Evaluating the Continuum of Prescription Drug Abuse Recovery in Matawa First Nations

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LIST OF ACRONYMS

CRaNHR	Centre for Rural and Northern Health Research, Lakehead University
MOHLTC	Ministry of Health and Long-Term Care
MHSSTG	Mental Health and Social Services Task Group
NNADAP	National Native Alcohol and Drug Abuse Program
OATC	Ontario Addiction Treatment Centres
OMHF	Ontario Mental Health Foundation
PDAM	Prescription Drug Abuse and Misuse
REB	Research Ethics Board

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Once the study was underway, Health Directors and Program Coordinators in the nine Matawa First Nations – Aroland, Constance Lake, Eabametoong, Ginoogaming, Long Lake #58, Marten Falls, Neskantaga, Nibinamik, and Webequie – played key roles in assisting us. They attended several meetings to share information about the progress of their programs, goals, objectives, and future plans, and helped to arrange community site visits.

Above all, we greatly appreciate the time, effort and thoughtfulness that program staff and clients showed in answering our many questions about the strengths and challenges of delivering local treatment and aftercare. Insights about ways that specific services and "extra" supports help individuals, families, and communities recover from prescription drug abuse were especially valuable.

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EXECUTIVE SUMMARY

Introduction

Between 2016 and 2018, researchers from the Centre for Rural and Northern Health Research (CRaNHR) at Lakehead University worked with Matawa First Nations to evaluate the Prescription Drug Abuse and Misuse (PDAM) programs operating in the Matawa communities.

The purpose of this evaluation was to gain insight into the successes and challenges that the nine Matawa First Nations have had in developing local PDAM treatment and aftercare programs. Evaluation questions were:

1. What treatment and recovery supports are available to people in the nine Matawa communities?
2. What are the signs that the community-based PDAM programs are making a positive difference in the Matawa communities?
3. What challenges do communities face in helping people recover from addictions?
4. What facilitates recovery as people move across the continuum of treatment and recovery?

Evaluation Data Collection: February 2017 – March 2018:

- 150 interviews:
  - 101 clients
  - 57 community members, staff and leadership (8 people in this group also shared their experiences as former PDAM clients)
- Program documents review

Findings

What treatment and recovery supports are available to people in the nine Matawa communities?

Community-based PDAM programs

- All nine communities had implemented a community-based PDAM program consisting of both treatment and aftercare components.
- Eight First Nations offered Suboxone treatment; Constance Lake developed a unique traditional and holistic approach to recovery.

Aftercare programming

Aftercare consisted of education, activities, and dealing with root causes of addiction.
All communities were developing or expanding traditional and land-based activities.

Community-wide programming

Matawa First Nations recognized that community-wide programming, rather than targeted programs offered just to PDAM clients, improved the wellness of individuals and families (e.g., health services, recreation, and education programs available to all community members as well as community events and feasts).

Specialized supports available from outside of the communities

Some PDAM programs referred clients to services accessible outside of the community (e.g., residential detox and treatment centres, specialized counselling, etc.).
Other PDAM programs made arrangements to bring services into the community on a regular basis (e.g., physicians and nurses to do detox and assessments, specialized counsellors, traditional counsellors).

➔ Note: A summary of the supports available to members of each Matawa community is presented in Tables 3, 5, 7, 9, 11, 13, 15, 17, 19.

Each community's PDAM program is summarized in Tables 4, 6, 8, 10, 12, 14, 16, 18, 20.

What are the signs that the community-based PDAM programs are making a positive difference in the Matawa communities?

Overall, participants viewed their community PDAM programs as moving people into recovery, and as positively contributing to improved client and community wellbeing.

Participants described many *"positive changes"* in their communities because of the PDAM programs. They identified the following signs that the PDAM program is making a positive difference in their communities:

- Reduced opiate, alcohol, and other drug abuse among community members.
- Program clients improved physical and mental wellbeing.
- Parents had more resources to support their children, and, as a result, children were happier, spent more time with families and more often attended school.
- Some parents who had their children taken into care by Child and Family Services had regained custody of their children.
- Families were reconnecting, supporting each other, and spending more time together.
- As they progressed in their treatment, program clients were upgrading their education, seeking and finding employment.
- In the eight communities where Suboxone was being used as a treatment, clients were tapering down on Suboxone. Some had tapered off completely.

- Clients were learning traditional knowledge and skills and communities were showing increased engagement in traditional activities.
- There was movement toward community wellness with increased '*vibrancy*' in the community. People were taking more pride in their homes and communities.
- People were becoming more involved in the community and participating in community activities and events.
- There was a perception that thefts and violence had decreased and that the communities were safer places to live.
- People were happier, especially the children, and clients were serving as role models for other community members.

What challenges do communities face in helping people recover from addictions?

Participants identified the following challenges related to helping people recover from addictions:

- Preventing relapse was a concern across the communities. Daily stressors and unresolved mental health issues, as well as being around friends and family who continue to misuse drugs, contribute to relapse. A lack of recreation and employment opportunities also is viewed as barrier to recovery.
- Where Suboxone was being used for treatment, there was a concern that clients are not tapering off Suboxone as quickly or as frequently as originally intended. It was explained that clients are reluctant to come off Suboxone due to fears of withdrawals and relapse. Suboxone diversion was also identified as a challenge.
- Funding remains a challenge affecting the ability of the communities to provide comprehensive care to community members addicted to prescription drugs. Program staff wanted to offer more comprehensive programming, including land-based activities, but lacked resources to do so.
- The communities had to use shared spaces in community health centres and administration buildings to deliver their PDAM programs. Shared spaces, however, created congestion among programs and confidentiality concerns for clients. There was a strong desire for dedicated space for treatment and aftercare.
- Running the PDAM program with few staff leads to burn out, exhaustion and high staff turnover. Lack of resources to hire and train more staff also limited capacity to offer extensive aftercare programs.
- In remote communities where supplies are delivered by plane, flight delays (e.g., weather) may mean Suboxone does not get delivered when planned.
- There were also a number of challenges related to PDAM program procedures. Clients stated that having to wait for community-based treatment intake cycles, inflexible dispensing policies, and long and complicated intake and referral processes for out-of-community residential treatment programs were barriers.
- Another challenge was that clients who were recovering from addiction felt stigmatized by community members and, in some places, felt there was a lack of support for the PDAM program.

What facilitates recovery as people move across the continuum of treatment and recovery?

The following facilitators of recovery were identified:

- Traditional and land-based activities that reconnected people to their communities, traditions and ceremonies helped people heal.
- Addressing root causes of addiction (i.e., '*work on why they take drugs in the first place*' and '*client readiness to quit'*) contributed to client success.
- Social support and supportive program staff, as well as keeping busy, promoted recovery and helped protect people against relapses.
- Integrated PDAM treatment, recovery supports and holistic healing programs improved clients' success in overcoming addiction.
- For pharmacological treatment, Suboxone is preferred over Methadone. Clients formerly on Methadone described feeling better and more productive on Suboxone. They also felt that tapering off Suboxone is easier than Methadone.
- National guidelines for management of opioid use disorders (CMAJ March 2018)[1] also position Suboxone as the first-line treatment for opioid use disorders.

Summary and Conclusion

The findngs from this evaluation demonstrate that an integrated, community-based PDAM program has been successfully implemented in each of the Matawa First Nations.

- Caseloads ranged from 26 clients (in the smaller commuities) to 150 clients (in the larger communities). The number of participants and their continuing involvement in treatment and aftercare are evidence that people are benefiting from these services.
- The findings also demonstrate that participants are progressing along the healing continuum, and that the programs are contributing to client and community well-being.
- Many facilitators of recovery were identified, including traditional and land-based healing, keeping busy, addressing root causes, social support and helpful staff. The ongoing challenges related to limited funding that the Matawa communities face in running comprehensive PDAM programs were also identified.

Moving forward, this evaluation illustrates that PDAM program staff are moving toward integration of treatment and recovery programs, and that each program is working to enlarge aftercare services, with an emphasis on preventing relapse. The findings suggest that the next steps envisioned in Matawa First Nations are the following:

- Help community members (who are ready to do so) to taper off Suboxone: being "*drug free*" is the ideal for many clients.
- Expand traditional and land-based activities that reconnect people to their communities, traditions and ceremonies to help people heal.
- Develop more aftercare supports to prevent relapse and help individuals heal from trauma and grief that lead to addictions.

[1] CMAJ 2018 March 5;190:E247-57. doi:10.1503./cmaj.170958

INTRODUCTION

Overview

Between 2015 and 2018, researchers from the Centre for Rural and Northern Health Research (CRaNHR) at Lakehead University worked with Matawa First Nations to evaluate the Prescription Drug Abuse and Misuse (PDAM) programs operating in the Matawa communities. The purpose of the evaluation was to explore the successes and challenges of delivering treatment and aftercare supports in rural and remote First Nation communities.

The goal was to provide evidence on the ways the Matawa programs support individuals, families and communities in their recovery from addictions. The evaluation is intended to provide an evidentiary basis for policy decisions at the community, provincial, and federal levels around the type of resources and services that that are needed during the recovery process. This report presents the results of that evaluation.

Report Structure

This report is divided into four sections. Section 1 describes the evaluation background, timeline and methodology. Section 2 provides a summary of the treatment and recovery supports available to people in each Matawa community. Section 3 provides an integrated summary of evaluation results related to facilitators of recovery and challenges of the PDAM programs operating in the Matawa communities. Section 4 presents a summary of program achievements to date and next steps.

1. EVALUATION BACKGROUND & METHODOLOGY

Responding to the Matawa Chief's Council Resolution supporting PDAM research and evaluation (#05-01-08-13, August 2013), and the Ontario Mental Health Foundation (OMHF) call for proposals (April 2014), this evaluation explored the strengths and challenges in various community approaches to treatment and recovery. Using a strengths-based lens, the emphasis was on collaborating with Matawa communities to gather information about the benefits of early recovery programs that assist with family transitions, cultural and community re-integration, educational upgrading and employment.

Purpose

The purpose of this evaluation was to gain insight into the success that the nine Matawa First Nations have had in developing local PDAM treatment and aftercare programs. The main goal was to understand the factors that facilitate or impede recovery as people move across the continuum of treatment and recovery services that are available in the Matawa communities. A secondary goal was to understand the resource issues, including funding and availability of human resources, which enhance or limit the capacity of the communities to develop local programs to aid residents requiring ongoing addiction treatment and recovery.

Objectives were to:

- Identify what treatment and recovery supports are available to people in the nine Matawa communities
- Explore the successes and challenges of the PDAM programs in the nine Matawa communities
- Explore the strategies and supports that contribute to client, family and community success

To explore these issues, the researchers asked community leaders, program staff and clients to answer four evaluation questions:

1. What treatment and recovery supports are available to people in the nine Matawa communities?
2. What are the signs that the community-based PDAM programs are making a positive difference in the Matawa communities?
3. What challenges do communities face in helping people recover from addictions?
4. What facilitates recovery as people move across the continuum of treatment and recovery?

The evaluation took place over five years, beginning in January 2014 when CRaNHR responded to the OMHF call for proposals and ending in March 2018, with the closure of the OMHF. Years 1 through 3 were devoted mostly to working with Matawa MHSSTG to develop an evaluation framework, finalize research questions, and obtain approvals from the Lakehead REB and Matawa MHSSTG. Years 4 and 5 involved intense work with each community to implement the evaluation, collect data, conduct analyses, and prepare deliverables for the MHSSTG and each First Nation. The timeline, including activities and milestones, is summarized in Table 1.

Table 1. Evaluation Timeline

Phase	Date	Activity/Milestone
Project Start Up & Approvals (Years I , II & III)	Jan 2014	• CRaNHR responds to OMHF call for Matawa PDAM Evaluation Letter of Intent
	Apr 2014	• OMHF and Matawa Working Group approves CRaNHR Letter of Intent, requests full proposal
	Jun 2014	• Full proposal submitted to OMHF and MOHLTC, additional revisions requested
	Aug 2014	• OMHF, Matawa, and MOHLTC approves CRaNHR's full proposal, for multi-year program of research
	Oct 2014	• OMHF forwards award letter to Lakehead and Lakehead provides REB early release of funds for development
	Nov 2014	• CRaNHR receives funding from OMHF; additional funding to Matawa from Northern Development & Mines
	Jan – Apr 2015	• Letters of support requested and received from Matawa First Nations Chiefs and Councils
	Jun 2015	• CRaNHR and Matawa MHSSTG Health Directors meet to discuss issues and project workplan (Jun 26)
	Sep 2015	• Health Directors approve meeting notes describing issues and project workplan
	Nov 2015	• Project workplan and instrumentation submitted to Lakehead REB for approval
	Jan 2016	• Lakehead University REB Requests amendments to project instrumentation
	Feb 2016	• Lakehead University REB approves project protocols (Feb 23)
	Mar 2016	• Request for extension to project timelines submitted to OMHF and MOHLTC
	Sep 2016	• Meet Matawa MHSSTG/Health Directors for update • Discussion of parallel Health Canada project summarizing prior PDAM program development
	Oct 2016	• OMHF and MOHLTC approve timeline extension and revisions to budget allocation
	Dec 2016	• Meet with Matawa MHSSTG/Health Directors for updates and discuss instrumentation revisions (Dec 12)

Phase	Date	Activity/Milestone
Data Collection, Analysis & Preparation of Deliverables (Years IV & V)	Jan 2017	• Amendments submitted to Lakehead University REB (Jan 15)
	Feb 2017	• CRaNHR and Health Directors meet to discuss program issues and challenges (Feb 8-9) • REB approval for protocol amendments (Feb 19) • REB waiver for Health Canada project summarizing prior PDAM progress (Feb 23) • Staff travels to Aroland, Long-Lake #58, and Neskantaga to interview community leaders, staff and clients
	Mar – Apr 2017	• CRaNHR team begins analysis of prior PDAM program reports and recommendations for Health Canada project (Feb) • Team travels to Webequie (Mar) and Ginoogaming (Apr) to interview community leaders, staff and clients • CRaNHR and Health Directors meet to discuss evaluation and PDAM programs, issues and challenges (Mar 28-29)
	May – Jun 2017	• CRaNHR and Health Directors meet to discuss evaluation and PDAM programs, issues and challenges (May 4) • Team travels to Constance Lake (Jun) completing interviews with community leaders, staff and clients • Staff prepares report for Matawa MHSSTG and Health Canada summarizing results and recommendations from prior PDAM evaluations
	Jul – Aug 2017	• CRaNHR begins data analysis of interviews completed during community visits • Team travels to Marten Falls to complete interviews with community leaders, program staff and clients (Aug)
	Sep – Oct 2017	• CRaNHR team travels to Eabametoong to interview community leaders, staff and clients (Sep) • Data analysis continues
	Nov – Dec 2017	• CRaNHR team schedules visit to Nibinamik (postponed) • CRaNHR begins preparing deliverables (i.e., community-specific technical reports outlining successes and challenges of each PDAM program)
	Jan – Mar 2018	• CRaNHR continues data analysis, and preparation of community-specific technical reports • CRaNHR team completes telephone interviews with Nibinamik staff (Mar) • CRaNHR prepares deliverables: community-specific technical reports and an overall report to present the integrated evaluation findings

Collecting Information

During meetings with the Matawa Health Directors in June 2015, it was decided that the evaluation methodology would be mostly qualitative. This is because the communities wanted to identify and describe issues (successes, facilitators, and challenges) they felt were not easily quantifiable or accurately captured with quantitative indicators (counts). Health Directors assisted in the development of a common set of interview questions and agreed that, with permission of participants, interviews could be recorded and transcribed word for word to allow the research team to read the transcripts closely for analysis.

- Thus, the main source of evaluation information was **interviews with Matawa community members** (community leaders, program staff and clients); interview data was supplemented by information shared with the researchers at meetings with the Health Directors and a review of prior Matawa program documents.
- Beginning in January 2017, the researchers planned a **site visit** to each community to conduct interviews with community members. The team worked with the Health Director (or delegated Community Liaison) in each First Nation to arrange the site visits, identify potential participants and schedule the interviews.
- Between March 2017 and September 2018, staff travelled to eight sites and spent approximately two days at each; as a visit to Nibinamik was not possible, interviews for that site were completed by telephone. Telephone interviews also were offered to key informants who were unavailable during other site visits.
- A total of **150 interviews** were conducted across the Matawa First Nations. The people who took part included community leadership, PDAM and other program staff/managers, and current and former PDAM program clients. Table 2 outlines the dates of interviews and summarizes the numbers by community and by group.

Table 2. Community Interview Dates and Numbers of Participants

Community	Date	# PDAM clients	# Leadership, staff, community members	Total # interviews
Neskantaga	Feb 2017	3	4	7
Aroland	Feb 2017	7	4	11
Long Lake#58	Feb 2017	11	4	12
Webequie	Mar 2017	41	18	59
Ginoogaming	Apr 2017	10	3	13
Constance Lake	Jun 2017	6	3	8
Marten Falls	Aug 2017	14	4	16
Eabametoong	Sep 2017	8	15	22
Nibinamik (phone)	Mar 2018	1	2	2
Total [a]		**101**	**57**	**150**

[a] Subtotals are greater than 150 because some participants occupied multiple roles

At the request of Matawa MHSSTG, this report also incorporates information from a 2017 report completed for Health Canada (*Matawa First Nations Prescription Drug Abuse and Misuse Programs: Common Approaches, Practices with Promise, Program Updates and Recommendations*). This project, which ran parallel to the data collection phase of this study (Feb - Jun 2017), summarized the progress that Matawa First Nations have made in developing unique initiatives that respond to community needs and, in culturally appropriate ways, support individuals and families recovering from opioid abuse and misuse.

Analysis

Analysis was done separately for each community. The transcripts were read closely to identify ideas and issues related to the evaluation objectives and questions. Each transcript was reviewed by two researchers who used qualitative data analysis software (NVivo) to organize the emergent ideas and issues. The ideas and issues (codes) were then organized into integrated themes related to the four research questions.

Following the analysis, a **community-specific technical report** was prepared for each of the nine communities summarizing: i) the treatment and recovery supports available to people in the community; ii) indicators of PDAM program success; iii) challenges faced in helping people recover from addictions; and iv) facilitators of recovery. Reports were forwarded to Health Directors for review and approval, then a summary of the treatment and supports available and integrated findings regarding common successes, challenges, and facilitators across the communities were prepared for this report (Sections 2 and 3).

2. COMMUNITY PROGRAMS

This section of the report focuses on answering evaluation question #1 "*What treatment and recovery supports are available to people living in the nine Matawa communities*".

The supports available to people living in the communities included **community-based PDAM treatment programs**, **aftercare programming** as well as **supports available from outside of the communities**.

PDAM Treatment Programs

Each community had developed its own distinctive treatment program. The supports available to people living in the communities included **community-based PDAM treatment and aftercare programs** as well as **supports available outside the communities**.

Treatment

Matawa First Nations offer a wide variety of PDAM treatments and services. In terms of treatment, Suboxone-based programs are delivered in eight First Nations (Aroland, Eabametoong, Ginoogaming, Long Lake #58, Marten Falls, Neskantaga, Nibinamik, Webequie), OATC methadone in four communities (on-reserve in Constance Lake; Aroland, Ginoogaming and Long Lake #58, off-reserve in Longlac); and abstinence-based programming in only one location (Constance Lake).

All communities offer clients regularly-scheduled opportunities to take part in detoxification programs. Some send clients to off-reserve residential detoxification programs (e.g. Long Lake #58 to Thunder Bay; Constance Lake to Smooth Rock Falls or Timmins); other First Nations bring a physician and nurse practitioner team into the community and deliver on-reserve detoxification when needed (Aroland, Eabametoong, Marten Falls, Neskantaga, Nibinamik, Webequie). Once clients are stable, they are usually assessed two to three times per year.

Suboxone-based programs use DOT (direct observation of therapy) to ensure client safety and prevent diversion of medication. Clients take their medication in the health centre or nursing station under observation of a nurse or trained dispenser. The hours of operation, however, varied: Some programs had dedicated "after hours" treatment times for employed clients to accommodate work schedules; a few dispensed medication throughout the day at times that were convenient to clients; and others delivered Suboxone only during a 3- to 4-hour window. Some programs, such as Ginoogaming and Nibinamik, give clients on low dose Suboxone who maintain drug-free urine tests the option of self-administering medication over weekends (i.e., "carries"). All programs advocate decreasing and tapering off of Suboxone to their clients.

Aftercare & Land-Based Activities

There are varying levels of additional resources provided to clients while they are receiving treatment. In Eabametoong, clients in the detox program have relapse prevention and life skills, seeking safety, harm reduction, as well as cultural and land-based programming as part of their treatment. The inpatient program at Constance Lake offers Traditional and Westernized healing approaches, trauma-informed care and counselling, educational sessions, and information packages; the community also offers a 20-day outpatient aftercare program.

All programs offer continuing medical and emotional support for the nausea, cramps, aches, sweats and anxiety that occur when clients are going through detoxification or tapering down on Suboxone. An example of this medical support comes from Ginoogaming First Nation, where clients are provided with withdrawal kits composed of items such as Tylenol, soups, heat bags, and A535, when transitioning from opioids to Suboxone. Gravol and Clonidine are also used to help with side effects during detoxification and/or relapses.

Aftercare programming consists of education, activity, and dealing with the root causes of addiction, and its components varied widely: individual and group counselling, workshops on relapse prevention, self-esteem, life skills and parenting, traditional activities like beading and making snowshoes, recreational activities such as hockey and volleyball, and the spiritual support of healing circles, sweat lodges and Elders' teachings. Participation ranged from clients only, to clients and their families, and at times to the whole community. Clients in the PDAM programs are also encouraged to access services that are available to the whole community (e.g., educational upgrading, workshops, etc.).

In addition to these aftercare activities that took place 'in town', all the programs were developing or expanding activities that took place on the land. Land-based aftercare aims to connect clients with their identity and community by connecting them with the land: activities such as camping trips, hunting, fishing, trapping, cutting wood, are ways of making these connections. Constance Lake, for example, has developed a traditional healing program to help people recover from addiction based on cultural teachings about personal identity and the land, including activities such as the harvesting, preparation and use of traditional medicinal plants. Webequie reconnects PDAM clients to their heritage, language and identity through traditional harvesting skills, medicines, and teachings, workshops and camping trips; land-based events and ceremonies that are open to the whole First Nation also help reconnect clients to their communities.

Community Profiles

In the pages that follow, a summary of the supports available to members of each of the Matawa communities is presented (Tables 3, 5, 7, 9, 11, 13, 15, 17, and 19). Each community's PDAM program is summarized (Tables 4, 6, 8, 10, 12, 14, 16, 18, 20), and plans for each program are presented. Profiles are based on program data provided to the research team and additional information shared during interviews and meetings with Community leaders, Health Directors, Program Coordinators or Staff.

Aroland

Table 3. Aroland First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone + Aftercare	➢ Specialized counselling outside community	➢ Methadone treatment in Longlac at Ontario Addiction Treatment Centres (OATC)

Table 4. Aroland First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Suboxone and other medications (such as Gravol and Tylenol) to help with withdrawal symptoms ➢ Staff actively encourage clients to taper down/off Suboxone	➢ Counselling services with a recently hired PDAM worker, as well as sending clients out to Thunder Bay or Geraldton (two weeks/month) ➢ Workshops and educational sessions ➢ Gatherings held for seasonal community feasts several times a year ➢ Activities are available for people to become involved with including an adult gym night, fire arms safety course, and crafting workshops ➢ Traditional activities, such as hunting and trapping courses, beading nights, and a healing circle, strengthen culture and social connections

Aroland's PDAM program has had seven intakes since 2013. As of April 2017, the program had 30 active Suboxone clients. Staff described the following plans for the program:

- Develop youth PDAM preventive programs based on consultations with youth and clients; purchase tents to get youth and their families "into the bush"
- Work with other community programs
- Work with Elders for traditional teaching programs

Constance Lake

Table 5. Constance Lake First Nation Summary of Treatment & Recovery Supports

Community-based NNADAP PDAM Program	Suboxone & Methadone Treatment	Residential Services (Outside of the community)
➢ Detox & Treatment Program	➢ OATC Constance Lake	➢ Residential detox and treatment services in Smooth Rock Falls, Timmins and Thunder Bay

Table 6. Constance Lake First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ 7-day abstinence-only Detoxification Program at Eagle's Earth Centre (inpatient) o Includes: Traditional & Western healing approaches; Land-based healing; trauma-informed care and counselling; educational sessions & information packages. ➢ 20-day "Red Path Treatment Program" (outpatient)	➢ 12 Week Aftercare ("Red Path") Program. Includes: wellness activities, counselling and workshops which are offered once a week at the community health centre

Constance Lake's unique NNADAP PDAM Detox and Treatment Program was established in 2015. Both the treatment and aftercare programs are Aboriginal-specific, and aim to strengthen clients' identity and awareness using a holistic approach.

As of March 2017, four program cycles had been run (approximately 48 clients).

Staff described the following plans for the program:

- To have all programs (Detox, Treatment and Aftercare) offered in a residential setting at Eagle's Earth
- Increase capacity at Eagle's Earth to offer sufficient beds for members from the eight other Matawa communities
- Staff credentialing
- Trademark this unique program model

Eabametoong

Table 7. Eabametoong First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Community Activities	Specialized Services
➢ Suboxone Treatment, ➢ Detox and Aftercare	➢ Community groups and activities ➢ Traditional and land-based activities	➢ Community-based counsellors (e.g., NNADAP workers). Specialized counselling available through visiting counsellors or outside of the community (e.g., in Thunder Bay)

Table 8. Eabametoong First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Individual Suboxone treatment and maintenance (extend low dose maintenance therapy) and individualized treatment timelines ➢ Client numbers fluctuate between 150 - 170 (depending on who is in the community) ➢ Detox program which includes relapse prevention, life skills, seeking safety, harm reduction and land-based programming ➢ Cultural and land-based teachings	➢ Individual level of care ongoing (coping strategies, teachings in self-esteem, self-care, relapse prevention) ➢ Community connection (land -based activities, traditional skills development) ➢ Education (life skills, self-care, drug education, coping strategies) ➢ "Tools for Staying Clean" workshops 3 weeks a month ➢ Support to families before and while the client is in detoxification ➢ Families encouraged to attend Al-Anon meetings ➢ Elders lead 4-5 detox sweats as part of continual care

As of September 2017, there were approximately 150 active PDAM program clients. Staff described the following future plans for the program:

- Focus on community wellness and acknowledge the Creator
- Ensure front line workers, leaders and their homes are well
- Establish ongoing circles of care for individual and family
- Ensure protocol for disclosures, suicide prevention or intervention
- Have professional addictions counsellor, nurses, doctor, and dietician
- Hire more staff and support front line workers (self-evaluation, debriefing)
- Involve youth and Elders

Ginoogaming

Table 9. Ginoogaming First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Methadone Treatment
➢ Suboxone Treatment + Aftercare	➢ Residential detox and treatment centres and specialized counselling are available outside of the community	➢ Methadone treatment is available in Longlac at OATC

Table 10. Ginoogaming First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Individualized Suboxone treatment . Staff actively encourage clients to taper down and eventually off Suboxone (tapering plans are individually tailored) ➢ 'Withdrawal kits' are offered to help clients through withdrawal from opioids before they start Suboxone (e.g., Tylenol, soups, heat bags, A535) ➢ Carries are allowed for clients who maintain clean urine tests	➢ Support for families with children in care. Aftercare is available through community NNADAP ➢ Offer Traditional and Christian spiritual care: pow wows and spiritual gatherings ➢ Gatherings held for special occasions (e.g., birthdays), and special meals (e.g., Thanksgiving and Christmas) ➢ Offer Spring and Fall land-based gatherings for clients and their families ➢ Workshops deliver life skills, cooking classes, physical activities, trauma education, parenting skills and mental health supports to clients and their families

Ginoogaming's PDAM program had had six intakes since 2013. As of April 2017, the program had 26 active Suboxone clients.

PDAM program future plans included:

- Build community capacity in mental health and addiction counselling
- Create a year-round a land-based campsite where aftercare activities could be held and where clients could learn life skills and traditional and cultural teachings

Long Lake #58

Table 11. Long Lake #58 First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone Treatment + Aftercare	➢ Community-based counsellors ➢ Specialized counseling services are available outside of the community	➢ Methadone treatment is available in Longlac (OATC)

Table 12. Long Lake #56 First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ 7-day residential induction and treatment of all needs including medical and dental at Dilico Anishnabek Family Care (Thunder Bay) ➢ After detox, clients return to the community for individualized Suboxone treatment and maintenance ➢ People also use Dilico Anishnabek Family Care residential treatment program in Thunder Bay to get off Suboxone and other drugs	➢ Extensive recovery supports including mandatory mental health and addictions counselling, traditional teachings, parenting skills, and life skills training ➢ Adult evening education program ➢ Prevention programs with the local school ➢ "Circles of Courage": an innovative approach to crisis prevention and anger management for young girls ➢ Land-based activities (ceremonies, "Starting the Fire", hunting, etc.). ➢ Approach to PDAM awareness: "Nuggets of information" dropped at events such as men's conference, children's rally, women's weekend

Staff described the following future plans for the program:

- Offer staff credentialing for counselling and prevention work
- Land-based program expanding from children and youth groups to include families
- Planning family treatment sessions
- Healthy community activities the whole community benefits from - Girls and Boys hockey teams being developed, uniforms and equipment purchased

Marten Falls

Table 13. Marten Falls First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone Treatment + Aftercare	➢ Monthly visits from mental health counsellors and traditional counsellors	➢ Suboxone and Subutex

Table 14. Marten Falls First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Individualized Suboxone (and Subutex) treatment and maintenance (with extended low dose maintenance therapy offered)	➢ Monthly counselling from visiting mental health counsellors ➢ Monthly visits from Traditional counsellors (1 male; 1 female) ➢ Traditional counsellors do individual and group sessions, workshops, male/female circles, and encourage clients to be more active in community ➢ Monthly workshops on relapse prevention, life skills, parenting and employment readiness ➢ Traditional activities (Pow Wows, sweat lodges, camping trip) offered monthly between June and September

As of August, 2017 there were 71 active clients on the PDAM program.

Staff described the following future plans for the program:

- Encourage clients to seek treatment (detoxification centres)
- Bring people into community to teach traditional skills
- Bring people into community to provide drug education (increase awareness of new drugs on the street, causes, effects, dangers, etc.)

Neskantaga

Table 15. Neskantaga Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone Treatment + Aftercare	➢ Specialized mental health and addiction counsellors from Thunder Bay visit the community on fly-in basis (available every week). ➢ Some clients go to Thunder Bay for counselling	➢ Suboxone

Table 16. Neskantaga First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Individualized Suboxone treatment ➢ Staff encourage clients to taper off Suboxone ➢ Unique case management model. 2 case managers, one for treatment and one for aftercare, to connect clients with needed services and track care and progress	➢ Collaboration between PDAM case manager/Mental Health worker and Case Manager/NNADAP worker ➢ PDAM mental health care is linked to broader community mental health program ➢ Aftercare coordinated with cultural programs (sacred fire teachings, sweat lodge and medicine wheel teachings) ➢ Offer summertime land-based activities such as fishing, wood gathering ➢ Land-based healing program offered twice a year (Summer & Fall) for PDAM program clients and their families at community camp site

As of February 2017, there were 48 active clients.

Staff described the following future plans for the program:

- Involve more youth in program design and delivery
- Develop land-based wellness programs for clients and families, including establishing a year-round, land-based healing program campsite on the mainland
- Need an aftercare building to protect confidentiality
- Develop family wellness program, men's healing program and Anishinabe cultural teachings program this early spring and summer
- Develop proposal for traditional medicine program to help some clients come off Suboxone

Nibinamik

Table 17. Nibinamik First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone Treatment + Aftercare	➢ Psychotherapist from Thunder Bay visits the community on fly-in basis	➢ Suboxone

Table 18. Nibinamik First Nation PDAM Program at a Glance

Treatment	**Aftercare**
➢ Individualized Suboxone treatment for 54 active clients ➢ Carries allowed on the weekends for people on low doses	➢ An aftercare to implement aftercare activities (including land-based activities) for the PDAM program clients, and monitor and support clients after they taper off Suboxone ➢ Land-based activities (land-based retreat for Suboxone clients, sweat lodges, fishing and rabbit snaring) ➢ There is a close connection among the community PDAM team, NNADAP, and mental health worker. ➢ Care is also linked to broader community programs (e.g. Choose life, Crisis Program, Victim Services, Transitional Family Outreach and Family Violence workers) and activities (e.g., summer festivals and sporting events).

The PDAM program had been in the community since 2013. As of March 2108, there were 54 active PDAM program clients.

Program staff described the following future plans:

- Implement more aftercare programming, including land-based activities
- Create a dedicated space for aftercare

Webequie

Table 19. Webequie First Nation Summary of Treatment & Recovery Supports

Community-based PDAM Program	Specialized Services	Treatment
➢ Suboxone Treatment + Aftercare	➢ Residential detox and treatment avaialable in Thunder Bay	➢ Suboxone

Table 20. Webequie First Nation PDAM Program at a Glance

Treatment	Aftercare
➢ 100 clients on individualized Suboxone treatment ➢ Tapering and extended low dose maintenance therapy offered, with the goal of all clients tapering off ➢ Computer-based tracking protocols document client progress and participation	➢ Education offered on life skills, well-being, social services, drug-awareness, employment readiness, and culture-based healing ("Awakening the Spirit", and language training) ➢ Activities to reconnect clients to traditions, history, community ➢ Peetwanakang Land-based healing camp (camping trips, traditional teachings, and traditional skills) for clients and families (Spring and Summer)

As of March 2017, there were 100 PDAM program clients.

Staff described the following plans for the PDAM Program:

- Building cabins at Peetwanakang Camp to offer 4 season land-based treatment and aftercare programs
- Dedicated space for detox, treatment, and aftercare
- Land-based prevention education for children and youth
- Social service program integration to better serve shared clients
- Address stigma with raising awareness activities
- Pursue funding for more staff and new initiatives
- Staff credentialing

3. SUCCESSES, CHALLENGES, AND FACILITATORS OF RECOVERY

This section of the report focuses on answering evaluation questions 2, 3, and 4:

- *What are the signs that the community-based PDAM programs are making a positive difference in the Matawa communities?*
- *What challenges do communities face in helping people recover from addictions?*
- *What facilitates recovery as people move across the continuum of treatment and recovery?*

Many common themes related to successes, challenges, and facilitators of recovery emerged from the interviews conducted across the communities. Themes were considered 'common' if they occurred in two or more communities. These common ideas are presented in the pages that follow. Many quotes are used to illustrate the themes that emerged. The selected quotes were edited to highlight the issues, concerns and suggestions that were offered by staff and clients interviewed.

Successes

This section focuses on answering the second evaluation question: "*What are the signs that the community-based PDAM programs are making a positive difference in the Matawa communities*"?

Overall, participants viewed their community PDAM programs as moving people into recovery, and as positively contributing to improved client and community wellbeing.

In communities where Suboxone was being used for treatment, the general feeling was that *"it's good for people … it helps them to go off drugs better".* Many participants described that *"the stuff works"* and that *"clients are happy with Suboxone".* It was noted that program clients are *"changing their lifestyle around slowly in a positive way",* and that "*Suboxone has really stabilized our community".* Participants described many *"good changes"* and *"positive stuff"* related to the PDAM programs in their communities and felt the programs had made *"a big difference"*.

Participants identified the following signs that the PDAM program is making a positive difference in their communities: Declining drug abuse, improved physical and mental well-being, becoming parents again, reconnecting families, finding employment and upgrading education, tapering off Suboxone, increasing traditional activities, and achieving community wellness.

Declining Drug Abuse

Participants across the communities felt that the community-based PDAM program had resulted in **reduced opiate, alcohol, and other drug abuse** among community members. For example, one participant noted, "*there's not very many people into drugs, ever since these programs opened".* Another noted, that "*some people got off the drugs …the drug epidemic that was happening"*. Since the PDAM programs were introduced, "*drug trafficking slowed*". As one of the interviewees noted, "*there is not much of any kind of pill selling in the reserve".*

There also was agreement that Suboxone significantly **reduced harms** of drug abuse, including risks of violence and death. Clients explained that Suboxone controlled their cravings for opioids and thereby stabilized their lives. It "*blocks up the opiates, you don't have to take the Percs* [Percocets] *anymore*"; another said, Suboxone "*keeps me calm; it doesn't make me edgy and want to go out there and get that meth*"; a third explained, "*it did make me stable…almost like I was addiction-free".* Another participant said Suboxone not only helped individuals with addiction but also helped the whole family *"because when you're on drugs, the family tends to break".* Community programs also had convinced pregnant women to use Subutex to reduce harms to their children.

Improved Physical and Mental Wellbeing

One sign of success that was common across all nine communities was **improved client wellbeing.** Participants described that clients are healthier both physically and mentally.

Physically, it was explained that people look *"healthier"*, *"they're gaining their weight back"*, and are *"looking much better than they did [when they were on drugs]"*. Once people went on Suboxone they began "*taking care of themselves*"; *"they dress better"*, they have better hygiene appear *"cleaner"*, and are becoming *"more active".*

Mentally, people were *"happier"*, *"friendlier"* and had a *"boost in their self-esteem"*. Clients reported that their *"attitude towards life is changing",* they were *"getting back to a normal life"* and are "*more focused on the future*". In the words of a PDAM program participant, "*now that we've started this like recovery process, you can see who we used to be coming back, like the joy for life is coming back*".

Becoming Parents Again

Another sign of success common across all nine communities was that people were becoming more involved and spending **more time** with their children

Community members commented that "*the kids are more active with their parents*" now, *"they're more involved" "with activities like baseball and stuff like that".* Because people *"are not going out looking for their next fix",* they are *"getting up in the morning and actually walking their kids to school", and "playing with their kids".* Another participant said: *"I see people with their children all the time; that's a sign that something's working, you know, we're getting somewhere".*

Participants also remarked that parents are *"back on their feet"*, and have their *"priorities straight".*

It was explained that, because parents were no longer spending all their money to feed their addiction, they are better able to take care of and provide for their children. For example, people noted that children "*have food now and clothing*", and that parents now *"buy their kids stuff".* As an interviewee said: *"look at the kids, all the kids got bikes and these kind of things; like that's the kind of things* [where] *you see the difference".*

It was also noted that some parents had regained custody of their children and that *"kids are finally getting their parents back".* Several examples were shared about the positive changes that were seen in parents and in children when "*moms got their kids back".* One participant remarked: *"my children are really happy that they see me trying to help myself".*

Reconnecting Families

Another sign of success common across many of the communities were **closer connections** among family members.

Since the PDAM programs started, clients were spending more time with their families. There was *"more family engagement"* and people were *"doing things as a family"* again. Once interviews observed: *"the biggest thing I've noticed is just the families have been more together".*

Participation in the PDAM programs also *"made relationships healthier".* Family members who went through the program *"get along more"* and have *"stability now".* Because clients are no longer preoccupied with how "*to get high"* they are caring more about family members. As one participant said, "*when I wake up, I'm more attentive towards my mom and my main focus is just like making sure she's okay".*

Finding Employment and Upgrading Education

Another sign of success common across all communities was that PDAM program clients were **seeking employment** and **going back to school** and better able to hold a job.

Community members reported clients are *"out looking for jobs, they're looking for schooling"*, and *"we have a lot of people working now, whereas before, they weren't".* people believed that clients *"have a positive future because they're employed now"*. One client explained: *"If I didn't get clean, I wouldn't' be working"*, another noted *"before I didn't have a job; like if I had a job, I only kept it for a week; but my last job I had for three years".*

Tapering off Suboxone

Another sign of success was that, in communities where Suboxone was being used as treatment, clients were **tapering down** on Suboxone.

Many *"people who are choosing Suboxone want to leave their drug"* and many clients who were interviewed reported they were tapering down on their Suboxone. Some *"have come down a lot"* and were at a low enough dose that they have *"their own carries".* Other clients were ready to begin the tapering process. As one participant stated *"I don't plan to be on Suboxone forever".*

Some clients had tapered down to very low maintenance doses of Suboxone; others *had "already quit Suboxone".* People admired community members who *"don't need Suboxone or Methadone or any other kind of drug now; we have some people who have gone that far".*

Knowing that some people had successfully tapered off Suboxone provided clients with inspiration to keep trying to decrease their doses. As a program participant stated, "*I want to get off it*"; *I don't want to depend on this like for the rest of my life or come to the clinic every day for my dose*". Another remarked: *"I see that there are people that have successfully completed the program and…I hope to get there someday".*

Increasing Traditional Activities

One sign of success that was identified in some communities was **increased engagement in traditional activities**.

Clients explained that since the program started, *"life is better, being able to understand my own tradition rather than losing it".* It was noted that people are more interested in *"traditional medicines and healing lodges and sweat lodges"*, and are becoming interested in learning traditional skills such as *"pow-wow[s]", "beading and moccasin making"*, and making tikinagans and snowshoes. People are also "*going out more on the land"*, and in "*hunting*", and "*fishing*". As a participant remarked: "*culture is coming up slowly, but it is coming up"*. Program staff who were teaching traditional skills explained that *"more people want to become involved; they want to understand more and they want to learn more".*

Achieving Community Wellness

Another sign of success, one that was common across all nine communities, was **improved community wellness**.

As a community member observed, *"there's a vibrancy that's happening within the community"* since the PDAM program started. In other words, improvements seen in individuals had positive impacts throughout the First Nation: *"the community too, benefits from that, people are working and the kids are going to school*".

Once the PDAM program was introduced, **people become more involved in the community**. Interviewees noted "*you could see more community togetherness"*, people are *"more social now",* and "*everybody is out and about".* Prior to the PDAM program, "p*eople used to stay home and not do anything*" and now they *"want to be more involved in the community activities".* There are more people "*in sports now*", "*young people [are] getting together and doing good*", and "*more people ... want to do stuff for the community"* such as

"*putting on things for the kids"* and "*helping out more".* In the words of a community member, *"seeing all these families coming out ... to the community gatherings and whatnot .. It used to never be like that"*.

It was frequently noted that **people are happier**; especially the children of parents who were in the recovery process who were said to feel "*more happy and secure"*. It was noted that "*their kids notice the difference",* and that "*you could see the smile on their children's faces, when they see their parent coming in".* Clients described wanting "*to do better in our lives"* because **change in lifestyle can serve as a role model** for the children in the community. The hope was *"that our kids follow and have a healthy lifestyle too".*

There was an obvious **decline in theft** because people who were on Suboxone did not "*need to steal to get their withdrawal fix". "As each year goes by", "people don't sell their things",* or *"steal things" "just to try to get their next fix".*

It was also noted that less drug abuse meant there were **fewer problems with violence and neglect within families**. As a community member observed, "*before the Suboxone clinic, [you] would hear a lot of stories of death, violence, domestic violence, negligence within the families; so nowadays … it still might be there but it's not so high*".

Families are also doing better economically and "*they have money to spend on things*". Prior to the introduction of the PDAM program, people spent all of their money on their addiction; it was also common for people to have sold all of their possessions, including furniture. In contrast, people now had "*food in the cupboards*", they *"save money", "bills were being paid*", and people were "*starting to have good life and provide for [their] families*".

As well, **people were taking more pride in their homes and communities**. Those who were on the PDAM program were "*back to cleaning their houses*" and "*their dishes*", two things which often were neglected when people were addicted. In the communities, people are *"doing more activities outdoors", "gardening*", and "*getting wood and water*" for Elders.

Challenges

This section focuses on answering the third evaluation question: "*What challenges to communities face in helping people recover from addictions*"?

Clients, program staff and community staff identified a number of common challenges, including preventing relapse, overcoming reluctance to come off Suboxone, program funding issues, addressing confidentiality concerns, and addressing stigma around addiction issues. From a program perspective, finding additional funding, creating dedicated spaces for treatment and aftercare, running the PDAM programs with limited staff, and ensuring timely delivery of supplies were ongoing concerns.

Preventing Relapse

Relapse was a challenge mentioned across most of the communities. Stressful personal situations, mental health issues, boredom, lack of employment and recreation contributed to relapses.

Participants described **stressors** such as "*having personal things happen*" or *"a day [that] doesn't go right"* that lead to relapse. As a program client said, such stresses increased the chance that people "*would just go out and do something stupid like get high or drunk*". **Mental health** concerns, particularly "*anger issues*", also triggered relapse.

Relapses were also linked to a **lack of recreation and employment opportunities** in communities. When *"there's no arcade, no theatre", "no work",* and people *"have nothing else to do, and they just go back to their drugs".* A PDAM participant explained his/her relapse occurred *"when I ended up not being employed and being at home, not doing anything, and that was hard for me".* It was felt that having comprehensive aftercare programs available in the communities could help prevent relapse would help, it was explained that: *"a lot of aftercare is needed, especially when you have to come back to [the community] where it's so normalized to do drugs, it's triggers everywhere. So definitely having a lot of safe places for people to go"*.

Another factor contributing to relapse was that some **community members continue to misuse drugs**. It was especially challenging for people to stay on the PDAM program when family members or friends were still actively using opioids. As an interviewee said, *"it was hard for me to get off because they [were abusing drugs] ... I needed to get away from my family*". Others had to distance themselves from friends because "*you got your people you used drugs with and your drug dealers; and people keep asking you*". People acknowledged "*it's hard to socialize*" because their friends are still using substances and "*peer pressure*" contributes to relapse. As one participant explained, *"it's hard to sort of keep… those bad things away".*

People who were trying to get healthy also had to contend with the fact that **drugs are available** *"in the streets".* It was also explained that some people *"go on a binge"* when they leave the community (for example, to Thunder Bay) for services.

Both staff and clients were concerned that people were **using alcohol and other substances while on Suboxone,** which was *"the worst thing they could do to themselves".* Some bought "*Percs [Percocets] and mix[ed] it up*", with very negative results: *"I got really sick, and I never touched it again".* There were additional worries that PDAM program clients might **divert Suboxone** and sell it *"in the streets"* for *"30 dollars a pop".* Dealers from "outside" the community also sometimes sold Suboxone to people who were *"are hurting" and "withdrawing from opiates".*

There was widespread recognition that overcoming addiction takes time and that healing must be viewed as a process. Summarizing the need to applaud small gains and not be discouraged by relapses, a PDAM staff member stated:

> "*Don't look at the drug itself, look at the small improvements that the people are making… If somebody didn't buy groceries all those years, but now you're seeing them, always buying groceries, but ... if their Suboxone or their urine is still dirty once in a while, so what."*

Overcoming Reluctance to Come off Suboxone

A theme that emerged across the communities with a Suboxone treatment program was that PDAM program participants are **reluctant to taper off** Suboxone. There was recognition that some clients viewed Suboxone as *"just another drug", "a replacement",* and were *"very dependent on it"* and not tapering off as frequently, or as quickly, as they should. Although "*the whole point of [the PDAM program] is you want to get people off it*", there were many clients who had been on Suboxone for "*the past three, four, or five years, and they're still on it*".

There was a strong endorsement of people wanting to "*completely get off Suboxone*", as well as a desire, on the part of program staff, for a "*faster way to wean clients off*". Other community members stated, they *"don't like the idea of seeing people taking drugs [e.g., Suboxone] for the rest of their lives".* Another staff person said, *"they're going to be on in for a lifetime if we don't try and help them quit".*

A **fear of withdrawal** was one reason identified for the reluctance to taper off Suboxone. Participants noted that tapering off Suboxone can be a difficult process, with side effects persisting for an extended time. One participant described "*trying to get off the program itself [I] found that Suboxone is more powerful than the OxyContin is*". Another explained that: "*if I knew Methadone or Suboxone was hard, I would have went cold turkey off Oxys*". Symptoms described included "*restlessness", "sweats", "nausea", "diarrhea", "cramps",* and *"aches".* Some suggested that *"counselling", "sweat lodges",* and *"drinking lots of water"* can help with withdrawal symptoms. The use of other medication (e.g., Tylenol for pain, clonidine for anxiety, & Gravol for upset stomachs) was also said to help. In some communities, "*traditional methods and medicines*" were available to help people come off Suboxone. Those who witnessed the side effects that other people faced in trying to withdraw from Suboxone, however, were reluctant to try themselves. As one client explained, "*I'm scared to get off Suboxone because of the hard withdrawal*".

A **fear of relapse** was also seen as a contributing factor to a reluctance to taper off Suboxone. One PDAM participant described that s/he did not go off Suboxone because she didn't *"want to go back to square one"* and lose the progress s/he had made. Another participant stated that "*I'm going to relapse once I stop taking it, and I was afraid of it*" and "*I don't know how I'm going to live without it*". Another client who had become addicted while taking opioids for chronic pain noted difficulties reducing his/her dose because they were "*afraid*" of intolerable pain. A staff member summed up fears about relapses this way: "*if their world falls apart, then it almost goes back to where they came from*".

In communities where aftercare was linked to the treatment program, a **fear of losing access to services** was another factor identified for reluctance to taper off. For example, one participant expressed a concern that if he/she tapered completely off Suboxone he/she would lose access to resources: "*if I stop the 0.5[mg], then I'm on my own and where to go, like aftercare and all that and counselling".*

A note on tapering. Many respondents explained that the PDAM program staff "*try to encourage clients to wean down"* on their Suboxone. In one community, staff emphasized the importance of tapering stating that the program "*wasn't designed for them to rely on Suboxone the rest of their lives; it was designed for them to get off".*

Most clients who were interviewed also agreed that they "*don't want to be on Suboxone forever".* Ideally, program participants favoured a gradual taper "*dropping every three months or two mon*ths". Other clients reported that they were "*going slowly*". Setting specific goals was said to be helpful. One participant reported a family member stated, "*I'm only going to use [Suboxone] for one year, two years at the most, but I'm not going to let myself get addicted to it, and now he's off*".

Tapering was viewed as something that should be directed by the client, and that clients should taper off Suboxone "*at their own pace".* Program staff realized the need to individually tailor tapering down plans. Those who had been "*heavy users*" or had been using "*since they were a young age*" need a longer time to taper down than the population who have not been using opioids as long. There also was recognition that getting off of Suboxone completely is not a goal for everyone, that maintenance to ensure client safety is a more realistic goal for some clients: "*it's just going to be harm reduction; it's just going to be keeping them alive*".

Addressing Confidentiality Concerns

Reluctance to participate in the PDAM program was linked to the small size of the communities, because confidentiality is difficult to maintain. As a worker stated, "*in a small town like this, everybody knows each other, they're cousins, relatives, friends*". Another PDAM interviewee also said that confidentiality concerns often meant that "*families don't want to come and talk to a worker here*". Because "*trust is an issue*" and "*a lot of people like to gossip*", people also did not want to attend programs or workshops that involve dealing with emotional or sensitive issues (e.g., trauma).

It was also explained that clients have "*a big problem"* with telemedicine appointments; specifically, "*seeing the doctor over the TV"*, "*because people can hear what you're saying"*, and that "*they do listen, they want to hear".* One client noted that "*a lot of people aren't really truthful or honest with the doctor because there's no privacy".* It was acknowledged that once confidentiality is compromised, people are less likely to trust services: "*it's hard to get them back in there because they're going 'no way man'" and "they get hurt after"*. Due to confidentiality concerns, some programs were bringing in counsellors from outside the community; resources permitting, this could be effective: "*people don't want to see local counsellors but if somebody comes from Thunder Bay, they'll flock that person*".

Overcoming Stigma Around Addictions

Another challenge in helping people recover is that PDAM program clients sometimes felt **stigmatized** by being "*talked about"* and "*put down"* by other community members. For example, a client described community members "*saying that we're still doing drugs or that they think they're better than us*". Another client stated, "*I don't think they mean to, but they look down on us"*. Other interviewees reported *"a lot of negative comments ... from the community".* Some people also choose not to go into the Suboxone program because they did not want other community members to know they were receiving treatment.

People also felt stigmatized when they had to take medication in front of other community members in a crowded nursing station or community clinic. This situation, unavoidable because of a lack of dedicated space for PDAM programs, made clients feel that they were *"unwanted"* and that other community members were negatively *"judging people who are trying to help themselves".*

Another challenge mentioned was overcoming negative perceptions about receiving treatment at off-reserve residential centres. One participant noted that people were reluctant to go into a residential treatment program for fear that "*if they go there, they're labelled as alcoholics*".

Finding More Funding

Funding challenges were common across the communities and "*money's always an issue*". Program staff explained that, while they want to offer more aftercare programming, it is only done "*occasionally, it's not a constant thing because of the costs*". Programs were planned, but "*sometimes we [have] to wait for the dollars to be there*". Funding shortfalls also limited the capacity to bring aftercare services, such as a counsellor or medicine man, into the community. Staff described wanting to expand the program and offer more programming and activities: "*like I just wish we had more like dollars to keep doing more*"; *"the idea is there, it's just there's no money, no funds"*. The need for more funding for land-based activities was also identified: it was explained that land-based programs, such as traditional skills projects or family camps *"have a dollar amount to them, and they are costly"*.

Creating Dedicated Spaces for Treatment and Aftercare

A *"lack of infrastructure"* was identified as another challenge to addressing PDAM. As noted in the preceding section, delivering PDAM treatment in a public setting in the community clinic or nursing station was said to create **congestion** and **confidentiality concerns.**

Accommodating clients' needs would be easier if the PDAM program "*had our own building, it'd be better instead of sharing with the nursing station, because we have some clients that comes in with kids and they're all running around…so it's better if we had our own Suboxone place where the kids could have a playroom there while their mother goes for their dose*".

A dedicated program space would also eliminate *"confidentiality issues"* so people would be more willing to see mental health professionals and visiting specialists if there was" a *building where they can feel safe".* Staff in one community explained: "*so how do you expect us to say OK, we're going to bring in a psychologist, but where should we put them…?*".

Finding **facilities for aftercare programming** was another challenge. It was explained that the ideal would be to have *"all the supports"* needed to address PDAM *"all in one place"* so "*when somebody wants to do a program all the supports are there*". Staff wanted to offer more aftercare, but lacked adequate space. They cannot deliver programs they "*want to do*" because they "*really don't have any facilities available*". Ideally, they wanted a building dedicated to aftercare programs, *"a good place"* that *"respects client privacy".* Clients also thought their program could be improved by "*having its own building*" where "*clients could hang around*" and connect with each other.

Running the PDAM Program with Limited Staff

In many of the communities, the PDAM programs were limited in the types of services they could provide due to **staffing issues**. For example, a program that serves 100 clients was "*very short staffed; we only got two [staff members]"*. Communities often faced staffing challenges, associated with lack of funding and absence of qualified people living in the communities. PDAM programs also lacked the resources to build local capacity by providing training in the communities.

Inadequate staffing meant that PDAM programs had **limited capacity to offer extensive aftercare** supports. Though staff wanted to offer more services and programs to their clients, they explained "*we can't do that with what we have now; we just need more people in the team".* It was explained that the lack of staffing contributes to **burn out and exhaustion**. Suboxone dispensers, for example, were "*always on call*" but often were not "*not getting paid"* for after-hours care.

High **staff turnover** also lead to interruptions in care for clients. Staff "*sometimes they move onto another job, so that person that they were helping gets left until somebody*" fills the vacant position. Although existing staff would benefit from "***more training***", having few staff also created challenges for continuing education. It was also noted that while staff would benefit from more training, sending them out of the community for training *"leaves a space"* (vacancy) in the program.

Service delivery was also complicated by shortages of **visiting professionals**. For example, counsellors from outside and the specialized addictions physician were only available once a month in some communities, which created long delays in receiving prescriptions or starting treatments. While having a physician on site on a regular basis "*does help*", clients explained there were delays of up to two months in getting physician appointments. People also became discouraged when there was no consistency in visiting care providers. When "*a different counsellor come[s] in*" each time, clients "*g[et] tired of*" talking about their histories "*again and again and again*".

Ensuring Timely Delivery of Supplies

In some of the remote communities, there were difficulties in getting Suboxone medication into the community in a timely manner. In some instances it was cited that "*air carriers [were] not coming in on time or not bringing the medications and Suboxone on time*". As a client noted, "*One time here ... we didn't have [Suboxone] for five days, due to weather*". Another participant reported "*a couple of incidents where the Suboxone that was supposed to be shipped out [to the community] never did get shipped out*". These issues had been resolved by communities keeping an emergency supply of Suboxone on hand.

Program Procedures

Staff and clients across all communities spoke about program procedures that affected recovery: waiting periods, staffing constraints, and dispensing schedules.

(a) Waiting for treatment

Regular, frequent **intakes to PDAM programs** were seen as an important facilitator for client recovery. For some clients, *any wait* between the decision to enter treatment and intake into the program "*would be a bit long*" and might cause them to not enter treatment. As another client explained "*in my situation it was critical for me to start right away … Like I knew it was do or die*".

There were times when programs were not able to deliver services when some community members needed it. **Wait times** varied. One participant reported *"two weeks"*, another reported *"three months, four months"*; a third client had to wait "*five months, six months*" to "*finally get on the program*".

It was explained that because intakes were managed by **professionals outside the community**, intakes were dictated by their availability. Community members in remote communities were told they needed to wait *"usually one month"* for the doctor to come to do the intake. A road-accessible community reported that clients waited three to six months for a visiting nurse practitioner to supervise Suboxone induction.

Wait times were also influenced by **intake capacity**: sometimes, more people wanted to begin the program than there were intake spaces. Although **infrastructure** dictated how many clients could enter treatment at a time, intake size was most often limited by **funding**. For example, while one community program had infrastructure to support 24 clients at a time, current funding could only support 8. One client remarked *"it would be nice if it was ready constantly, like if you needed it, it can be done".*

Some strategies to **decrease wait times** for community-based treatment were reported. In one case, clients were flown to Sioux Lookout to detox, assessed and stabilized on Suboxone while there, and returned home to continue treatment. Also, having local staff trained to manage intakes shortens wait times. For example, in one community, the PDAM program coordinator (who is also a nurse) is trained to do intakes. This was seen to facilitate timely intakes because "[*the program] doesn't have to go through the process of waiting*" for a professional from Thunder Bay to travel to the community.

Residential treatment and detox centres are available in Thunder Bay and other cities. However, a **long and complicated intake and referral** process was described as a barrier **for residential treatment**. Because "*these centres [are] so booked"* it can take "*three to four, even six months just to get a person in there".* Some participants waited for "*a year, sometimes two years"* for residential treatment, because the program is *"always full".* Considering the lengthy wait, staff often recommended community members start local Suboxone treatment while they wait to begin residential programs.

(b) Staffing Constraints

When programs are staffed by a combination of community members and people from outside the community, **scheduling program cycles** can be challenging. The need for more staff was also identified: "*we need more workers that can go and do this kind of work*"; "*a bigger staff would be nice …to always have something ready for people that want to quit*".

Insufficient funding to hire staff **limits the ability of communities to run the kind of programs they know are needed.** For example, clients in one community noted that aftercare supports such as a counsellor and medicine man had been coming to the community, but those services stopped because of a "*lack of funds*". Funding staff to help people to stop using opiates without Suboxone was ideal; however, resources required would be a barrier to implementing that approach: "*manpower is going to be enormous and huge and the money that's going to be involved in creating something like that*".

Inadequate staffing for existing programs also constrained the ability to provide one-on-one supports to effectively help people: "*[the program] doesn't have a lot of staff, no one is there to help this client follow through*". Another participant noted "*staff can get exhausted in helping their people*". This led to **high turnover** and created interruptions in client care, until **vacant positions** could be filled.

Lack of **qualified staff** also made it difficult to ensure that clients had the "*professional counselling that's needed for them to open up [about] what's keeping them in that path [to recovery]*". Even when community members had the qualifications to fill positions, service delivery often became complicated when clients and staff were related. As a staff member said, "*it's really hard sometimes when you have to deal with your own family*".

(c) Dispensing Schedules and Policies

Once on Suboxone, clients often became frustrated with **inflexible dispensing policies**. Firm dispensing hours (e.g., "*they cut you off right at 11:30*" or "*they close right away at lunch"*) made it difficult for clients who are late. Programs that were only "*open a couple of hours*" were "*challenging for some people*". Work or education schedules, sickness, family emergencies, adverse weather or travel plans may not fit dispensing hours, resulting in clients choosing between their dose and their other obligations.

Similarly, some policies designed to limit diversions were viewed negatively by clients. Some programs, for example, gave Suboxone in "***crushed doses***" rather than "*whole pills*" to ensure that clients did not "*pocket*" the medication and later sell to other community members. Those who took the crushed doses remarked that the medication "*didn't last as long*" and they felt withdrawal symptoms before their next dose. Other participants felt that

policies **limiting the number of** "***carries***" (e.g. medication given to the client to be self-administered) when they were travelling outside the community had similarly negative effects. In one example, a client who wanted to go out on the land to fish and hunt for 12 days, worried that he might relapse if only given 10 days of medication: "*I don't think they're going to give me the whole 12 days so when I'm out there, I'm just going to take whatever they give me and I might be off the program*".

Conversely, flexible dispensing schedules that accommodated clients' needs were seen as a facilitator for recovery. One client said program coordinator who *"bent over backwards"* to meet community needs*;* schedules could be adjusted more easily when program staff were *"always here [at the health centre]"*. Other examples were given of staff who would do special *"home visits"* to dispense medication "*if someone's sick at home or somebody's baby is sick".* Program staff also sometimes went to client *"work site(s) to help us there".* Also, to facilitate client participation, workshops were offered at times convenient for clients (e.g. while the children were in school so that childcare is not a barrier).

Facilitators of Recovery

This section focuses on answering the fourth evaluation question: "*What facilitates recovery as people move across the continuum of treatment and recovery*?"

The following facilitators of recovery were identified:

Traditional and Land-based Healing

Participants in all of the Matawa communities felt that land-based and traditional healing help people toward recovery. Programs often offered "*traditional healers*", "*sweats and healing ceremonies*". Those healing practices reinforced traditional holistic views of wellness that incorporate "*the spiritual and, the mental and the emotional and then the physical ... core of ... everyone*". Participants noted the importance of including "*the Creator*", a "*higher power*", or "*spirituality*" in their healing journey.

Traditional teachings and medicine were also seen as being useful in recovery. For example, participants noted: *"a very simple way to stay sober is use those seven [grandfather] teachings, that's all you need in your recovery, you don't need to make it complicated*"; "*being able to smudge daily ... really works too*". In reference to the land, a client explained that land-based activities were healing: "*I think the connection to the land ... the peace, the tranquility ... the fresh air, just the love of being free".* Clients and staff also described traditional medicines as helpful and calming. A staff person emphasized traditional medicine also helped with recovery: "*the clients share with me that the medicines really help curb their withdrawals*".

Addressing Root Causes

Clients and staff explained the **need to address the root causes of addiction** in order for people to recovery from PDAM and become healthy again. They "*need to work on why they*

take drugs in the first place". As an interviewee put it: "*no one is born a drug addict or an alcoholic, it's all the problems that led up to it*".

Root causes of PDAM specified were "*grief and loss issues*", "*sex abuse*", other "*trauma experiences*", and the residential school system's negative impact on mental health*, which have been* "*passed onto generations*". It was noted that Suboxone does help people with cravings for opioids but medication was *"just a Band-Aid"* as people need counselling "*to help them release whatever area that they need to get over".* It was noted that people who "*will talk about their issues…tend do better than those that won't*".

Additionally, people **need to be ready to quit** in order to succeed. In the words of PDAM participants: "*you got to want to want to change… want to be off of your pills ... want to be healthy; like that's my goal"; "I had to challenge myself to change"*; *"as an individual, it's up to you if you want to continue on with your healing";* and "*you can't force anybody"*. A staff member noted "*we give them the tools to quit but it's really up to them*" and another stated "*you get what you put into it*". Those who were willing to ask for help were also seen as having better results: "*when you look for help, it's when you do better*" and "*the ones that are looking for help are the ones that are doing good*". Being motivated by others was another reason to quit; for example, a parent said "*what drove me is the kids*".

Social Support

"Social support" from **spouses, friends and extended family** was seen as a *"very important"* factor across all communities. It was explained that *"there's no way you can do it alone",* and that *"if you have strong supports or even just one could make a difference".* To be successful, clients need to make *"sure that your family is in support of you getting the help too."* Clients also needed practical help, such as someone to "*take care of their children*" while they went to get medication or attend "*workshops or activities*". In the longer term, they needed "*encouragement"* to continue with their recovery and *"get off Suboxone or look for work or go to school*".

On the other hand, lack of support, especially having family or friends who were still actively addicted, was a barrier to healing. Staff explained *"a lot of clients can't make it because they still live in homes with people using".* One client said *"honestly, I know I wouldn't be clean if my wife didn't quit with me".* Another said *"you got to build a support system".* A third client described having *to "change who their friends are ... change everything that is bad and surround yourself with the people who keep you up there".*

Having a **role model** and sharing personal stories was helpful. Clients needed to feel that *"they're not alone"*, others have *"been there"* too, and they can forgive themselves and overcome their addiction. Supportive peers also could *"help you out"* by sharing their experiences of coming off Suboxone. Other sources of social support that were mentioned include community members, Elders, friends, siblings, and employers.

Keeping Busy

Keeping busy with **employment, education and physical activity** were ways that people coped with the challenges of getting off drugs and preventing relapses. As a community member observed "*they went to work, so they were pretty much busy every week so aftercare wasn't a problem because they were busy".* Those who were employed also benefited from having a daily plan or schedule.

When counselling was unavailable, keeping busy also provides a distraction from distressing thoughts; a client said: *"I try to keep myself busy because there's no therapy here".* Activity was also recommended as a way of **coping** when people were trying to taper down or get off Suboxone. A client found it was beneficial "*exercise more ... to help flush it out";* another explained they "*didn't even think about Suboxone [when they were]* "*driving around in the wilderness and going fishing [and] hunting*".

Suboxone Preferred to Methadone

A preference for **Suboxone over Methadone** as a treatment method was expressed in many of the communities.

People who had used both medications often stated they **felt better physically** while using Suboxone, because "*you don't feel like this weight that you feel with the methadone… more of a lighter feeling".* Methadone was referred to as "*liquid handcuffs"* because the fatigue and other side effects meant that people "*couldn't go anywhere"* and "*couldn't do anything*". A community member related how "*Methadone took over [a friend's]* life ... but after she went on Suboxone*, she's been more active with her grandkids and going places*".

It was also noted that "***it's easier to get off Suboxone****"* than Methadone. While those who were on methadone often felt they could not be tapered off the drug, those who were on Suboxone believed it was more likely that they could be weaned completely off the medication. As a participant described, "*going down was a little bit uncomfortable, but it wasn't anything that to the point where it made me sick, like it did when I was on Methadone".* Clients described strong and lengthy withdrawal symptoms when trying to taper down on Methadone. One client said "*you withdraw for like at least two months*". This preference described among participants is in line with the recently released **national guidelines** which position Suboxone as the first-line treatment (ahead of Methadone) for opioid use disorders.[2]

Integrated Treatment & Recovery Programs

The importance of many **elements working together** to facilitate recovery was emphasized. For example, it was noted Suboxone is *"a treatment, but it's not the resolution"* to the problems that lead to addiction in the first place. As one participant put it, *"it's not only Suboxone, you got to do more than that; it's also mental and emotional".* While it was explained that Suboxone is good for "*harm reduction"* and will "*help instead of*

[2] CMAJ 2018 March 5;190:E247-57. doi:10.1503./cmaj.170958

looking for that opiate every day", it was recognized "*Suboxone is not going to be the miracle drug that will heal you"*. In that regard, aftercare elements such as counselling and wellness activities have to be in place to help clients *"release whatever area that they need to get over .. something to keep them busy from going back into [substance use]".* In communities with integrated PDAM programs, aftercare often included parenting programs, addiction or mental health support groups, and recreational activities.

Additionally, the importance of **holistic healing** was emphasized. As one participant recommended, people need to *"take care of themselves mentally, physically, emotionally, and spiritually"* to regain their health. They also were strengthened "*a traditional healer come in*" and offered "*sweats and healing ceremonies and training*" to community members.

Supportive Program Staff

PDAM **program staff** were viewed as an important factor in people's recovery.

Viewed as particularly supportive were staff who were *"**open to the clients' needs**"* and *"**flexible**"* in accommodating schedules. Those qualities were *"a big help"* for clients. A client shared a positive reflection about the PDAM program staff, as follows: *"they didn't look down on you, they still treated you like you were their equal; there was no shame in coming and talking about [your addiction] and whatnot; there was just **acceptance**".* Another client explained *"I knew that [program coordinator] actually cared about my recovery".* A third person said *"I was completely taken care of sincerely by, people that care, as opposed to people just watching [you take your medication] for a day job".*

4. ACHIEVEMENTS AND NEXT STEPS

Achievements

The findings presented here demonstrate that an integrated, community-based PDAM program has been **successfully implemented** in each of the Matawa First Nations.

Overall, participants viewed their community PDAM programs as moving people into recovery and positively contributing to improved client and community well-being. While some people had hesitations about Suboxone as a treatment and viewed it as "*just another drug*", most described "*good changes*" had occurred since the PDAM programs had been introduced. Clients were progressing along the healing continuum and perceived the programs to be *"working"*. They identified many facilitators, including traditional and land-based healing, keeping busy, addressing root causes, social support and helpful staff. A staff member explained healing from drug abuse was like a healing bone:

> *"imagine breaking your leg and you can't walk around, you need crutches, you need someone to help you, that's the same picture you need to have when you work with someone with addictions and they need to recover; but eventually that bone heals, it will never be the same*" and "*eventually the crutches, they come… they come off*".

PDAM program coordinators also were moving towards **full integration** of treatment and recovery programs. Each program was working to enlarge aftercare services, with emphasis on preventing relapse, overcoming stigma around addictions, as well as confidentiality concerns in small communities. In programs where medication was being used as a treatment method, Suboxone was preferred over Methadone, and there was an emphasis on encouraging people to taper off Suboxone.

PDAM programs also were successful in **recruiting and retaining clients**, with caseloads ranged from 26 to 150 clients. Staff noted that the number of participants and their continuing involvement in treatment and aftercare were strong evidence that communities were benefiting from these services. They also identified many other signs of success: declining PDAM, improved client and community well-being, improved parenting and family connections, increasing rates of educational achievement and employment as well as an increase in traditional activities.

At the same time, Matawa First Nations faced ongoing challenges in running comprehensive PDAM programs due to **limited funding**. Coordinators, community leaders and clients recognized the difficulties that occurred when programs lacked the resources to fill staff vacancies, bring in specialized services, and, in each community, build dedicated facilities for their programs. With limited capacity to offer treatment and aftercare locally, clients often had to wait several weeks to months to detoxify and start treatment; they also faced similar delays for specialized aftercare, such as counselling.

Next Steps

Findings from the current evaluation of community PDAM programs suggest that the next steps envisioned in Matawa First Nations to help community members who are recovering from PDAM are the following:

- Help community members (who are ready to do so) to **taper off Suboxone**: being "*drug free*" is the ideal for many clients.
- Expand traditional and **land-based activities** that reconnect people to their communities, traditions and ceremonies to help people heal.
- Develop more **aftercare supports** to prevent relapse and help individuals heal from trauma and grief that lead to addictions.