousands of addicted individuals.

THE NEED FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN NORTHWESTERN ONTARIO IS SIGNIFICANT AND URGENT.

THE NEED FOR EFFECTIVE PRESCRIPTION DRUG DETOX AND TREATMENT PROGRAMS IN NORTHWESTERN ONTARIO IS CRITICAL AND GROWING.

The summary estimates based on information provided by health directors and service providers in First Nation communities were as follows:

- Estimates of numbers of residents abusing prescription drugs were:
  - 61 adults and 51 youth in Constance Lake First Nation,
  - 591 adults and 335 youth in 8 of 10 Matawa First Nations Tribal Council member communities, and
  - 2,650 - 3,200 adults and 1,000 - 3,600 youth in the NAN territory.
- Estimates of numbers of residents abusing other substances were:
  - 2,400 - 5,000 adults and 1,000 - 2,500 youth in the NAN territory.

Interviews with health directors and service providers in 35 communities in the NAN region led to the conclusion that based on the long wait times for entrance into the continuum of care and between stages of the continuum, there was

A CRITICAL NEED FOR LOCAL RESOURCES FOR PROGRAMS FOR PRE-TREATMENT AND LONG-TERM AFTERCARE SUPPORTS FOR THOSE ATTENDING DETOX AND TREATMENT PROGRAMS.

The following discussion focuses on the numbers of addicted individuals in Constance Lake, the Matawa First Nations member communities, and in NAN member communities.

4.1 Current Treatment Services Needs in Constance Lake First Nation

Severity of substance use based on Constance Lake First Nation resident survey (n = 159):

- ~60% used substances more than 2x mo.
- ~75% used beer mostly; 8% prescription drugs mostly.
- 14% (22) acknowledged that they had sold drugs in the previous six months.

A variable was created to reflect the concerns of health directors interviewed, in that prescription drugs were reported as an increasing concern and the use of beer remained a concern. The variable reported below as Frequency of Prescription Drug and/or Beer Binging was created as follows:

- **Extreme Problem Users** included residents who both used prescription drugs to get high more than one a month **AND** drank five or more beers at any one sitting more than once a month.
- **Problem Users** included residents that used prescription drugs get high more than once a month **OR** drank five or more beers at any one sitting more than once a month.
- **Users** were defined as residents who used prescription drugs once a month or less and/or drank five or more beers at any one sitting less than once a month or less, but at least once a year.
- **Non-Users** included those who reported never using prescription drugs nor drinking five or more beers at any one sitting.

The pattern among the 159 residents surveyed within these categories was:

- Non-Users 42%
- Users 31%
- Problem Users 20%
- Extreme Problem Users 7%

Females were more likely to be non-users than males (53% of women versus 30% of men). Where 4% of females were *extreme problem users*, 11% of men were *extreme problem users*.

High school graduates, those working, living in overcrowded homes, and who had parents who attended residential school were just as likely to fit into any one of the four categories.

Over a third of *extreme problem users* (36%) were youth (aged 15-24), almost half of *problem users* (48%) were youth, and 34% of *users* were 15-24.

No one above 44 was an *extreme problem users* and no one above 54 was a *problem user*. *Users* were aged up to 64 years. Increases in age reduced using with 70% of those aged 45-54 as *non-users* and 80% of those aged 55-64 as *non-users*.

Very frequent cigarette users (40+ times per year) were more likely to be problem or extreme problem users, with 12% of these cigarette users as *extreme problem users* and 35% of them as *problem users*.

Extreme problem users were almost four times more likely to be diagnosed with asthma -- making up over a quarter (26%) of those with asthma, yet *extreme problem users* are only 7% of users.

Difficulty hearing, seeing, communicating, walking, bending, learning, of doing other similar activities was pronounced for problem or extreme problem users. *Problem users* made up 31% of those with difficulties and *extreme problem users* made up 23%.

Physical or mental conditions reducing the amount of *other work* residents could do was higher among *extreme problem users* at 18% (almost three times their expected rate).

In terms of ever attending a treatment centre less than half of *extreme problem users* ever attended (45%). Slightly fewer *problem users* had ever attended (42%) and a quarter of *users* (28%) ever attended. Among *non-users*, 18% had attended a treatment centre at least once in their lifetime.

4.2 Matawa First Nations Treatment Services Needs

Service provider interviewees from the nine communities were of the opinion that addiction to prescription drugs was the most common addiction pattern and that rates of addiction to prescription drugs were increasing. The survey data provided evidence that prescription drug abuse was the most common addiction experienced in First Nation communities in the Matawa First Nations. All of the community representatives indicated that they dealt with high rates of prescription and over the counter substance abuse issues. When asked about the prevalence of drugs in their communities, all health service providers (N=9) stated that prescription drugs and over the counter drugs were *prevalent* or *very prevalent* abused substances in their communities.

Percocet and Oxycontin were identified as commonly abused prescription drugs. Table 4.1 identifies the number of people who were estimated to be addicted to prescription drugs by health service providers in the community at the time of the survey.

Estimates of numbers of residents abusing prescription drugs were:

- 591 adults and 335 youth in 8 of the 10 Matawa First Nations member communities,

Table 4.1: Estimated Number of Mattawa First Nations Band Members Addicted to Prescription Drugs: Adults and Youth

First Nations	Population on-reserve (N=4,730)	Addicted Adults	Addicted Youth
Aroland	300	54	20
Constance Lake[1]	795	61	51
Marten Falls	321	61	*grouped with adults*
Neskantanga	324	48	43
Eabamatoong	1353	180	166
Nibinamik	333	40	6
Long Lac No.58	443	120	38
Ginoogaming	168	27	11
Total	**4,037**	**591**	**335**

Alcohol was the second most prevalent substance issue, with 6 of 9 service providers indicating that it was either *very prevalent* or *prevalent*, followed by marijuana (5) and cocaine (4). Service providers indicated that current treatment programs and facilities were more useful in helping them to tackle alcohol and marijuana as compared to prescription drugs. Less commonly abused, but present substances included: heroin, solvents, methamphetamines and ecstasy.

4.3 Nishnawbe Aski Nation Prevalence

Many of the 31 Nishnawbe Aski Nation representatives were well aware of the changing patterns of addictive substances, especially the rise of prescription drugs, and the lack of available programs that treat those particular addictions. Alcohol and street drugs were mentioned frequently, but not with the sense of treatment resource scarcity as the prescription drugs. There were several mentions of alcohol as a gateway substance for prescription addictions.

[1] CLFN numbers were estimated from the CLFN Resident Survey completed by 29% aged from 15 to 65.

Of 30 First Nation representatives responding to the question, over 20 judged the addiction level for prescription drugs and alcohol to be *very prevalent* or *prevalent.* Percocet and Oxycontin were the most prevalent prescription drugs. Half of the respondents judged the same for marijuana and over-the-counter drugs.

Eleven to 15 community representatives judged needle addictions, glue/aerosol cans/paints/sprays/gas, marijuana, and cocaine as *somewhat exists.*

Ten to 14 representatives judged that addictions to heroin, methamphetamines, ecstasy, and glue/aerosol cans/paints/sprays/gas *exists a little bit* or *doesn't exist*.

Thirty-one First Nation health service providers within the 49 NAN First Nations were interviewed and asked a series of five questions regarding the demand and usage of treatment services, as well as proportions of band members that were addicted to prescription drugs and other substances.

Many estimated a percentage of their residents that fit into each of five categories. The five categories were further broken down by most of the respondents into youth and adults. Respondents were asked to provide data in three ways, 1) within a range (none, under 10%, 10-25%, 25-40%, 40-50%, More than 50%), 2) providing an exact number, or 3) providing an estimated specific percentage. A formula was used to estimate the number of residents in each of the surveyed First Nations, the NAN territory, as well as some of the tribal councils, where almost all of the First Nations in the tribal area answered the interview questions. The formula utilized Statistics Canada (Table 19) figures for on-reserve First Nations in Canada to determine the approximate proportion of First Nation residents that were youth (aged 15 to 24 years) and adults (aged 25 to 54 years). The proportion was 19% for youth and 36% for adults. Using these proportions the percentage for each category was multiplied by the total on-reserve population and the respective proportion for each age category. In the instance where a range was provided the midpoint was used. The formula determined the number of on-reserve residents that were youth or adults and then multiplied that number by the health service provider's estimate of the percentage of youth or adults affected by each of the five categories.

Estimates of numbers of residents in the NAN territory were:

- 2,650 - 3,200 adults and 1,000 - 3,600 youth abusing prescription drugs.
- 2,400 - 5,000 adults and 1,000 - 2,500 youth abusing other substances.

Table 4.2: Youth (15 to 24) Prescription Drug and Other Substance Abuse Use Among Respondent First Nation Band Members (n=14/20), Projected NAN Territory (n=49), and Respondent Tribal Councils

Youth Affiliation	Substance Abuse Data for the Previous Year	
	Prescription Drugs	Other Substances
First Nation Health Staff Respondents		
	n=14	n=20
Mean per First Nation	72.97	50.88
Median per First Nation	19.95	19.95
Sum of all Respondents	1,094.59	1,068.47
Standard Error of Mean	38.77	17.04
Estimated Sum within the NAN Territory (n=49; N=28,555)		
Sum based on Mean	3,575.67	2,493.11
Conservative Sum using the Median per FN	977.55	977.55
Estimated Sums within First Nation Respondents' Tribal Councils		
Independent Nations Alliance (n=5 *where 3 FNs had data; N=4,753*)	(Mean) 36.20	(Mean) 40.76
	(Median) 36.20	(Median) 40.76
KO Health Authority (n=6 *where 5 FNs had data; N=2,877*)	(Mean) 206.34	(Mean) 193.69
	(Median) 206.34	(Median) 225.44
Matawa (n=9 *where 8 FNs had data; N*=4,730)	(Mean) 431.62	(Mean) 247.00
	(Median) 346.28	(Median) 180.00
Mushkegowuk (n=8 *where 6 FNs had data; N=7,507*)	(Mean) 55.1	(Mean) 1,332.41
	(Median) 55.1	(Median)1,366.18
Shibogama (n=5 *where 3 FNs had data; N=2,361*)	(Mean) 58.71	(Mean) 39.14
	(Median) 58.71	(Median) 39.14

Table 4.3: Adult (25 to 54) Prescription Drug and Other Substance Abuse Use Among Respondent First Nation Band Members (n=18/19), Projected NAN Territory (n=49), and Respondent Tribal Councils

Adult Affiliation	Substance Abuse Data for the Previous Year	
	Prescription Drugs	Other Substances
First Nation Health Staff Respondents		
	n=18	n=19
Mean per First Nation	65.62	101.76
Median per First Nation	54.00	49.50
Sum of all Respondents	1,246.78	2,035.11
Standard Error of Mean	11.57	32.24
Estimated Sum within the NAN Territory (n=49; N=28,555)		
Sum based on Mean	3,215.38	4,986.24
Conservative Sum using the Median per FN	2,646.00	2,425.50
Estimated Sums within First Nation Respondents' Tribal Councils		
Independent Nations Alliance (n=5 *where 3 FNs had data; N=4,753*)	(Mean) 77.22	(Mean) 154.98
	(Median) 77.22	(Median) 154.98
KO Health Authority (n=6 *where 5 FNs had data; N=2,877*)	(Mean) 487.98	(Mean) 509.94
	(Median) 443.88	(Median) 443.88
Matawa (n=9 *where 8 FNs had data; N*=4,730)	(Mean) 665.00	(Mean) 481.93
	(Median) 481.93	(Median) 445.50
Mushkegowuk (n=8 *where 6 FNs had data; N=7,507*)	(Mean) 165.28	(Mean) 1,415.55
	(Median) 165.28	(Median)2,157.12
Shibogama (n=5 *where 3 FNs had data; N=2,361*)	(Mean) 185.4	(Mean) 111.24
	(Median) 185.4	(Median) 111.24

5. Demand Less Than Need

Need was based on the numbers of addicted individuals while demand was based on the numbers of individuals expressing an interest in obtaining treatment. This interest was measured by whether or not their name was on a waiting list at a treatment centre.

When the estimates of the numbers of prescription drug and other substance abusers were compared to the estimates in this section, it was obvious that

DEMAND FOR TREATMENT PROGRAMS IS GREAT, BUT UNDERESTIMATES THE REAL NEED.

The summary estimates based on information provided by health directors and service providers in communities were as follows:

- Estimates of demand (kept on a waiting list) for addictions treatment programs were:
  - 185 adults and 78 youth in Matawa First Nations member communities, and
  - 500 - 1000 adults and 200 - 400 youth in the NAN territory.

5.1 Matawa First Nations Demand

In personal interviews, health directors and service providers from nine First Nation community members of the Matawa First Nations representatives agreed that substance abuse was a major issue facing their communities. While the communities had devised a variety of ways of dealing with the individual, family and community challenges from addiction, the consensus was that residential treatment facilities were the best option for success.

All service providers reported that current programs and treatment centres were not adequate in helping communities address these substance abuse problems.

Estimates of the numbers of community adult and youth members who wanted treatment and attended a treatment program revealed

- A gap for the Matawa First Nations district of 240 adults and 107 youth who had wanted to attend a treatment program, but who did not.
  - Of those 240 adults, 185 still had their names on a waiting list and 55 had taken their names off.
  - Of the 107 youth, 42 attended, 78 were still on a waiting list and 29 had removed their names.

While these numbers appear as precise, they were summarized from a set of estimates by different program providers and should only be viewed as estimates.

Table 5.1: Treatment Centre Demand, Use, and Need among Respondent First Nations: Adults and Youth

First Nation	Wanted to Attend		Attended		On a Waiting List	
	Adults	Youth	Adults	Youth	Adults	Youth
Aroland	24	6	14	1	10	5
Eabametoong	113	59	45	24	68	36
Ginoogaming	12	3	6	1	6	2
Long Lac #58	73	38	8	4	24	4
Marten Falls	61	0	31	0	15	0
Neskantaga	48	25	24	5	10	20
Nibinamik	52	9	17	3	34	6
Constance Lake	19	9	17	4	18	5

5.2 Nishnawbe Aski Nation Demand

Tables 5.2 and 5.3 show the treatment centre previous demand, use in the past year, and unmet demand for youth and adults in the Nishnawbe Aski Nation.

The key information is in the last column in the middle section *Estimated Sum within the NAN Territory*. An assumption was made that since the median and the mean estimates were so different that they probably bracket the actual numbers. Hence:

- the estimate of 178 youth still on waiting lists based on the median was at the low end of the range of the actual number and was probably an underestimate.
- the estimate of 438 youth still on waiting lists based on the mean was at the high end of the range of the actual number and was probably an overestimate.

With reasonable rounding this gives rise to the estimates of demand (still on waiting lists):

- 500 - 1000 adults and 200 - 400 youth in the NAN territory.

Table 5.2: Youth (15 to 24) Treatment Centre Demand, Use, and Need among Respondent First Nations (n=18), Projected NAN Territory (n=49), and Respondent Tribal Councils

Youth Affiliation	Treatment Centre Data for the Previous Year		
	Wanted to go	Attended	Were waiting to go
First Nation Health Staff Respondents (n=18)			
Mean per First Nation	18.24	10.67	8.95
Median per First Nation	8.0	3.5	3.64
Sum of all Respondents	328.28	192.01	161.10
Standard Error of Mean	5.27	4.70	3.01
Estimated Sum within the NAN Territory (n=49; N=28,555)			
Sum based on Mean	893.65	522.69	438.55
Conservative Sum using the Median per FN	392.00	171.5	178.36
Estimated Sums within First Nation Respondents' Tribal Councils			
Independent Nations Alliance (n=5 *where 3 FNs had data; N=4,753*)	(Mean) 147.12	(Mean) 73.26	(Mean) 73.87
	(Median) 27.36	(Median) 12.77	(Median) 14.59
KO Health Authority (n=6 *where 5 FNs had data; N=2,877*)	(Mean) 143.27	(Mean) 51.68	(Mean) 91.59
	(Median) 143.27	(Median) 51.68	(Median) 91.59
Matawa (n=9 *where 8 FNs had data; N*=4,730)	(Mean) 192.87	(Mean) 55.1	(Mean) 99.3
	(Median) 81.82	(Median) 36	(Median) 45
Mushkegowuk (n=8 *where 6 FNs had data; N=7,507*)	(Mean) 91.3	(Mean) 216	(Mean) 21.3
	(Median) 73.6	(Median) 8	(Median) 24
Shibogama (n=5 *where 3 FNs had data; N=2,361*)	(Mean) 17.5	(Mean) 17.5	(Mean) --
	(Median) 17.5	(Median) 17.5	(Median) --

Table 5.3: Adult (25 to 54) Treatment Centre Demand, Use, and Need among Respondent First Nations (n=23), Projected NAN Territory (n=49), and Respondent Tribal Councils

Adult Affiliation	Treatment Centre Data for the Previous Year		
	Wanted to go	Attended	Were waiting to go
First Nation Health Staff Respondents (n=23)			
Mean per First Nation	44.22	20.05	21.81
Median per First Nation	15.00	11.12	9.54
Sum of all Respondents	1,017.03	461.20	501.74
Standard Error of Mean	16.17	7.92	8.41
Estimated Sum within the NAN Territory (n=49, N=28,555)			
Sum based on Mean	2,166.71	982.55	1,068.92
Conservative Sum using the Median per FN	735.00	545.08	467.46
Estimated Sums within First Nation Respondents' Tribal Councils			
Independent Nations Alliance (n=5 *where 3 FNs had data; N=4,753*)	(Mean) 1,024.20	(Mean) 512.10	(Mean) 512.10
	(Median) 1,024.20	(Median) 512.10	(Median) 512.10
KO Health Authority (n=6 *where 5 FNs had data; N=2,877*)	(Mean) 175.83	(Mean) 47.17	(Mean) 128.67
	(Median) 90	(Median) 33	(Median) 60
Matawa (n=9 *where 8 FNs had data; N*=4,730)	(Mean) 451.13	(Mean) 182.01	(Mean) 208.26
	(Median) 447.20	(Median) 154.02	(Median) 149.77
Mushkegowuk (n=8 *where 6 FNs had data; N=7,507*)	(Mean) 74.67	(Mean) 29.33	(Mean) 45.33
	(Median) 80	(Median) 24	(Median) 40
Shibogama (n=5 *where 3 FNs had data; N=2,361*)	(Mean) 76.87	(Mean) 75.21	(Mean) 1.67
	(Median) 75	(Median) 70	(Median) --

6. Difference between Need and Demand

The reasons that were given for the lost incentive between applying for admission to a program and removing one's name from the waiting lists (or never applying at all) were primarily tied to two salient factors – long waiting times and great distances.

LONG WAITING TIMES FROM APPLICATION TO ENROLLMENT IN RESIDENTIAL ADDICTION TREATMENT PROGRAMS LED TO PERSONAL DISCOURAGEMENT AND PRESSURES ON COMMUNITIES TO FILL THE SUPPORT GAPS.

The consequences of long waiting times can include:

- Lost incentive, discouragement and acceptance of addiction as a way of life by potential applicants.
- Pressure on the community resources to provide support during those long waits.
- An even greater sense of hopelessness for those for whom there were even scarcer programs such as culture-based, for women and youth, with family involvement, and for prescription drug addictions.

DUE TO THE DISTANCE THAT MUST BE TRAVELED FROM HOME TO TREATMENT FOR MOST RESIDENTS OF NORTHWESTERN ONTARIO, MANY NEVER APPLY FOR ADMISSION.

Distance was a factor in discouraging applications because:

- For some, the basic transportation costs were not covered.
- Individual applicants who were close to their families need the option to visit with their families' mid-course and the transportation costs were prohibitive.
- For some, the cultures in the distant locales could be unfamiliar and therefore stressful.

6.1 Long Wait Times

Long wait times came up as a major obstacle to solving the addiction problems in First Nation communities.

Based on the interviews with health directors and service providers of 31 NAN First Nations, access to treatment was impeded most by long waiting lists for inpatient treatment facilities (15 respondents listed this in an open-ended question). For comparison, the next most listed impediments were travel costs for family visits (8 mentions; a distance issue) and lack of appropriate venues (5 mentions; youth, women, family units, cultural).

> *"Wait times cause our people to fall back into addiction [seeking treatment] is a spur of the moment thing and it is ideal to send*

> *"The addiction is so powerful that 6 weeks is not long enough."*

6.2 Matawa First Nations Local Capacity

All of the communities with representatives in attendance at the Matawa First Nations meeting were either in the process of or had developed a community plan for addressing substance abuse and or prescription drug abuse specifically within their communities. For the most part community approaches to addiction involve referring people out of the community for treatment, providing in community counseling, education and awareness activities, and land-based activities/outings.

The survey data suggest that community capacity to address post treatment needs was limited. Only two communities (Constance Lake and Nibinamik) had training about implementing a comprehensive aftercare program for people returning from treatment. Most said that they would like to have better training in this area but that they lacked the human resources and funding. Further only two communities (Constance Lake and Long Lac #58) had designed a process for handling community members who return without completing treatment.

They were further challenged by a lack of evaluation of current programming, lack of leadership, mistrust between community members and NNADAP staff, and the far distance between treatment centres and the communities.

In spite of these challenges, communities in the Matawa First Nations have developed approaches to tackle substance abuse in their communities. Community based strategies for addressing substance abuse issues can be understood in terms of community policy and administration, prevention and intervention.

6.2.1 Policy and Administration

- Community level alcohol bans.
- Employee drug testing including mandatory testing for people who operate heavy machinery or are associated with children.
- Staff to check luggage at the airport and confiscate banned substances.
- Research into community needs and treatment options.

6.2.2 Prevention

- Increasing awareness about prescription drug abuse through community meetings and workshops.
- Tackling poverty and nutrition through food programs.
- Parenting programming.
- Working with pharmacists and local schools to raise awareness.

6.2.3 Intervention

- Offering land based outings to give families an opportunity to reconnect in a healthy way.
- Creating an environment to support intervention: Professional development for community health staff on prescription drug abuse, advocacy for longer patient visits with physicians, and implementation of community health care teams.
- Mental health programming.
- Aftercare programming.

6.3 Nishnawbe Aski Nation Local Capacity

For participants in the NAN panel of health directors and program providers, enquiries about local capacity for treatment centres and alternative local approaches listed one actual treatment centre (Dilico) and three in the planning or seeking funding stages. Alternative programming was very varied: referred off reserve (4) or to TIPS (telephone hot line) (1); provided local programs (2), local counseling (4), spirituality, ceremonies, circles (3), and/or workshops and trainings (2); had visiting professional counselors or traditional people (2) and/or NNADAP workers (2).

Eight communities had or proposed aftercare capacity. Of the five that specified, each had a different approach: counseling, ceremonies and teachings, crisis team, sending NNADAP worker to workshops and one unspecified proposal to build capacity. For those that did not have or plan to have aftercare, the reasons included: not enough intent/interest by providers (2), not enough human resources/time constraints (2), insufficient funding (1). One 'no' respondent mentioned having aftercare manuals.

None of the communities mentioned a procedure for dealing with members when they quit a treatment centre early except to make them responsible for their own transportation home in accordance with policy.

Obstacles to improving local capacity included both inadequate resources (funding (4), competence (5), time (3)), and cooperative difficulties (lack of support from leaders, lack of trust and respect, different mandates, lack of commitment and participation by representatives of vested interests (1 each)).

Also based on responses to the NAN health director interviews, the opinion was that local capacity for pre- and post-treatment support was limited.

- Some communities did not have the capacity for local support for legitimate reasons.
    - Time (only one half-time NNADAP worker and/or high local need)
    - Commitment (sometimes did not see benefits of local support)
    - Competence (sometimes did not have training or experience to deal with difficult cases)

One of the consequences of an insufficient local capacity was that only 8 of 30 communities offered aftercare programs.

7. Limited Supply Exists

While 15 addiction treatment programs were located in northern Ontario or served Aboriginal residents of the NAN area, they were characterized by

- Distant locations: of the 4 that included Aboriginal residents of the NAN area in their primary catchment area:
  - 2 were located in fly-in communities
  - 2 specialized in solvent abuse only
- The 5 non-residential communities were not within commuting distances for most (combined they serviced 11 First Nations and Thunder Bay reasonably)
- NAN community residents would have had low priority in the remaining ones (again located outside of NAN territory) as they had specified primary catchment areas that did not include NAN communities.

From the point of view of Constance Lake First Nation and the other First Nations of the Matawa First Nations,

THERE WAS NO ADDICTIONS RESIDENTIAL TREATMENT CENTRE THAT COULD EFFICIENTLY SERVE THE 15 FIRST NATIONS IMMEDIATELY SURROUNDING AND ACCESSIBLE TO CONSTANCE LAKE BY ROAD; FLY-IN CENTRES REQUIRED A SIX-HOUR DRIVE TO THUNDER BAY AIRPORT.

THE ALTERNATIVES TO RESIDENTIAL TREATMENT PROGRAMS GENERALLY RELIED ON REFERRALS TO LOCAL RESOURCES AND MANY COMMUNITIES HAD RESOURCE CHALLENGES.

There were other limits to the supply of the treatment programs and they will be discussed in the next section *Supply is out of sync with demand and need*.

7.1 Treatment Facilities Available in the Nishnawabe Aski Nation Territory

This section provides first a map showing three levels of treatment centre coverage in the Nishnawabe Aski Nation Territory, followed by a series of three tables detailing the location, geographic catchment, gender and age requirements, and a summary of treatment services offered.

The three levels of treatment centre coverage included:

- Primary catchment area includes NAN communities.
- Primary catchment includes non-NAN northern communities although NAN communities are considered secondary catchment
- Non-residential programs in northwestern Ontario.

All centres serve Aboriginal clients. Summaries of the various centres that have best practices to share with this needs assessment are included in Appendix F.

Figure 7.1: Map of Nishnawabe Aski Nation First Nations by Tribal Council and Treatment Centres by Location and Type of Catchment Area Covered

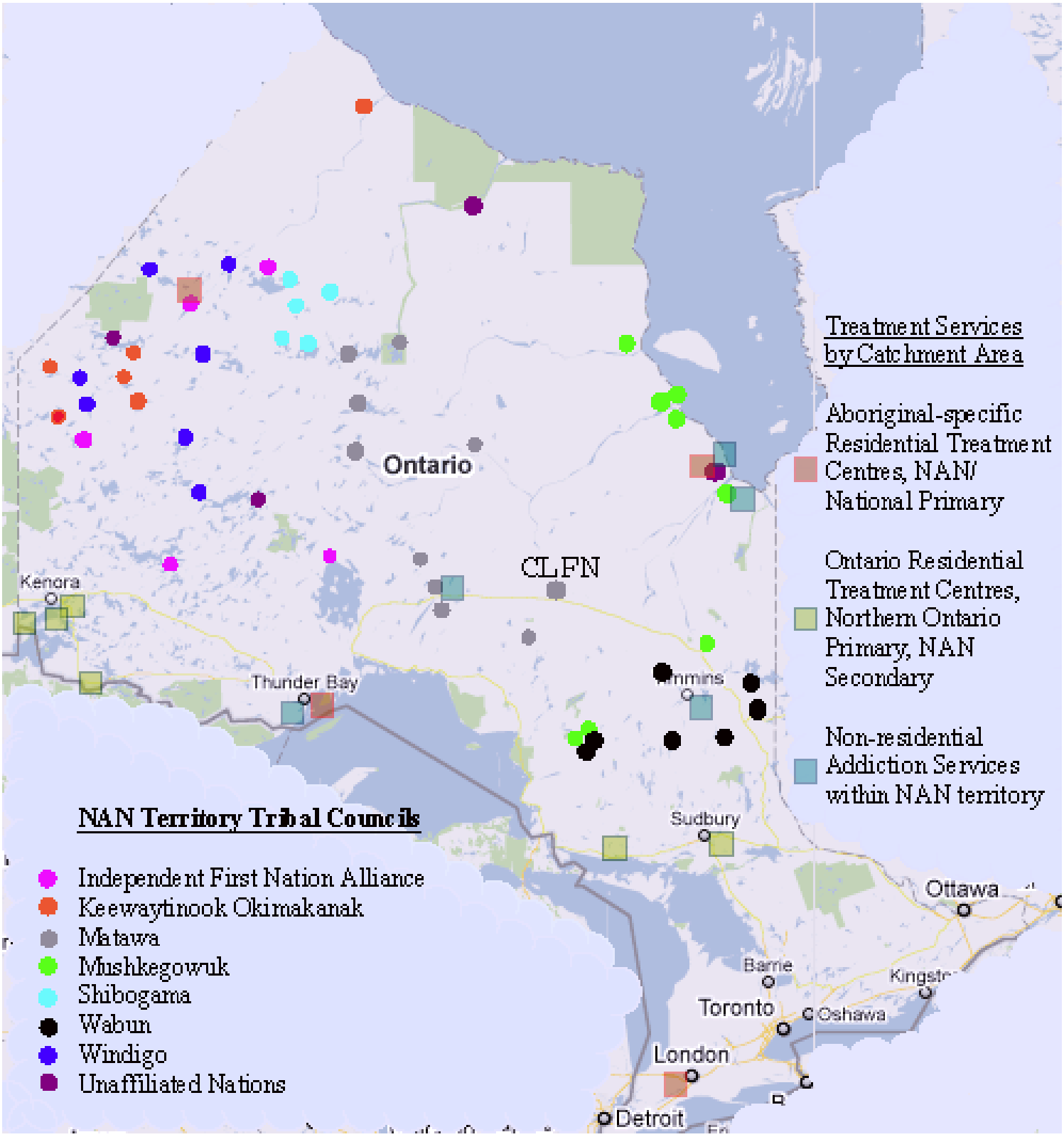


Table 7.2 identifies four Aboriginal-specific residential treatment options located in northern Ontario and having primary catchment areas that included some or all of NAN territory. The two residential treatment facilities available in the NAN region were located in fly-in communities in the northwest (Muskrat Dam) and the northeast (Moosonee) (See Figure 7.1) and their primary catchment areas did not include all of NAN communities. Only one of those two dealt with prescription drugs. The two road-accessible centres were specific to solvent use, both for men, one youth only.

Table 7.2: Aboriginal-specific Ontario Residential Treatment Facilities with Primary Catchment within the NAN territory or nationally

Treatment Facility Name (and Treatment Focus)	Location	Geographic Catchment	Gender	Age	Treatment Services Offered
Reverend Tommy Beardy Memorial Wee Che He Wayo-Gamik: Family Treatment Centre (Alcohol; Narcotics; Solvent Abuse; Prescription; Hallucinogens)	Muskrat Dam	Treaty 9 communities	Men and Women	0-99	• Residential treatment • Intake assessment and planning • Aftercare • Programming for the whole family with follow up and support up to one year post treatment
Sagashtawao Healing Lodge (Alcohol; Narcotics; Hallucinogens)	Moosonee	West Hudson and James Bay First Nation	Men and Women	18-99	• Short term residential care • Residential continuing care program (3 weeks)
Nimkee Nupi Gawagan (youth solvent abuse)	Muncey	Canada	Men	12-17	• Long-term residential treatment • Intake assessment and planning
Ka Na Chi Hih Specialized Solvent Abuse Treatment Centre (solvent abuse)	Thunder Bay	Canada	Men	16-25	• Long-term residential treatment program • 12 beds

Table 7.3 includes six residential treatment facilities with primary catchment areas in the north and whose secondary catchment policy meant that they were open to NAN communities. There were two co-ed facilities, two that were women specific and two that were male specific. There was one residential program that targeted youth specifically.

Table 7.3: Ontario Residential Treatment Centres with Northern Ontario Primary Catchment Areas with NAN Territory on the Secondary Catchment Areas

Treatment Facility Name (and Treatment Focus)	Location	Geographic Catchment	Gender	Age	Treatment Services Offered
Anishnaabe Naadmaagi Substance Abuse Facility (Alcohol; Narcotics; Prescription; Hallucinogens)	Blind River	Primary: Blind River/Algoma Secondary: North East LHIN	Men and Women	18-99	• Treatment assessment. • Community therapy. • Residential treatment -28 days.
Changes Recovery Home: Clarissa (sober in pre and post treatment)	Kenora	Primary: Kenora/Rainy River Secondary: NWLHIN/Ontario	Women	18-99	• Residential supportive Treatment-level 1. • Pre and post treatment support. • Max. stay 6 months. • Some child care and family support.
Changes Recovery Home: Del Art Manor (sober in pre and post treatment)	Keewatin	Primary: Kenora Secondary: NWLHIN/Ontario	Men	18-99	• Residential supportive Treatment-level 1. • Pre and post treatment support. • Max. stay 6 months.
Iris Addiction Recovery for Women (recovery from any form of substance)	Sudbury	Primary: Sudbury/Manitoulin Secondary: NELHIN/Ontario	Women	16-99	• Initial assessment and planning. • Day/evening community treatment. • Residential treatment – 35 days. • Outpatient ECD based programming for mothers with children under 6.
Migisi Alcohol and Drug Treatment Centre (Alcohol; Narcotics; Prescription; Solvent Abuse; Hallucinogens)	Kenora	Primary: Treaty 3 area Secondary: Ontario	Men and Women	18-99	• 4 week residential program.

Treatment Facility Name (and Treatment Focus)	Location	Geographic Catchment	Gender	Age	Treatment Services Offered
Wee chi-it-te-win Training and Learning Centre (youth with alcohol and/or other substances combined with mental health issues and related behavioural, social and emotional difficulties)	Fort Frances	Primary: Fort Frances Secondary: Ontario	Men and Women	12-17	• Residential treatment program.

Table 7.4 includes five non-residential addiction services that were offered locally (within NAN territory) for Aboriginal clients. These services ranged from initial assessment and treatment planning, through community and individual outpatient treatment, to aftercare. This represented local outpatient services for about 11 of the 49 NAN communities plus Thunder Bay.

Table 7.4: Non-Residential Addiction Services Available for Residents in the NAN Territory

Facility Name (and Treatment Focus)	Location	Geographic Catchment	Gender	Age	Treatment Services Offered
Balmoral Centre, St. Joseph's Care Group (Mental Health, Addiction & Problem Gambling)	Thunder Bay	Thunder Bay/Ontario	Men and Women	16-99	• Residential withdrawal management level 2 • Non-medical detox unit • Open-ended stay
Dilico Anishnabek Family Care and Mental Health and Addictions (mental health and substance abuse)	Longlac	Longlac 58, Longlac, Geraldton, Ginoogamig, Caramat, Aroland, and Nakina	Men and Women	18-99	• Initial assessment and planning. • Community treatment. • Aftercare phase 2. • Individual treatment.
James Bay General Hospital-Alemoeta James Bay Community Mental Health and Addictions	Moosonee	Moosonee, Moose Factory, Attawapiskat, Peawanchuk, Fort Albany, and Kashechewan	Men and Women	0-99	• Initial assessment and planning. • Community treatment.

Facility Name (and Treatment Focus)	Location	Geographic Catchment	Gender	Age	Treatment Services Offered
Moose Cree Healing Centre (alcohol)	Moose Factory	Moose Factory First Nation	Men and Women	18-99	• Community Treatment.
South Cochrane Addictions Services (alcohol, drugs and gambling)	Timmins Iroquois Falls Matheson	Timmins Iroquois Falls Matheson	Men and Women	0-99	• Initial assessment and planning. • Community treatment.

7.2 Matawa First Nations Pattern of Referrals

Communities varied by the frequency with which they were referring members to outpatient treatment facilities. Typically communities within the Matawa First Nations were referring their members on a monthly basis or two to three times per year to residential treatment facilities. The pattern of referral was essentially similar for Native treatment programs and mainstream treatment programs.

Community members were referred to programs within the community more frequently than to in-patient facilities elsewhere. These community-based treatments included traditional healing, ceremonies, crisis lines, community health nurses and NNADAP workers on a monthly or weekly basis. Members were referred less frequently to outpatient programs outside of the community (at a rate of monthly or 2-3 times per year).

7.3 Nishnawbe Aski Nation Patterns of Referral

Based on the table below, there were three tiers of referrals for addictions.

The most used referral paths were to:

- NNADAP workers (over half of communities made such referrals daily/weekly)
- Native treatment program, mental health/addictions centre, Community Health Nurse (over half made daily, weekly or monthly)

Moderate use was made of referrals to mainstream treatment centres, traditional healing, and traditional ceremonies.

Least use was made of crisis shelters, crisis lines and outpatient treatment programs.

Table 7.5: Over the past year, on average, how often has your jurisdiction (First Nation) referred band members to…*(bolded numbers identify the frequency category with the median)*

	Daily	Weekly	Monthly	2-3 x year	Less often	Not at all
A NNADAP worker	4	**9**	8	0	0	2
Counselling	2	7	**13**	3	2	0
a Native treatment program	2	1	**11**	9	3	1
A mental health and addictions centre	2	2	**8**	5	4	5
A Community Health Nurse	0	9	**9**	1	1	6
a Mainstream treatment centre	2	1	7	**5**	2	9
Traditional Healing	0	5	7	**5**	2	6
Traditional ceremonies	0	4	5	**7**	2	7
A crisis shelter	0	1	3	8	**2**	11
Call a 1-800 crisis line	2	3	0	2	4	**12**
Outpatient treatment program	0	0	4	5	1	**16**
Other: health worker, hospital, mental health worker, child and family services, integrated services	0	0	5	0	0	n.a.

8. Supply Is Out Of Sync with Demand and Need

In addition to the wait times, distance and local capacity factors discussed in previous sections, the existing addiction treatment programs were of limited usefulness to residents of Constance Lake First Nation, the Matawa First Nations communities, and NAN communities because:

- Funding and other limits made it difficult to treat the whole person and providing sufficient programming to go beyond the addiction treatment and restore individuals and families to functioning better in their home communities.
- Community partnerships and involvement was limited due to large catchment areas (many communities) and inconsistent local capacity.
- There was limited continuity between detox, treatment and aftercare programs for some clients and limited supply of detox and aftercare.
- Few programs had the capacity for effectively meeting the detox and treatment needs of prescription drug and poly-substance addicts or those with additional mental health challenges.
- Family unit healing was emphasized in only one non-residential program and one residential program.
- Youth and women were harder to place in safe environments.
- Treatment programs typically provided short-term aftercare, but many addicts needed longer-term transitional support in their home communities and some even needed lifetime support to remain clear.

MOST RESIDENTS OF CONSTANCE LAKE FIRST NATION, OTHER MATAWA TRIBAL COUNCIL COMMUNITIES, AND OTHER NAN COMMUNITIES DID NOT HAVE A REASONABLY PROXIMATE ADDICTION TREATMENT OPTION THAT WAS

- BASED ON CULTURAL AND OTHER RELEVANT PRINCIPLES OF TREATMENT
- WITH STRUCTURAL ATTRIBUTES THAT WOULD EFFECTIVELY MEET THE NEEDS OF THEIR MOST UNDERSERVED COMMUNITY MEMBERS.

8.1 Prescription Drug and Polysubstance Abuse

None of the existing inpatient facilities was designed with the current complexities of prescription drug and polysubstance dependence in mind. Based on discussions with residential treatment providers, facility administrators were working to retrofit their programming and facilities to meet the challenges that were posed by the intense cases of polysubstance addictions that were increasing coming through their doors.

8.2 Detox Bed Supply

Treatment facility operators and NAN based addictions workers and health directors emphasized the need for a greater number of locally available detox beds. Not all of the facilities that we spoke with required detoxification prior to entry into treatment. Others required detox prior to treatment. However, all agreed that detox was an essential element of the treatment process. Generally speaking there was a need for more detox beds. Iris Addiction Treatment Centre for Women in Sudbury emphasized the need for more women-only detox facilities.

8.3 Youth

There were few residential treatment options available for youth and very few for female youth. In Ontario, there were seven in-patient treatment facilities that were open to youth. Three of these were youth-only facilities and only one of these (Fort Frances) was open to female youth. While there were two facilities for male youth-only there was not a similar facility for female youth-only. The remaining four facilities offered services for adults as well as youth 16 and over (except Muskrat Dam which accepted whole families). Based on discussions with facility operators, it is apparent that youth have unique addiction challenges and needs. They were described as particularly resistant to treatment and sensitive to being far away from their families and communities.

8.4 Women with Children

A lack of facilities for women especially women with children under six and youth. Anecdotal evidence suggested that prescription drug abuse was common among single parent households. Given the fact that most of these households were headed by women, there may be a need for services that allow women to work through addictions while supporting the development of parenting skills. There was only one female-only treatment facility in the north (Iris located in Sudbury) and while the facility did offer programming for Aboriginal women, the program was not Aboriginal specific.

8.5 Matawa First Nations Overview

Health directors and health service providers in the Matawa First Nations area repeatedly described current treatment options as not keeping pace with the changing face of addiction in their communities. Providers were more likely to report that current programs and treatment centres were working *well* or *somewhat well* for alcohol and cannabis addictions (6 of 9), but *not working well* for prescription drug addictions as illustrated by high relapse rates. List 8.1, describes treatment needs as stated in interviews and surveys. The primary concerns included the need for culture-based facilities to address the intensity of prescription drug addictions from detoxification to aftercare and follow up.

List 8.1: Reported Treatment Needs in the Matawa First Nations Territory (N=9)

- More facilities specializing in prescription drug abuse. Participants identified that only two such facilities were available in Ontario.
- Greater availability of local treatment options as transportation was increasingly becoming problematic; e.g., it can be difficult to get funding necessary to transport people to distant treatment facilities.
- More local detox facilities including medical detox.
- Some did not support methadone as a treatment option while others expressed difficulty in making methadone available in their communities.
- Longer treatment cycles
- More follow up and post treatment support.
- More funding for community based programming.
- More efficient, expedient access to treatment including detox, residential treatment and aftercare. There was concern that the system needs to be able to accommodate people who want to get treatment immediately as many revert back to their addictive behavior while waiting for treatment.
- Inpatient facilities designed with the current complexities of prescription drug and polysubstance dependence in mind.
- Facilities that are rooted in connecting people with their traditions, culture and spirituality.
- Greater availability of aftercare and longer aftercare treatment cycles.
- Treatment options that recognize addiction within the context of the family as prescription drug abuse is thought to be common among single parent families.

Surveyed health care providers were asked to determine the relative importance of potential aspects of an inpatient treatment program. Table 8.2 identifies the elements of a treatment program that were identified as being important/very important by survey participants. Participants agreed that it is very important that any treatment programs address polysubstance addictions, nutrition, counseling, community stabilization, and discharge planning/aftercare.

Table 8.2: Very Important/Important Aspects of Addictions Treatment: Matawa Service Providers (N=9)

Rated as Very important by *ALL* Participants	**Rated as Very Important or Important by *MOST* participants (6-8 for each type)**	
• Multi substance/dual addictions and process addictions	• Elder and Spiritual supports	• Physical Care
• Nutrition	• Psychological well being	• Family Unit Healing
• Counseling	• Group Work	• Housing Needs
• Community stabilization	• Physical Fitness	• Occupational Counseling
• Discharge planning for home community/After care	• Life Skills	

One health director commented that "if a program addresses all of these (factors above), we would have a much higher [treatment] success rate.

8.6 Nishnawbe Aaski Nation Health Directors

From the following table, it can be seen that the respondents to the health director interviews gave highest marks to the residential treatment cycles of their experience. The next highest marks went to medical detox and detox cycles and cultural aspects of their experience. Lowest marks went to short-term and home community aftercare as well as the length of the program.

Table 8.3: How well do the treatment centres that you currently work with meet your standards? (*The bold numbers in the cells indicate the median of each row).*

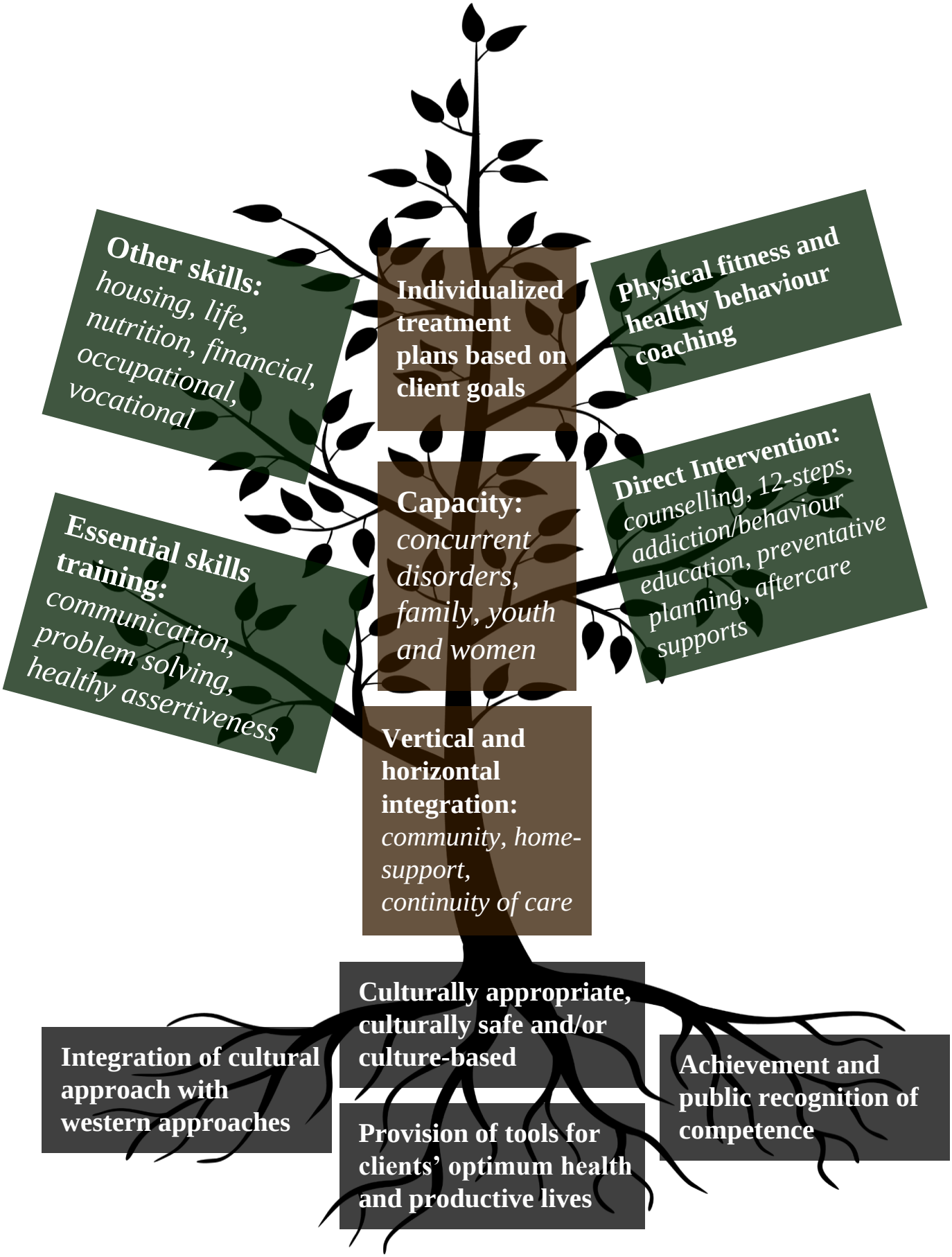
	Very well	Well	Somewhat well	Not well	Very poorly
Medical detox cycle	1	6	**8**	7	5
Detox cycle	4	8	**6**	4	5
Residential treatment cycle	7	**11**	5	2	0
Short-term after-care cycle	2	2	6	**11**	10
Traditional circles, sweats, and ceremonies	3	11	**8**	5	3
Long enough program	2	4	5	**12**	8
Providing follow-up supports to clients after they get back home	2	1	4	**9**	15

Most of the assessments of the efficacy of treatments for various addictions were about equally divided between *very well/well* and *not well/poorly* with only a few (1 to 3) saying *somewhat well* for each type of addictions. These include marijuana (8 *very well/well*, 3 *somewhat well*, 6 *not well/poorly*), over-the-counter drugs (5,3,6), cocaine (7,1,7), needle additions (6, 2, 7), methamphetamines (5,0,6), ecstasy (6,2,4), and heroin (3,1,4). The exceptions were alcohol with a more positive assessments (8,9,4), and prescription drugs (6,2,12), Percocet and Oxycontin (7,2,11) and glue, etc. (6,1,10) with more negative assessments.

Models for Supporting First Nations Members *with* Addictions

A visual model is shown on the next page, the three parts of the model are matched to three parts of a tree. The roots are the *Program Principles,* the trunk of the tree is the *Program Structure*, and the branches are ever growing and evolving to represent the *Program Activities*.

Together these three parts of the tree and model make up the whole -- a strong foundation on which to operate a successful treatment centre.


Other skills: housing, life, nutrition, financial, occupational, vocational
Individualized treatment plans based on client goals
Physical fitness and healthy behaviour coaching
Capacity: concurrent disorders, family, youth and women
Direct Intervention: counselling, 12-steps, addiction/behaviour education, preventative planning, aftercare supports
Essential skills training: communication, problem solving, healthy assertiveness
Vertical and horizontal integration: community, home-support, continuity of care
Culturally appropriate, culturally safe and/or culture-based
Integration of cultural approach with western approaches
Achievement and public recognition of competence
Provision of tools for clients' optimum health and productive lives

9. Models

Using the multiple sources of recommendations for an ideal addictions treatment program and/or best practices as well as research results that support aspects of a variety of treatment programs, a set of characteristics of a program model has been constructed. It would be unrealistic to expect a new program to achieve all of these characteristics at the outset; nevertheless all aspects come with recommendations or positive evaluations.

THREE TYPES OF RECOMMENDATIONS/ VALUED ASPECTS WERE PUT FORWARD:

1. PRINCIPLES
2. STRUCTURE OF THE PROGRAM, INTERNALLY AND IN RELATION TO THE CLIENTS' LOCAL COMMUNITIES
3. PROGRAM OFFERINGS/ACTIVITIES

The recommendations came from a variety of sources. The most important was the Constance Lake First Nation's community vision as presented by Chief Arthur Moore (Moore, 2010). For this needs assessment, health directors and program providers from nine communities within the Matawa First Nations added their views in a meeting, as did 35 of the 49 health directors from NAN communities through interviews. A report done for the Chiefs of Ontario and FHNIB also included recommendations (COO and FHNIB, 2008). Best practices were gleaned from interviews with representatives of existing programs and from the research literature. Detailed discussions of the sources follow this summary except for the details of the existing programs that can be found in Appendix F. Tables 9.1 through 9.3 include additional details for the three aspects of the model and the sources of the recommendations/ valuations.

9.1 Principles

Culturally appropriate, culturally safe and/or culture-based

a. wholistic health, balance of physical, emotional, mental and spiritual
b. land-based including Elders and fishing and hunting
c. local language spoken by staff
d. recognition of the role of cultural trauma

Integration of cultural approach with western approaches

Provision of tools for clients' optimum health and productive lives

Achievement and public recognition of competence

9.2 Program Structure

Vertical and horizontal integration:

a. community-based approach
   - community-based primary, secondary and tertiary prevention
   - community stabilization
   - partnership with nearby community to provide health services and recreational facilities for residential clients

b. residential program with local out-patient support in home communities
   - reasonable distance from home
   - on land in or near FN
   - pre-treatment and aftercare coordination/support through video conferencing; partnerships to achieve
   - gatekeeper training

c. continuity of care from detox to aftercare in one program

Capacity to deal with

a. multiple and emerging addictions and mental health issues concurrently
b. family unit healing
c. youth and women

Individualized treatment plans based on client goals

9.3 Program Activities

Direct intervention

a. individual and group counseling
b. 12-step programs
c. educational teachings on addictions and related behaviours
d. relapse prevention planning
e. aftercare/outpatient additional treatment support

Physical fitness and healthy behaviour coaching

Essential skills training in communication, problem solving, healthy assertiveness

Other skills and related needs: housing needs, life skills, nutrition, financial management, occupational counseling, vocational training

Table 9.1: Program Model: Principles and Sources of Recommendations/ Evaluations

Item	Const. Lake	Matawa, NAN or COO priority	Existing program best practices	Research best practices
Culturally appropriate, culturally safe and/or culture-based	Moore, 2010	NAN health directors survey; COO & FNIHB, 2009	Sioux Lookout Meno Ya Win Health Centre	Jiwa, et al., 2008
- Wholistic health, balance of physical, emotional, mental and spiritual	Moore, 2010			
- land-based including Elders - fishing and hunting		NAN health directors survey	Wee Che He Wayo Gamik, Muskrat Dam	
- local language spoken by staff			Wee Che He Wayo Gamik, Muskrat Dam; Sagashtawao Healing Lodge, Moosonee	
- recognition of the role of cultural trauma				Spicer et al., 2003
Integration of cultural approach with western approaches	Moore, 2010		Sagashtawao Healing Lodge, Moosonee	Jiwa, et al., 2008
Provision of tools for clients' optimum health and productive lives	Moore, 2010	NAN health directors survey		
Achievement and public recognition of competence: accredited by Accreditation Canada			Sagashtawao Healing Lodge, Moosonee	

Table 9.2: Program Model: Program Structure and Sources of Recommendations/Evaluations

Item	Const. Lake	Matawa, NAN or COO priority	Existing program best practices	Research best practices
I. Vertical and horizontal integration				
a. Community-based approach				Jiwa, et al., 2008 Ellis, 2003 Chandler and Lalond, 1998, 2003
- community-based primary, secondary and tertiary prevention				May, Serna and Hurt, 2005
- community stabilization		NAN health directors survey		
- partnership with nearby community to provide health services and recreational facilities for residential clients			Sagashtawao Healing Lodge, Moosonee	
b. Residential program with local out-patient support in home communities				
- reasonable distance from home		NAN health directors survey		
- on land in or near FN		NAN health directors survey		
- pre-treatment and aftercare coordination/support through video conferencing; partnerships to achieve			Wee Che He Wayo Gamik, Muskrat Dam	Jiwa, et al., 2008

Item	Const. Lake	Matawa, NAN or COO priority	Existing program best practices	Research best practices
- gatekeeper training				Isaac et al., 2009
c. Continuity of care from detox to aftercare in one program	Moore, 2010	NAN health directors survey COO & FNIHB, 2009		
II. Capacity to deal with …				
a. multiple and emerging addictions and mental health issues concurrently		NAN health directors survey COO & FNIHB, 2009		
b. family unit healing		NAN health directors survey	Wee Che He Wayo Gamik, Muskrat Dam	Jiwa, et al., 2008
c. youth and women		NAN health directors survey		
III. Individualized treatment plans based on client goals; tiered approach	Moore, 2010	COO & FNIHB, 2009		

Table 9.3: Model: Program Activities and Sources of Recommendations/Evaluations

Item	Const. Lake	Matawa, NAN or COO priority	Existing program best practices	Research best practices
Direct Intervention				
- individual and group counseling	Moore, 2010	NAN health directors survey		
- 12-step programs	Moore, 2010			
- educational teachings on addictions and related behaviors	Moore, 2010			
- relapse prevention planning	Moore, 2010			
- aftercare/outpatient additional treatment support; discharge plan for home community	Moore, 2010	NAN health directors survey		
- one-week residential follow-up after one year			Iris Addiction Recovery Centre for Women, Thunder Bay	
Physical fitness and healthy behaviour coaching	Moore, 2010	NAN health directors survey		Jiwa, et al., 2008
Essential skills training in communication, problem solving, healthy assertiveness	Moore, 2010			
Other skills and related needs: housing needs, life skills, nutrition, financial management, occupational counseling, vocational training		NAN health directors survey		Jiwa, et al., 2008

9.4 Constance Lake Chief Arthur Moore

The treatment centre model presented at the 2010 Chiefs of Ontario Health Forum by Chief Arthur Moore would be based on the teaching of the Medicine Wheel concept (Moore, 2010). For First Nation peoples, health is achieved by maintaining balance in the four dimensions of our selves: the mental, physical, emotional, and spiritual. Chief Moore stated that "It is our belief that addiction destroys these dimensions and the only effective method of recovery is a holistic approach". Accordingly, this unique approach in effect will address these dimensions in a culturally appropriate way to maximize recovery for clients receiving treatment.

In addition, the program will integrate traditional Aboriginal spirituality with 12 Step programs, such as AA and NA, informational lectures, and group therapy to help clients restore balance to their lives. Essential skills training in communication, problem solving, and healthy assertiveness will also be provided to ensure clients have the tools to stay sober and live healthy. Treatment program specifics include the following:

- Potential for continuity between detoxification and treatment – it was emphasized that the current wait time between the two was unacceptable as it discouraged clients from continuing their treatment
- individualized treatment plans based on client goals
- individual and group counseling
- educational teachings on addictions and related behaviors
- cultural and spiritual awareness through the use of ceremonies
- physical fitness and health promotion
- relapse prevention planning
- aftercare/outpatient additional treatment support

Despite the efficacy in care and treatment options for clients at the methadone clinic in the Jane Mattinas Health Centre, it is evident that a centralized and comprehensive drug treatment facility will allow for greater success in reducing drug use among Aboriginal peoples.

9.5 Realities of Treating Addictions

Addiction is a multifaceted issue that cannot be addressed by one treatment approach or attributed to one underlying cause. The face of addiction in Aboriginal communities today is one that presents a high incidence of multiple addictions including alcohol, prescription drugs, crack/cocaine, cannabis, and opiates. It is one where the addictive behaviour often coexists with multiple mental health issues. Furthermore, it is an issue that affects individuals throughout the life span starting in some cases in the womb or alternately starting at 13-14 years of age. It is clear that the consequences for individuals, families and communities can be severe. Substance abuse cannot be divorced from the greater socioeconomic, health, and political issues as well as spiritual deprivation facing First Nation communities.

Anecdotal and academic literature suggests that the nature of addictions is changing in the First Nation community. Where alcohol was once the primary concern, abuse of prescription medication and multiple addictions are becoming more prevalent. In 2002, Wardman, Khan, and el-Guebaly surveyed 69 Aboriginal clients at a Calgary addiction treatment facility. They found that 48% of clients identified that they had used prescription medicines inappropriately in the past year. Commonly misused substances included stimulants and sedative classes of drugs. The researchers also reported that common sources included friends (52%), street purchases (45%) and prescribed by a physician prescriptions (41%).

In a 2009 addictions service needs assessment prepared for the First Nations and Inuit Health Branch and the Chiefs of Ontario, it was noted that the most commonly abused substances in Ontario's First Nation communities were alcohol, cannabis (marijuana, hashish), cocaine and oxycodone (Oxycontin and Percocet). While alcohol was still the most commonly abused substance, community members and leadership were increasingly becoming concerned with high levels of prescription drug abuse in their communities (Sioux Lookout First Nations Health Authority, 2009). Furthermore, there was an emerging trend toward the abuse of multiple substances or polysubstance addiction (COO & FNIHB, 2009).

Respondents also identified common challenges to treating and accessing services for people struggling with addictions. Some of the identified barriers are as follows:

- At least 80% of their clients had concurrent mental health issues. This co-morbidity made it even more difficult for people to access appropriate treatment services.

- A lack of specific treatment facilities and services for youth and drug addicted mothers.

- A lack of family treatment centres.

- Poor accessibility of treatment facilities and resources for in-community aftercare continued to plague communities especially for those who reside in remote communities.

- The need for training and treatment options that are sensitive to the changing face of addiction in Aboriginal communities. Participants identified that many of the current addiction services were focused on alcohol; however, most people were dealing with multiple addictions including prescription drugs (COO & FNIHB, 2009).

In moving forward in addressing addiction treatment and services for First Nation peoples in Ontario, the needs assessment report emphasized the need for a collaborative and integrated continuum of care. This review speaks to the necessity to move beyond the individual to facilitate environments that prevent addiction. While offering culturally appropriate multidisciplinary care that not only targets addictive behaviours, also addresses other underlying mental health issues. This includes a tiered approach to care, whereby the level of treatment corresponds to the type, nature, and severity of the addiction and/or concurrent mental health issues. Lastly, the model encourages aftercare support and in-community resources to help support relapse prevention.

Section 9.6, next, identifies community-based culturally rooted approaches to treatment and prevention that were demonstrating promising results for treating addictions, reducing relapse, and creating healthy and safe therapeutic environments. Treatment models that move beyond the individual to include the whole family were showing positive results for Aboriginal clients as were those that are respectful of Aboriginal culture. It should be noted that this discussion is not intended to provide an in-depth understanding of commonly used treatment approaches for mental health and addiction. For an overview of treatment approaches see Chiefs of Ontario and First Nations and Inuit Health, 2009.

Fourteen years ago, the Royal Commission on Aboriginal Peoples asserted that one- on- one clinical psychological approaches were not conducive to addressing the mental health concerns of Aboriginal people in Canada. It was argued that these approaches failed to recognize that mental health and wellness are deeply rooted in the community and family experience. Furthermore, manifestations of mental illness could not be isolated from the

historical trauma and political context of Aboriginal life (RCAP, 1996). Fortunately, some treatment program facilitators have recognized this and have begun to incorporate family and community-based approaches to their treatment cycles.

In the discussion below, a selection of studies are examined to explore the efficacy and process of creating treatment environments and processes that respect and incorporate culture-based approaches. Moving beyond the concept of mental illness as an individual problem, these studies demonstrated and investigated how communities can be empowered and mobilized through the treatment process. While this field of study is relatively new in the academic literature, emerging results suggest that culturally appropriate care facilitated in culturally safe environments resulted in higher rates of treatment uptake, greater retention, and healthier communities.

9.6 Substance Abuse and Health: Wholistic Community Approaches

A recent clinical review conducted by Jiwa et al. (2008) revealed that studies utilizing community-based approaches to substance abuse demonstrated promising results. These models were community driven and addressed prevention, treatment and post-treatment support within the community. The study examined data taken from 34 journal articles and other literature to determine community-based approach models and efficacy. Quantitative data suggest that treatment models that incorporate culture, partnerships, community, and family resulted in better outcomes for Aboriginal clients. These outcomes are described in Table 9.4.

The article also suggested that the infusion of cultural activities into mainstream treatment approaches has also been shown to have higher efficacy (i.e. higher retention, decreased alcohol consumption) compared to treatments that did not include cultural activities.

It has been argued that community level post treatment supports were inconsistent, contributing significantly to high rates of relapse (Jiwa, Kelly and St Pierre Hanson, 2008).

Prevention was also identified as a key aspect of community-based approaches. These elements are consistent with the mental health promotion models described in detail in Section 9.7. Mental Health Promotion models include encouragement of ‘healthy appropriate behaviors’ intended to increase positive self-image, self-worth and self-esteem. In theory individuals with higher levels of self-worth have fewer to no self-destructive behaviors. This assumption moves beyond a traditional education-based model of substance abuse prevention where students can be passive recipients of messages about the

harmfulness of substances. Fitness training, vocational training and local cultural activities have all demonstrated a positive effect in increasing positive image.

Policy change was a second preventive approach that some communities have used to address substance abuse. A study by Ellis (2003) demonstrated clearly positive outcomes as a result of policies and initiatives (including taxation, Sunday sales bans, and closing troublesome bars) aimed at reducing alcohol-related injuries. With a 150% decrease in motor vehicle collisions and a decline in mortality due to collisions, the program was considered a success. The authors cautioned however, that policy to reduce harm must be considered carefully within the context of the community to ensure that the effects can be positive and are not likely to exacerbate the problem.

In addition to community-based preventive measures, communities have also been increasingly taking control and defining treatment internally. It was difficult to determine the rate at which communities were mobilizing to providing in-house substance treatment because much of these data were unpublished. Table 9.4 highlights models of community-based treatment approaches identified by Jiwa, et al. (2008). The author cautioned that the long-term efficacy of these programs have not been evaluated through empirical longitudinal studies.

The evidence presented next provides an empirical basis for community approaches that addressed substance abuse wholistically through prevention, policy, treatment, and aftercare. While based on a limited body of research, it suggests that with effective supports, leadership, and partnerships, communities have been empowered to provide treatment options that have the potential to be more successful than in- patient treatment provided outside of the community.

Table 9.4: Community Based Treatment Models for Substance Abuse Treatment (Jiwa et al., 2008)

Model	Location	Treatment Approach	Results
Selkirk Healing Centre	Manitoba	• wholistic approach employing Elders to address spiritual and cultural components of care.	• ↓ in substance abuse. • ↑ in self reliance.
Shadow Project	*Not specified in article*	• 8 week residential program • Culturally appropriate family approach through group and individual therapy. • Recognition of historical trauma.	• ↓ in alcohol consumption in those that received enhanced family therapy compared to the control group. • No difference for substance abuse.
Community Mobile Treatment (CMT)	Prince George, BC	• Alcoholism viewed as a community problem. • Goal is to involve the whole community and to allow the community to set standards that will create an environment to support a "culture of sobriety". Stages: 1. The community identified the need and belief that change is possible. (1-2 Years). 2. 21-28 days of CMT with almost the whole community participating. 3. Aftercare programming.	• 6 months post treatment there was a 75% abstinence rate. • Results have been replicated in Saskatchewan and Alberta. • Required strong leadership and community commitment.
Roundlake Treatment Centre	BC	• Community based and in-patient services. • Rooted in cultural awareness and family involvement.	• Most participants reported to be alcohol and drug free two years post treatment. • Self- reported ↑quality of life, family relations, and self image.
Petro Sniffing	Australia	• Community set standards for acceptable behavior within the community. • Community member patrolled to enforce standards • Local families cared for and provided support for identified youth	• ↓ sniffing from 54 youth to 1 within the community.
Community Readiness	Alaska	• Measures the community's stage of readiness or capacity and develops complimentary intervention strategies.	*No results were provided, since this was a planning tool only.*

9.7 Mental Health Promotion: Suicide Prevention Evidence

Studies showed that suicide among the Aboriginal population was significantly more common as compared to the general population. However, not all First Nations communities reported high levels of suicide (Kirmeyer et al., 2005). This variation by community is suggestive of mitigating factors at the local level. The ongoing research of Chandler and Lalonde (1998, 2003) that examined suicide in 80 British Columbia First Nation reserve communities, has illustrated that while some communities had epidemic levels of suicide, others had experienced few to no suicides. Chandler and Lalonde explained that this difference might be attributed to the function of *cultural continuity*. They found that the greater the level of community control over resources and services such as self-government, involvement in land claims, control over education, health services, cultural facilities, police services, and fire services, then the lower the levels of suicide. Conversely, communities that possessed little or no control over the aforementioned services had higher rates of suicide. In other words, suicide prevalence for Aboriginal youth was related to the functioning of the community. This suggests that for these youth, environment was implicated in the manifestation of psychological distress that contributed to higher rates of suicide.

At the individual level, suicide is typically understood in terms of psychological conditions such as depression, distress, anxiety and substance abuse related to self-esteem and identity (Kirmeyer et al., 2009). A 2003 survey of 3,084 members of two American Indian tribes found that there were no differences between the Aboriginal and non-Aboriginal population in the rate of psychiatric diagnoses (Spicer et al., 2003). However, there was a marked difference in the nature of the diagnoses with Native Americans being more likely to be diagnosed as having post-traumatic stress disorder and alcohol dependence (Spicer et al., 2003). Interestingly, post traumatic stress disorder can be linked to historical trauma caused by colonialism, assimilation and the legacy of residential schools, and systemic power imbalances between Aboriginal communities and mainstream society.

This interaction between community factors or continuity and individual manifestation of suicidal behaviour, was supportive of community-based approaches to addressing suicide and mental health. According to Kirmeyer, Simpson, and Cargo (2003) suicide prevention strategies were best envisioned and organized as a community wellness strategy that promoted individual wholistic health. Evidence from a US study supported this through their findings that community-based public health interventions that incorporated primary, secondary and tertiary levels of prevention led to a decrease in suicidal behaviour within the community (May, Serna, Hurt et al., 2005).

A suicide prevention program named *Gatekeeper training* provided a select group of individuals with two to five days of training in suicide behaviour, identification, support and referral. Gatekeepers used these skills to identify, assist and refer suicidal individuals. However, there was lack of consensus of who would constitute an "ideal" gatekeeper. Studies to date have focused on gatekeepers as medical service providers, peers, school staff and counsellors. Thus, there was a high degree of flexibility concerning who might make a good gatekeeper (Isaac et al., 2009).

There is agreement in the literature that gatekeeper training increased individuals' knowledge, attitudes, and skills in identifying and assisting at-risk individuals (Isaac et al., 2009). That is, people who have taken the training felt more confident and comfortable with their ability to deal with suicide in their communities. In a study conducted in an Australian Aboriginal community, Capp, Deane, and Lambert (2001) found that the effects of training were maintained over time. In a two-year follow up, researchers found that gatekeepers continued to feel confident in their ability to identify suicidal individuals. Furthermore, almost 40% of those trained had gone on to help a suicidal individual. Emerging data also suggested that over time gatekeepers may decrease referrals as they become more comfortable dealing with the individual directly (Capp et al., 2001).

Less conclusive and certainly more difficult to ascertain was whether gatekeeper training decreased suicide and suicide risks. In a cohort study of 800 American Aboriginal youth, a community suicide prevention program including gatekeeper training resulted in a 73% decrease in the mean number of self destructive acts, however the average number of completed suicides was unchanged (May, 2005).

The limitations of this model from an Aboriginal community perspective may include:

- The degree to which referral resources were available in the community.
- Community commitment to the need for suicide prevention.
- Confidentiality, privacy, and trust (Isaac et al., 2009).

Limitations aside, this model also holds promise in a First Nation context due to:

- The inherent flexibility of the model. It is easy to envision adapting the model to fit the cultural context. Communities in northern Manitoba have been using the ASIST model of gatekeeper training (Isaac et al., 2009).
- The ability to mobilize resources and people within the community without relying on outside experts. This includes respected Elders, and other trusted community members or peers acting as gatekeepers. By focusing on the community, capacity was developed and retained (Isaac et al., 2003).
- The potential to expand the model to include other social problems including mental health, substance abuse, healthy living, etc. This model can be viewed as compatible with the 12-step sponsor program; however, the anonymity of the gatekeepers allowed them to offer support without being directly solicited.

9.8 Culturally Safe Therapeutic Environments

Cultural safety is a construct that is emerging in the health care field. Collaboration between Aboriginal and non-Aboriginal practitioners and clients is almost inevitable due to limited Aboriginal health human resources. The National Aboriginal Health Organization (NAHO, 2008) envisions cultural competence as a last stage of a continuum that begins with cultural awareness moving to cultural safety and culminating in cultural competence.

According to the Aboriginal Nurses Association (2009: 9), cultural safety is reflected in situations where power imbalances are "exposed and managed". It should be noted that cultural competence is not about treating everyone the same as would be the case in multi-cultural models of care. Rather, a culturally competent environment is one where the unique culture of the client is understood, respected, and reflected through the actions of the practitioner (NAHO, 2008).

The lack of cultural safety in the Canadian health care system can create situations where Aboriginal people may be reluctant to access mainstream care. This can lead to non-compliance with medical advice due to mistrust and or lack of understanding. Furthermore, health service providers who are not culturally competent may experience less job satisfaction, feel less competent in their ability to help clients and can result in higher rates of staff turnover. Arguably, the creation of cultural safe therapeutic environments can lead to more efficient, cost-effective and ethical care environments (NAHO, 2008).

It is with these benefits in mind that the managing staff at the Sioux Lookout Meno Ya Win Health Centre (SLMYW) has developed a model that aimed at incorporating cultural safety into their hospital environment at the organizational level.

In a recent article, Roger Walker, CEO of SLMYW introduced the Healing, Medicines, Foods and Supports Programme that their health centre has developed to ensure cultural safety for their Aboriginal clients (2009). According to Walker et al. (2009), critical components of a culturally safe environment means that the model of care is client-centered and the local culture is empowered and strengthened in the therapeutic environment.

However, cultural safety is difficult to define as a result of the diversity among First Nation peoples. For instance, northern communities may define cultural safety differently than southern communities and the definition would also likely vary between urban and rural populations. Therefore, it is important to imbed the concept of cultural safety within the context of the specific cultures, traditions, and experiences of the community or region.

The goal for SLMYW is complete integration of First Nation cultures and ways of knowing into all aspects of hospital functions. As the model is implemented, it is anticipated that local First Nations' philosophies will become seamlessly imbedded in the institution where staff and clients are on equal footing. This would entail adopting a paradigm that is consistent with the First Nations' concepts of health and disease. Additionally, this model would encompass the notion that bodies have an inherent ability to heal and recuperate with the use of natural products and through life processes. Thus, disease would not solely be seen as a physical aberration, but rather caused by an imbalance between the spirit, body, and mind (Walker et al., 2009).

In proceeding with their work, Walker et al. (2009) identified eight patient risk factors that resulted in culturally unsafe environments for patients in their service area. As will be illustrated below, it is these factors that the authors propose to eliminate through the Traditional Healing, Medicines, Foods and Supports Programme.

The risk factors are as follows:

- Language barriers – translation needs.
- Cultural barriers- understanding pathology in the cultural context.
- Medical literacy.
- Programme or practice issues where treatments are inherently opposed to traditional practices.
- Contextual or structural issues-cultural habits that may lead to misunderstandings.
- Systemic issues- jurisdiction, regional gaps.
- Genetics.
- Racism/discrimination.

Meno ya Win is addressing these factors through a variety of methods presented in detail in Table 2.3. One primary element of their program includes the provision of cultural orientation training to all staff members. This unique approach not only teaches staff about culture and tradition, it also aims to educate them about colonial history, political relationships, and the systemic issues that continue to perpetuate a power imbalance between First Nation communities and mainstream society.

The pathway to achieving complete cultural safety is understood in terms of a continuum developed by Walker and Cromarty (2006). The institution is seen as moving through the following levels of enlightenment on the pathway to complete congruence between culture and the institution:

- Cultural awareness
- Culturally attuned responsiveness
- Cultural appropriateness
- Cultural competence as determined by the client
- Cultural congruence whereby the staff internalize “diversity based values” and demonstrate this understanding through their interactions with clients.

The authors contend that First Nation cultures will be completely integrated into their model of care through the targeted activities. These integral activities are explored in table 9.5.

Although this model is currently in the implementation phase, preliminary results suggest that the program has been successful. Specific short-term outcomes include: fewer client complaints, greater availability of interpreters, greater patient satisfaction, and almost all patients have accessed some level of the program. The authors also maintain that their work requires the buy-in and partnership with local, regional and provincial organizations. One of the major obstacles in this process is convincing funding agents of the importance of creating equity in the hospital environment. Given the well-documented success that the effect of incorporating culture and strengthening cultural identity has had on mental health, this would likely be less of an obstacle in a substance treatment program.

Table 9.5: Sioux Lookout Meno Ya Win Tradtitional Healing, Medicines, Foods and Supports Programme (Walker et al. 2009)

Element of Care	Specific Strategies
Odabiidamageg Governance and Leadership	• Board of directors (2/3 local First Nations; 1/3 non-Native). • 8 person Elder's council to support the board. • Senior Management Team: includes a Special Advisor on First Nations health and an advisor to the Board and CEO.
Wiichi'iwewin Patient, Resident Client Supports	• Cultural support workers to interface between staff and patients supporting translation, support etc. • Cultural support workers are supported by 2 Elders and culturally appropriate resources.
Andaw'iwewin Traditional Healing Practices	• Incorporation of traditional ceremonies on site.
Mashkiki Traditional Medicines	• Introduction of traditional medicines in a medically responsible way.
Miichim Traditional foods	• Providing continuity between the foods that they are used to eating in their home communities and those that are provided at the hospital.

A study of an Indigenous Australian substance use program also sheds light on approaches to creating culturally safe environments for Aboriginal clients (Berry and Crowe, 2009). Berry and Crowe recognized that the involvement in substance abuse treatment was not consistent with the high rates of substance misuse within the population. This discrepancy was believed to be caused by a lack of 'culturally respectful mental health services', due in part to the lack of indigenous substance abuse professionals.

In the absence of Aboriginal substance abuse professionals, "cultural consultants" were employed as co-therapists. The consultants helped create an environment of trust and understanding, presumably allowing the client to feel more comfortable within the treatment environment. It was suggested that consultants be the same gender as the client and from the same language group. The relationship described in this article appears to be unidirectional in that the cultural consultant's role is to 'vouch' for the therapist. The Meno Ya Win model pushes the concept further by providing cultural safety training for all staff (Aboriginal and non-Aboriginal) and by identifying processes and guiding principles for embedding local culture in the model of care for the entire organization.

9.9 Prioritizing the Range of Services

From the NAN health director interviews, aspects of ideal treatment centre for First Nations people were gathered from a set of answers to the question about an ideal centre. Of the 49 respondents, 22 commented on aspects of a basic approach, 15 commented on the types of addictions that needed to be covered, 4 commented on location, 3 on the populations served, and 1 on the competence of the staff.

Basic approaches mentioned were that the centre be family oriented (5 respondents), local culture-based/Native specific (5), land-based including Elders (3) and had a continuum of treatment stages: detox, treatment, aftercare (2). There were three exceptions to the cultural, Aboriginal approach: allow for non-traditional religious approaches, allow for non-Aboriginal participants, allow for a non-cultural option. There were one mention each of implementing the existing (NNADAP) aftercare model, excellence, limitation of risk levels of clients to either low, medium or high, and less paperwork/medical screening.

Assurance of the addiction issues to include: prescription drugs (4 respondents), alcohol (3), (street) drugs (3), solvents (1) and any (1). Two related issue to be included were nutrition/healthy lifestyles (2) and violence (1).

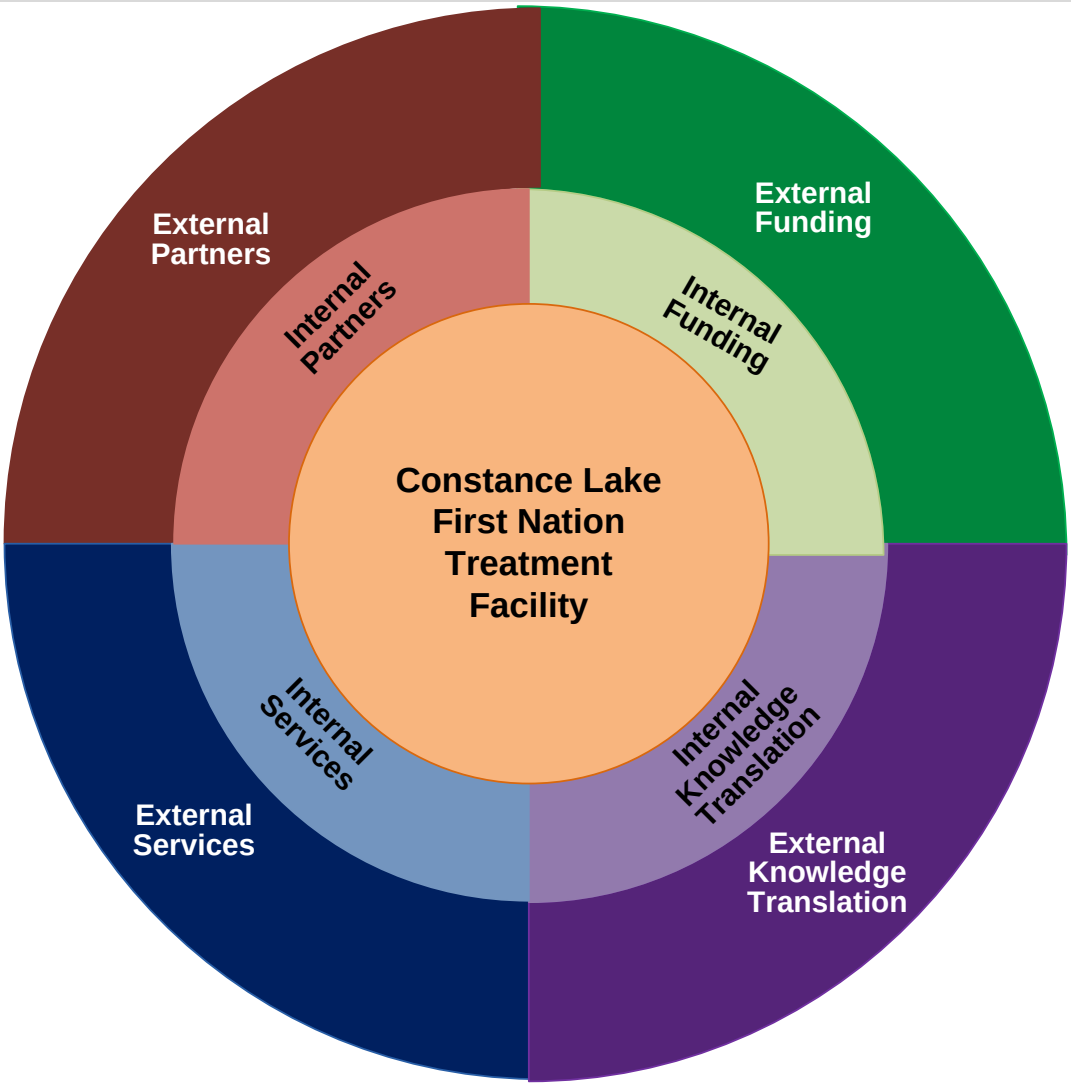
Locations issues were about distance from home (2) and on land in or near FN territory (2).

Populations to be served should include youth and women. It was mentioned that those who benefited most were those who came voluntarily and had external supports.

A more structured question about the importance of various types of program components shows that all but one were considered *very important* or *important* by 75% or more of the respondents.

- Counseling (*25 very important, 7 important, 0 somewhat important, 0 not important*)
- Discharge plan for home-community/after-care (21, 3, 4, 1)
- Psychological well-being (19, 10, 2, 0)
- Family unit healing (19, 9, 2, 1)
- Group work (17, 14, 1, 0)
- Multi-substance/dual addictions and process addictions (17, 13, 2, 0)
- Elder and spiritual supports (17, 12, 2, 0)
- Community stabilization (17, 8, 6, 0)
- Housing needs (16, 7, 7, 2)
- Life skills (15, 15, 2, 0)
- Nutrition (15, 14, 2, 0)
- Financial management (14, 11, 3, 3)
- Physical care (13, 15, 2, 1)
- Occupational counseling (13, 10, 5, 2)
- Physical fitness (11, 16, 3, 0)

Opportunities *for Service Integration for* Constance Lake First Nation



10. Opportunities for Service Integration

The data from this section comes from reported findings from surveys, health directors meetings as well as through communication and interviews with potential partnership groups. A list of key contacts and resources for strategic partnership building and service integration are provided in Appendix H.

10.1 *Setting the Stage*: Addictions is a Priority Area for First Nation, Provincial and Federal Governments

The time for addressing mental health and addictions in the province of Ontario is ripe. Three levels of government are currently developing and implementing strategies that target mental health and addictions.

- In September and November 2007, the **NAN chiefs** passed two resolutions. The first set out the chiefs' joint commitment to tackling the urgent issue of prescriptions drug abuse in their communities. In the second, the chiefs' resolved to support Constance Lake First Nation in establishing a proposal for an addictions treatment facility in their community. (See Appendices B and C)

- In June 2009, the **Chiefs of Ontario** released a report on "Ontario Region First Nations Addictions Service Needs Assessment"[2]. This report reiterated the current systemic inadequacies in addressing prescription drug treatment. The COO is also in the process of developing a regional Prescription Drug Strategy.

- In July 2009, the **MOHLTC** released a discussion paper "Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy"[3]. One of the primary goals of the strategy is to "provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex mental illnesses and/or addictions."

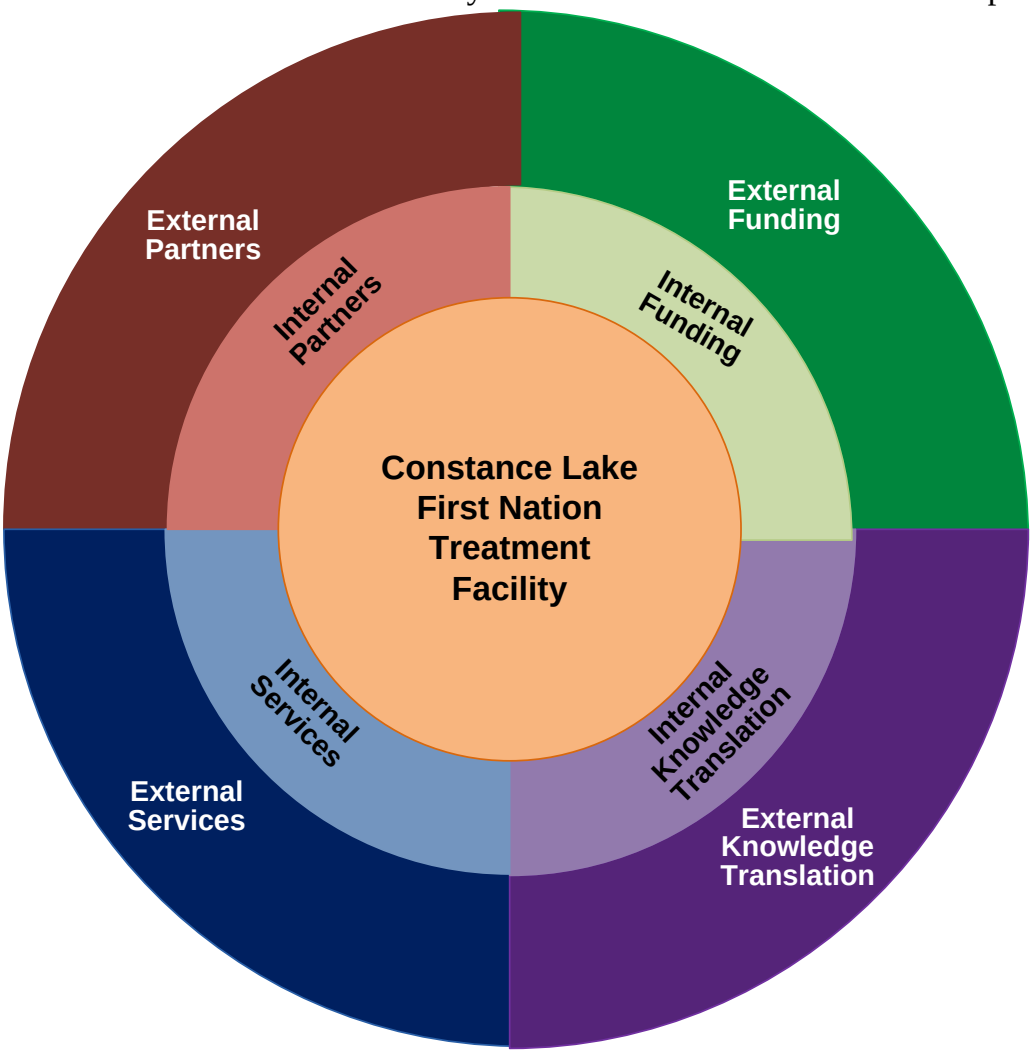
- In September 2010, the **NELHIN** will be releasing its own mental health and addictions framework.

[2] A copy of this report can be found at: http://chiefs-of-ontario.org/Assets/Final%20Addictions%20Services%20Needs%20Assessment%20w%20Appendices_june%208%2009.pdf.
[3] A copy of this discussion paper can be found at: http://www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/pdf/discussion_paper.pdf

- In Late 2010, the First Nations Addictions Advisory panel will be releasing the Renewed Program Framework for the NNADAP sponsored by the **Federal** National Anti Drug Strategy.[4]

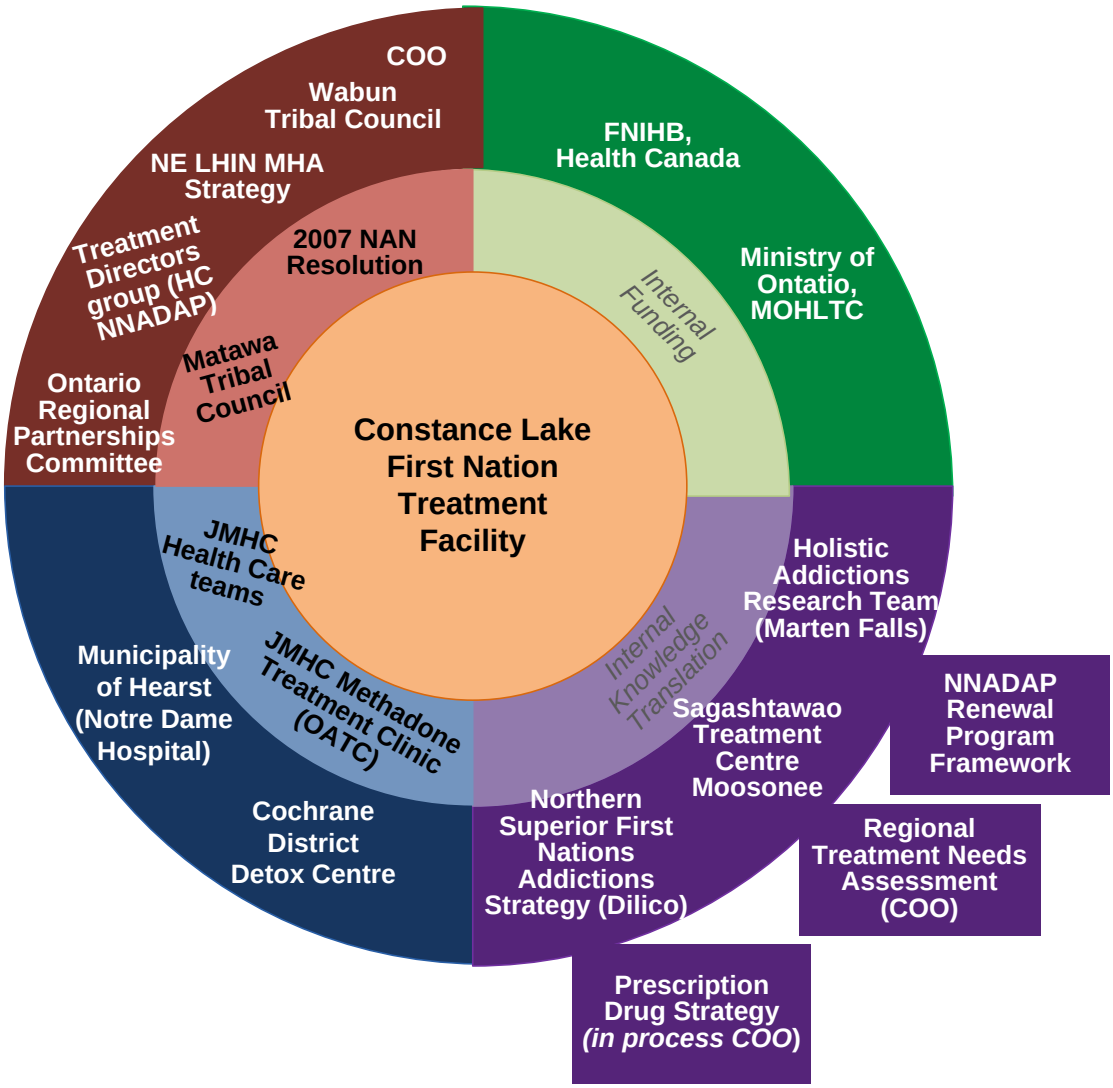
10.2 *Realizing the Vision:* Resources for Partnership, Services and Knowledge Translation for Optimal Integration of Services

The diagram below outlines the types of service integration resources that are available to Constance Lake First Nation. The focus is on delineating opportunities for strategic partnership, integrated service delivery, knowledge translation, and funding. Available resources are also organized based on their proximity to the community. For example, *internal* resources are located closest to Constance Lake First Nation in the inner sphere and *external* resources are located further away from Constance Lake on the outer sphere.



[4] More information on the NNADAP renewal process can be found on the following website: http://www.nnadaprenewal.ca/en/

While the diagram above provide the outline for a model of service integration resources available to Constance Lake First Nation, the model below places the various organizations and related resource names on the diagram. These resources are described in more detail following the next model.



10.3 Partnerships

The partners described below were ultimately supportive of a treatment facility in Constance Lake and expressed their willingness to support the project in any way possible. This list should be taken as a preliminary list of partners; it is likely that as a business plan develops new partners will be added to this initial list.

- **NAN Chiefs'** 2007 resolution provided the political support for Constance Lake First Nation and represents a first step in building partnerships with NAN communities. Further, the findings in this study demonstrate a high level of support among the NAN territory First Nations (76% of the surveyed health directors were supportive).

- **Matawa Tribal Council** − In a May 2010 meeting of the Matawa Tribal Council (which includes Constance Lake First Nation) Health Directors, all of the communities in the Tribal Council were supportive of a treatment centre in Constance Lake First Nation. Ginogming, Marten Falls, Neskantanga, Aroland and Nibnamik First Nations may represent good partners for Constance Lake as they move forward with their proposal. Not only do the health staff in these communities support Constance Lake's plan, but they also have a high level of interest in addressing substance abuse in their communities, utilizing varying and complementary initiatives/approaches.

- **Wabun Tribal Council**, is also interested in working with Constance Lake First Nation as they continue to develop their plan. These First Nations are geographically close to Constance Lake and primarily employ Community Health Representatives (CHR) and do not have health directors/centres in each of these communities; instead one health director stationed within the Wabun offices works with the CHRs.

- The **North East Local Health Integration Network** indicated that they would be willing to engage in 'relationship building' with Constance Lake First Nation to explore opportunities for service integration and meeting joint objectives. Given the focus on mental health and addictions at the provincial and LHIN level, a partnership between the LHIN and the Constance Lake is quite timely.

- The **treatment directors group**, supported by the FNIHB, is a group of treatment facility directors from 11 of Ontario's NNADAP. This group meets twice a year to report to FNIHB and network with other facilities. This group has invited Constance Lake First Nation to present on their proposal at the next meeting to be held November 16th-17th, 2010.

- **Ontario Regional Treatment Centres Partnership Committee** – this group, organized through the health coordination unit at COO, represents NNADAP workers working both in the community and in treatment facilities in Ontario. They provide perspective on the 'grassroots' issues surrounding provision of treatment. This is a critical partnership group as they represent workers who make referrals to treatment centres through the province. It currently has two NAN representatives. This group has also invited Constance Lake First Nation to present at their next meeting in January/February 2011.
- **Chiefs of Ontario –** may also represent a promising partnership for Constance Lake, as they have recently produced an addiction treatment needs assessment identifying prescription drug treatment as a primary need and are currently developing a prescription drug strategy.

10.4 Services

Constance Lake First Nation is also positioned to leverage and engage service providers within their local community.

- The **methadone clinic in CLFN** opened in 2005, it is operated by the Ontario Addiction Treatment Centres (OATC). Approximately 150 band members are currently receiving methadone treatment through the clinic. The Jane Mattinas Health Centre staff estimate that the methadone clinic will serve as a primary channel for referrals to the treatment centre. Further, the JMHC staff want to see the methadone clinic, in partnership with the CLFN treatment centre, develop a process for addressing treatment needs of clients when they enter into the treatment program while still taking methadone. At present, there is no formal partnership between the methadone clinic and the community, nor is there a community governance structure in place for the clinic. At the time of writing, we were waiting hear back from the Executive Director of the OATC to determine how Constance Lake First Nation can establish a service integration model between the clinic and the proposed treatment centre to ensure that services provided are complimentary and that the two work in partnership to provide the best possible treatment services.

- The **Jane Mattinas Health Centre**, located in the community, is currently in the process of developing Health care teams -- these teams are made up of health professionals (doctors, nurses, dieticians) within and outside of the community, as far as Toronto. Currently, the health centre is working to establish a psychiatrist as part of the care team to provide services in the community twice per month. These health care teams will support integrated care to Constance Lake First Nation members and will be a primary vehicle for referrals to the treatment centre. The health centre also supports a NNADAP worker and a mental health and crisis intervention worker.

- **Constance Lake Education Authority** – offers daycare, and education from Junior Kindergarten to Grade 12, as well as, evening classes for adult education in a school built in 2004. Resource sharing between the proposed treatment centre and the local school would be another piece of the service integration structure for the new treatment facility.

- Constance Lake First Nation **Kunumanio Child and Family Services** − provides child welfare services for community members and plays an important role in providing services for children of families dealing with addiction in the community. This would serve both as a referral source, but also as a post-treatment support. A data sharing arrangement should be established and signed by clients, allowing the centre to receive the treatment facility file and the treatment facility access to files for follow-up research purposes on results.

- **Notre Dame Hospital** in Hearst – is the closest hospital to CLFN, located about 30 minutes away, the CLFN has an established relationship with the hospital primarily through their home and community care program. The hospital is trying to become more responsive to Aboriginal clients and the community recently provided cultural sensitivity training to the staff. There are no detox beds in this facility.

- **Local Detox Services –** the closest detox facility to CLFN is Cochrane District Detox Centre in Smooth Rock Falls Hospital. Located approximately 150 kms from the community.

10.5 Opportunities for Knowledge Sharing

Through data collection efforts, a number of knowledge tools were identified to potentially support Constance Lake First Nation in developing their treatment facility proposal.

- **Marten Falls First Nation** currently has a holistic addictions research team in place in the community.
- **Dilico Anishnabek Family Care** –has developed a Northern Superior First Nations Addictions Strategy and accompanying toolkit.
- **Sagashtawao Healing Lodge** (Moosonee) − is a First Nations run treatment centre within a First Nation community offering residential treatment services for Aboriginal people living in Ontario. This is an accredited treatment facility with established partnerships between the treatment centre, the local health centre, and the community in general. This treatment centre is open to sharing information with Constance Lake and has invited Constance Lake to visit their facility to learn about their implementation and treatment process.
- **NNADAP Renewal Process** − working through First Nations Addictions Advisory Panel, a comprehensive review of the NNDAP programs is slated for completion in late 2010. This group had commissioned a number of research papers, needs assessments, and interviews to create a strategic vision for delivery of on-reserve addictions services over the next 5 to10 years.
- **The Chiefs of Ontario** have completed a regional addictions services needs assessment and are in the process of developing a prescription drug strategy.

10.6 Funding

This feasibility and needs assessment report will be followed by a treatment facility business plan, which will provide more concrete direction on funding needs and sources. Potential funding sources could include:

- Health Canada, First Nations and Health Branch, funded this feasibility study through the Aboriginal Health Transition Fund (AHTF) and were also supportive of Constance Lake First Nation developing a business plan; while there are no

guarantees of an available funding source at this time for a treatment facility.

- Given the MOHLTC's new investment funding into the Mental Health and Addictions strategy, and the recent activities initiated by the NE LHIN, there are opportunities available that could result in secured funding through the MOHLTC in partnership with the NE LHIN.

10.7 *First Steps*: Strategies for Partnership Development and Service Integration

The following strategies are intended to be an initial step in ensuring that service integration and resource sharing are incorporated into the treatment facility proposal at an early stage of development. Setting up a foundation of collaboration is key to ensuring community involvement, as well as anticipating barriers and challenges.

1. Obtain **letters of support** from the surrounding First Nations communities/tribal councils and the NE LHIN for Constance Lake First Nations' proposal to open a First Nations prescription drug treatment facility.

2. Initiate/form a **local strategic networking group** comprised of local leadership, Jane Mattinas Health Centre, the CLFN Education authority, CLFN Child welfare Centre, the CLFN methadone clinic, and Notre Dame Regional hospital to determine strategies and areas for collaboration between the community services and the proposed treatment facility.

3. Initiate a formal process of **relationship building with the NE LHIN** to explore alignment of the proposal with the MOHLTC's MHA strategy and the NE LHIN's strategy for potential funding partnerships.

4. Explore networking opportunities through the **treatment director's group** and Ontario's **Regional Partnerships Committee** by meeting with the groups at upcoming meetings.

5. Set up a **business plan steering committee** to formalize partnerships and guide the development of the treatment centre in partnership with surrounding communities and organizations. Membership could include: Community leaders, Jane Mattinas Health Centre, Tribal Councils, NAN, NELHIN, and the Ontario Association of Treatment Centres (OATC), and local/regional expert advisors.

6. Initiate a **technical sub-steering committee** to oversee business and treatment aspects of the business plan proposal. Members of this committee would possess either a management background and or technical expertise in addictions treatment and or operation of a treatment facility.

Strengths *of* Constance Lake First Nation Proposal *for* Meeting Unmet Needs *with* Effective Treatment Model

11. Strengths of Constance Lake

There has been overwhelming political and local First Nation support expressed in support of the Constance Lake First Nation operating a treatment centre that services primarily the NAN territory with a strong focus on prescription drugs, as well as providing detoxification, treatment, maintenance, and aftercare services within one facility. Further Constance Lake has been a leader in initiating solutions to address increased use of prescription drugs within First Nations communities. It was the first in Canada to open a Methadone Clinic within a First Nation. Every Health Director within the Matawa First Nations Tribal Council and 76% of the NAN territory First Nation respondents stated they would definitely refer their band members to the First Nation operated and controlled facility, indicating that distance and location were either reasonable or not a concern.

11.1 Chiefs of Ontario and Nishnawbe-Aski Nation Resolutions and Chief's Forums

In 2007, Chief's and Tribal Council's within the NAN territory expressed their commitment to addressing prescription drug abuse in their communities through two separate resolutions, including naming Constance Lake First Nation as a host for new treatment centre facility in the North. Further a Chief's Forum in 2009 developed a NAN territory strategy for addressing the prescription drug abuse crisis.

In resolution 07/07 passed in September 2007, the Chiefs of the Sioux Lookout Zone and the Paadwigong Tribal Council (Dryden Area Treaty 3) resolved to support the NAN and the Grand Council of Treaty 3 to hold a Chief's Forum on social issues around the use of prescription drug abuse in their communities. Through this resolution, the Chiefs also mandated the NAN and Treaty 3 develop a political action strategy to deal with the increasing prevalence of prescription drug abuse. For a copy of the resolution see Appendix C.

In Resolution 07/88 passed in November 2007, the Chiefs of the NAN territory resolved to support a treatment centre in Constance Lake First Nation. Their support stems in part from the increasing awareness of the problem of prescription drug abuse in First Nation communities. The Chiefs supported the development of a regional treatment facility located in Constance Lake First Nation with services to include detoxification, treatment, maintenance, and aftercare in one facility. For a copy of the resolution see Appendix B.

On February 10-12, 2009, a Chiefs' Forum was held in the NAN territory. The forum brought together community members, community leaders, health service providers, government officials, the Ontario Provincial Police, local Aboriginal organizations, substance abuse treatment operators, and local airlines to "develop regional and community based strategies to address the social issues related to the increased usage of manufactured intoxicants within the communities" (p.3).

The group identified the following needs in addressing prescription drug abuse in the North:

- Better collaboration and cooperation between the police, leaders, Elders, resource workers, crisis counselors, and health care professionals.
- Improved leadership -- community public policy on dealing with substance abuse, drug dealing and drug access. More treatment facilities that are culturally appropriate as well as improving pre- treatment services to include detoxification.
- Increased support for mental health promotion including increased opportunities for safe and healthy recreation particularly for youth.
- Leveraging the 'natural helpers' within our communities to help tackle the issues at hand.
- Engaging youth.

The group also identified challenges in addressing substance abuse in the north:

- Lack of treatment facilities that deal specifically with prescription drugs.
- Lack of funding.
- Issues with leadership not 'cracking down' on community substance problems.
- Lack of education and training opportunities for community level workers.
- Socioeconomic factors at the community level – low education attainment, lack of economic opportunities, lack of community recreation resources, etc.
- Lack of continuity of care between community program staff and health service providers.

11.2 Synchronization with an Effective Treatment Model

11.2.1 Progressive Leader in Substance Abuse and Prevention Programming

Currently, the Jane Mattinas Health Centre (JMHC) offers a substance abuse and prevention program for the members of Constance Lake First Nation. In 2006, due to demand for a substance abuse treatment program as a result of increased prevalence of drug addictions in the Constance Lake First Nation (CLFN) community, the first on-reserve methadone clinic in Canada was established at JMHC.

The present Methadone Maintenance Program offered at JMHC is based on an Outpatient Harm Reduction Model which aims to reduce harm related to drug use among opiate dependant clients (Ontario Addiction Treatment Centres, 2009). In partnership with the Ontario Addiction's Treatment Centre network, it was anticipated that the location and availability of the methadone clinic within the CLFN would contribute to the overall goals of the OATC to reduce the rate of drug addiction and work to promote healthier, prosperous communities abroad. Methadone is a temporary solution that is not accompanied by a wholistic model of support and treatment that would otherwise be provided by a First Nation controlled and operated treatment centre with in-community post-treatment supports.

11.2.2 Existing Building and Structure

The proposed site for the development of a drug treatment facility is the *Eagle's Earth* facility located on the shores of Shekak River, 45 minutes west of Hearst and 20 minutes west of Constance Lake First Nation off of highway 11. The features of the Eagle's Earth facility include 11,000 square-feet in the main building, fully-equipped kitchen, craft store, convenience store, 20 cabins, parking, pow-wow ground, hiking trails, and plenty of workshop rooms that make it ideal to maintain the various planned treatment services. The facility was originally opened as a tourist facility and is currently being used as a short-term location to house and train northern chef students.

The extensive area coverage of the facility will allow for the physical separation of medical detoxification from actual treatment areas, as indicated in the needs assessment interviews. It has been mentioned time again that current wait times from detox to treatment is a significant barrier to obtaining treatment; thus it is imperative that those completing detox be seamlessly transitioned to treatment.

11.2.3 Land-Based Treatment

Furthermore, the surrounding landscape will support the treatment centre model that will provide clients the opportunity to participate in outdoor traditional activities such as sweat lodge, sweet grass, and pipe ceremonies as part of their healing process.

It has been emphasized by CLFN community members that the holistic drug treatment model of balancing the four dimensions of our selves (physical, mental, emotional, and spiritual) will optimize recovery and promote self as well as family-unit healing. According to these teachings of the medicine wheel, the combination of the treatment approach, location, and structure of the facility will allow clients to reconnect not only to the land, but with their culture and spirituality through participating in culturally appropriate therapeutic activities (Moore, 2010).

Furthermore, existing infrastructure of Eagle's Earth will support the establishment of start-up materials and equipment, communication lines, food, etc. Most importantly, the geographical location of the proposed drug treatment facility will allow for comprehensive and centralized service provision. This will eliminate the need for both clients and staff to travel to other locations to obtain services such as the Alcohol and Drug Assessment Tool; thus, clients will have access to all treatment options at one central location.

11.2.4 Aboriginal-Specific Care

Some patients not only have to receive care far from home, they rarely have the option of receiving Aboriginal-specific care as facilities of this stature are limited. As a result, Aboriginal clients often find themselves receiving mainstream care that is not optimal for their recovery. Research has shown that successful recovery cases are those that utilize cultural values and traditions in their treatment strategy (McCormick 2000). Hence, the program model strategy that is proposed for the treatment centre would be beneficial and effective for recovery of First Nations people seeking drug treatment in Constance Lake.

11.3 First Nations Support for Constance Lake as a Host Site

As mentioned previously, the location of Constance Lake is one of the major strengths of hosting a drug treatment facility. Presently, First Nation individuals seeking treatment often travel far distances to receive Aboriginal-specific drug treatment care. This can be an obstacle to treatment if individuals are not willing or unable to leave their families

and/or home communities for long periods of time. Further consequences of the insufficient supply of appropriate treatment facilities includes lost interest due to long waits for treatment and lack of accommodations for women/families with children.

Interviews conducted by Johnston Research Inc. revealed that 26 out of 34 communities asserted that they would refer band members to Constance Lake if a treatment facility was established. Furthermore, 10 of the communities reported that Constance Lake would be closer than currently utilized drug treatment facilities, 5 communities reported that it would be the same distance, 3 confirmed it was further away but could be overcome, and 3 reported that distance was not a factor. Therefore, 21 of the 26 communities not only supported the establishment of a Constance Lake drug treatment facility, they also maintained that the factor of distance was either beneficial or not sufficient to discourage them from referring patients to this location. Since the majority of community stakeholders have publicized their support for this initiative, the potential to partner with Constance Lake for post-treatment and aftercare support is promising.

11.3.1 Support within Matawa First Nations

The survey data suggest that all of the health service providers support the development of a treatment facility in Constance Lake. They felt that Constance Lake was a feasible distance for their members to travel to obtain treatment. Some of their comments include:

- "Yeah, I heard it [the treatment facility] may be at Eagles Nest-an ideal spot, beautiful and secluded."
- "We need a central location close by in our regional territory."
- "I fully support Constance Lake and I'm sure my community would too. This is a good thing; we need more Aboriginal treatment facilities."

None of the service providers expressed concern about a treatment facility in Constance Lake specifically. Concerns raised by the Health Directors centered on the potential impact that a local treatment facility would have on their community based funding, the level of priority that their community members would have in being admitted to the new facility and the overreaching hope that support for the treatment facility would not supplant the need to address the issues that underlie the substance abuse problems. In the words of one health director: "Today this issue is pills.

Tomorrow it will be something else. Let's not get hung up on the pills. We need to address the roots − pain in people's lives".

While all of the communities in the Tribal Council were supportive of a treatment centre, Ginogming, Marten Falls, Neskantanga, Aroland and Nibnamik may represent good partners for Constance Lake as they move forward with their proposal. Not only do the health staff in these communities support Constance's Lake's proposal, but they also have a high level of interest in addressing substance abuse in their communities, utilizing varying initiatives/approaches.

Two of the communities stated in either the health director's meeting or the survey that their communities were also looking into the feasibility of establishing a treatment facility in their community. These communities include: Neskantanga and Eabamatoong. The communities are at various stages of planning with Constance Lake being the farthest along in planning.

Appendix A:

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Appendix B:

NAN Resolution 07/88

Nishnawbe Aski Nation
ᐊᓂᔑᓇᐯ ᐊᐢᑭ ᐃᓅᑎᓂᒃᓴᐃᐧᐣ ᐅᑭᒪᐧᐃᐣ
100 Back Street, Unit 200, Thunder Bay, ON P7J 1L2
Tel: (807) 623-8228 Fax: (807) 623-7730 www.nan.on.ca

RESOLUTION: 07/88
SUPPORT FOR CONSTANCE LAKE TREATMENT CENTRE

WHEREAS Constance Lake First Nation and regional First Nations have been dealing with an epidemic of prescription and drug abuse for several years;

WHEREAS prescription and drug abuse is causing widespread health, social, and economic problems and risks for Constance Lake First Nation and regional First Nations;

WHEREAS a methadone treatment clinic has recently been set up to service the community of Constance Lake First Nation;

WHEREAS the methadone treatment clinic is only a temporary fix in relation to a major and long-standing problem;

WHEREAS the community of Constance Lake First Nation is seeking the support of Nishnawbe Aski Nation (NAN) First Nations to establish a regional treatment centre to include detoxification, treatment, maintenance, and aftercare programs in one permanent facility;

WHEREAS the proposed permanent facility will provide treatment programs and services regionally to all NAN members who require help;

THEREFORE BE IT RESOLVED NAN Chiefs-In-Assembly fully support the development of a Treatment Centre to be located in Constance Lake First Nation.

DATED AT TIMMINS, ONTARIO THIS 15th DAY OF NOVEMBER, 2007.

MOVED BY: Chief Arthur Moore, Constance Lake First Nation

SECONDED BY: Proxy Noah Ooshag, Nibinamik First Nation

CARRIED

Grand Chief **Deputy Grand Chief**

Appendix C:

Resolution 07/07: Chiefs Forum Document, p. 26

APPENDIX A

Sioux Lookout First Nations Health Authority
"IN PARTNERS **WITH** FIRST NATIONS TO DEVELOP FUTURE HEALTH CARE SYSTEMS"

P.O. Box 1300
61 Queen Street
Sioux Lookout, ON
P8T 1B8

Phone: (807) 737-1802
Fax: (807) 737-1076
Toll Free: 1-800-842-0681

SIOUX LOOKOUT ZONE CHIEFS MEETING

RESOLUTION 07/07

FORUM ON SOCIAL ISSUES

WHEREAS the Sioux Lookout Zone Chiefs in Assembly, receive representation from NAN and Grand Council of Treaty # 3 for political lobbying and advocacy;

WHEREAS the Sioux Lookout Zone Chiefs in Assembly have expressed concerns regarding the increasing level of social unrest within their communities;

WHEREAS the incidences related to manufactured intoxicant usage are increasing;

WHEREAS the Sioux Lookout Zone Chiefs in Assembly feel that a unified strategy is required to address many of these social issues;

THEREFORE BE IT RESOLVED that we, the Sioux Lookout Zone Chiefs in Assembly, mandate that NAN and Grand Council of Treaty # 3 work in collaboration to hold a Chiefs forum on social issues;

FURTHER BE IT RESOLVED that we, the Sioux Lookout Zone Chiefs in Assembly, direct the planners to include other stakeholders in the planning process (i.e. OPP, NAPS, NODIN, Tikinagan, NAN Legal Services, NNADAP, Spiritual Leaders etc.);

FINALLY BE IT RESOLVED that we, the Sioux Lookout Zone Chiefs in Assembly, mandate that NAN and Grand Council of Treaty # 3 develop a political action strategy to address these issues.

DATED AT SIOUX LOOKOUT, ONTARIO, THIS 5TH DAY OF SEPTEMBER, 2007

MOVED BY: _____
Chief Solomon Atlookan
Eabametoong First Nation

SECONDED BY: _____
Chief Donny Morris
KitchenuhmaykoosibInniuwug

Appendix D:

NAN Territory Approximate Population by Tribal Council and First Nation

Table D.1: NAN Territory Approximate Populations by Tribal Council and First Nation (2006-2008 data sources)

Tribal Council	Population on-reserve
Independent First Nations Alliance (3)	
Pikangikum	2,189
Muskrat Dam Lake	215
Lac Seul	807
Total	**3,211**
KO (6)	
Deer Lake First Nation	962
Fort Severn First Nation	503
Keewaywin First Nation	504
MacDowell Lake First Nation	21
North Spirit Lake First Nation	415
Poplar Hill First Nation	472
Total	**2,877**
Matawa First Nations (10)	
Aroland First Nation	300
Constance Lake First Nation	795
Eabametoong First nation	1353
Ginoogaming First Nation	168
Hornepayne First Nation	*not included in count* 0
Long Lac #58 First Nation	443
Marten Falls First Nation	321
Neskantaga First Nation	324
Nibinamik First Nation	333
Webequie First Nation	693
Total	**4,730**
Mushkegowuk Council (7)	
Attawapiskat First Nation	1756
Chapleau Cree First Nation	32
Fort Albany First Nation	2619
Kashechewan First Nation	1180
Missanabie Cree First Nation	188
Moose Cree First Nation	1606
Taykwa Tagamou Nation (New Post)	126
Total	**7,507**
Shibogama First Nations Council (5)	
Kasabonika Lake First Nation	932
Kingfisher Lake First Nation	466
Wapekeka First Nation	386
Wawakapewin First Nation	45

Tribal Council	Population on-reserve
Wunnumin Lake First Nation	532
Total	**2,361**
Wabun Tribal Council (6)	
Flying Post First Nation	0
Beaverhouse First Nation	158
Brunswick House First Nation	182
Chapleau Ojibwe First Nation	32
Matachewan First Nation	40
Mattagami First Nation	170
Total	**582**
Windigo First Nations Council (7)	
Bearskin Lake First Nation	440
Cat Lake First Nation	541
Koocheching First Nation	40
North Caribou Lake First Nation	764
Sachigo Lake First Nation	476
Slate Falls First Nation	183
Whitewater First Nation	90
Total	**2,534**
Unaffiliated Bands (5)	
Mishkeegogamang First Nation	1054
Mocreebec Council of the Cree Nation	950
Sandy Lake First Nation	2351
Weenusk/Peawanuk First Nation	261
Wahgoshig First Nation	137
Total	**4,753**
Grand-Total	**28,555**

Table D.2: Sources for the First Nation Population Provided Above

Community Name	Population Source
Aroland	Nishnawbe Aski Nation (2010). Community Profile: Aroland. [Electronic version]. Retrieved May, 24, 2010 from http://www.nan.on.ca/upload/documents/ign-aroland.pdf
Attawapiskat	Five Nations Energy Inc. (n.d). Attawapiskat. [Electronic version]. Retrieved May 24, 2010, from http://www.fivenations.ca/attawapiskat.htm.
Brunswick House First Nation	Nishnawbe Aski Nation (2010). Community Profile: Brunswick House First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-brunswick-house-first-nation.pdf.
Deer Lake	Nishnawbe Aski Nation (2010). Community Profile: Deer Lake. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-deer-lake.pdf
Eabametoong First Nation	Nishnawbe Aski Nation (2010). Community Profile: Eabametoong First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-eabametoong.pdf
Fort Albany First Nation	Nishnawbe Aski Nation (2010). Community Profile: Fort Albany First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-fort-albany-community-profile.pdf
Fort Severn First Nation	Nishnawbe Aski Nation (2008). Community Profile: Fort Severn First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-fort-severn.pdf
Constance Lake First Nation	Constance Lake First Nation (2010). Constance Lake First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.clfn.on.ca/
Kasabonika First nation	Kasabonika First Nation (2009). Community Profile: Kasabonika First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.kasabonikafirstnation.com/index.php?pid=4
Keewaywin First Nation	Nishnawbe Aski Nation (2008). Community Profile: Keewaywin First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-keewaywin.pdf
Long Lac	Nishnawbe Aski Nation (2008). Community Profile: Long Lake #58 First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-long-lake--58.pdf
Marten Falls	Nishnawbe Aski Nation (2008). Community Profile: Marten Falls First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-marten-falls.pdf
Mattagami First Nation	Nishnawbe Aski Nation (2008). Community Profile: Mattagami First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-mattagami-first-nation-community-profile.pdf
Missanabie Cree	Indian and Northern Affairs Canada. Missanabie Cree First Nation Profile. [Electronic version]. Retrieved May 24, 2010, from http://fnpim-cippn.inac-ainc.gc.ca/index-eng.asp
Moose Cree First Nation	Moose Cree First Nation (2005). Community Profile: Population. [Electronic version]. Retrieved May 24, 2010, from http://www.moosecree.com/our_community/profile.html

Community Name	Population Source
Muskrat Dam First Nation	Nishnawbe Aski Nation (2008). Community Profile: Muskrat Dam First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-muskrat-dam.pdf
Nibinamik First Nation	Nishnawbe Aski Nation (2008). Community Profile: Nibinamik First Nation. [Electronic version]. Retrieved May 24, 2010, from http://www.nan.on.ca/upload/documents/ign-nibinamik.pdf
Neskantaga First Nation	Neskantaga First Nation (n.d.). Neskantaga First Nation community information. [Electronic version]. Retrieved May 24, 2010, from http://www.neskantaga.ca/
North Caribou Lake First Nation	Nishnawbe Aski Nation (2008) Community Profile: North Caribou Lake First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://www.nan.on.ca/upload/documents/ign-north-caribou-lake-first-nation.pdf
North Spirit Lake	Nishnawbe Aski Nation (2008) Community Profile: North Spirit Lake First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://www.nan.on.ca/upload/documents/ign-north-spirit-lake.pdf
Peawanuk/Weenusk First Nation	Nishnawbe Aski Nation (2008) Community Profile: Weenusk First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://www.nan.on.ca/upload/documents/ign-weenusk.pdf
Pikangikum First Nation	Nishnawbe Aski Nation (2008) Community Profile: Pikangikum First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://www.nan.on.ca/upload/documents/ign-pikangikum.pdf
Poplar Hill First Nation	Nishnawbe Aski Nation (2008) Community Profile: Poplar Hill First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNMain.aspx?BAND_NUMBER=190&lang=eng
Taykwa Tagamou Nation	Indian and Northern Affairs Canada (2008) First Nation detail: Taykwa Tagamou Nation. [Electronic version]. Retrieved May 24, 2010, from, http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNMain.aspx?BAND_NUMBER=145&lang=eng
Wapekeka First Nation	Indian and Northern Affairs Canada (2008) First Nation detail: Wapekeka First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNMain.aspx?BAND_NUMBER=206&lang=eng
Whitesand First Nation	Indian and Northern Affairs Canada (2008). First Nation detail: Whitesand First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNMain.aspx?BAND_NUMBER=190&lang=eng
Wunnimen Lake	Indian and Northern Affairs Canada (2008). First Nation detail: Wunnimen First Nation. [Electronic version]. Retrieved May 24, 2010, from, http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNMain.aspx?BAND_NUMBER=217&lang=eng

Appendix E:

Tables for Constance Lake First Nation Resident Survey

Table E.1: Resident Survey Data from 2010 Constance Lake First Nation Community Survey, N= 159

Describing the Respondents to the 2010 CLFN Resident Survey	Total	Breakdown within Males	Breakdown within Females
Gender			
Female	51%		
Male	49%		
First Nation	99%		
Age			
Aged 15-24	31%	29%	34%
Aged 25-34	31%	31%	31%
Aged 35-44	19%	22%	14%
Aged 45-54	13%	15%	12%
Aged 55-64	6%	3%	9%
Marital Status			
Married / Common Law	44%	42%	43%
Divorced / Widowed	2%	0%	5%
Separated	5%	4%	6%
Single	49%	54%	46%
Educational Attainment			
Graduated High School	21%	21%	21%
Completed Trade School	13%	20%	5%
Completed College	3%	3%	4%
Complete University	1%	0%	1%
Completed Training	6%	5%	8%
Currently Employed			
Currently working	20%	23%	19%
Median hours per week	35	40	35

Describing the Respondents to the 2010 CLFN Resident Survey	Total	Breakdown within Males	Breakdown within Females
Labour Force Participation			
In the Labour Force	36%	48%	25%
Employed	28%	36%	20%
Unemployed	8%	12%	5%
Not in the Labour Force	63%	59%	67%
Income Characteristics			
Median Income			
Employed Income	25%	32%	19%
Government Assistance Income	59%	55%	63%
Other Income	7%	8%	5%
Sources of Income			
Have Paid Employment	25%	32%	19%
Self-Employment	3%	4%	1%
Receive Employment Insurance	8%	12%	5%
Social Assistance	45%	44%	46%
ODSP	9%	8%	10%
Canada Pension or other	4%	0%	7%
GIS or Spouse Allowance	1%	3%	0%
Other income	4%	4%	4%

Respondent Housing Needs	Total	Breakdown within Males	Breakdown within Females
Overcrowded homes *(National Occupancy Standards)*	33%	31%	35%
Mean number of rooms per household	5.5	5.49	5.46
Mean number of persons per room	0.80	0.85	0.76
Dwellings with more than one person per room -- as a % of total occupied private dwellings	23%	23%	22%
Proper and working bathroom	80%		
Working fire extinguisher	50%		
Phone with service	45%		
Computer	52%		
High-speed Internet connected	43%		
Refrigerator and Stove	97%		
Generator	10%		
Cable / Satellite Television	69%		
Homes needs modification due to health issues	19%		
Modifications are required to doors and hallways	31%		
Home requires ramps	9%		
Modification is required to bathroom	29%		
Modification is required to kitchen	20%		
Home needs alerting devices	30%		
Home needs major repairs	28%		
Home needs minor repairs	22%		
Main water supply is safe to drink	9%		
Water is often contaminated	70%		

Respondent Personal Experiences and Opinions	Total	Breakdown within Males	Breakdown within Females
Parent/Grandparent attended Residential School	61%	57%	63%
Health Negatively affected by Intergenerational or direct impact of Residential School	30%	31%	32%
Personal or parental health Negatively affected by other traumatic experience	35%	36%	35%
Difficulty hearings, seeing, communicating, walking, climbing stairs, bending, learning, or doing other similar activities	Often: 8% Sometimes: 20%	Often: 9% Sometimes: 13%	Often: 8% Sometimes: 26%
Physical or mental condition reduces the amount of work done:			
at home	Often: 6% Sometimes: 16%	Often: 5% Sometimes: 15%	Often: 6% Sometimes: 19%
at work or school	Often: 4% Sometimes: 13%	Often: 3% Sometimes: 15%	Often: 6% Sometimes: 14%
at other environments	Often: 7% Sometimes: 15%	Often: 7% Sometimes: 13%	Often: 7% Sometimes: 19%
Difficultly in all four areas mentioned above.	10%	9%	10%
Agree or Strongly Agree:			
he/she can solve his/her problems	64%	64%	69%
no one pushes him/her around	62%	62%	67%
he/she has control over things that happen to his/her self	65%	68%	65%
he/she can do anything he/she sets her/his mind towards	74%	80%	74%
he/she often feels helpless in dealing with problems	35%	33%	37%
happens to him/her in future mostly depends on him/her	72%	70%	78%
there is little he/she can do to change the important things in his/her life	38%	47%	34%

Respondent Personal Experiences and Opinions	Total	Breakdown within Males	Breakdown within Females
Believes it is a often major problem in CLFN:			
Suicide	11%	6%	15%
Unemployment	71%	65%	80%
Family violence	31%	15%	47%
Sexual abuse	23%	15%	31%
Drug abuse	72%	64%	80%
Alcohol abuse	53%	39%	65%
Prescription medicine abuse	72%	63%	81%
Gang violence	15%	11%	17%
Poor housing conditions	57%	51%	62%
Very Often looks towards others for someone he/she can:			
Count on to listen when needed	21%	16%	27%
Count on for advice	16%	10%	21%
Rely on to go to the doctor or nurse	25%	25%	25%
Rely on for love and affection	36%	32%	41%
Have a good time with	37%	27%	46%
Confide in about his/her problems	26%	25%	28%
Get together and relax with	27%	23%	31%

Health Behaviours	Total	Breakdown within Males	Breakdown within Females
Healthy behaviours/ situations:			
Good home	61%	53%	67%
Sleep/ proper rest	60%	56%	66%
Happy/ content	58%	51%	66%
Regular exercise/ sports	55%	54%	54%
Social supports	51%	44%	56%
Good diet	49%	46%	52%
Transportation to health care	43%	39%	46%
In balance	37%	32%	40%
Reduced stress	33%	30%	37%
Unhealthy behaviours/ situations:			
Insufficient transportation to health care	20%	21%	18%
Poor social supports	20%	18%	20%
Lacking balance	24%	22%	24%
Unhappy/ discontent	26%	25%	25%
Poor housing	26%	23%	29%
Poor sleep/ improper rest	31%	27%	33%
Little or no exercise	35%	34%	35%
High stress	38%	39%	35%
Poor diet	40%	35%	43%

A variable was created to reflect the concerns of health directors interviewed, in that prescription drugs were reported as an increasing concern and the use of beer remained a concern. The variable reported below as *Frequency of Prescription Drug and/or Beer Binging* was created as follows:

- **Extreme Problem User** included residents that both used prescription drugs and drank five or more beers at any one sitting more than once a month.
- **Problem User** included residents that used prescription drugs or drank five or more beers at any one sitting more than once a month.
- **User** was defined by residents that used prescription drugs and/or drank five or more beers at any one sitting less than once a month, but at least more than once a year.
- **Non-User** included those that reported never using prescription drugs and/or drinking five or more beers at any one sitting.

Females were more likely to be non-users than males (53% of women versus 30% of men). Where 4% of females were extreme problem users (EPU), 11% of men were EPUs. Over a third of EPUs (36%) were youth, aged 15-24 and almost half of problem users (48%) were youth aged 15-24, and 34% of users were 15-24. No one above 44 was an EPU and no one above 54 was a problem user. Users were aged up to 64 years. However, 70% of those aged 45-54 were non-users and 80% of those aged 55-64 were non-users.

Risk Behaviours: Substance Use in Past Year	Total	Breakdown within Males	Breakdown within Females
Severity of Substance Use by Frequency:			
Never	14%	10%	18%
Rarely (1-5x yr)	17%	18%	16%
Sometimes (~2x mo)	10%	12%	9%
More than 2x mo	59%	60%	57%
Frequency of Prescription Drug and/or Beer Binging			
Non-User	42%	30%	53%
User	31%	36%	28%
Problem User	20%	24%	15%
Extreme Problem User	7%	10%	4%

Sold any drugs in the past 6 months: 22 yes (14%)
Money went to: gang (2), personal (10), family (10), friends (1).

In terms of ever attended a treatment centre over half of EPUs had never attended (55%). Just about as many or problem user had never attended (58%) and 72% of users never

attended. Among non-users, 18% had attended a treatment centre at least once in their lifetime.

Health Status and Conditions	Total	Breakdown within Males	Breakdown within Females
Health Self Assessment: 39			
Excellent	11%	9%	12%
Very good	6%	7%	5%
Good	2%	3%	1%
Fair	6%	5%	6%
Poor	4%	4%	4%
Dk/na	1%	0%	1%
Long-term conditions (% yes)			
High blood pressure	23%	21%	23%
Asthma	20%	25%	14%
Allergies	19%	15%	22%
Type 2 Diabetes	11%	6%	13%
Type 1 Diabetes	9%	2%	14%
Stomach problems or intestinal ulcers	8%	2%	12%
Borderline or Pre-diabetes	6%	14%	2%
Heart problems	6%	11%	2%
Chronic bronchitis	5%	2%	7%
Cancer	5%	2%	6%
Effects of a stroke	3%	2%	4%
Emphysema	1%	2%	0%
Kidney disease	1%	2%	0%
Tuberculosis	1%	2%	0%
Liver disease, excluding Hepatitis	0%		
Hepatitis	0%		
HIV	0%		
AIDS	0%		

Health Care Usage and Satisfaction	Total	Breakdown within Males	Breakdown within Females
Frequency of health care utilization in past year (% very often):			
Family doctor	11%	9%	12%
JMH Centre	8%	4%	13%
Hospital	6%	7%	5%
Dentist	6%	5%	6%
Nurse	4%	4%	4%
Traditional healer	3%	1%	4%
Traditional ceremonies	3%	1%	4%
A crisis shelter	3%	3%	4%
(Call a) 1-800 crisis line	3%	5%	1%
Specialist	2%	3%	1%
Community Health Nurse	2%	1%	3%
Native treatment program	2%	3%	1%
Mainstream treatment centre	1%	1%	1%
Counselling	1%	1%	1%
Alternative health	1%	0%	1%
Outpatient treatment program	1%		
NNADAP worker	0%		
How often leave Constance Lake First Nation to get health care:			
Every time	13%	12%	14%
Most of the time	16%	14%	19%
Some of the time	27%	29%	25%
Hardly ever	23%	22%	25%
Never	12%	9%	14%
Dk/na	8%	14%	2%
How often leave Constance Lake First Nation to get treatment or crisis help:			
Every time	10%	12%	6%
Most of the time	3%	3%	4%
Some of the time	8%	9%	8%
Hardly ever	17%	14%	21%
Never	49%	47%	52%

Dk/na	12%	16%	9%
Overnight patient:			
Yes	18%	9%	26%
No	69%	72%	65%
Dk/na	14%	19%	9%
Treatment Centre for Addiction:			
Yes	28%	29%	25%
Type:			
Prescription drugs	13%	14%	10%
Street drugs	12%	9%	14%
Alcohol	10%	8%	13%
Gambling	1%	0%	1%
In past 5 years:			
Yes	22%	23%	21%

Treatment/Crisis Care Barriers and Preferences	Total	Breakdown within Males	Breakdown within Females
Factors Affecting Respondent's Access:			
Transportation	30%	36%	24%
Don't trust workers	18%	8%	28%
No Services Available	10%	8%	11%
No support at home	9%	9%	9%
Can't leave work	6%	5%	6%
Workers not qualified	5%	3%	6%
Language barriers	2%	1%	2%
Needed to make access easier (Strongly agree):			
Support programs for children	32%	24%	39%
More programs outside of work hours	31%	23%	38%
Prevention programs	31%	22%	38%
Support programs for parents	29%	20%	38%
More information on programs	27%	19%	32%
Transportation	27%	23%	29%

Treatment/Crisis Care Barriers and Preferences	Total	Breakdown within Males	Breakdown within Females
Counselors or psychologist available	26%	17%	34%
More workers to provide intake or help	22%	14%	28%
Type of aftercare programs preferred:			
Fun nights	62%	49%	73%
Workshops	57%	44%	70%
Children/Youth programs	54%	31%	76%
Education programs	43%	35%	51%
Relapse prevention	41%	34%	47%
AA/NA/DA meetings	36%	29%	42%

Health Care Satisfaction	Total	Breakdown within Males	Breakdown within Females
Satisfaction with health care in Constance Lake First Nation:			
Very satisfied	5%	5%	4%
Satisfied	52%	53%	50%
Somewhat satisfied	24%	23%	26%
Unsatisfied	4%	4%	4%
Very unsatisfied	3%	4%	1%
Dk/na	12%	10%	14%
Satisfaction with health care in Hearst:			
Very satisfied	8%	10%	6%
Satisfied	39%	42%	36%
Somewhat satisfied	30%	29%	31%
Unsatisfied	9%	6%	12%
Very unsatisfied	5%	6%	4%
Dk/na	9%	8%	10%

Health Care Satisfaction	Total	Breakdown within Males	Breakdown within Females
Satisfaction with treatment and crisis care in Constance Lake First Nation:			
Very satisfied	5%	3%	7%
Satisfied	25%	28%	22%
Somewhat satisfied	25%	21%	30%
Unsatisfied	10%	11%	8%
Very unsatisfied	3%	4%	1%
Dk/na	32%	33%	31%
Satisfaction with treatment and crisis care in Hearst:			
Very satisfied	5%	5%	4%
Satisfied	20%	23%	17%
Somewhat satisfied	25%	25%	25%
Unsatisfied	10%	7%	11%
Very unsatisfied	2%	3%	1%
Dk/na	39%	37%	41%
Satisfaction with aftercare programs in Constance Lake:			
Very satisfied	5%	6%	4%
Satisfied	17%	16%	18%
Somewhat satisfied	29%	27%	31%
Unsatisfied	14%	12%	14%
Very unsatisfied	8%	8%	8%
Dk/na	28%	30%	26%

Appendix F:

Current Aboriginal Drug Addiction Treatment Approaches in Northern Ontario

Current Aboriginal Drug Addiction Treatment Approaches in Northern Ontario

Administrative executives at both the Muskrat Dam and Moosonee facilities were very supportive of another Aboriginal treatment facility. Both offered to host planners from Constance Lake to visit their facilities and learn about their processes. In words of advice, Sagashtawao emphasized the importance of accreditation in providing legitimacy and transparency for clients, funding sources and staff.

Across the board, the providers that we spoke to identified that the nature of addictions that they are coming across are changing. In the words of one staff member "the addictions are becoming more intense" with more people addicted to prescription drugs as well as other substances. Commonly identified treatment needs included: detox beds, treatment cycles and facilities for prescription drugs, services for women and families.

Common treatment challenges included transportation, funding, and communication after the client leaves treatment. Interestingly, neither Sagashtawao or Muskrat Dam felt as though getting clients to their remote locations was a problem. The only transportation challenge that was identified from a facility perspective was getting clients who do not complete treatment home. One facility identified staffing as a challenge.

Detailed results from the telephone interviews are as provided on the following pages.

Reverend Tommy Beardy Memorial Wee Che He Wayo- Gamik - Muskrat Dam

Muskrat Dam is a small First Nation community of approximately 300 residents in northeastern Ontario. The Reverend Tommy Beardy Memorial Wee Che He Wayo Gamik is a Native specific treatment centre that opened in 1991 and offers substance abuse treatment and healing for families. Their primary catchment is the NAN territory but they also offer treatment to clients from Ontario and Canada, space permitting. Core elements of their intake and treatment are presented in Table 7.1.

Staff identified that within recent years, the needs of their clients have changed. More clients are presenting with poly- substance abuse issues such as prescription drugs and alcohol. An estimate of half of the families treated this past year had prescription drug addictions along with alcohol addiction, was provided by the treatment centre staff person interviewed. She noted that this is more common among younger families, while older families typically present with alcohol only or alcohol and cannabis addiction.

This provides a challenge to their organization because the client needs are very different depending on the nature of the addiction. For example, the withdrawal period for prescription drugs is much different and takes a lot longer than alcohol addiction. Thus, it is important for them to detox before being admitted into the facility because the current program is geared for people who are ready for treatment. It can take a person with an addiction to prescription drugs up to 2 weeks of withdrawal management before they are ready for actual treatment.

Table F.1: We Che He Wayo Gamik- Family Treatment Centre- Muskrat Dam First Nation: Treatment Services, Best Practices and Challenges

Treatment Length	**6 weeks**
Caseload/Intake Schedule	6 intakes/year 4-5 families per intake (depending on family size)
Wait Times	Ranges from 2 weeks to 2 years depending on the number of cancellations and client readiness to attend
Services Offered	Physical care, psychological well being, family unit healing, poly substance support, nutrition, counseling, group work, spiritual support (Christian based), life skills training, community stabilization, discharge planning, limited aftercare. Participation in land-based activities- hunting, fishing and craft.
Services not provided	• Detoxification • Financial management • Limited physical activity • Occupational counseling • Short-term residential • In-patient after care • Limited aftercare
Transportation	• Cost covered by Non-Insured Health Benefits program. • Landing strip within the community allows clients to fly in.
Pretreatment	• Detoxification is recommended but not required.
Best Practices	• The isolation of the treatment facility results in fewer distractions for the clients. • All staff speak the local language and the clients feel more comfortable because it is in a First Nations community. • The fact that people come with their family provides continuity between the treatment and home environments. • Incorporation of traditional activities such as fishing and hunting is appreciated by many clients. • Strengthening aftercare and pre-treatment by incorporating video conferencing with community NNDAP and resource workers.
Treatment Needs	• Good collaborative relationships with the referral agent to support pre-treatment, aftercare, and community support • Detox facility • Facilities and treatment cycle that support prescription drugs specifically

Challenges	• Follow up has been difficult because:
	  ○ Not all communities have NNDAP workers
	  ○ They are currently getting video conferencing in place to support pre-treatment and follow up with the community NNDAP workers
	• Funding
	• Staff retention:
	  ○ Problematic because of a lack of housing and they do not offer benefits.
	  ○ Retention was better when housing was available in the community.

> *"The addiction and treatment is very different for prescription drug abuse and alcohol."*

Iris Addiction Recovery Centre for Women

The Iris addiction recovery centre for women is a non-Aboriginal specific treatment facility exclusively for women. It is the only program that offers residential treatment for women north of Toronto and east of Thunder Bay. They offer treatment services from women across the north and have many Aboriginal clients.

Staff identify that addictions are becoming more intense and more severe. They are noticing high levels of opiate addictions, many poly substance users, and increases in concurrent mental health issues. Anecdotally speaking, they are seeing that younger clients have been having a more difficult time completing treatment and staying sober. These clients are more likely to have addictions to oxycodone. .

In terms of treatment needs that are not currently being met, service providers reveal that there is:

- A lack of detox beds for women specifically – co-ed detox can be problematic as many of the women are dealing concurrently with issues of abuse.
- Youth have different treatment needs and the treatment methods currently used are not as successful.

Table F.2: Iris Addiction Recovery Centre for Women-Thunder Bay: Treatment Services, Best Practices and Challenges

Treatment Length	**5 weeks** **Aftercare Program- 4 months but can stay for 8 months**
Caseload/Intake Schedule	Can house up to 15 women at one intake.
Wait Times	4 months with some flexibility due to cancellation.
Services Offered	Physical care, psychological well being, family unit healing, poly substance support, nutrition, counseling, group work, life skills training. Community stabilization, discharge planning, limited aftercare.
Services not provided	• Detoxification. • Fianancial management. • Occupational counseling.
Transportation	*See challenges below.*
Pretreatment	• Detoxification is recommended but not required.
Best Practices	• HER Aftercare program. • Kwe Aftercare-follow up for Aboriginal women- 1 year follow up programs allows successful clients to come together and have a refresher residential week long support.
Treatment Needs	• Detox is not keeping clients long enough to get over the initial withdrawal (withdrawal for prescription drugs is different) • Women-specific detoxification beds.
Challenges	• Transportation is a central issue for Aboriginal clients as travel costs are not covered unless the treatment program is completed- this is especially difficult for young Aboriginal women who find it difficult to be away from their families. • Aboriginal clients do not have community support to fill out the Provincial Assessment Tool prior to entering treatment.

"Medical services won't pay for their way home unless they complete treatment. Some clients can't do it, especially the young ones, they want to go home and see their families."

Sagashtawao Healing Lodge

The Sagashtawao Healing Lodge is located in Moosonee on James Bay in northeastern Ontario. This treatment facility offers residential and aftercare addiction treatment services for Aboriginal men and women throughout Ontario. The Lodge is an accredited facility and has been open for 21 years. Consistent with comments from other facility operators, they recognize that the nature of addiction is changing. They are seeing more clients with poly addictions and are noticing that their clients are younger and more likely to be addicted to prescription drugs as well as alcohol, cannabis, crack, cocaine and or other illicit substances. Commonly abused prescription drugs are primarily analgesics or pain killers. When the facility opened, they mainly treated alcohol and non-prescription drug addictions. They are currently trying to determine how to adjust their programming to deal with the changing needs and addictive behaviors of their clients.

Table F.3: Sagashtawao Healing Lodge: Treatment Services, Best Practices and Challenges

Treatment Length	6 weeks 2 week follow up program
Caseload/Intake Schedule	Intake every 6 weeks and can accommodate up to 12 people
Wait Times	6-8 weeks for 6 week residential No waiting period for 2 week aftercare
Services Offered	Physical care, psychological well being, poly substance support, nutrition, counseling, group work, life skills training, physical fitness, community stabilization, discharge planning, limited aftercare.
Services not provided	• Family unit healing - are currently trying to expand • Detoxification • Treatment for people with concurrent mental health issues varies • They do not accept clients who are on mood altering medications. • Financial management • Occupational counseling
Transportation	• Clients come in by plane and by train.
Best Practices	• Partnerships – the Lodge partners with the community to provide clients with access to mental health services, community gyms, the community health centre and local hospital • Accreditation – accredited through Accreditation Canada – it provides operating standards and makes clients feel more comfortable with the services that they are getting • Incorporation of culture and ceremony- some staff speak Cree and they have found that ceremonies are helping the clients
Treatment Needs	• There is no specific residential treatment for young people and or families. • Specialized treatment for people with addictions to prescription drugs. There should be a different approach for prescription drugs because withdrawal is different. There should be more medical staff available to deal with prescription drug addictions.
Challenges	• Funding - they would like to expand their aftercare programming because the success rate is higher if an aftercare program is in place.

Appendix G:

CLFN Partnerships/Service Integration Contact List

Name	Community/Organization	Contact information	Details
Bruce Achneepineskum	Marten Falls First Nation	807-349-2697 HIGHBANK1221@aol.com	
Karen Pine Cheechoo	Senior Aboriginal/First Nation/Metis Advisor for the North EAST LHIN	Karen.PineCheechoo@lhins.on.ca (705) 840-2872 ext 217	September 15- NELHIN will release their MHA framework. Karen can be contacted for participation details
Jane Mattinas Healing Centre	Methadone clinic	705-463-2121 Rhonda Daiter (Ontario Addiction Treatment Centres)- info@oatc.ca	
	Dilico Anishnabek Family Care and Mental Health and Addictions *Longlac*	Longlac District Office 118 Forestry Road P.O. Box 509 Longlac ON P0T 2A0 (807) 876-2267	Northern Superior First nations Addictions Strategy and toolkit available on request
Rolanda Manitowabi Co-chair of: Treatment Directors group Chair of: Ontario Regional partnership Committee	Ngwaagan Gamig Recovery Centre Inc. Rainbow Lodge	PO Box 81 Wikwemikong, Ontario P0P 2J0 705-859-2324 rmanitowabi@ngwaagan.ca	**Treatment Directors group** meets November 16th and 17th, 2 2010. One month notice needed to be put on the agenda **Ontario Regional partnership Committee** conference Nov. 2-4 and meeting in January or February 2011
Collette Hookimaw	Sagashtawao Healing Lodge	Box 99 Moosonee Ontario P0L 1Y0 705-336-3450	Invitation to visit their treatment facility
Knowledge Sharing Resources			
NNADAP renewal Process		http://www.nnadaprenewal.ca/en	
MOHLTC 10 – year MHA Strategy		http://www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/pdf/discussion_paper.pdf	

Appendix H:

Feasibility Study Survey and Interview Tools

KEY INFORMANT INTERVIEW GUIDE
Other First Nation Community/Organization Respondents
(Health Director, NNADAP Worker, CHRs)

Date Completed: _____

Name of First Nation/Organization: _____

Name of Interviewer: _____

Current role _____ Length of time in current role: _____

Johnston Research Inc. is a First Nation owned and operated firm. We are under contract with Constance Lake First Nation to conduct a feasibility study for the establishment of a treatment centre. They are looking to understand your community's needs and gather your input into the design of such a treatment centre.

We will analyze your information we gather in a culturally-safe manner. This information will help not only the CLFN community but other individuals and families from other communities. All information will be kept confidential and used for statistical purposes only. While your participation is voluntary, your assistance is very important to ensure that the survey results depict an accurate picture.

We are grateful for the time and effort you are willing to put into this research.

1.0 Overall

1.1 **What role has the government played in the delivery of addiction referral and treatment programs and initiatives in your jurisdiction (First Nation)?**

Gov. role in FN	

1.2 In your opinion, what role <u>should</u> the government play in your jurisdiction (First Nation)?

Preferred government role in FN	

1.3 What is your understanding of the ideal "treatment centre" for First Nations people in your area (First Nation)?

Ideal 'treatment centre'	

2.0 Need for Treatment Services

2.1 Over the past year, what factors have driven the demand and the need for treatment services in your jurisdiction (First Nation), now and into the future?

Drivers	

2.2 Over the past year, what percentage of YOUTH band members in your jurisdiction (First Nation) said they wanted to go to a treatment?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

2.3 Over the past year, what percentage of ADULT band members in your jurisdiction (First Nation) said they wanted to go to treatment?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

2.4 Over the past year, what percentage of YOUTH band members in your jurisdiction (First Nation) actually attended a treatment centre?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

2.5 Over the past year, what percentage of ADULT band members in your jurisdiction (First Nation) actually attended a treatment centre?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

2.6 Over the past year, what percentage of YOUTH band members in your jurisdiction (First Nation) were named on a treatment centre waiting list (and were unable to attend)?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
☐ Or provide the actual number: _____ ☐ no answer

2.7 Over the past year, what percentage of ADULT band members in your jurisdiction (First Nation) were named on a treatment centre waiting list (and were unable to attend)?

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

2.8 Other explanation to the above questions

2.9 **How important are the following treatment centre services in your mind and how well would they help with substance abuse issues?** *(read for each row below).*

	1 - Very important 2 - Important 3 - Somewhat Important 4 - Not important 5 - Not at all important **Importance of service**	**How well any of these helped.**
Financial management		
Physical care		
Psychological well-being		
Family unit healing		
Housing needs		
Multi-substance/dual addictions and process addictions		
Nutrition		
Counselling		
Group work		
Physical fitness		
Elder and Spiritual Supports		
Life Skills		
Occupational counselling		
Community stabilization		
Discharge plan for home-community / After-care		

2.10 How well do the treatment centres you currently work with meet the following standards:

1 - Very well; 2 - Well; 3 - Somewhat well 4 - Not well; 5 - Very poorly	*Write 1 to 5 below*
Medical detox cycle	
Detox cycle	
Residential treatment cycle	
Short-term after-care cycle	
Traditional circles, sweats, and ceremonies	
Long enough program	
Providing follow-up supports to clients after they get back home	

2.11 What are the challenges for your jurisdiction (First Nation) in using treatment centre programs to meet the need for your band members? (Explain for: funding access; service delivery; timeliness of services; reporting requirements) What changes to the programs would you suggest?

Challenges in meeting need for treatment services	

3.0 Community Substance Issues

3.1 What factors are driving the use of substances in your jurisdiction (First Nation), now and into the future?

Drivers	

3.2 In your opinion, over the past year, what percentage of YOUTH band members in your jurisdiction (First Nation) were addicted to prescription drugs? Please provide your best educated guess.

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

3.3 In your opinion, over the past year, what percentage of ADULT band members in your jurisdiction (First Nation) were addicted prescription drugs? Provide your best educated guess.

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

3.4 Other explanation to the above questions

3.5 In your opinion, over the past year, what percentage of YOUTH band members in your jurisdiction (First Nation) were addicted to other substances? Please provide your best educated guess.

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

3.6 In your opinion, over the past year, what percentage of ADULT band members in your jurisdiction (First Nation) were addicted to other substances? Provide your best educated guess.

☐ None, 0% ☐ Under 10% ☐ Between 10-25%
☐ Between 25-40% ☐ Between 40-50% ☐ More than 50%
Or provide the actual number: _____ ☐ no answer

3.7 Other explanation to the above questions

3.8 How are these rates of substance abuse affecting your community's quality of life and/or health and safety? What changes, if any, would you suggest?

Community quality of life	
Band member health	
Band member safety	

3.9 What are the challenges for your jurisdiction (First Nation) in cleaning-up these substance abuse issues? Probes for any gang-related and drug dealing issues.

Cleaning-up substance abuse issues	

3.10 To what degree do various types of substance abuse issues exist in your area and how well are current programs and treatment centres able to help you address these issues?

	1 - Very Prevalent 2 - Prevalent 3 - Somewhat exists 4 - Exists a little bit 5 - Doesn't exist	1 - Very well 2 - Well 3 - Somewhat well 4 - Not well 5 - Very poorly
Alcohol		
Marijuana		
Cocaine		
Heroin		
Glue, aerosol cans, paints, sprays, gas		
Methamphetamines		
Ecstasy		
Needles		
Prescription drugs		
Over-the-counter drugs		
Perc/oxy		
Other substances: _____		

4.0 Treatment Services Capacity

4.1 What capacity does your jurisdiction (First Nation) have to meet your treatment centre needs? Do you...

	Yes/No	Please explain
Currently have a local native treatment centre (or plan to build one)		
Currently utilize another approach to assist with treatment needs locally (or have a plan)		
Have a training on implementing a comprehensive and successful after-care program when your membership returns home (or a plan for or want one)		
Have procedures for dealing with members when they quit a treatment centre early (or a plan for or want it)		
Other...(specify)		

4.2 Can you describe any challenges your area has faced in improving your local capacity?

4.3 **Can you describe any challenges your area has faced in accessing treatment centre programs**? (Possible probes: access to funds; timeliness of services; capacity of government representatives, transportation, your staff knowledge of options)

4.4 Over the past year, on average, how often has your jurisdiction (First Nation) referred band members to… *(put an* **X** *in selected column/rows below)*

	Daily	Weekly	Monthly	Bi-annually	Not at all
a Native treatment program					
a Mainstream treatment centre					
Counselling					
Traditional Healing					
Traditional ceremonies					
A mental health and addictions centre					
Outpatient treatment program					
A crisis shelter					
Call a 1-800 crisis line					
A Community Health Nurse					
A NNADAP worker					
Other: _____					

4.5 Is Constance Lake First Nation a reasonable and feasible distance for you to send your band members for treatment services?

4.6 How does the distance of Constance Lake First Nation compare to the various other treatment centres distances you have previously sent band members to and what other logistical issues may exist? (What would make it worthwhile, or why would they want to travel further away from a urban centre)

5.0 Other comments:

Do you have any further comments to make about the issues we've discussed? Would you like a copy of the report?

Thank you for the time and effort you took to participate in this survey.

INTRODUCTION

We have contracted an experienced First Nation owned and operated company to assist us with this research project. Johnston Research Inc. will analyze this information we gather in a culturally-safe manner. This information will help not only our community but other individuals and families from other communities. **All information will be kept confidential and used for statistical purposes only.** While your participation is voluntary, your assistance is very important to ensure that the survey results depict an accurate picture.

CONFIDENTIAL WHEN COMPLETED (remove cover)

Completed by: ☐ Telephone ☐ Visit to home ☐ In-person outside of home

Family Name:;	FINAL OUTCOME CODE
Given Name:	☐ Complete
Number and Street or lot and concession or exact location:	☐ Partial
Province or Territory:	☐ Not Aboriginal
P.O. Box No.:	☐ No contact
Postal code :	☐ Absent for duration of survey
Telephone Number:	☐ Language barrier (not official language)
Alternate Number:	☐ Unable to trace
	☐ Not eligible
	☐ Deceased
	☐ Refusal
	☐ Part refusal
	☐ Unusual / Special circumstances

Interviewer's Identification Number: _____

Interviewer's Signature: _____

A. IDENTIFICATION

1. Do any of your ancestors belong to any of the following Aboriginal groups?

	Yes	No	Don't Know	Refused
First Nation	☐	☐	☐	☐
Métis	☐	☐	☐	☐
Inuit	☐	☐	☐	☐

2. Are you...

- ☐ Status First Nation
- ☐ Non-status First Nation
- ☐ Métis
- ☐ Inuit
- ☐ Not First Nations, Métis, or Inuit
- ☐ Mixed of any above
- ☐ Don't know
- ☐ Refused

B. PERSONAL INFORMATION

3. Gender

- ☐ Male
- ☐ Female
- ☐ Refused

4. Approximate Age

☐ 18-24 years	☐ 45-54	☐ 75 +
☐ 25-34 years	☐ 55-64	☐ Refused
☐ 35-44 years	☐ 65-74	

5. Name of community where you currently live.

_____

6. Present marital status

☐ Married	☐ Common law	☐ Separated
☐ Divorced	☐ Widowed	☐ Single

C. EDUCATION

7. What is the highest grade that you have completed in elementary and secondary school?

☐ No Schooling

1 2 3 4 5 6 7 8

9 10 11 12 13

☐ Don't know ☐ Refused

8. Did you graduate from high school?

☐ Yes
☐ No
☐ Don't know ☐ Refused

9. Other than elementary and secondary grades, what education have you completed?

Check all that apply.

☐ Some trade, technical, or vocational school
☐ Some community college or CEGEP
☐ Some university
☐ Diploma or certificate from trade, technical or vocational school
☐ Diploma or certificate from community college, CEGEP, or university
☐ University degree
☐ Master's degree
☐ Earned doctorate (PhD)
☐ Other (such as training)
_____
_____
☐ Don't know
☐ Refused
☐ None

D. INCOME AND EMPLOYMENT

10. During the year ending December 31, 2009, did you receive any income from the following sources? *Specify for each income source.*

	Yes	No	Don't Know	Refused
Paid employment (wages/salary)	☐	☐	☐	☐
Earning from self-employment	☐	☐	☐	☐
Employment Insurance	☐	☐	☐	☐
Social assistance	☐	☐	☐	☐
Basic Old Age Security	☐	☐	☐	☐
Ontario Disability Support Program (ODSP)	☐	☐	☐	☐
workman's comp (WSIB)	☐	☐	☐	☐
Benefits from Canada or Quebec Pension Plan	☐	☐	☐	☐
Royalties, trusts and land claims payments	☐	☐	☐	☐
Guaranteed Income Supplement or Spouse's Allowance	☐	☐	☐	☐
Retirement, pensions, superannuation, annuities	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

11. Are you currently working for pay (wages, salary, self-employment)?

☐ Yes Go to 11.
☐ No Go to 12.
☐ Don't know
☐ Refused

12. On average, how many paid hours do you work per week?

____ ____ Number of hours

E. OTHER PERSONS IN THE HOUSEHOLD

13. How many children usually live in this household?

Include all children 15 or under who reside in the household at least half of the time (3-4 days a week). If none, mark "0".

___ ___ Number of male children ages 0 -5 years old

___ ___ Number of male children 6 - 15 years old

___ ___ Number of female children ages 0 -5 years old

___ ___ Number of female children 6 - 15 years old

☐ Refused

14. Including yourself, how many adults usually live in this household?

Include all adults, 16 years and over, who reside in the household at least half of the time (3-4 days a week).

___ ___ Number of couples/partners aged 16-64 years of age

___ ___ Number of couples/partners aged 65 years and over

___ ___ Number of single individuals aged 16-64 years of age

___ ___ Number of single individuals 65 years and over

☐ Refused

G. HOUSING FEATURES

15. When was your home built?

-- -- -- -- Year

☐ Don't know ☐ Refused

16. How many rooms are in your home? Include kitchen, bedrooms, living rooms, dining rooms and finished basement rooms. Do not count bathrooms, halls, laundry rooms and attached sheds.

1 2 3 4 5 6 7 8

9 10 11 12 13 or more

☐ Don't know ☐ Refused

17. How many bedrooms are in your home?

1 2 3 4 5 6 7 8

9 10 11 12 13 or more

☐ Don't know ☐ Refused

18. How many bathrooms are in your home?

1 2 3 4 5 or more

☐ Don't know ☐ Refused

19. Does your home have the following occupant options:

	Yes	No	Somewhat	Refused
A proper and working bathroom?	☐	☐	☐	☐
A working fire extinguisher?	☐	☐	☐	☐
A telephone with service?	☐	☐	☐	☐
A computer?	☐	☐	☐	☐
A high speed Internet connection?	☐	☐	☐	☐
A refrigerator (fridge)?	☐	☐	☐	☐
A stove for cooking?	☐	☐	☐	☐
A generator?	☐	☐	☐	☐
Cable or satellite television?	☐	☐	☐	☐
Garbage collection service?	☐	☐	☐	☐
Recycling collection service?	☐	☐	☐	☐
Green bin / organic waste collection service?	☐	☐	☐	☐

H. HOUSING NEEDS

20. Do you need modifications to your home as a result of a physical condition or health problem? (e.g., ramp, handholds in bathroom)

☐ Yes

☐ No

☐ Don't know

☐ Refused

38b. Does your home need:

	Yes	No	Don't Know	Refused
Modifications to doors or hallways?	☐	☐	☐	☐
Ramps?	☐	☐	☐	☐
Modifications to the bathroom?	☐	☐	☐	☐
Modifications to the kitchen?	☐	☐	☐	☐
Alerting devices?	☐	☐	☐	☐
Any other special features	☐	☐	☐	☐

21. Is this dwelling in need of repairs?
Major repairs include: defective plumbing or electrical wiring, structural repairs to walls, floors, ceilings, etc. Minor repairs include: missing or loose floor tiles, bricks, shingles, defective step, railing, siding, etc.

☐ Yes, major repairs
☐ Yes, minor repairs
☐ No, only regular maintenance is needed (painting, furnace cleaning, etc.)
☐ Don't know
☐ Refused

22. In the last 12 months, has there been mold or mildew in your home?
☐ Yes
☐ No
☐ Don't know
☐ Refused

23. Do you consider the main water supply in your home safe for drinking?
☐ Yes
☐ No
☐ Don't know
☐ Refused

24. Are there times of the year that your water is contaminated?
☐ Yes
☐ No
☐ Don't know
☐ Refused

25. Do you use any other sources of drinking water?
Ask about each. Mark all sources used.

- ☐ None other sources.
- ☐ Bottled water
- ☐ Water from another house
- ☐ Boiled tap water
- ☐ River, lake or stream
- ☐ Other: _____

K. WELL-BEING IMPACTS

"For the purpose of this survey, the term "Residential Schools" means the residential school systems attended by Aboriginal students which include residential schools run by religious orders, industrial schools, boarding schools, student residences, hostels and billets."

26. Did you, your parents or grandparents attend residential school?

- ☐ Yes — Go to 27.
- ☐ No — Go to 28.
- ☐ Don't know
- ☐ Refused

27. Do you believe that your overall health and well-being has been negatively affected by your, your parents or grandparents attendance at residential school?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

28. Did you, your parents or grandparents experience any other traumatic events that you feel have had a negative impact on your well-being?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

29. Do you have any difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activities?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No
- ☐ Don't know
- ☐ Refused

30. Does a physical condition or mental condition or health problem reduce the amount or the kind of activity you can do…

	Yes, often	Yes, sometimes	No	Don't Know	Refused
Home	☐	☐	☐	☐	☐
At work or school	☐	☐	☐	☐	☐
In other activities	☐	☐	☐	☐	☐

31. Choose 1 for *Strongly Disagree* and 5 for *Strongly Agree* for each of the following statements.

	Strongly Disagree	**Disagree**	**Neither Agree nor disagree**	**Agree**	**Strongly Agree**	*Don't know*	*Refused*
I can solve the problems that I have	1	2	3	4	5	*8*	*9*
No one pushes me around in life	1	2	3	4	5	*8*	*9*
I have control over the things that happen to me	1	2	3	4	5	*8*	*9*
I can do just about anything I really set my mind to	1	2	3	4	5	*8*	*9*
I often feel helpless in dealing with the problems of life	1	2	3	4	5	*8*	*9*
What happens to me in the future mostly depends on me	1	2	3	4	5	*8*	*9*
There is little I can do to change to many of the important things in my life	1	2	3	4	5	*8*	*9*

32. Do you believe that any of the following is a MAJOR Problem in the community of CLFN?

	Yes, often	Yes, sometimes	No	Don't know
Suicide?	☐	☐	☐	☐
Unemployment?	☐	☐	☐	☐
Family violence?	☐	☐	☐	☐
Sexual abuse?	☐	☐	☐	☐
Drug abuse?	☐	☐	☐	☐
Alcohol abuse?	☐	☐	☐	☐
Prescription medicine abuse?	☐	☐	☐	☐
Unemployment?	☐	☐	☐	☐
Gang violence?	☐	☐	☐	☐
Poor housing conditions?	☐	☐	☐	☐

33. People sometimes look to others for companionship, assistance, guidance or other types of support. Choose 1 for *Very Often* and 5 for *Never* for each of the following kinds of supports.

	Very Often	Often	Sometimes	Not often	Never	Don't know	Refused
Someone you can count on to listen to you when you need to talk.	1	2	3	4	5	*8*	*9*
Someone you can count on when you need advice.	1	2	3	4	5	*8*	*9*
Someone to take you to the doctor or a nurse if you need it.	1	2	3	4	5	*8*	*9*
Someone who shows you love and affection.	1	2	3	4	5	*8*	*9*
Someone to have a good time with.	1	2	3	4	5	*8*	*9*
Someone to confide in or talk about yourself or your problems.	1	2	3	4	5	*8*	*9*
Someone to get together with for relaxation.	1	2	3	4	5	*8*	*9*

34. Over the past year, how often have you…(Choose 1 -*Very Often* and 5 - *Never*)

	Very Often	Often	Sometimes	Not often	Never
See a family doctor	1	2	3	4	5
Go to the hospital for care	1	2	3	4	5
See a specialist	1	2	3	4	5
See a dentist	1	2	3	4	5
See a Nurse	1	2	3	4	5
Go to Jean Mattinas Health Centre	1	2	3	4	5
See a traditional healer	1	2	3	4	5
Go to ceremonies	1	2	3	4	5
Access alternative health care	1	2	3	4	5

35. How often do you need to leave Constance Lake First Nation to get health care?

☐ Every time ever ☐ Most of the time ☐ Some of the time ☐ Hardly

☐ Never ☐ Don't know ☐ Refused

36. How satisfied are you with the kind of health care you currently access in Constance Lake First Nation?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / Refused

37. How satisfied are you with the kind of health care you currently access in Hearst?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / Refused

38. How often would you prefer to access…(Choose 1 -*Very Often* and 5 - *Never*)

	Very Often	Often	Sometimes	Not often	Never
A family doctor	1	2	3	4	5
The hospital for care	1	2	3	4	5
A specialist	1	2	3	4	5
A dentist or orthodontist	1	2	3	4	5
A Nurse	1	2	3	4	5
Jean Mattinas Health Centre	1	2	3	4	5
A traditional healer	1	2	3	4	5
Ceremonies	1	2	3	4	5
Alternative health care	1	2	3	4	5
Chiropractor	1	2	3	4	5
Physiotherapist or occupational therapist	1	2	3	4	5
Social worker, counselor or psychologist	1	2	3	4	5
Eye doctor, such as an ophthalmologist or optometrist	1	2	3	4	5
Other medical doctor, such as surgeon, allergist or orthopedist	1	2	3	4	5

L. HEALTH IMPACTS

39. In general, would you say that your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

40. What things do you currently have that make you healthy?
Mark all that apply.

- ☐ Keeping a good diet (low fat, high fibre, fruits, vegetables, etc.)
- ☐ Getting regular exercise/ Active in sports
- ☐ Feeling reduced stress
- ☐ Feeling in-balance (physical, emotional, mental, spiritual)
- ☐ Having good social supports (family, friends, co-workers)
- ☐ Getting good sleep / Proper rest
- ☐ Feeling happy / content
- ☐ Have a good home to live in
- ☐ Having transportation to get to needed health care services
- ☐ Other: _____
- ☐ Don't know ☐ Refused

41. What things do you currently have that make you unhealthy?
Mark all that apply.

- ☐ Making poor dietary choices (high fat, low fibre, little fruits and vegetables, etc.)
- ☐ Doing irregular or no exercise/ Inactivity, no sports
- ☐ Having high stress
- ☐ Lacking balance (physical, emotional, mental, spiritual)
- ☐ Having poor social supports (family, friends, co-workers)
- ☐ Keeping poor sleep patterns / improper rest
- ☐ Feeling unhappy, discontent
- ☐ Having poor housing conditions
- ☐ Not having the transportation you need to get to health care services
- ☐ Other: _____
- ☐ Don't know ☐ Refused

42. In the past 12 months, have you been a patient overnight in a hospital, nursing home or convalescent home, health centre or nursing station?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

43. Have you been told by a doctor, nurse or other health professional that you have… (*if you answer yes, write the age you were diagnosed)*

	Yes	*Age Diagnosed*	No	Don't Know	Refused
Asthma?	☐		☐	☐	☐
Allergies?	☐		☐	☐	☐
Chronic bronchitis?	☐		☐	☐	☐
Emphysema?	☐		☐	☐	☐
Cancer?	☐		☐	☐	☐
Effects of a stroke?	☐		☐	☐	☐
High blood pressure?	☐		☐	☐	☐
Type 1 Diabetes?	☐		☐	☐	☐
Type 2 Diabetes?	☐		☐	☐	☐
Borderline or Pre-diabetes?	☐		☐	☐	☐
Heart problems?	☐		☐	☐	☐
Liver disease, excluding Hepatitis?	☐		☐	☐	☐
Stomach problems or intestinal ulcers?	☐		☐	☐	☐
Hepatitis?	☐		☐	☐	☐
Kidney disease?	☐		☐	☐	☐
Tuberculosis?	☐		☐	☐	☐
HIV?	☐		☐	☐	☐
AIDS?	☐		☐	☐	☐
Any other long term condition?	☐		☐	☐	☐

Over the past year, how often have you...

44. …Been drunk or high in public *(outside of your home or a friend's home)?*

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

45. ...Smoked a cigarette, even just a puff?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

46. ...Had more than a sip or two of beer, wine, or hard liquor *(for example, vodka, whiskey, or gin?)*

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

47. ...Had 2 or more alcoholic drinks at one time *(in a row, within a couple of hours)***?**

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

48. …Had 5 or more alcoholic drinks at one time *(in a row, within a couple of hours)***?**

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

49. …Used marijuana *(also called pot, hash, weed, reefer)* **to get high?**

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

50. …Used any form of cocaine *(including crack, powder, freebase)***?**

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

51. …Used heroin (also called smack, junk, China White)?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

52. …Sniffed glue, breathed the contents of aerosol spray cans, inhaled any paints/sprays/gas?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

53. …Used methamphetamines (also called speed, crystal meth, crank, ice)?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

54. …Used ecstasy (also called E or X)?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

55. …Used a needle to inject any illegal drug into your body?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

56. …Used prescription drugs to get high (such as morphine, anti-depressants, Oxycontin, Ritalin, painkillers, etc.)?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

57. …Used over-the-counter drugs to get high (such as Gravol, Tylenol, cold medication, etc)?

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

58. …Used any other drug to get high (please state which drugs)?

_____

☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ 6 to 9 times
☐ 10 to 19 times ☐ 20 to 29 times ☐ 30 to 39 times ☐ 40 + times

59. ...In the past 6 months, have you sold any drugs?

☐ Yes ☐ No
☐ Do Not Know ☐ No Response

60. ...If yes, did the money go to:

☐ Benefit a Gang ☐ Personal Use ☐ Family ☐ Friends
☐ Do Not Know ☐ No Response

61. Over the past year, how often DID YOU go to...

(Choose 1 -*Very Often* and 5 -*Never*)

HAD GONE to	Very Often	Often	Sometimes	Not often	Never
a Native treatment program	1	2	3	4	5
a Mainstream treatment centre	1	2	3	4	5
Counselling	1	2	3	4	5
Traditional Healing	1	2	3	4	5
Traditional ceremonies	1	2	3	4	5
a CAMH centre	1	2	3	4	5
Outpatient treatment program	1	2	3	4	5
A crisis shelter	1	2	3	4	5
Call a 1-800 crisis line	1	2	3	4	5
See a Community Health Nurse	1	2	3	4	5
See a NNADAP worker	1	2	3	4	5
Other: _____	1	2	3	4	5

62. How often would you LIKE TO go to…

(Choose 1 -*Very Often* and 5 -*Never*)

Would LIKE to go to	Very Often	Often	Sometimes	Not often	Never
a Native treatment program	1	2	3	4	5
a Mainstream treatment centre	1	2	3	4	5
Counselling	1	2	3	4	5
Traditional Healing	1	2	3	4	5
Traditional ceremonies	1	2	3	4	5
a CAMH centre	1	2	3	4	5
Outpatient treatment program	1	2	3	4	5
A crisis shelter	1	2	3	4	5
Call a 1-800 crisis line	1	2	3	4	5
See a Community Health Nurse	1	2	3	4	5
See a NNADAP worker	1	2	3	4	5
Other: _____	1	2	3	4	5

63. How often do you need to leave Constance Lake First Nation to get treatment or crisis help?

☐ Every time ever ☐ Most of the time ☐ Some of the time ☐ Hardly

☐ Never ☐ Don't know ☐ Refused

64. Have you ever been to a treatment centre for an addiction?

If the answer is no, go to question 66.

☐ Yes ☐ No ☐ Refused

65. What type of addiction were you treated for when you attended treatment?

☐ Prescription Drugs ☐ Street Drugs ☐ Alcohol ☐ Gambling

☐ Don't know ☐ Refused

66. Did you attend this treatment centre in the last 5 years?

☐ Yes ☐ No ☐ Don't know ☐ Refused

If no, what year did you attend treatment? : _____

67. How satisfied are you with the kind of treatment or crisis help you currently have access to in the CLFN community?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / Refused

68. How satisfied are you with the kind of treatment or crisis help you currently have access to in Hearst?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / Refused

69. What factors play a part in your ability to access treatment or crisis help when you need it?

☐ Transportation ☐ No Services Available
☐ Don't Trust Workers ☐ Workers are not qualified
☐ Language Barriers ☐ No Support at home
☐ Can't access programs without leaving work
☐ Don't know ☐ Refused

70. What is needed to make accessing treatment services or crisis help easier? Choose 1 for *Strongly Disagree* and 5 for *Strongly Agree*.

	Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree	*Don't know*	*Refused*
Transportation	1	2	3	4	5	*8*	*9*
More workers to provides intake or help	1	2	3	4	5	*8*	*9*
More information programs	1	2	3	4	5	*8*	*9*
Counselors or psychologist available	1	2	3	4	5	*8*	*9*
Support programs for parents	1	2	3	4	5	*8*	*9*
Support programs for children	1	2	3	4	5	*8*	*9*
Prevention programs	1	2	3	4	5	*8*	*9*
More Programs outside of work hours	1	2	3	4	5	*8*	*9*
Other: _____	1	2	3	4	5	*8*	*9*

71. Are you satisfied with the type of aftercare programs available within Constance Lake for yourself or others?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / Refused

72. What type of aftercare programs would you like to see implemented or increased?

☐ AA/NA/DA meetings
☐ Education Programs
☐ Relapse Prevention
☐ Other:

_____

☐ Don't know / Refused

☐ Fun Nights
☐ Workshops
☐ Children/Youth Programs

WRAP-UP

73. Your answers were extremely helpful and will serve to work towards bettering your community? Is there anything else you would like to add?

☐ Yes _____
☐ No
☐ Don't know
☐ Refused