Metro Vancouver Aboriginal Executive Council's Urban Indigenous Opioid Task Force Recommendations Report

Revised February 20th, 2018

The following recommendations have been formed in response to the stakeholders' working session Minister Darcy held on October 11th, 2017. Kevin Barlow, MVAEC CEO, asked to submit a written response to express needs identified by people who serve the 70,000 urban Indigenous people in Metro Vancouver. Priority issues were identified by MVAEC board & council and members of the *Urban Indigenous Opioid Task Force (UIOTF)*. These recommendations are necessary to establish an adequate, proactive Indigenous mental health & addictions system rather than the insufficient reactive-based approach currently in place. The following interventions are upstream to foster *resiliency in action*, are to be implemented in a wrap-around service approach, and should support people across lifespans. Vancouver's opioid epidemic is disproportionately affecting urban First Nations people nine times more than non-First Nations people (FNHA, 2017). Those we consulted clarified that these are demands for change, not asks.

1. Host a consultation meeting exclusively with urban Indigenous community members.
    I. We recognize the constructive move of the government to consult with the urban Indigenous community, however, the process was incomplete. It is recommended for the Ministry of Mental Health and Addictions to host and fund a stakeholders meeting exclusively with Indigenous leaders to hear their demands and have recommendations documented and reported by trusted knowledge holders, opposed to a sub-contracted service in order to preserve the context of the remarks shared.

2. Remove jurisdictional barriers between health authorities.
    I. Vancouver must coordinate its responses with other province-wide efforts. The difference between on & off-reserve should be acknowledged and jurisdictional restrictions across health authorities are removed.
    II. Establish a Metro-focused clarity to remove jurisdictional issues between health authorities to support fluid service for those residing/existing between multiple areas.
    III. Distinguish the identity of urban Indigenous from those on-reserve to ensure service is tailored to their specific needs (TRC: Call to Action 20).

3. Increase access to existing services.
    I. A place for immediate support and shelter from the street is needed to protect those most at risk now.
    II. Maintain a Suboxone stabilization unit.
    III. Liaison workers are needed to assist people into treatment.
    IV. Provide sustainable support for Indigenous peer street/mobile outreach workers to increase access points into supportive services.
    V. Care begins at the access point to services and individuals should be provided wrap-around supports to build consistent, trusting relationships between client and providers.
    VI. People need guide service providers to accommodate their needs to eliminate barriers to accessing support.
    VII. Sustainable long-term programs that foster continuous care and improve client-worker relationships should be implemented over short-term projects.
    VIII. Assess current complaint & evaluation protocols for stigma and discrimination at health service centres to improve trust in health care system.

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4. Support wrap-around service integration
    I. To reduce the inefficiency of a revolving-door system, improved access to walk-in services, maintenance programs, extended premade discharge plans, and effective aftercare supports are needed.
    II. Services would benefit from increased cross-communication & cross-referrals with clients.
    III. Build on community trust in agencies like *Vancouver Aboriginal Friendship Centre Society* and their need for stable funding.
    IV. To increase access to OATs, expand the scope of nurses for them to administer them.
    V. Allow for staff support to be built into programming to reduce stress, burnout, and trauma for frontline workers.

5. Evaluate and reduce waitlists across the spectrum of care
    I. More funding is needed for existing services to meet increased demands and reduce/eliminate waitlists, frontline workers in response to burnout & cultural support.
    II. Reduce waitlists by funding homecare, treatment facilities, treatment beds, and adequately trained staff.

6. Establish an Indigenous healing centre
    I. MVAEC asks for Ministry of Mental Health & Addictions to match the $1.3 million that has been offered by by VCH & FNHA for the establishment of a comprehensive healing centre similar to *Hey Way Noqu' Healing Circle* that closed in 2015. A gap in service was left in the community when it closed in 2015, just prior to the opioid crisis's escalation.
    II. Healing Centre is to offer wrap-around all-barrier services inclusive of everything from drop-ins for coffee to longer-term trauma counselling support.
    III. The established wellness centre is to be accessible to nature and will provide professional mental health services in conjunction with Indigenous cultural practices (TRC: Calls to Action 21 &22).
    IV. We recommend community-based, healing centres to provide continuity of service and opportunity for reconnection/belonging through an *Indigenous Wellness Framework*.

7. Support *Culture as Treatment* for substance use services
    I. The opioid crisis should be acknowledged first as a crisis of social disconnection. *Culture as Treatment* has been shown to have benefits in all areas of wellness and reduce substance use problems[i].
    II. Support low-barrier access to culture to heal the wounds inflicted by colonization.
    III. Adequate funding needs to be available for residential treatment and access to *Culture as Treatment* in these programs.

8. All healthcare workers are to be educated with cultural humility training
    I. These programs reduce stigma by practising cultural humility and increase accessibility to service for marginalized clients (Call to Action 23)[ii].

II. Every healthcare worker is to be trained in cultural safety/humility practices and trauma-informed response.

9. Advocate for policy analysts to support systems change
   I. Timely, accurate data sharing can guide policy changes to reduce disparity in health services facilities and create consistency in service.
   II. End criminalization and incarceration of people who use drugs.
   III. Allow and promote pilot projects for the responsible legal regulation of currently illicit drugs including opioids, to replace and bypass criminal organizations that drive and benefit from the current black market.[iii]
   IV. Tools and support must be available to Indigenous people as an alternative to depending on the Colonized medical system.

10. Support children in care
   I. Support youth specific services for those aging out of care.
   II. More caregivers are needed to house infants born to women experiencing addiction and for children in need of placement homes.
   III. Ensure smooth transition of services between youth and adult mental health services to prevent youth from falling through cracks in services at critical development periods.

11. Create access to low-barrier Indigenous housing
   I. Low-barrier Indigenous housing for those "hard on housing" and to ensure that those who are using and are not able to meet the requirements of some housing options are still able to find housing. The top priority should be to secure low-barrier Indigenous housing with a zero tolerance for exclusion policy to offer people the right to housing[iv] that is not conditional on abstinence. We should begin with a backwards approach, supporting those "*hard on housing*" to shift responsibility back to service providers. Building damage should be expected and maintenance is to be built into program funding.
   II. Funding for housing navigators is to be included in programming costs and all levels of the barrier spectrum and these levels (low-high) should be clearly defined to reduce the cycle of homelessness after treatment.
   III. Housing for 2-Spirited youth is also to be prioritized because current faith-based shelters do not address their needs.
   IV. Need an advocacy chapter dedicated to issues associated with the housing shortage.
   V. Long-term follow-up/aftercare should be comprehensive including access to stabilized housing and employment/training support.

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[i] https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-9-34
Rowen et al., (2014) Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy*, *9*(34).

[ii] http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf Truth and Reconciliation Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Winnipeg: Truth and Reconciliation Commission of Canada.

[iii] http://www.globalcommissionondrugs.org/position-papers/opioid-crisis-north-america-position-paper/

[iv] http://www.cwp-csp.ca/poverty/a-human-rights-violation/the-right-to-housing/