North West Local Health Integration Network

Aboriginal Health Programs and Services Analysis & Strategies:

Final Report

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EXECUTIVE SUMMARY

INTRODUCTION

The Local Health Integration Networks (LHINs) were created by the Government of Ontario to address the often fragmented, complex and isolated manner in which many health care professionals provided service to Ontario residents. They were formed to work with local health providers and community members to identify and decide upon health service priorities in their respective regions. The North West (NW) LHIN, which represents one of the 14 regions and encompasses four sub-regions - the Districts of Rainy River and Thunder Bay, most of the Kenora District, and the City of Thunder Bay - assists with the planning, the integration and the allocation of local health services funding of hospitals, a Community Care Access Centre, community support service organizations, long-term care homes, community mental health and addictions agencies and community health centres. The NW LHIN is concerned with improving the quality and accessibility of health care for all residents within the region through enhanced integration and coordination of health services.

The NW LHIN region is geographically large with a relatively small population. Many of its communities are located in rural and remote setting which creates significant challenges to health care delivery such as limited access to care, limited health human resources, need for extensive travel and higher costs per capita. The NW LHIN is comprised of approximately 1.9% of the entire population of Ontario. Within the NW LHIN Region 19.8% of the population identifies themselves as Aboriginal and is the highest Aboriginal population of all of the LHINs in Ontario (only 2% of Ontario's population identifies as Aboriginal).

Aboriginal people across the country suffer a disproportionate burden of disease and ill-health than their non-Aboriginal counterparts. Their health is influenced by an interconnected confluence of historic and contemporary factors including poverty, unemployment, limited educational attainment, discrimination, marginalization and loss of cultural way of life. As a consequence of these factors and many others, Aboriginal people experience higher rates of chronic and infectious diseases (e.g., diabetes, tuberculosis, sexually transmitted infections), suicides, injuries, addictions (e.g., drug and alcohol abuse), family violence and disability, than Canadian non-Aboriginal people.

DPRA Canada was contracted to carry out the Aboriginal Health Programs and Services Analysis and Strategies project on behalf of the NW LHIN. Since its inception, the NW LHIN has identified the health status of, and access/utilization of health services by, Aboriginal peoples located within its catchment area as an important priority. The intent of the project was to:

- Develop an inventory of health programs, services and resources available to Aboriginal people in the North West region.
- Report on the health status and health needs of Aboriginal people residing in the NW LHIN.
- Identify gaps in programs and services offered to Aboriginal people in the NW LHIN.
- Highlight challenges associated with the delivery and access to health programs and services experienced by Aboriginal people in the NW LHIN.
- Highlight current and potential linkages and partnerships between health care providers offering programs and services aimed at the NW LHIN Aboriginal population as well as opportunities for integration and enhanced health care technology practice.
- Identify best practices and lessons learned with respect to the delivery and administration of mental health addictions programs and services offered to Aboriginal people.

It is anticipated that the findings and evidence-based conclusions and recommendations within this report will assist the NW LHIN in more effectively and appropriately planning, integrating and allocating local health services resources aimed at Aboriginal people residing in the North West region.

METHODOLOGY

The methodology undertaken for the Aboriginal Health Programs and Services Analysis and Strategy project included the following:

- Development of a detailed methodology and work plan
- Environmental scan of health programs and services available to Aboriginal people residing in the NW LHIN
- Review of 111 sources of literature
- Completion of 12 community engagement sessions involving 20 communities (n=58 participants) and 11 one-on-one community interviews
- Completion of 27 community telephone interviews
- Completion of 31 key stakeholder interviews

KEY FINDINGS

- Health Status of Aboriginal People Residing in the NW LHIN
  - The primary health concerns identified by community participants include addictions (e.g., prescription drug abuse), mental health issues (e.g., depression, suicide), and chronic diseases (e.g., diabetes, cardiovascular disease, respiratory problems/asthma, cancer).
  - Poor health status in Aboriginal communities in the NW LHIN is thought to be associated with factors such as: poor nutrition/diet; poverty/lack of employment; poor familial relationships (due primarily to intergenerational residential school impacts); inadequate housing conditions (e.g., mould); lack of exercise, lack of health promotion and disease prevention activities as well as poor access to programs and services; and loss of traditional lifestyles.

- Aboriginal Health Programs and Services
  - Health programs and services available to Aboriginal people residing in the NW LHIN are provided by a variety of service providers, and include services available both on-reserve and/or off reserve in surrounding communities.
  - Communities located in more remote locations are more limited in their access to programs and services while those located near urban centers are able to access off-reserve programs with fewer challenges.
  - Health programs and services are administered by a number of Aboriginal agencies/groups/organizations/councils including: Provincial Tribal Councils, Health Planning Authorities, Métis Nation of Ontario, Ontario Native Women's Association, Aboriginal Health Access Centres, Aboriginal Family Health Team and Aboriginal Friendship Centres.
  - Several other providers offer health programs and services to Aboriginal people (although not exclusively): hospitals, public health units, Cancer Care Ontario, Community Care Access centre, Family Health Teams and Women's Shelters/Transition Houses.
  - A number of Aboriginal programs and services are available both on- and off reserve that address different Aboriginal sub-populations (e.g., infants, children, youth, adults, seniors) and a variety of health concerns (e.g., diabetes, fetal alcohol syndrome disorder, mental health and addictions, family violence) utilizing health promotion, disease prevention and/or treatment approaches.

- Gaps in Aboriginal Programs and Services
  - Health programs and services available to Aboriginal people in the NW LHIN are not fully meeting their needs. Participants noted gaps in health programs and services in the following areas:
    - Mental Health and Addictions (e.g., lack of adequate and timely diagnosis)
    - Chronic Disease Diagnosis and Management (e.g., diabetes management)
    - Acute Diseases / Accidents and Injuries (e.g., lack of preventative measures)
    - Active and Engaged Parenting

    - Children Programs and Services
    - Youth Programs and Services (e.g., lack of recreational and cultural activities)
    - Seniors Programs and Services (e.g., lack of community home supports)
    - Continuity of Care / Provision of Essential Services and Specialized Care (e.g., lack of dental services)
    - Infrastructure
    - Culturally appropriate services
    - Transitional assistance
    - Wellness Education and Preventative Health Care

- Challenges to Delivery and Access
  - A range of challenges associate with the day-to-day delivery of health programs and services on-reserve were identified: limited human resources, capacity and infrastructure; onerous reporting requirements; limited financial resources; and complex jurisdictional issues.
  - Off reserve health program and service delivery challenges were also noted, including: difficulties developing and delivering culturally appropriate programs and services; difficulties establishing collaborations and building strong and supportive partnerships; overly high patient expectations; and problems associated with attempting to provide patient aftercare and follow-up.
  - A variety of challenges and barriers associated with community members accessing programs and services on-reserve were mentioned: lack of awareness and understanding of programs; lack of desire and motivation to participate; lack of trust and confidentiality; and limited transportation services.
  - Aboriginal clients attempting to access off reserve programs and services encounter similar challenges to those experienced on-reserve: limited awareness of programs and services available; lack of motivation and interest to participate in healing process; limited availability of programs and services; lack of financial support and challenges with Non-Insured Health Benefits; limited transportation; and issues associated with transitioning to an urban environment as well as language barriers.

- Health Program and Services Opportunities
  - There currently exist many formal (e.g., through memoranda of understanding) and informal health partnerships in the NW LHIN. Across the NW LHIN region partnerships have been established between community health providers and the following: other community health providers, Health Canada, Northern Ontario School of Medicine, and Family Health Teams, for example.
  - New partnerships or better partnerships should be established and that some of the existing partnerships could be further developed.
  - Opportunities for new and/or enhanced integration exist with respect to: incorporating more traditional and cultural practices into western health care; non-Aboriginal health care providers becoming more aware of, and knowledgeable about, community needs and priorities by spending more time visiting the communities and speaking with its members.
  - A wide variety of health technologies are being used in the NW LHIN region to improve the quality of health care provided to residents: videoconferencing; webcasting; store forward; tele-homecare; tele-rehab; and tele-psychiatry.

- Best Practices and Lessons Learned
  - Generally speaking, successful Aboriginal mental health and addictions programs and services while diverse, are community-based, and culturally-appropriate approaches that acknowledge the long-term nature of healing as well as the connections between physical, mental, emotional and spiritual health. Successful approaches also recognize and address the historic and contemporary realities of life for Aboriginal people.

- A number of best practices and/or lessons learned were mentioned by participants that could be adopted to help guide future Aboriginal mental health and addictions programs and services in the NW LHIN. Some of the best practices and/or lessons learned include:
  - Improved planning and collaboration with Aboriginal people
  - Motivation and encouragement from staff and leadership
  - Provision of incentives for participation
  - Increased awareness
  - Incorporation of traditional values and cultural activities
  - Adoption of an holistic approach to health
- A variety of best/promising Aboriginal mental health and addictions programs/initiatives (and practices within those programs) exist at the national, regional and community level. Examples include: Sioux Lookout First Nation Authority Chiefs' Forum on Social issues: Conference on Reducing Prescription Drug Abuse; Wapakeka First Nation Survivors Suicide Conference; Nishnawbe-Aski Nation Decade for Youth and Development Suicide Strategy; Capacity Building for Mental Health Initiatives; The Red Path; Poundmaker's Lodge; and Hollow Water Community Holistic Circle Healing

RECOMMENDATIONS

- The NW LHIN should take the lead in developing a broad-based strategic approach aimed at building upon existing programs/services/resources to more effectively deal with mental health and addictions issues affecting Aboriginal people in the North West region.

- The proposed Aboriginal Mental Health and Addictions Advisory Board should work to develop integrated and collaborative partnerships with key stakeholders with the intent of indentifying Aboriginal mental health and addictions priorities and programs/services best practices.

- The NW LHIN should support increased provision of electronic health information and communication technologies (eHealth ICT) as a means of improving access to and delivery of mental health and addictions treatment targeted at Aboriginal people in the North West region.

- The NW LHIN should work with Aboriginal and non-Aboriginal health care providers to develop a case management approach to addressing mental health and addictions issues in the Aboriginal population.

- The NW LHIN should work with Aboriginal representatives and non-Aboriginal health care providers to enhance the cultural competency of all non-Aboriginal health professionals.

- The NW LHIN should work to develop stronger partnerships with its key stakeholders and with Aboriginal communities located within the North West region.

ACRONYMS

ADI	Aboriginal Diabetes Initiative
AFN	Assembly of First Nations
AHF	Aboriginal Healing Foundation
AHSOR	Aboriginal Head Start Program on Reserve
AHWS	Aboriginal Health and Wellness Strategy
BF	Brighter Futures
BHC	Building Healthy Communities
CCAC	Community Care Access Centre
CCO	Cancer Care Ontario
CHC	Community Health Centres
CHR	Community Health Representative
CHN	Community Health Nurse
COHI	Children's Oral Health Initiative
CPNP	Canada Prenatal Nutrition Program
CSS	Community Support Service
CYFS	Child, Youth and Family Services
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FNIHB	First Nations and Inuit Health Branch
FNIHCC	First Nations and Inuit Home and Community Care
HCC	Home and Community Care
IHSP	Integrated Health Services Plan
IRS	Indian Residential School(s)
KO	Keewaytinook Okimakanak
LHIN	Local Health Integration Network
LTC	Long-Term Care
MCH	Maternal and Child Health
MH&A	Mental Health and Addictions
MOHLTC	Ministry of Health and Long-Term Care
NAHO	National Aboriginal Health Organization
NAN	Nishnawbe-Aski Nation
NAYSPS	National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)
NCBR	National Child Benefit Reinvestment
NIHB	Non-Insured Health Benefits

NNADAP	National Native Alcohol & Drug Abuse Program
NW	Northwest
NW LHIN	North West Local Health Integration Network
OFIFC	Ontario Federation of Indian Friendship Centres
ONWA	Ontario Native Women's Association
OTN	Ontario Telehealth Network
PHAC	Public Health Agency of Canada
PTO	Political Territorial Organization
RHS	First Nations Regional Longitudinal Health Survey
WHO	World Health Organization
YSAP	Youth Solvent Abuse Program

1.0 INTRODUCTION

1.1 PURPOSE OF THE PROJECT

DPRA Canada was contracted to carry out the Aboriginal Health Programs and Services Analysis and Strategies project on behalf of the North West Local Health Integration Network (NW LHIN). Since its inception, the North West LHIN has identified the health status of Aboriginal peoples including their access to, and utilization of health services located within its catchment area as an important priority. The intent of this project was to develop an inventory of health programs, services and resources available to Aboriginal peoples in the North West region as well as to identify gaps in programs and services, challenges to accessing health programs and services, health programs and services opportunities, and community health issues and concerns. It is anticipated that this report will assist the NW LHIN in more effectively and appropriately planning, integrating and allocating local health services resources aimed at Aboriginal peoples residing in the North West region.

The Final Aboriginal Health Programs and Services Analysis and Strategies Report builds on the findings presented in the:

- Environmental Scan Report
- Health Status Report
- Data Analysis Report

A note on terminology within this report: the term “First Nations” is used within this report to refer to those communities and/or individuals who identify as such, and the term “Aboriginal” is used to encompass those individuals who identify as Métis, First Nations, Inuit, or any other self-identified form of Aboriginal identity.

1.2 STRUCTURE OF THE REPORT

The Draft Final Report is structured as follows:

- Section 1: Introduction
- Section 2: Background
- Section 3: Methodology
- Section 4: Limitations and Challenges
- Section 5: Key Findings
- Section 6: Conclusions
- Section 7: Recommendations

This report includes 5 appendices:

- The bibliography of the literature is provided in Appendix A.
- The list of key stakeholders interviewed is provided in Appendix B.
- The invitation letter sent to potential community engagement session participants asking if they wanted to take part in the project process is provided in Appendix C.
- The questions posed to key stakeholders are provided in Appendix D.
- The questions posed during community engagement session, one-on-one community interviews and community telephone interviews are provided in Appendix E.

2.0 BACKGROUND

2.1 LOCAL HEALTH INTEGRATION NETWORK

2.1.1 BRIEF OVERVIEW OF THE LOCAL HEALTH INTEGRATION NETWORK

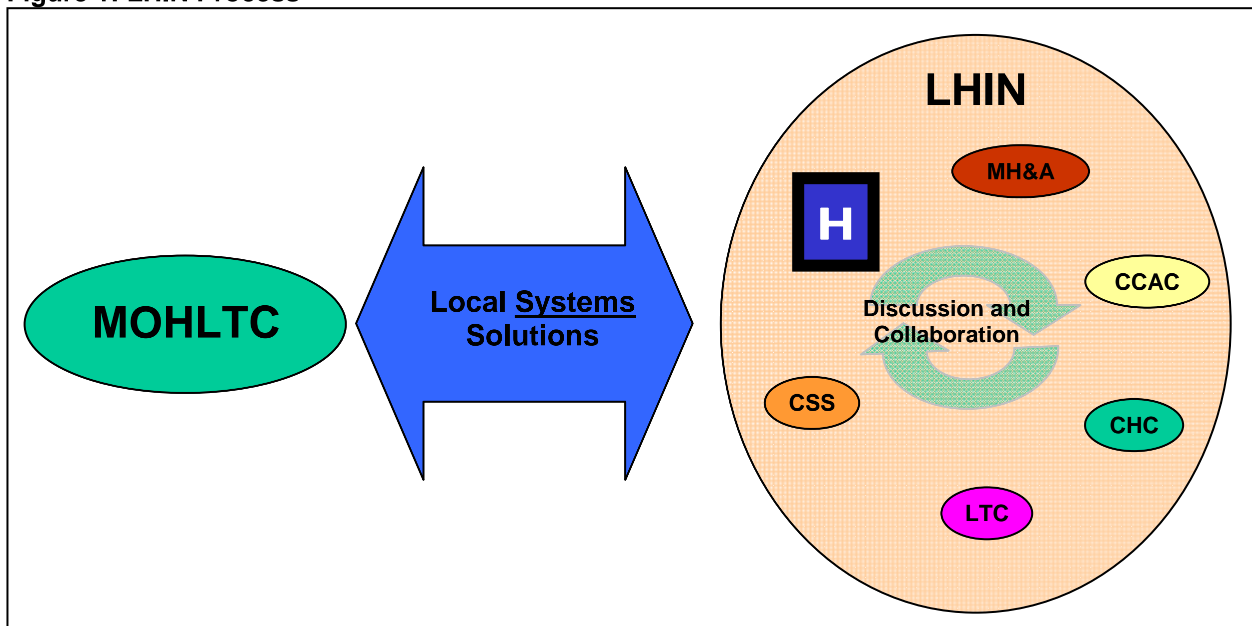
The LHINs were created by the Government of Ontario to address the often fragmented, complex and isolated manner in which many health care professionals provided services to Ontario residents. They were formed to work with local health providers and community members to identify and decide upon health service priorities in their respective regions. The NW LHIN assists with the planning, the integration and the allocation of local health services funding of:

- Hospitals (13)
- Community Care Access Centre (CCAC) (1)
- Community support service (CSS) organizations (61)
- Long-term care (LTC) homes (14)
- Community mental health and addictions (MH&A) agencies (37)
- Community health centres (CHC) (2)

Their involvement helps to ensure more efficient and effective access and integration of services for regional residents[1].

Figure 1 highlights the process through which the LHIN interacts with the various health providers and the bi-directional dissemination of 'local systems' solutions'.

Figure 1: LHIN Process



[Source: NW LHIN (2007). A Strong Health System, Healthy People…A Solid Future. PPT. September 24, 2007.]

[1] Ontario's Local Health Integration Networks. (2009). *About LHINs*. Retrieved from http://www.lhins.on.ca/aboutlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink

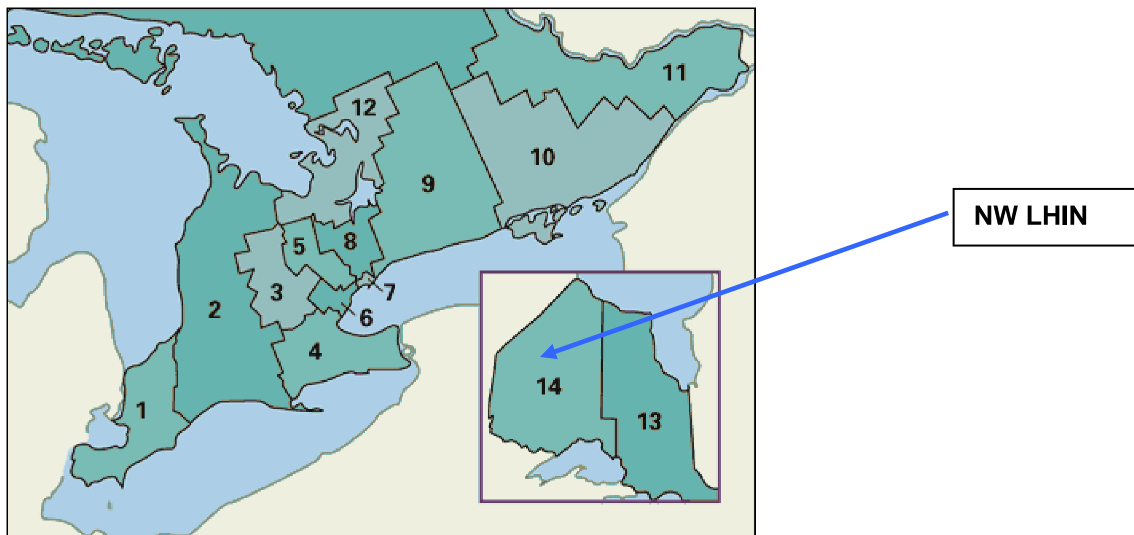
While devolving responsibility of the above mentioned providers to the LHINs, the Ministry of Health and Long-Term Care (MOHLTC) continues to fund major capital projects and has retained responsibility for the following providers:

- Public Health
- Physicians
- Ambulance services (emergency and non-emergency)
- Laboratories
- Provincial networks and programs[2]

2.1.2 THE NORTH WEST LOCAL HEALTH INTEGRATION NETWORK

Ontario is composed of 14 regions or LHINs (refer to Figure 2). The North West (NW) LHIN, which represents one of the regions, encompasses four sub-regions: the Districts of Rainy River and Thunder Bay; most of the Kenora District; and the City of Thunder Bay[3]. Figure 3 illustrates the geographically large size of the region and the location of its many small towns and First Nation communities. It also highlights the fact that many communities are accessible by air only. The rural and remote location of these communities results in significant challenges to health care delivery such as limited access to care, limited health human resources, need for extensive travel and higher costs per capita.

Figure 2: Map of the LHINs



[Source: NW LHIN. Ontario LHINs Map. http://www.northwestlhin.on.ca/map.aspx]

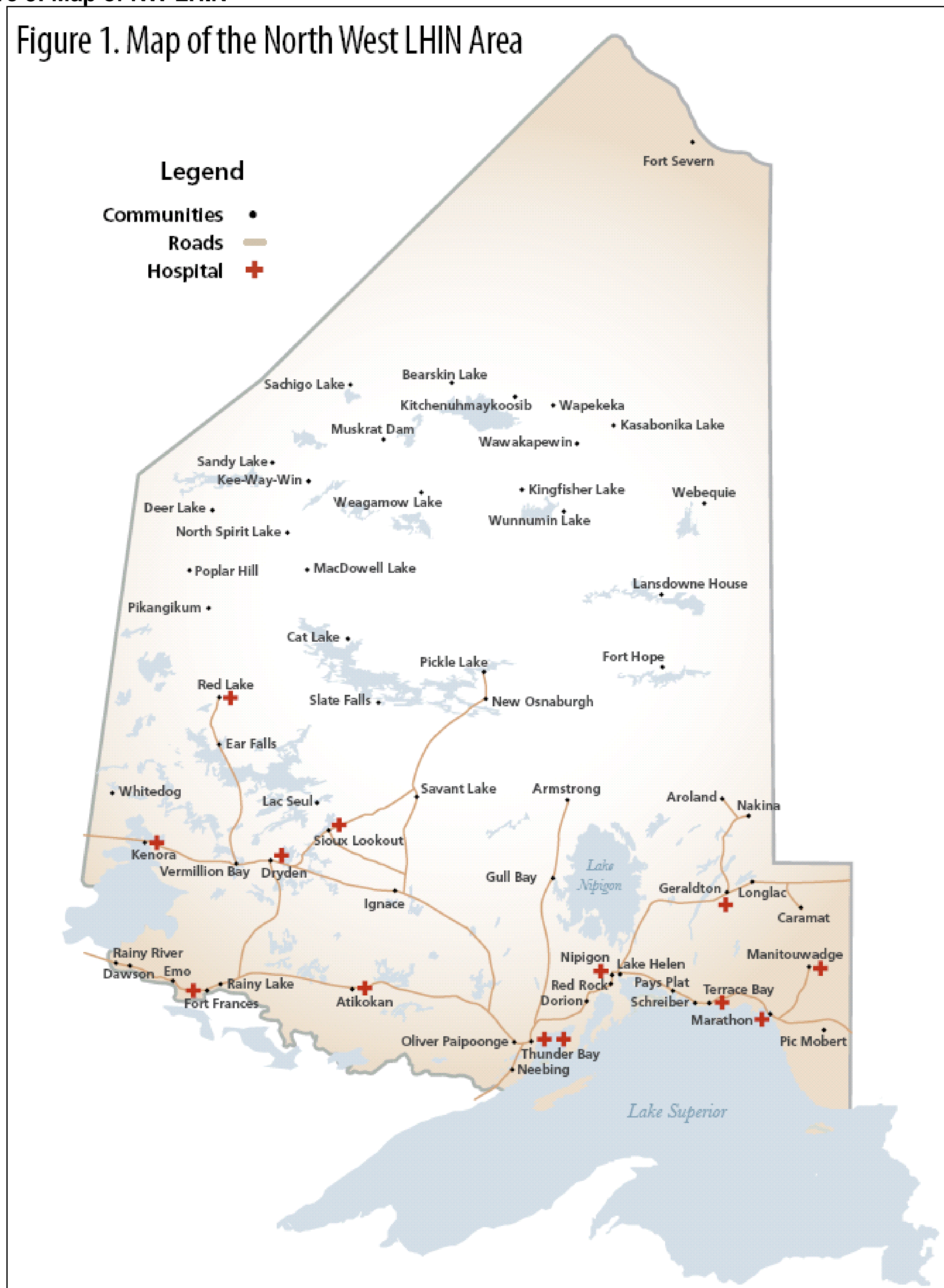
The NW LHIN is concerned with improving the quality and accessibility of health care for all residents within the region through enhanced integration and coordination of health services. The mission statement of the NW LHIN is: Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN. The vision of the NW LHIN is: Healthier people, a strong health system--our future[4]. The NW LHIN is established on the following values:

- Person-centred
- Culturally Sensitive
- Sustainable

[2] North West LHIN. (2010). *Ontario LHIN Legislation*. Retrieved from http://www.northwestlhin.on.ca/ontariolhinslegislation.aspx
[3] NW LHIN. 2009. About Our LHIN. Retrieved from: http://www.northwestlhin.on.ca/aboutourlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink
[4] NW LHIN. 2009. About Our LHIN. Retrieved from: http://www.northwestlhin.on.ca/aboutourlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink

- Accountable
- Collaborative
- Innovative

Figure 3: Map of NW LHIN



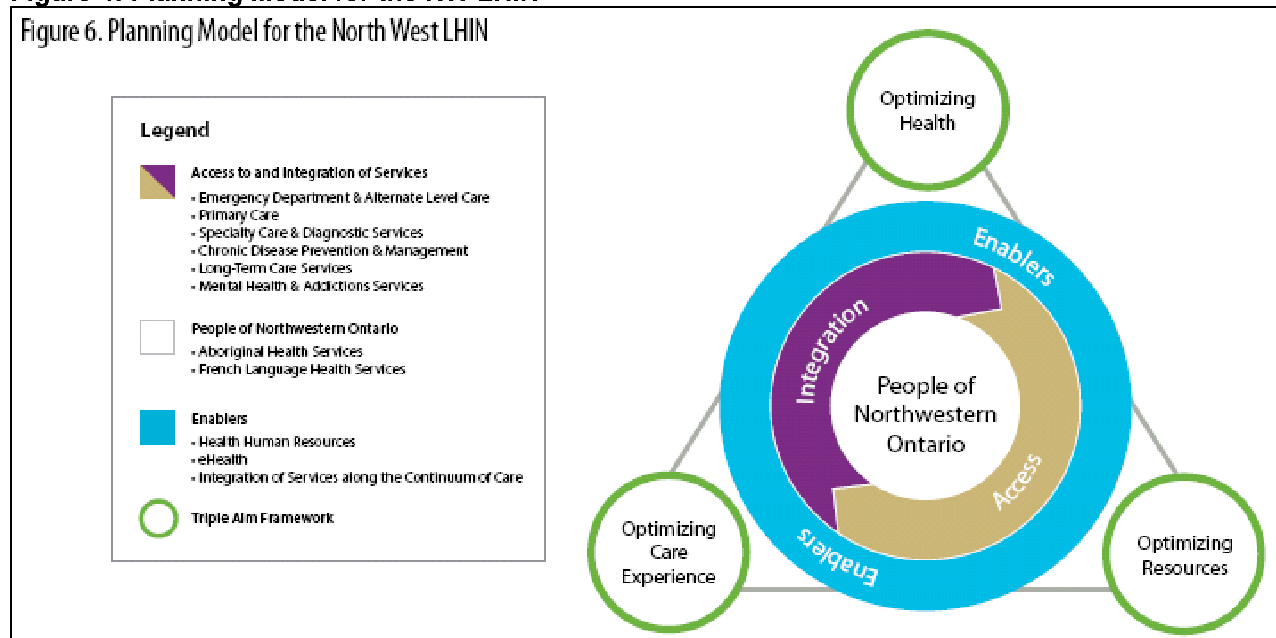
[Source: NW LHIN. (n.d.). Integrated Health Services Plan. Ontario LHIN.]

The 2010-2013 North West LHIN IHSP identifies the following priority areas:

- Access to and Integration of Services:
    - Emergency Department & Alternate Level of Care
    - Primary Care
    - Specialty Care & Diagnostic Services
    - Chronic Disease Prevention & Management
    - Long-Term Care Services
    - Mental Health & Addictions Services
- Enablers:
    - Health Human Resources
    - e-Health
    - Integration of Services along the Continuum of Care
- People of North-western Ontario:
    - Aboriginal Health Services
    - French Language Health Services[5].

Figure 4 represents the model of planning adopted by the NW LHIN that is based on the above mentioned priorities that were identified during community engagement sessions as well as in-person, on-line and video conference/teleconference discussions with Advisory Team members, Working Groups and Committee members and health service providers. The model is also based on quantitative data contained within local, provincial and national data sets.

Figure 4: Planning Model for the NW LHIN



[Source: North West LHIN Integrated Health Services Plan 2010-2013, no date]

2.2 NW LHIN POPULATION

2.2.1 SOCIO-DEMOGRAPHIC PROFILE OF THE NW LHIN POPULATION

The NW LHIN region is geographically large with a relatively small population. The region is comprised of approximately 1.9% of the entire population of Ontario. According to 2006 census data the population is

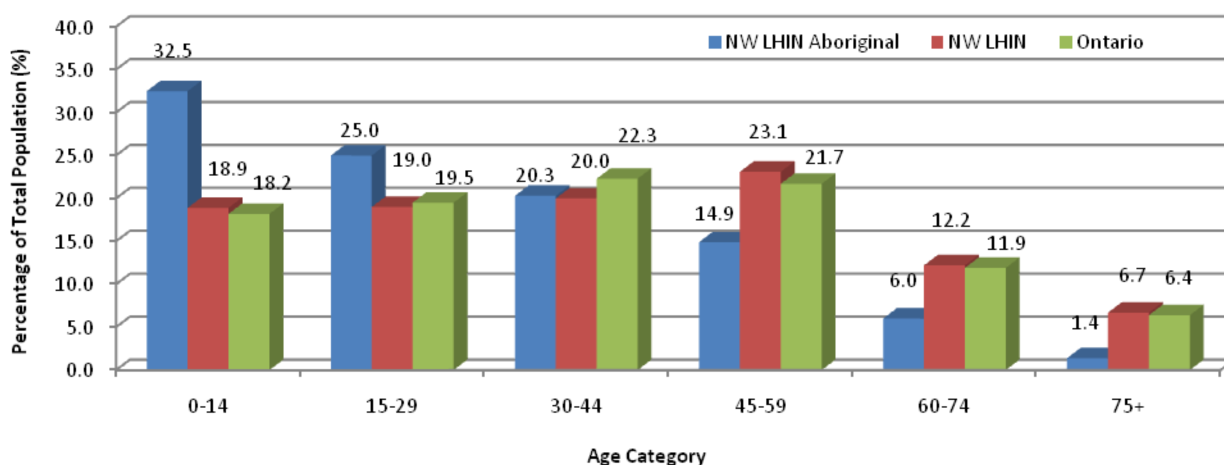
[5] North West LHIN. 2009. Integrated Health Services Plan. Retrieved from: http://www.northwestlhin.on.ca/integratedhealthserviceplan.aspx

highly concentrated around the urban centre of Thunder Bay. This census metropolitan area comprises of more than 52% of the population within the NW LHIN. Kenora and Dryden are the next most populous areas with 6.4% and 3.4% of the NW LHIN population respectively[6].

The NW LHIN is comprised of approximately 1.9% of the entire population of Ontario. Within the NW LHIN Region 19.8% of the population identifies themselves as Aboriginal and is the highest Aboriginal population of all of the LHINs in Ontario.

Figure 5 illustrates the population distribution by age group for the Aboriginal population within the NW LHIN Region, for the overall population of the NW LHIN Region, and for the province of Ontario.

Figure 5: Population Distribution by Age Group



[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

The Aboriginal population within the NW LHIN Region is significantly younger than that of the overall population within the NW LHIN and that of Ontario. Over half (57.5%) of the Aboriginal population is between the ages of 0 to 29, whereas these figures are 37.9% in the NW LHIN and 37.7% in Ontario overall.

The percentage of the Aboriginal population in the NW LHIN aged 15 years or older is 67.5% compared to 81.1% and 81.8% for the overall NW LHIN Region and Ontario, respectively (refer to Table 1). These numbers highlight the high percentage of children comprising the Aboriginal population (32.5%).

Table 1: Percentage of Population 15 Years and Older

	Total	Male	Female
Aboriginal NW LHIN	67.5%	66.7%	68.2%
Overall NW LHIN	81.1%	80.6%	81.7%
Ontario	81.8%	80.9%	82.7%

[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

Based on the 2006 census data the median age of the Aboriginal population in the NW LHIN is 24.8 years compared to 40.0 years for the overall population in the NW LHIN Region and 39.0 years in Ontario (refer to Table 2).

[6] North West LHIN. (2009). *Population Health Profile: North West LHIN*. Retrieved from http://www.northwestlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/North%20West%20LHIN%20Population%20Health%20Profile%202009%20v.2.pdf

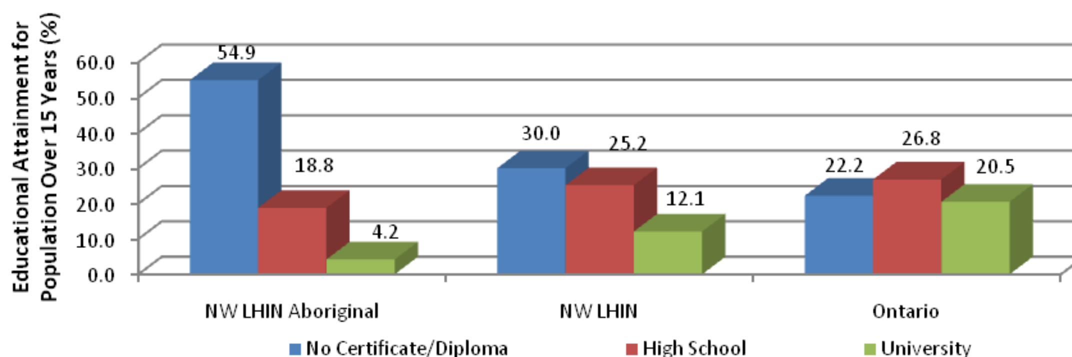
Table 2: Median Age of Population in NW LHIN and Ontario

	Total	Male	Female
Aboriginal NW LHIN	24.8	23.8	25.6
Overall NW LHIN	40.0	39.4	40.5
Ontario	39.0	38.1	39.9

[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

Figure 6 illustrates the educational attainment of the Aboriginal population over 15 years of age within the NW LHIN Region, the overall population over 15 years of age within the NW LHIN Region, and the Ontario population over 15 years of age. The Aboriginal population within the NW LHIN Region demonstrates lower educational attainment for individuals aged 15 years and older. More than half (54.9%) of that population does not have a certificate, diploma or degree, furthermore only 18.8% of the Aboriginal population have obtained a high school certificate or equivalent, which is lower than the attainment rate of the overall population within the NW LHIN Region and in Ontario (25.2% and 26.8%, respectively). The availability of education on-reserve is limited with the majority of communities only being able to provide elementary level education. This places a hindrance on the attainment of higher education for the on-reserve Aboriginal population as children and youth are required to leave their First Nation communities to continue their education (sometimes leaving their families and communities for extended periods).

Figure 6: Educational Attainment for Population Over 15 Years of Age

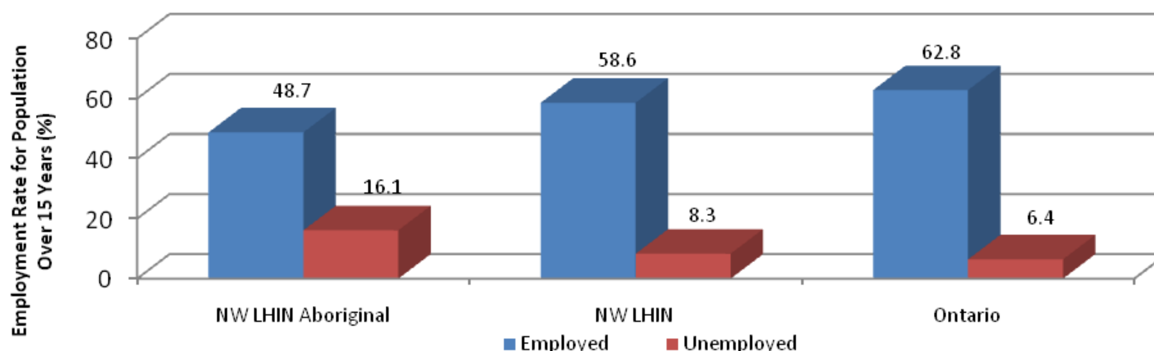


[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

Figure 7 reveals that within the NW LHIN Region, the Aboriginal population's employment rate is almost 10% lower than the overall population within the NW LHIN. The unemployment rate of the Aboriginal population within the NW LHIN Region is almost double that of the overall population of the NW LHIN and almost 40% lower than that of Ontario. Despite the difference in employment rate between the Aboriginal and overall population of the NW LHIN, the participation rate[7] is similar with 58.0% of the Aboriginal population within the NW LHIN participating the labour force and 58.6% of the overall NW LHIN population participating within the labour force.

[7] Participation rate includes those individuals who are active in the labour force either by employment or by actively seeking employment.

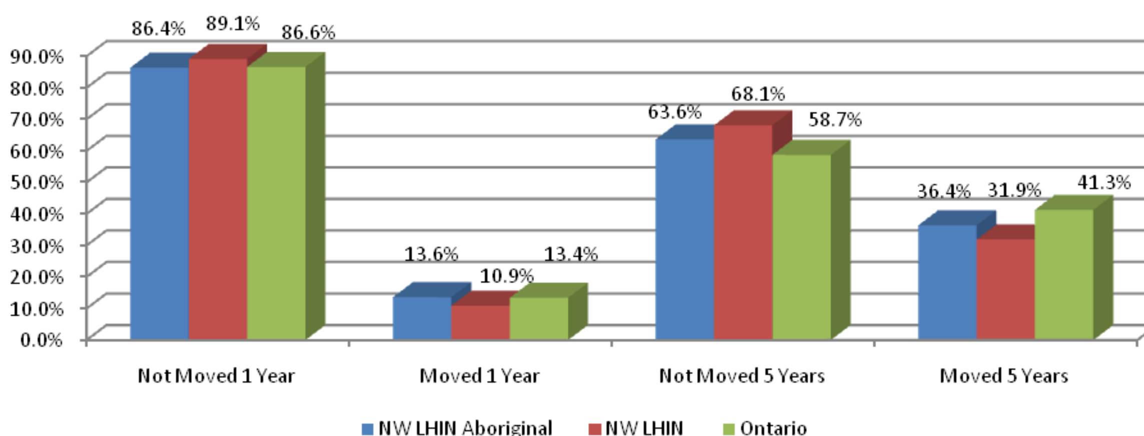
Figure 7: Employment Rate for Population Over 15 Years in Labour Force



[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

While the mobility rates are relatively similarly among the populations (refer to Figure 8), the Aboriginal population within the NW LHIN Region does have a slightly higher mobility rate in comparison to the overall population of the NW LHIN Region – 2.7% greater for 1 year and 4.5% greater for 5 years.

Figure 8: NW LHIN Mobility Rates



[Source: Statistics Canada, 2006 Community Profiles, 2006 Aboriginal Population Profile]

Within the NW LHIN, 58.5% of housing of the Aboriginal population is in need of both minor and major repair. Crowding is also a significant concern for First Nations housing. This is evident in that 6.5% of Aboriginal dwellings within the NW LHIN Region have more than one person per room – conversely only 1.5% of dwellings within the overall NW LHIN Region and 1.9% in Ontario have more than one person per room.

2.2.2 Health Profile of the NW LHIN Population

The following section presents an overview of health status information for the residents of the NW LHIN and for the population of Ontario.

Table 3 highlights the lower life expectancy for males and females in the North West region compared to Ontario overall. It also reveals that considerably less people in the North West believe their health to be ‘excellent’ or ‘very good’ (53.1% versus 60.0%, respectively) and that significantly more in the NW LHIN report activity limitations (40.8% versus 33.1%, respectively). On the positive side, the North West population reports less low birth weight babies than the province (3.8/100 versus 6.1/100, respectively) and somewhat lower rates of infant mortality (4.73/1000 versus 5.4/1000, respectively).

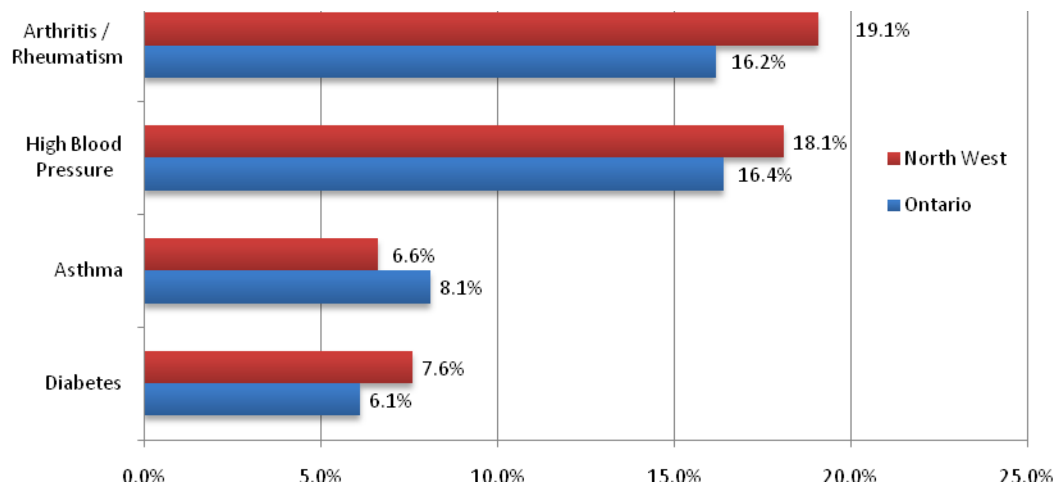
Table 3: Health Status of the Overall Northwest and Ontario Populations

	NORTHWEST	ONTARIO	LHIN RANGE
Female Life Expectancy at birth (years), 2005	80.5	82.7	80.2-84.8
Male Life Expectancy at birth (years), 2005	76.8	78.6	75.6-81.5
Low Birth Weight Babies (per 100), 2006	3.8	6.1	3.8-7.39
Infant Mortality Rate (per 1000 live births), 2003-2005	4.73	5.4	3.78-7.30
Population who say their health is Excellent or Very Good (12+), 2007	53.1%	60.0%	53.1%-65.3%
Population with an Activity Limitation (12+), 2007	40.8%	33.1%	27.3%-43.4%

[Source: NW LHIN. (2009). Population Profile: North West LHIN [Source: Vitals Statistics, CCHS]]

With the exception of asthma (6.6% versus 8.1%), on a selected range of chronic conditions, the North West population fairs slightly worse than the overall Ontario population with respect to arthritis/rheumatism (19.1% versus 16.2%), high blood pressure (18.1% versus 16.4%) and diabetes (7.6% versus 6.1%) (refer to Figure 9).

Figure 9: Prevalence of Selected Chronic Conditions (Population Age 12 and older) for Overall North West and Ontario Populations



[Source: NW LHIN. (2009). Population Profile: North West LHIN]

Tables 4 and 5 reveal that the North West population has a higher mortality rate (all causes: 675.6 versus 559, respectively) and a higher rate of potential years of lost life (all causes: 6509/100,000 versus 4681.6/100,000, respectively) than the province as a whole.

Table 4: Age Standardized Mortality Rates by ICD-10 per 100,000 for the Overall Northwest and Ontario Populations (2004)

	NORTHWEST	ONTARIO
ALL CAUSES	675.6	559
I. Infectious Diseases	†	9.3
II. Neoplasms	187.1	173.1
III. Diseases of Blood	†	1.8
IV. Endocrine/Nutritional Disorders	38.7	26.5
V. Mental and Behavioural Disorders		14.5
VI. Nervous System Diseases	36.3	23.6
VII. Eye Diseases	†	†
VIII. Ear Diseases	0.0	†
IX. Circulatory System Diseases	213.5	178.7
X. Respiratory System Diseases	42.2	43.2
XI. Digestive System Diseases	†	22.0
XII. Skin Diseases	†	1.0
XIII. Musculoskeletal Diseases	†	3.4
XIV. Genitourinary Diseases	†	11.9
XV. Maternal Conditions	†	†
XVI. Perinatal Conditions	†	4.8
XVII. Congenital Conditions	†	3.3
XVIII. Symptoms Not Classified Elsewhere	†	8.1
XIX. Injury and Poisoning	N/A	N/A
XX. External Causes of Mortality	59.5	33.7
XXI. Factors Influencing Use of Services	N/A	N/A

[Source: NW LHIN. (2009). Population Profile: North West LHIN. [Source: Vital Statistics]]

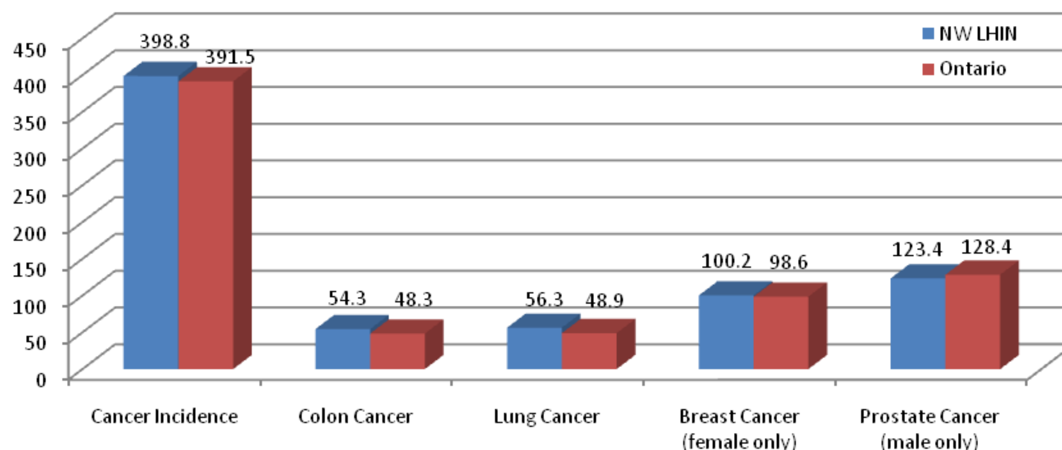
Table 5: Potential Years of Lost Life Rate by ICD-10 per 100,000 for the Overall Northwest and Ontario Populations (2004)

	NORTHWEST	ONTARIO
ALL CAUSES	6509	4681.6
I. Infectious Diseases	99.1	105.5
II. Neoplasms	1,534.8	1,546.7
111. Diseases of Blood	†	15.4
IV. Endocrine/Nutritional Disorders	452.5	184.8
V. Mental and Behavioural Disorders	128.2	63.6
VI. Nervous System Diseases	175.4	143.9
VII. Eye Diseases	†	†
VIII. Ear Diseases	†	†
IX. Circulatory System Diseases	1,197.7	803.4
X. Respiratory System Diseases	162.2	138.9
XI. Digestive System Diseases	372.8	188.0
XII. Skin Diseases	†	3.1
XIII. Musculoskeletal Diseases	37.0	21.9
XIV. Genitourinary Diseases	87.2	35.1
XV. Maternal Conditions	†	4.7
XVI. Perinatal Conditions	†	285.5
XVII. Congenital Conditions	175.0	155.5
XVIII. Symptoms Not Classified Elsewhere	149.1	161.7
XIX. Injury and Poisoning	N/A	N/A
XX. External Causes of Mortality	1,748.0	823.9
XXI. Factors Influencing Use of Services	N/A	N/A

[Source: NW LHIN. (2009). Population Profile: North West LHIN. [Source: Vital Statistics]]

Incidence rates of cancer in the NW LHIN region are slightly higher in all instances, with the exception of prostate cancer, than in Ontario (refer to Figure 10).

Figure 10: Incidence of Cancer for the Overall North West and Ontario Populations



[Source: Statistics Canada Community Health Profiles, 2009]

With respect to mental health and addictions issues specifically, the NW LHIN Integrated Health Services Plan 2010-2013 reports the following[8]:

- Rate of suicide in the NW region is almost double the provincial average (15.2/100,000 versus 7.7/100,000)
- 10% of Ontario's substance abuse and problem gambling clients reside in the NW region (versus 2% in Ontario's total population)
- Substance-related disorders account for the highest percentage (45%) of mental health visits to the emergency departments (versus 27.5% in Ontario's total population)
- Mental health inpatients are more highly represented in substance-related disorders that in Ontario (37.6% versus 15.1%)
- More than half (56.1%) of clients requiring addictions services are unemployed or their employment status is unknown (versus 35.3% in Ontario)
- As a consequence of a lack of specialized services in most communities, challenges associated with accessing mental health services have been identified for clients in crisis and for those needing specialized care, transitional care, supportive housing and walk-in services.

[8] NW LHIN. (2009). Integrated Health Services Plan, 2010-2013.
http://www.northwestlhin.on.ca/uploadedFiles/Home_Page/Integrated_Health_Service_Plan/North%20West%20LHIN%20Integrated%20Health%20Services%20Plan%202010-2013%20FINAL(1).pdf p. 13.

3.0 METHODOLOGY

3.1 KEY RESEARCH QUESTIONS

Table 6 presents the overarching research questions guiding the Aboriginal Health Programs and Services Analysis and Strategies project and indicates the lines of evidence employed in answering the questions.

Table 6: Research Questions and Lines of Evidence

Questions	Lines of Evidence			
	Program and Service Inventory	Literature Review	Community Consultations	Key Stakeholder Interviews
What health programs and services are currently available to Aboriginal people residing in the NW LHIN?	√		√	√
▪ What are the utilization patterns of the programs and services?	√		√	√
▪ What resources (human and financial) are available to the programs and services?	√		√	√
▪ What are the referral patterns of the programs and services?	√		√	√
▪ What are the wait times for access to programs and services?	√		√	√
▪ What challenges, if any, do Aboriginal people encounter when trying to utilize programs and services?	√	√	√	√
What are the gaps/duplications in programs and services offered to Aboriginal people residing in the NW LHIN?	√	√	√	√
What partnerships (formal and informal) currently exist between health care professionals providing programs and services to Aboriginal people residing in the NW LHIN?	√	√	√	√
▪ What partnerships could be developed?	√		√	√
What opportunities exist for integration between the programs and services (at all levels) offered to Aboriginal people residing in the NW LHIN?			√	√
To what extent are health care technologies being used by Aboriginal communities residing in the NW LHIN?		√	√	√
▪ What possibilities exist for the expansion of technology and innovation in Aboriginal communities?			√	√
What is the health status of Aboriginal people residing in the NW LHIN with respect to chronic disease, injury, mental health and addictions, acute illness and mortality rates?		√	√	√

Questions	Lines of Evidence			
	Program and Service Inventory	Literature Review	Community Consultations	Key Stakeholder Interviews
▪ Are there variations in health status by Treaty/group/geographic area (e.g., Treaty #9, Treaty #3, Robinson Superior, Métis, urban, rural, on-reserve, off-reserve)?		√	√	√
▪ What are the primary health needs and concerns of Aboriginal community members?		√	√	√
What best practices and lessons learned could be adopted to help guide future Aboriginal mental health and addictions programs and services in the NW LHIN?		√	√	√

3.2 Project Methodology

The findings presented in the Final Report reflect research information collected from multiple lines of evidence. These include:

- Environmental Scan
- Literature Review
- Community engagement sessions and one-on-one community interviews
- Community telephone interviews
- Key stakeholder interviews

Such an approach allows for the triangulation of results, thereby improving the reliability and validity of the overall report findings.

3.2.1 Environmental Scan

The environmental scan was conducted to create a service map/inventory of current health programs, services and resources available to Aboriginal people in the NW LHIN, including mental health and addictions programs and services.

The scan involved gathering, assembling and organizing health care capacity (programs, services, funding agencies) for the following health programs and services available to Aboriginal peoples and communities:

- NW LHIN funded health programs and services
- Provincially funded health strategies and programs (Aboriginal Healing & Wellness Strategy (AHWS))
- Health programs and services funded by other Ministries (e.g., Child, Youth & Family Services (CYFS))
- Federally funded programs and services (e.g., programs offered through First Nations and Inuit Health Branch (FNIHB))
- Aboriginal-specific initiatives managed by mainstream health providers
- Aboriginal-specific initiatives managed and administered by community members

Multiple methods were used to collect information for the environmental scan: internet searches; document/report review; and, contacting service and program providers.

Internet Search

The preliminary method of data collection was through internet searches. This involved the identification and review of a number of relevant websites, including:

- Aboriginal organizations (e.g., Political Territorial Organizations (PTOs), Tribal Councils, Chiefs of Ontario, Métis Nation, Ontario Native Women's Association (ONWA), Friendship Centres)
- Aboriginal organizations providing services within urban centres were identified through searches of AHWS partnership organizations, Aboriginal Health Access Centres, and Aboriginal Health Planning Authorities.
- Tribal Councils and PTOs were identified primarily through Chiefs of Ontario.
- First Nation communities
- Through Chiefs of Ontario, DPRA confirmed First Nations communities within the NW LHIN area and affiliated Tribal Councils / PTOs.
- K-Net (http://communities.knet.ca) provided additional detail on community-level services where available.
- Internet searches were carried out using First Nation community names as well as search terms such as Ontario Aboriginal, Métis Aboriginal, and combined variations.
- If websites detailing community information or services were found, they were scanned for any relevant information detailing services provided by the Nation or by other organizations within the community.
- Municipalities (e.g., Municipality of Greenstone, City of Thunder Bay, Municipality of Red Lake)
- Internet searches for other community websites were conducted using the NW LHIN-identified community list.
- Community websites were then scanned for programming related to seniors, community support programs, and/or other relevant programs and services.
- Provincial Ministry programs (e.g., Akwe:go and Wasa Nabin – Ministry of CYFS)
- DPRA scanned Ontario provincial ministry websites for related programming.
- First Nations and Inuit Health Branch (FNIHB)
- Program information was identified through searches of specific program names as found in the First Nations and Inuit Health Program Compendium[9] and through review of other First Nations and Inuit Health Branch publications.
- Social- and health-related websites (e.g., Community Care Access Centre website)
- Several other databases of health and mental health/addictions programs were searched for treatment centres, services, or service providers located within the NW LHIN geographic area, including:
- DART – the Drug and Alcohol Registry of Treatment Centres
- 310ccac.ca
- Lakehead Social Planning Council
- Using the NW LHIN background documents on available programs (including recent Ontario Telehealth Summary of Telemedicine Activity in the NW LHIN, NW LHIN Health Providers, Programs and Services 2005), internet searches were also conducted on health service providers as identified in the NW LHIN to review each provider for possible programs.

Document /Report Review

Health programs and services available to First Nations/Aboriginal/Métis within the NW LHIN were also identified through a scan of documents and reports focusing on Aboriginal health in Ontario and Canada. Some of these sources provided information on the names of programs and the URL addresses of websites that were then searched. These were primarily identified through internet searches for documents with search terminology such as "aboriginal health programs" and "environmental scan of health programs", as well as through websites for organizations or agencies already identified through other searches. Examples include:

[9] Health Canada. (2007, March). First Nations and Inuit Health – Program Compendium. Retrieved January 2010, from: http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2007_compendium/index-eng.php

- Health Canada. (2001). National Program Inventory - Concurrent Mental Health and Substance Use Disorders. Prepared by the Centre for Addiction and Mental Health in collaboration with the Canadian Centre on Substance Abuse. Ottawa: Minister of Public Works and Government Services Canada.
- Lamouche, J. (2002). Environmental Scan of Métis Health Information, Initiatives and Programs. Métis Centre, National Aboriginal Health Organization.
- Greenwood, M. (2006). Landscapes of Indigenous Health: An Environmental Scan by the National Collaborating Centre for Aboriginal Health. Prince George: University of Northern British Columbia.
- Health Canada. (2007, March). First Nations and Inuit Health – Program Compendium. Retrieved January 2010, from: http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2007_compendium/index-eng.php.

Contacting Service and Program Providers

Telephone calls were made to several Aboriginal service and program providers including Friendship Centres, the AHWS, and Aboriginal Health Access Centres in order to confirm information retrieved from websites and to obtain any addition information. This method proved to be unsuccessful given that many of the organizations contacted were reluctant to provide information not publicly available on their respective websites and/or were too busy to reply. Further contact was conducted through key informant interviews.

Health Canada's First Nation and Inuit Health Branch (FNIHB) was also contacted in order to help confirm the programs offered at the community level (i.e., specific programs offered in specific communities). This information was used to populate the program inventory[10].

Additionally, information for the environmental scan was derived from the community engagement session, community telephone interviews and key stakeholder interviews. Those methods are described below.

3.2.2 Literature Review

A review of relevant literature was carried out in order to gather information on Aboriginal health status, as well as community health concerns and priorities in the NW LHIN region and more generally in Ontario and Canada. Sources of literature were provided to the research team by relevant organizations and/or obtained through internet searches and key search terms (e.g., First Nation, Métis, Aboriginal, Native and Canada, Ontario, Northwestern Ontario, specific community names and specific health conditions (e.g., diabetes, accidents).

Key websites utilized include:

- Assembly of First Nations (AFN) http://www.afn.ca.
- North West Local Health Integration Network (NW LHIN) http://www.nwlhin.on.ca.
- Centre for Rural and Northern Health Research http://www.cranhr.ca/romanow.html.
- College of Family Physicians of Canada http://www.cfpc.ca/english/cfpc/research.
- National Aboriginal Health Organization (NAHO) http://www.naho.ca/english.
- Health Canada http://www.hc-sc.gc.ca.
- Ministry of Health and Long Term Care (MOHLTC) http://www.health.gov.on.ca/en/default.aspx.
- Health Council of Canada http://www.healthcouncilcanada.ca/en/.
- Public Health Agency of Canada (PHAC) http://www.phac-aspc.gc.ca/index-eng.php.
- Statistics Canada http://www12.statcan.ca.
- World Health Organization (WHO) http://www.who.int/topics/chronic_diseases/en/

[10] FNIHB provided program funding amounts by community to DPRA. FNIHB asked that this information not be made publicly available.

Additionally the following health surveys were utilized:

- Aboriginal Peoples Survey, 2006 (An Overview of the Health of the Métis Population).
- A Statistical Profile on the Health of First Nations in Canada – Self-rated Health and Selected Conditions, 2002 to 2005.
- First Nations Regional Longitudinal Health Survey (RHS) 2002/03.

The First Nations Regional Longitudinal Health Survey (RHS) is "…the only First Nations governed, national health survey in Canada. It is longitudinal in nature and collects information based on both Western and traditional understandings of health and wellbeing"[11]. It is overseen by the First Nations Information Governance Committee (FNIGC) who is appointed by the Assembly of First Nations (AFN). Data collection for RHS Phase 1 (the version of the RHS referred to within this report) was conducted in 2002-2003 and includes information for First Nations participants (no Inuit communities were included). A total of 238 First Nations communities participated, and a total 22,602 surveys were collected and analyzed. Of those 238 communities, 29 were within Ontario and the following were within the NW LHIN geographic area:

- Couchiching First Nation
- Eabametoong First Nation
- Eagle Lake
- Ginoogaming First Nation
- Grassy Narrows First Nations
- Kee-Way-Win
- Lac Seul
- Naotkamegwanning Anishinabe First Nation
- Ojibways of Pic River First Nation
- Sachigo Lake
- Sandy Lake
- Saugeen
- Wabigoon First Nation
- Whitefish Lake First Nation

While participating community names are available, the RHS is dedicated to providing national-level statistics and cannot report on health on a regional or community level[12]. A regional report for Ontario is not currently available.

A bibliography of materials is located in Appendix A.

3.2.3 COMMUNITY ENGAGEMENT SESSIONS

Community Engagement Sessions were held to collect information on health programs and services available to Aboriginal peoples in the NW LHIN and on the health status/conditions (e.g., chronic disease, mental health and addictions, injuries) of the Aboriginal population by community.

The sessions provided an opportunity to gather perceptions, opinions and knowledge pertaining to Aboriginal community health more generally. An invitation letter was emailed or faxed to the Chief and the Health Director of all First Nation communities in the NW LHIN Region explaining the nature of the project and inviting their respective community participate in the process (refer to Appendix C).

For those communities that expressed an interest, DPRA scheduled sessions, in consultation with community contacts, and arranged days and times convenient to the staff. Sessions organized in the urban centres were held in available meetings venues, including hotels or community centres.

[11] RHS. (2010). *RHS Background and Governance*. Retrieved from: http://www.rhs-ers.ca/english/background-governance.asp
[12] RHS. (2010). *RHS Background and Governance*. Retrieved from: http://www.rhs-ers.ca/english/background-governance.asp

The sessions were approximately 2 to 3 ½ hours in duration and included a brief presentation on the project and a facilitated discussion on the following key themes (refer to Appendix E):

- Gaps in program and services
- Challenges faced by Aboriginal people in accessing health programs and services
- Community health programs opportunities and successes
- Community health issues and concerns
- Inventory of community health programs and services

With respect to the inventory, posters were prepared that presented the key programs and services identified in the inventory and believed to be available in the community. Participants were invited to review the posters and identify programs that were no longer available or programs that were missing from the inventory. DPRA facilitated the events and used flip-charts to capture the comments.

Twelve engagement sessions were completed with a range of 5 to 12 participants per session. Subsequent interviews were also conducted during the community visit with relevant staff and leadership. In total 20 communities participated in the engagement sessions.

Table 7 presents the engagement session locations, participating communities and number of participants at the sessions.

Table 7: Community Engagement Sessions

Engagement Session Location	Participating Communities	Number of Participants
Fort Frances	Anishinaabeg of Naongashining First Nation Big Grassy First Nation Naicatchewenin	4
Couchiching First Nation	Couchiching First Nation	7
Cat Lake First Nation	Cat Lake First Nation	7 at the engagement session 1 additional interview
Fort Hope First Nation	Fort Hope First Nation	2 at the engagement session 5 additional interviews
Thunder Bay	Namaygoosisagagun First Nation Red Rock First Nation Whitesand First Nation Gull Bay First Nation	4
Geraldton	Ginoogaming First Nation	2
Marathon	Ojibways of Pic River First Nation Pic Mobert First Nation	2
Kenora	Northwest Angle #37 First Nation Naotkamegwanning First Nation Ochiichagwe'babigo'ining First Nation	6
Dryden	Eagle Lake First Nation	6
Sioux Lookout	Slate Falls First Nation	2
Sandy Lake	Sandy Lake First Nation	11 at the engagement session 5 additional interviews
Webequie	Webequie First Nation	8

Participation in the Community Engagement Sessions was generally well received by First Nations communities within the Region. It is believed that participation in these sessions reflects the fact that health and its associated challenges are important issues for many First Nations communities and that participation in these sessions would help to further highlight the need for adequate, appropriate and well-

funded health programs and services. Having said that, however, many participants did highlight several concerns which they wished to be represented in this report.

Participants discussed the historical relationship between First Nation communities and the federal government including the historical and contemporary reasons why communities lack trust that the federal or provincial governments will act in the best interest of Aboriginal people.

The First Nation communities that participated in the sessions were also concerned about the overall intent of the data collection and the manner in which the information would be used by the NW LHIN (e.g., as justification to cut services from communities). Participants also indicated their general lack of awareness surrounding the NW LHIN and/or their lack of understanding and knowledge about the role that the NW LHIN plays in Aboriginal health programs and services.

3.2.4 COMMUNITY TELEPHONE INTERVIEWS

Communities that were unable to attend a session were invited to participate in a telephone interview to discuss the following (refer to Appendix E):

- Gaps in program and services
- Challenges faced by Aboriginal people in accessing health programs and services
- Community health programs opportunities and successes
- Community health issues and concerns
- Inventory of community health programs and services

The telephone interviews were 20 to 30 minutes in length and included a brief overview of the project and interview questions. There were 27 communities that participated in a telephone interview. Table 8 presents the communities that provided feedback through a telephone interview.

Table 8: Community Telephone Interviews

North Caribou	Nibinamik	Kingfisher
Wabauskang	Fort Severn	Bearskin Lake
Deer Lake	Rainy River	Lac la Croix
Fort William	Wunnumin Lake	Biinjitiwaabik Zaaging Anishinaabek
Wapekeka	Sachigo Lake	Lac Seul
Pays Plat	Shoal Lake	Wabigoon
Obaskaandagaang	Neskantanga	Wawakapewin
Ojibways of Onigaming	Poplar Hill	Keewaywin
Pikangikum	Kasabonika	
	Nigigoonsiminikaaning	

3.2.5 KEY STAKEHOLDER INTERVIEWS

Key Stakeholder Interviews were held to collect information on health programs and services available to Aboriginal peoples in the NW LHIN and on the health status/conditions of the Aboriginal population by community and region.

Stakeholder interviews were semi-structured and conducted by telephone. Thirty-one interviews were completed, with interviews lasting approximately 30 to 45 minutes in length.

Refer to Appendix D for a copy of the interview questions.

Key Stakeholder Interviews were conducted with representatives from:

- Community and Regional Hospitals

- NW Aboriginal Health Services Advisory Committee
- Northern Ontario School of Medicine
- Health Canada
- Health Access Centers
- Dilico Anishinabek Family Care
- NW CCAC
- Community Health Centers
- Keewaytinook Okimakanak
- Family Health Teams
- Tribal Councils
- Health Planning Authorities

Appendix B contains a list of the Key Stakeholder participants.

Detailed notes were taken during the interview, transcribed to computer, and the results entered into a summary.

4.0 LIMITATIONS AND CHALLENGES

4.1 PROJECT CHALLENGES

A number of project challenges were encountered by DPRA during the planning and facilitation of project tasks as well as during the reporting of Aboriginal programs and services.

- **Availability to Participate:** The health staff and leadership invited to participate in the engagement sessions or through telephone interviews were occupied with end of fiscal year tasks and associated day-to-day responsibilities. Thus, a number of contacted individuals were not available at designated times and some interviews were re-scheduled multiple times. Some invited participants indicated that they were too busy during the month of March and would not be available to participate during the allotted timeframes.

- **Interest and Commitment to Participate:** Some participants are unaware of the LHIN, its mandate and the role it plays with respect to Aboriginal health programming. Some contacted individuals were not supportive of the LHINs and as such did not want to take part. Because others did not understand how they would benefit from the project or how their information would be used to improve health services and programs in their community, they chose not to participate.

- **Government and Jurisdictional Challenges:** Jurisdictional complexities (federal, provincial/territorial, Aboriginal governing authority or combination thereof) also create problems in the collection of data[13]. First Nations, Inuit and Métis people in Canada receive healthcare from a complicated system that involves federal, provincial/territorial governments, and/or Aboriginal organizations (often in partnership with different levels of government)[14]. The challenge associated with this complexity is a result of the multi-jurisdictional nature of current Aboriginal populations, resulting in clients crossing jurisdictional boundaries as they move from primary care services in their home communities to larger centers for tertiary care[15,16]. The fractured jurisdictional responsibilities and lack of communication that appear to surround jurisdictions leads to data getting lost and to a duplication of research[17]. It is anticipated that additional jurisdictional problems will arise as more Aboriginal people migrate to urban centres. Currently, half of the Canadian Aboriginal population resides in urban areas, and that number is on the rise[18].

- **Accessibility of Data:** While some information was obtained from Aboriginal organizations and communities, most indicated an unwilling to share their health data with the researchers. Aboriginal people have expressed concern with the manner in which the information they provide to researchers is both used and interpreted

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[13] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).
[14] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[15] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).
[16] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[17] Métis Centre at National Aboriginal Health Organization. (2007). NAHO: A Knowledge Translation Organization – How We See It! Broader Determinants of Health Within Aboriginal Contexts [presentation, delivered at VACCHO, October 23, 2007, Melbourne].
[18] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).

4.2 DATA LIMITATIONS

Improving Aboriginal Health Programs and Services in the North West Local Health Integration Network is hindered by the lack of a health information system that documents fundamental facts and statistics about Aboriginal people's health status and services utilization. While there is evidence that Aboriginal people in Canada experience poorer health compared to other Canadians, the health status and health services utilization of Aboriginal people in Ontario is not readily known due to incomplete and inaccurate information collection. There are a number of reasons why the collection of valid and reliable data for Aboriginal groups presents a challenge in Ontario.

- **Lack of ethnic identifier:** The lack of an Aboriginal identifier masks the health status, health services utilization and ultimately, the health needs and priorities of Aboriginal people. There is an inability to consistently track treatment and outcome data specific to Aboriginal clients once they enter the provincial system[19]. It is often difficult to document the health and care of Métis or other Aboriginal people who do not have registered status. In many cases, they can only be identified if they are members of an Aboriginal organization[20,21]. In many cases, Aboriginal people access health care services from hospitals or private practice physicians under provincial jurisdiction; the data relating to those services does not necessarily identify the clients as either First Nations (or Inuit)[22]. As a result, the needs of Aboriginal Canadians that use these provincial services are unknown because client's ethnicities are not recorded in the provincial database[23]. For example, all Canadian Provinces are equipped with population-based cancer registries that report data on the number of cancer cases within their population; however, determining the incidence and prevalence of cancer in Aboriginal populations is impossible because these provincial registries do not report cancer data by ethnicity[24].

- **Data Gaps:** There is a lack of standard, comprehensive and repeated measures of health status at the population level. Existing data provides indirect measures of health outcomes such as hospital admissions, but further direct measures are required in order to track changes in health status before and after care[25]. There is a lack of comprehensive information regarding the full spectrum of health care services received by clients – specifically at the primary care level. This information is critical for the study of outcomes for individuals with chronic conditions such as diabetes and depression[26]. There is even less health information readily available for the Métis population than the First Nations and Inuit populations. More generally, health information is not always gathered for each Aboriginal sub-population (e.g., Métis, First Nations, Inuit) and thus information about a particular topic may be available for one group but not another[27]. There is insufficient data for many areas of Aboriginal health and well-being[28].

- **Data Quality:** The data collected on Aboriginal health is often of poor quality and as such precludes the ability of health care professionals to use it to improve Aboriginal health planning, programming and policy development. Population-based epidemiological studies require an

[19] Health Canada. (2004). *Healthy Canadians: A Federal Report on Comparable Health Indicators 2004* (ISBN: 0-662-68495-8). Ottawa, ON: Her Majesty the Queen in Right of Canada.
[20] Health Canada. (2004). *Healthy Canadians: A Federal Report on Comparable Health Indicators 2004* (ISBN: 0-662-68495-8). Ottawa, ON: Her Majesty the Queen in Right of Canada.
[21] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[22] Health Council of Canada. (2005). *The Health Status of Canada's First Nations, Métis and Inuit Peoples: A Background Paper to Accompany Health Care Renewal in Canada: Accelerating Change*. Toronto, ON: (publisher details unknown)
[23] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[24] Reading, J, Ph.D. (n.d.). *The Crisis of Chronic Disease Among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. Centre for Aboriginal Health Research: University of Victoria, British Columbia.
[25] Statistics Canada. (2008). *Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census, Catalogue no. 97-558-XIE*. Retrieved from http://www12.statcan.ca/english/census06/analysis/aboriginal/index.cfm.
[26] Statistics Canada. (2008). *Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census, Catalogue no. 97-558-XIE*. Retrieved from http://www12.statcan.ca/english/census06/analysis/aboriginal/index.cfm.
[27] Health Council of Canada. (2005). *The Health Status of Canada's First Nations, Métis and Inuit Peoples: A Background Paper to Accompany Health Care Renewal in Canada: Accelerating Change*. Toronto, ON: (publisher details unknown)
[28] Health Council of Canada. (2005). *The Health Status of Canada's First Nations, Métis and Inuit Peoples: A Background Paper to Accompany Health Care Renewal in Canada: Accelerating Change*. Toronto, ON: (publisher details unknown)

accurate count of people diagnosed with a condition in a population whose size is known exactly. The problem of identifying the number of patients who are Aboriginal is compounded by inaccurate population figures of First Nations, Inuit and Métis populations[29]. Recent research on schizophrenia in Indigenous populations is limited; however, the studies that do exist both contradict and support earlier research on the topic[30]. Also, depression is often assumed to be prevalent among Indigenous peoples because of high suicide rates in some communities; however, reports of depressive episodes among Indigenous peoples vary considerably. Further, reports of depression among Aboriginal peoples are almost exclusively restricted to First Nations, with little information for Métis, Inuit, and non-Status Natives[31]. Poor data quality leads to variable and sometimes questionable research findings.

- **Operational Challenges:** There is a need for increased infrastructure development in capturing Aboriginal health data, which will require a workforce that is competently able to draw on Aboriginal conceptual and governance frameworks, as well as the best public-health tools that the country has to offer[32]. The preference is to establish the infrastructure for Aboriginal organizations to perform all data management functions[33]. This requires a substantial number of people with diverse backgrounds, but as of yet, individuals of Aboriginal background with the advance training to conduct this research are few in number and high in demand[34]. For example, Smylie and Anderson (2006) were only able to identify between 10 and 20 people of Indigenous ancestry with graduate-level training in public health in Canada[35]. Canada is behind Australia, New Zealand and the U.S. in the systematic development of an Aboriginal public-health workforce[36] and a significant investment must be made before functional capacity can be realized[37].

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[29] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[30] Reading, J, Ph.D. (n.d.). *The Crisis of Chronic Disease Among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. Centre for Aboriginal Health Research: University of Victoria, British Columbia
[31] Reading, J, Ph.D. (n.d.). *The Crisis of Chronic Disease Among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. Centre for Aboriginal Health Research: University of Victoria, British Columbia
[32] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).
[33] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[34] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).
[35] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).
[36] Smylie, Janet and Marcia Anderson. (2006). Understanding the Health of Indigenous Peoples in Canada: Key Methodological and Conceptual Challenges. *Canadian Medical Association Journal*, Vol. 175(6).
[37] Minore, B., Katt, M. and M.E. Hill. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. *Journal of Agromedicine*, Vol. 14(2).

5.0 KEY FINDINGS

The following sections present the high level findings derived from all lines of evidence: environmental scan; review of the literature; community engagement sessions (and one-on-one community interviews); community telephone interviews; and key stakeholder interviews. More detailed information is available is available in the:

- Environmental Scan Report
- Health Status Report
- Data Analysis Report

5.1 HEALTH STATUS OF ABORIGINAL PEOPLE

5.1.1 BRIEF OVERVIEW OF ABORIGINAL HEALTH IN CANADA

The health of Canadian Aboriginal people is poorer than their non-Aboriginal counterparts on most measureable health indicators: life expectancy, infant mortality, unintentional injuries; chronic disease (e.g., diabetes, asthma, heart disease, HIV/AIDS); infectious disease (tuberculosis, pneumonia); and hospitalizations[38]. Aboriginal health, like the health of all Canadians, is affected by a number of social determinants including income, employment, education, gender, culture, geography (e.g., remoteness) and the social environment)[39,40]. Unlike other Canadians, however, the health and well-being of Aboriginal people is also influenced by determinants such as colonialism, poverty and self-determination[41].[42] The complex interaction between factors such as sub-standard housing, overcrowding, isolation, low income, and the residential school experience has led many Aboriginal people to suffer from much poorer physical and mental health. This lived reality puts many Aboriginal people at increased risk for substance and solvent abuse, suicide and family violence. Based on a 2007 AHF report:

- The cause of death due to alcohol use is 43.7 per 100,000 in the Aboriginal population, almost twice the rate of the general population (23.6 per 100,000);
- Death due to illicit drugs is approximately three times the rate of the general population;
- Overall, rates of spousal homicide among Aboriginal women are more than eight times higher than for non-Aboriginal women; and,
- Suicide and self-injury accounted for 38 per cent of deaths among youth and 23 per cent among adults aged 20 to 44[43].

Moreover, linguistic, cultural and geographic barriers to adequate health care adds substantially to the vulnerability of Aboriginal people in Canada.

Another factor that contributes to the disparity in the health of Aboriginal people is the lack of sufficient baseline health data. A Health Canada report noted that "the multi-jurisdictional complexity of health services to First Nations and Inuit challenges the ability to gather comprehensive health information"[44]. Even less health information is available for the Métis population. The significant gaps that exist in the health data, seriously limit the ability to successfully analyze and thus accurately capture the health status and health services utilization of Aboriginal people in Canada. The inadequacy of information

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[38] AFN. RHS: Our Voice, Our Survey, Our Reality. Selected Results from RHS Phase 1 (2002/03). Ottawa. ON
[39] PHAC. (2001). *What determines health?* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php
[40] WHO. (2010). *The determinants of health*. Retrieved from http://www.who.int/hia/evidence/doh/en/
[41] NAHO. How we see it! Broader Determinants of Health within Aboriginal Contexts. VACCHO, October 23, 2007, Melbourne.
[42] Adelson, N. (2005). The Embodiment of Inequity: Health Disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96: S45-61.
[43] AHF. (2007). Addictive Behaviours Among Aboriginal People in Canada. Ottawa, ON. p. 25.
[44] Health Canada. (2003). A Statistical Profile on the Health of First Nations in Canada. Minister of Public Works and Government Services Canada. Ottawa.

compromises the ability of health care professionals and researchers to effectively plan for the development and implementation of culturally appropriate Aboriginal programs and services[45].

5.1.2 ABORIGINAL HEALTH IN THE NW LHIN

In more than 60% of the engagement sessions (either in-person or via telephone[46]), addictions were noted as a health issue or concern (one community noted that around 90% of their community members experience some struggle with addictions). Addictions noted include: prescription drug use / narcotics, gas sniffing, alcohol, and methadone. It was noted on a number of occasions that prescription drug use is increasing.

In 20% of engagement sessions, other mental health issues (e.g., depression, PTSD) were identified as a concern (often in conjunction with addictions).

Chronic disease concerns were noted for the following ailments:

- Diabetes (in more than 80% of sessions)
- Cardiovascular diseases / heart disease (in 25% of sessions)
- Obesity (in almost 20% of sessions)
- High blood pressure / hypertension (in over 15% of sessions)
- Asthma / respiratory diseases (in more than 8% of sessions)
- Cancer (in almost 20% of sessions)
- Arthritis (in more than 5% of sessions)

Poor nutrition or poor diet (linked to lack of activity/exercise) was noted in several sessions, and is also linked to risk of chronic diseases.

A wide range of other health issues or concerns were noted in at least one session, and include:

- Suicide
- Children in care
- Intergenerational issues
- Teen pregnancy
- FASD
- H1N1 cases
- A lack of dental services/coverage
- Back problems

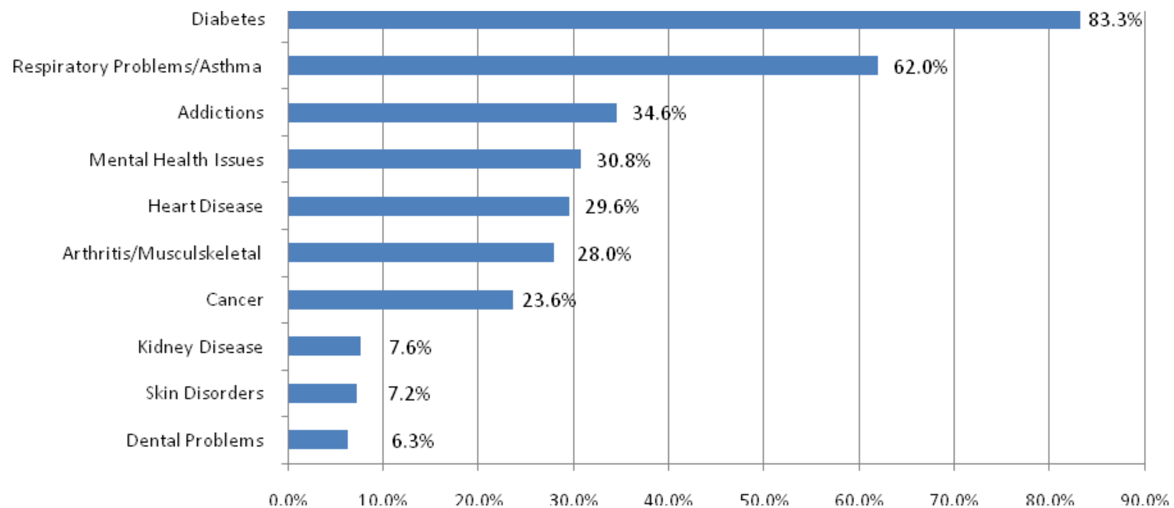
In over 15% of the engagement sessions and community interviews socio-economic factors were identified as negatively affecting the health and well-being of the Aboriginal people of the NW LHIN Region. These factors include:

- Housing – overcrowding, mould, and homes in need of repair;
- Employment – a lack of employment (and associated stress);
- Cost of living – high cost of living, particularly in remote communities, limits the ability to maintain a healthy lifestyle (e.g., high cost of food, housing); and
- Family Relationships – poor familial relationships as a result of family violence, the impacts of Residential Schools (including intergenerational impacts), children in care, and mental health and addictions issues.

[45] Minore, B., Katt, M. and Hill M.E. (2009). Planning Without Facts: Ontario's Aboriginal Health Information Challenge. Journal of Agromedicine, 14: 90-96.
[46] In total 36 engagements were conducted with communities via telephone or in-person. During the in-person engagement sessions, health issues were noted as a group, rather than individually by community, thus percentages are based on how often during sessions health concerns were listed, rather than in how many communities.

Information gleaned from the Sioux Lookout First Nations Health Authority (SLFNHA) 2006 Anishinabe Health Plan corroborates these findings[47]. Figure 11 shows that diabetes and respiratory problems/asthma were the primary health concerns by Sioux lookout Region community participants, followed by addictions (e.g., alcohol, drugs, solvents and gambling), mental health issues (e.g., ranging from suicidal thoughts to various psychiatric disorders), heart disease, arthritis/musculoskeletal and cancer.

Figure 11: Top 10 Community Health Problems in Sioux Lookout Region (2006)



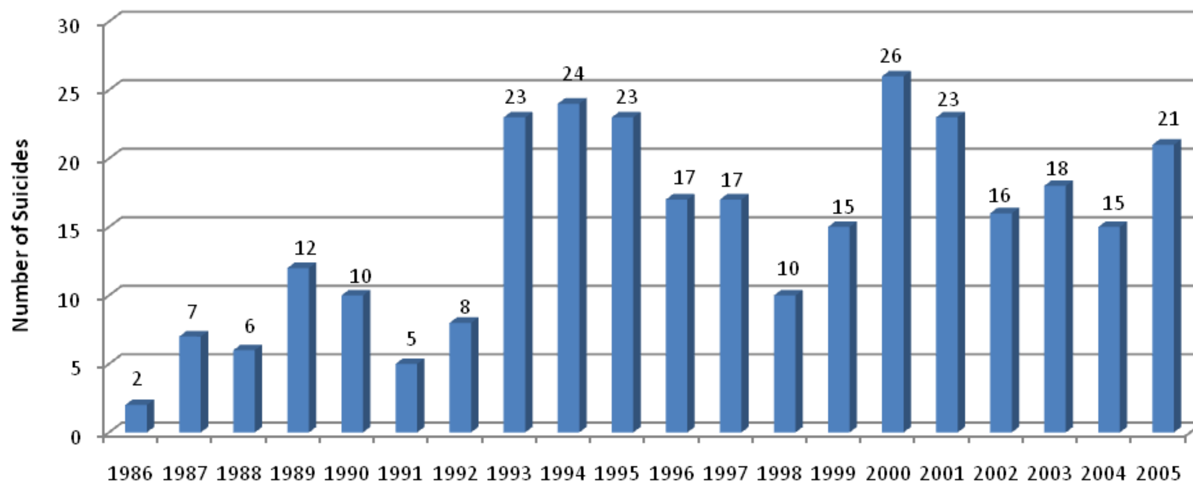
[Source: Sioux Lookout First Nations Health Authority, The Anishinabe Health Plan, 2006. p. 30]

Based on information provided by Nodin Child and Family Intervention Services (Nodin/CFI) to the Sioux Lookout First Nations Health Authority, Figure 12 highlights the number of completed suicides from 1986 to 2005. The most recent year, 2005, shows 21 completed suicides over an 11 month period, most of whom were young males. A recent Nodin/CFI Services Review (not publicly available) describes the population as

> …both economically depressed and mentally distressed…The suicide rate in the Sioux Lookout ranges from 50 times higher for children under the age of 15 than the national average, to 5 times higher for those between the ages of 25-44[48].

[47] The health information presented in the plan is based on information provided by 385 participants (participants from 26 communities and two high schools took part in interviews or focus group sessions).
[48] Dougherty, J. (2005). Nodin/CFI Services – Services review Draft Report. December 15, 2005.Soiux Lookout First Nations Health Authority: Sioux Lookout, ON – cited in the Sioux Lookout First Nations Health Authority. (2006). The Anishinabe Health Plan. P.23.

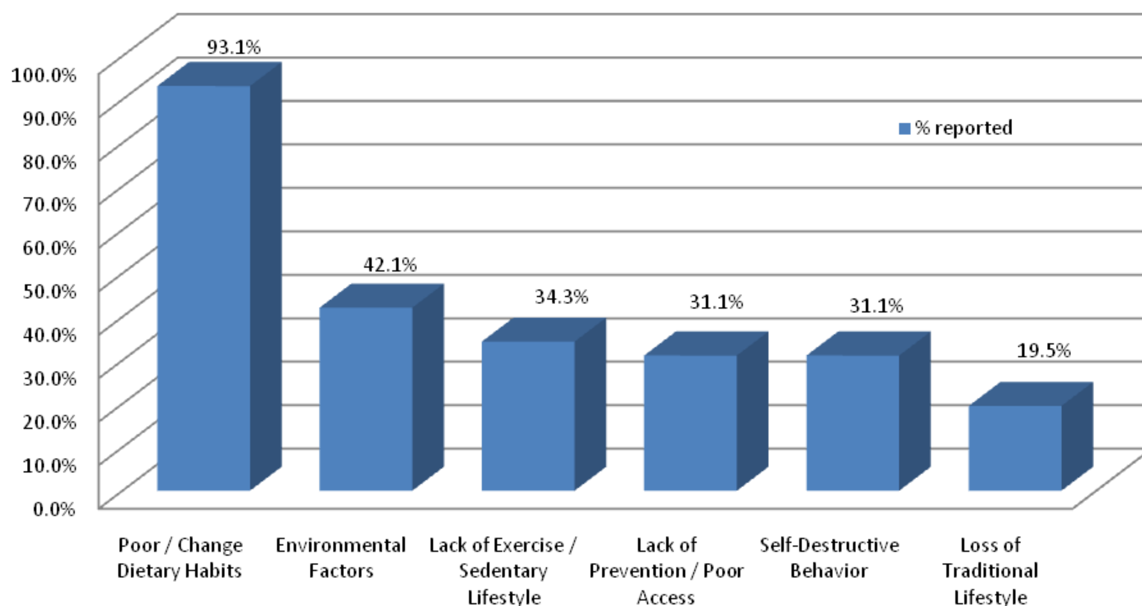
Figure 12: Completed Suicides in Sioux Lookout Region, 1986-2005



[Source: Sioux Lookout First Nations Health Authority, The Anishinabe Health Plan, 2006. p.23]

Figure 13 highlights some of the perceived causes of poor health status in the Sioux Lookout Region population. These include: poor dietary habits and/or changes in diet, environmental factors (ranging from pollutants to poor air quality, mould, poor housing conditions), lack of exercise, lack of prevention/lack of access, self destructive behaviours (e.g., excessive alcohol intake, prescription drug abuse, illegal drug use) and a loss of traditional lifestyles.

Figure 13: Causes of Poor Health in Sioux Lookout Region (2006)



[Source: Sioux Lookout First Nations Health Authority, The Anishinabe Health Plan, 2006. p.31]

The health status information collected during project community engagement sessions and community telephone interviews as well as information presented in the SLFNHA report is further supported by the national and provincial published literature[49] which identifies the primary health problems affecting Aboriginal people as: chronic diseases (e.g., diabetes, cardiovascular disease, arthritis, asthma and

[49] Refer to the Health Status Report.

cancer), accidents and injury; and mental health and addictions issues (linked to intergenerational impacts due to residential school impacts).

The available literature highlights the fact that Aboriginal people continue to suffer disproportionately from almost every health status indicator (e.g. mortality, morbidity, chronic disease, communicable disease, mental health and addictions and accidents and injuries) when compared to their non-Aboriginal counterparts.

5.2 ABORIGINAL HEALTH PROGRAMS AND SERVICES

Health programs and services available to Aboriginal people residing in the NW LHIN are provided by a variety of service providers, and include services available both on-reserve and/or in surrounding communities. Communities located in more remote locations are more limited in their access to programs and services. Those located near urban centers are able to access off-reserve programs with fewer challenges.

The following two sections list the health care service providers and present, at a high level, the health programs and services available on-reserve and in surrounding communities.

More detailed information on the health programs and services available in the NW LHIN is presented in the Inventory Report.

5.2.1 SERVICE PROVIDERS

5.2.1.1 Aboriginal Health Service Providers

The provision of Aboriginal health programs and services in the North West LHIN jurisdiction is multi-layered and complex. Services may be offered through a Provincial Territorial Organization (PTO) to community members; through a Tribal Council or Aboriginal Health Planning Authority; or offered directly by the First Nation to its members. Other Aboriginal organizations (e.g. Ontario Native Women's Association) also offer health services to First Nation communities and the Aboriginal urban population. In some instances, organizations may be solely responsible for administering the program, while in other communities, organizations may be exclusively responsible for funding services offered through a local agency.

The Health Transfer Policy of FNIHB offers First Nations the opportunity to assume a degree of administrative control over community-based health services. These funding agreements vary in terms of level of control, flexibility, authority, reporting requirements and accountability. Many communities within the NW LHIN have signed Health Transfer Agreements that have allowed them to develop a local process of Health Control by administering the community-based health programs.

This section is intended to serve as a listing of potential agencies/organizations/councils administering programs and services and not to delineate the complexities of jurisdictional challenges.

Provincial Territorial Organizations (PTOs) – operating within North West LHIN territory include:

- Grand Council Treaty #3 (GCT3) (Treaty No. 3)
- Union of Ontario Indians (UOI) (Robinson Superior Treaty)
- Nishnawbe Aski Nation (NAN) (Treaty No. 5 and Treaty No. 9)

Tribal Councils – may offer health services both on and off reserve, and include:

- Independent First Nations Alliance (members are not part of any PTOs)
- Anishinaabeg of Kabapikotawangag Resource Council (AKRC)
- Bimose Tribal Council
- Nokiiwin Tribal Council (Thunder Bay)

- Pwi-Di-Goo-Zing Ne-Yaa-Zhing Advisory Services (Fort Frances Area Tribal Chiefs)
- Keewaytinook Okimakanak
- Matawa First Nations
- Shibogama First Nations Council
- Windigo First Nations Council

Health Planning Authorities – funded (in part) by the Aboriginal Healing & Wellness Strategy, provides a variety of health services both on and off reserve and coordinates health services for member First Nations:

- Kenora Advisory Chiefs
- Pwi-Di-Goo-Zing Ne-Yaa-Zhing Advisory Services (Fort Frances Tribal Area Health Authority)
- Paawidigong First Nations Forum Inc.
- NAN Health Planning Authority
- Union of Ontario Indians

Sioux Lookout First Nations Health Authority (SLFNHA) – provides direct services through a variety of agencies and serves to coordinate health planning. Health services provided include:

- Canadian Prenatal and Nutrition Program
- Transitional Youth Initiatives Program
- Client Services Department
- Tuberculosis Control Program
- Primary Health Care Unit
- Telemedicine Program
- Nodin Child & Family Intervention Services

Sioux Lookout First Nations Health Authority provides service for 31 First Nation communities in the Sioux Lookout Zone.

Nodin Counseling Services, through SLFNHA, has been overseeing the provision of mental health services since 1994 to First Nations clients. Mental health services for children and youth formally under the family counseling unit of Tikinagan Child and Family Services were formally transferred to Sioux Lookout First Nations Health Authority in April of 2002.

Métis Nation of Ontario – also provides various health planning and health services throughout the North West LHIN region. The health service-specific sites are:

- Kenora – Kenora Métis Council
- Dryden – Northwest Métis Council
- Fort Frances – Sunset Country Métis
- Thunder Bay – Thunder Bay Métis Council

Métis Nation of Ontario, Health Programs and Services offer assistance in the areas of:

- Assisting Métis persons with disabilities access program
- Nutrition and Fitness Awareness
- Stress Management
- Alcohol-related Health Problems
- Diabetes Awareness and Intervention
- Prenatal Infant Mortality Prevention and Intervention
- Child Safety in the Home
- Counseling Support Services
- General Emotional Support
- Friendly Visits
- Workshops and Educational Outreach

Specific health programs offered by the Métis Nation of Ontario include:

- Health Careers Support
- Aboriginal Healing & Wellness Strategy (AHWS)
- Aboriginal Healthy Babies
- Healthy Children
- Aboriginal Responsible Gambling
- Diabetes Awareness Strategy
- Long Term Care Program
- Victim Services Program
- Telemedicine

Ontario Native Women's Association – and local affiliated councils act as service providers in several communities for various programs funded by the Aboriginal Healing and Wellness Initiative.

Aboriginal Health Access Centers (n=3) – are major sources of health support and health services for urban Aboriginal people:

- Gizhewaadiziwin Health Access Centre (Fort Frances)
- Wassay-Gezhig Na-Nahn-Dah-We-Igamig (Keewatin)
- Anishnawbe Mushkiki (Thunder Bay)

Aboriginal Family Health Team – through Dilico Child & Family Services in Thunder Bay. Dilico provides a large variety of health services in addition to their child welfare services, including primary care and various health programs sponsored by other funders (e.g. Healthy Babies Healthy Children), and mental health and addictions programs. Other Aboriginal Child and Family Services agencies provide some mental health supports and other programs.

Aboriginal Friendship Centers (n=8) – within the NW LHIN region:

- Thunderbird Friendship Centre (Geraldton, ON)
- Thunder Bay Native Friendship Centre / Thunder Bay Indian Friendship Centre
- Atikokan Native Friendship Centre
- United Native Friendship Centre (Fort Frances)
- Nishnawbe-Gamik Friendship Centre (Sioux Lookout)
- Dryden Native Friendship Centre
- Ne'Chee Friendship Centre (Kenora)
- Red Lake Friendship Centre

There are also a variety of healing lodges and other independent addictions, mental health and other wellness programs throughout the region. (Many of these healing programs were funded primarily through the Aboriginal Healing Foundation).

5.2.1.2 Other Service Providers

There are several other types of service providers that offer health supports and programs to the population at large, or that offer Aboriginal-specific programs. These service providers may include community support groups, municipalities, health centres and recreation centers.

Hospitals – The following hospitals are located in the NW LHIN region and provide services primarily for acute care, accidents and injuries:

- Atikokan Regional Hospital
- Dryden Regional Health Centre
- Riverside Health Care Facilities Inc. (Emo)
- Fort Frances Riverside Health Care Facilities (La Verendrye)

- Geraldton District Hospital
- Lake of the Woods District Hospital
- Manitouwadge General Hospital
- Wilson Memorial Hospital
- Nipigon District Memorial Hospital
- Riverside Health Care Facilities Inc. (Rainy River)
- Red Lake Margaret Cochenour Memorial Hospital
- Sioux Lookout Meno Ya Win Health Centre
- Sioux Lookout District Health Centre (5th Avenue)
- Sioux Lookout Zone Hospital (7th Avenue)
- St. Joseph's Care Group
- Lakehead Psychiatric Hospital Site
- Thunder Bay Regional Health Sciences Centre

Public Health Units – there are 2 public health units operating within the NW LHIN region, with satellite offices in various communities:

- Northwestern Health Unit (Kenora)
- Thunder Bay District Health Unit (Thunder Bay)

Cancer Care Ontario (CCO) – there is one regional Cancer Care Centre (Northwest Regional Cancer Care Centre) in Thunder Bay at the Thunder Bay Regional Health Sciences Centre, as well as several sites in partner hospitals.

CCO offers programs aimed specifically at Ontario's First Nations, Métis and Inuit people. These programs are mandated to ensure that Aboriginal people in Ontario have access to quality cancer prevention, screening and symptom information that incorporates the Aboriginal holistic approach. These include the Aboriginal Cancer Strategy, the Aboriginal Tobacco Program, and the Aboriginal Cancer and Prevention Team.

Community Care Access Centre (CCAC) (n=1) – within the NW LHIN. There are several long-term care homes and other supportive living facilities within the region.

Family Health Teams (n=12) – there are 12 Family Health Teams within the NW LHIN (including the Dilico Family Health Team, also mentioned above).

- Atikokan and District Family Health Team
- Dilico Family Health Team (Thunder Bay)
- Dryden Area Family Health Team
- Ear Fall Community Health Centre Family Health Team
- Fort Frances Family Health Team (in Fort Frances Community Clinic)
- Fort William Family Health Team, Thunder Bay (in Fort William Clinic)
- Greenstone Family Health Team (Geraldton)
- Machin Family Health Team (Vermilion Bay)
- Marathon Family Health Team
- North Shore Family Health Team (Schreiber)
- Red Lake Family Health Team
- Sunset Country Family Health Team (Kenora, Keewatin)

Women's Shelters/Transition Houses – often offer supports and counseling to women in transitional housing, as well as outreach programming and community support programs.

5.2.2 INVENTORY OF HEALTH PROGRAMS AND RESOURCES

Below is a list of some of the major programs provided both on and off reserve specific to Aboriginal people. Not all programs may be available in each community, nor at each site. In addition, programs such as those provided through Health Canada to on-reserve First Nations may be listed as a program through Health Canada's reporting structure, yet in terms of service delivery at a community level, may function in a different manner than listed here (e.g., FASD Program funding may be used to augment Early Childhood Development programs or Maternal Child Health services, depending on how a community breaks down programs and needs).

One of the major limitations in terms of identifying programs in this manner is that local supports, such as unofficial Elders' groups, Elders' teaching and wisdom generally, or other cultural activities that may have a great impact on mental health are not necessarily captured. Non-formal traditional activities (such as sweats and talking circles) were identified during community engagement sessions as a 'program' that would benefit greatly from increased support, but are not listed below, nor within the Program Inventory. (Cultural activities and programming are captured when they function as part of more readily identified programs, such as NNADAP workers providing services like healing circles.)

5.2.2.1 On-Reserve Programs

Formal on-reserve programs include programs provided by Health Canada, Tribal Councils, Health Authorities, other services providers and community efforts. Listed below are programs generally available on a provincial wide (or national) scale.

First Nations & Inuit Health Programming (Health Canada)

According to the First Nations and Inuit Health Program Compendium, there are five major areas of health services programs that may be available to First Nations. A brief description of programs identified through the various lines of research is listed below.

- ***Children and Youth***
  - **Fetal Alcohol Spectrum Disorder (FASD)** – prevention and intervention activities for the purpose of "1) reduce the number of babies born with FASD; and 2) support children who are diagnosed with FASD and their families to improve their quality of life"[50].
  - **Canada Prenatal Nutrition Program, First Nations and Inuit Component (CPNP - FNIC)** – education and prevention activities to improve maternal and infant nutrition.
  - **Aboriginal Head Start On Reserve (AHSOR)** – early childhood development and intervention activities for children up to 6 years of age, including culture and language, education, health promotion, nutrition, social support, and parent and family involvement.
  - **Maternal Child Health (MCH)** – activities to improve maternal child health broadly, including home visitations, screening and assessment, case management, and health promotion.

- ***Mental Health and Addictions***
  - **National Native Alcohol and Drug Abuse Program (NNADAP), Community-based Program** – prevention, treatment and aftercare activities delivered within the community (often by addictions counselors, Elders, or outreach workers)
  - **National Native Alcohol and Drug Abuse Program (NNADAP), Residential Treatment** – "a national network of 50 treatment centers operated by First Nations organizations and/or communities that provide culturally appropriate in-patient and out-patient treatment services for alcohol and other forms of substance abuse"[51].
  - **Building Healthy Communities (BHC)** – "designed to assist First Nations and Inuit communities (which includes the individuals and families) and territorial governments in

[50] First Nations and Inuit Health. 2007. *Program Compendium.* P.2.
[51] First Nations and Inuit Health. 2007. *Program Compendium.* P.14.

developing community-based approaches to mental health crisis management"[52]. Activities include mental health crisis intervention and solvent abuse.
  - Indian Residential Schools Resolution Health Support Program
  - **Brighter Futures (BF)** – designed to "improve the quality of, and access to, culturally appropriate, holistic and community-directed mental health, child development, and injury prevention services at the community level"[53].
  - **Youth Solvent Abuse Program (YSAP)** – "a community-based prevention, intervention, after-care and in-patient treatment program that targets First Nations and Inuit youth who are addicted to, or at the risk of inhaling solvents [and] includes a network of solvent addiction treatment centers and community supports."[54] (*Within communities this often amounts to a small funding pot and can be used for resources or small workshop activities, rather than full programs.)*
  - **National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)** – intended to "support a range of community-based solutions and activities that contribute to improved mental health and wellness among Aboriginal youth, families, and communities"[55].

- ***Chronic Disease and Injury Prevention***
  - **Aboriginal Diabetes Initiative (ADI)** – "ensures access to prevention and promotion programs which emphasize healthy eating and active living, and build awareness of diabetes around issues such as risk factors and complications. The program also provides resources for screening and care and resources to train health service providers and improve access to their services in communities"[56].

- ***Communicable Disease Control***
  - **Blood Borne Diseases and Sexually Transmitted Infections** – HIV/AIDS – intended to "prevent HIV/ AIDS transmission and support the care of those impacted by HIV and AIDS."[57] Like the YSAP, often funding amounts are quite small.

- **First Nations and Inuit Home and Community Care** (FNIHCC)
  - "[A] coordinated system of home and community-based health care services that enable First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities"[58]. Many programs within the HCC umbrella may be identified at the community level as other services, e.g. Personal Support Workers.

Other FNIHB programs noted by the communities included the Children's Oral Health Initiative (COHI) (a primary-care initiative) and medical transportation services (under Non-Insured Health Benefits (NIHB)).

Aboriginal Healing Foundation

Indian Residential Schools (IRS) officially operated in Canada from 1892 to 1996, either entirely government administered, or through funding arrangements between the Government of Canada and the major Christian churches of the period. Thousands of Aboriginal people who attended these schools have reported that physical, emotional, and sexual abuses were widespread in the school system[59].

The legacy of this trauma has reverberated through Aboriginal communities until the present. By one estimate, there are approximately 86,000 of these survivors still living in Canada[60]. The Royal Commission on Aboriginal Peoples (RACP) recommended that Canada take action to address these impacts on individuals, families and communities, and the Government of Canada's "Gathering Strength –

[52] First Nations and Inuit Health. 2007. *Program Compendium.* P.16.
[53] First Nations and Inuit Health. 2007. *Program Compendium.* P.24.
[54] First Nations and Inuit Health. 2007. *Program Compendium.* P.27.
[55] First Nations and Inuit Health. 2007. *Program Compendium.* P.29.
[56] First Nations and Inuit Health. 2007. *Program Compendium.* P.33.
[57] First Nations and Inuit Health. 2007. *Program Compendium.* P.38.
[58] First Nations and Inuit Health. 2007. *Program Compendium.* P.49.
[59] The 2008 Annual Report of the Aboriginal Healing Foundation, p.14
[60] AHF. 2006. Summary Points of the AHF Final Report. p 8.

Canada's Aboriginal Action Plan"[61], recommends "a healing strategy to address the healing needs of Aboriginal People affected by the Legacy of Indian Residential Schools, including the intergenerational impacts"[62].

In response to this recommendation, the federal government provided a $350 million grant in 1998 for community-based healing of residential school trauma, and on March 31, 1998, the Aboriginal Healing Foundation (AHF) was created, with a ten year mandate. Before the end of the initial 10 year funding period, the federal government subsequently provided an additional $40 million for 2005-2007. Since 1998, the Government of Canada (GOC) has contributed $515 million to the AHF to support the objective of addressing the healing needs of Aboriginal People affected by Residential Schools.

As part of the Indian Residential Schools Settlement Agreement (IRSSA) reached through a judicial process involving a number of parties, the government of Canada provided an additional $125 million endowment, to apply to the AHF for the period from April 1, 2007 to March 31, 2012. The Aboriginal Healing Foundation applied this $125 million to existing AHF projects. The $125 million endowment extended funding for existing projects for three years (ending March 31, 2010) and for eleven healing centers for four and a half years (ending March 31, 2012).

Although a recent evaluation of the AHF funded projects strongly recommended the continuation of the AHF, the 2010 federal budget did not allocate funds to the Foundation. This decision by the Federal Government means that a nation wide network of 134 community-based healing initiatives no longer have AHF funding as of March 31, 2010.

Several communities within the NW LHINs received funding through the AHF for community-based healing projects; unless these projects have alternate funding sources, they will no longer be able to continue (past March 31, 2010). The Couchiching Healing Centre (now known as the Giizhikaandag Healing Centre) located in Fort Frances, has AHF funding until 2012.

- **Giizhikaandag Healing Centre** [formerly known as Couchiching Healing Centre] - Couchiching First Nation
- **Residential School Community Family Healing Program** - Eagle Lake First Nation – Migisi Sahaigan
- **Gull Bay First Nation Healing Program** - Gull Bay First Nation
- **Biiwaasaya Healing Project** - Lac Seul First Nation
- **Mishkeegogamang Healing Community** - Mishkeegogamang First Nation – Osnaburgh
- **Nokomis Traditional Healing -** Nimishomis-Nokomis Healing Group Inc. – Kejick, ON - Nimishomis
- **Healing The Generations 2 -** Nishnawbe-Aski Nation – Thunder Bay
- **One Community** - Sandy Lake First Nation
- **Wapekeka First Nation Healing Journey** - Wapakeka First Nation
- **Wheel of Life** - Windigo First Nations Council – Sioux Lookout

5.2.2.2 Other/Off Reserve Programs

FNIHB

- **Aboriginal Head Start in Urban and Northern Communities** (see above for AHSOR)
- **Canada Prenatal Nutrition Program** – off-reserve (see above for CPNP)
- **Community Action Program for Children** - provides long term funding to community coalitions to deliver programs that address the health and development of children (0-6 years) who are living in conditions of risk. It recognizes that communities have the ability to identify and respond to the needs of children and places a strong emphasis on partnerships and community capacity

[61] Indian Affairs and Northern Development Canada. 2000. "Gathering Strength – Canada's Aboriginal Action Plan".
[62] Funding Agreement Aboriginal Healing Foundation and Her Majesty the Queen in Right of Canada, as Represented by the Minister of Indian Affairs and Northern Development and Federal Interlocutor for Métis and Non-Status Indians. Internal document provided to DPRA by INAC.

building. CAPC targets children living in low income families; children living in teenage-parent families; children experiencing developmental delays, social, emotional or behavioral problems; and abused and neglected children. However, special consideration is given to Métis, Inuit and off-reserve First Nations children, and the children of recent immigrants and refugees, children in lone-parent families and children who live in remote and isolated communities.

Indian and Northern Affairs Canada Funding Programs

- **Assisted Living Program** – this program is often delivered in conjunction with other Home and Community Care programming
- **Family Violence Prevention Program** – available funding for programs in communities and urban centers for the prevention of family violence.

Aboriginal Healing & Wellness Strategy (Government of Ontario Ministries)

The Aboriginal Healing and Wellness Strategy (AHWS) is a policy and service initiative that brings together Aboriginal people and the Government of Ontario in a distinctive partnership to promote health and healing among Aboriginal people. Several programs are available through the AHWS within NW LHIN communities. These may be delivered through various agencies (e.g. Friendship Centers, PTOs, women's groups, Métis Councils). These include:

- **Aboriginal Healthy Babies/Healthy Children Program** – program available both in First Nations communities and larger urban centers through Friendship Centers and other agencies
- **Community Development Support Workers** – skills and capacity building / development positions
- **Community Wellness Workers** – family violence activities (outreach, prevention, etc.) throughout the region
- **Crisis Intervention Workers** – managed through NAN, focused on suicide/family violence/crisis intervention in First Nations communities and urban centers
- **Health Policy Analysts** – working with PTOs / Aboriginal organizations
- **Health Outreach Workers** – workers for areas without access to an Aboriginal Health Access Centre
- **Aboriginal Health Access Centres** – n=3 (also mentioned above)
- **Aboriginal Health Planning Authorities** – (also mentioned above)
- **Healing Lodges** (2 within NW LHIN area)
- **Outpatient Hostels**
- **Translator Services** – available through Health Access Centers
- **Treatment Centres** (1 within NW LHIN region)

KO Tele-health and Ontario Tele-health Network

Keewaytinook Okimakanak (KO) is a Tribal Council serving six member First Nations. KO delivers telehealth services through the use of videoconferencing and advanced information communication technologies. Clinical, educational and administrative services are provided to 27 First Nation communities in the NW Region and are partnered with the Ontario Telehealth Network to deliver programs off reserve.

There are 125 telehealth sites within the NW LHIN, including 42 provided by KO Telemedicine. Others are provided by the Ontario Telehealth Network (OTN).

Friendship Centre Programs – many services are provided through the Friendship Centers in the region, including programs delivered through other health providers (e.g. Healthy Babies, Healthy Children Initiative, CPNP program). Several programs and services are available through the Ontario Federation of Indian Friendship Centers (OFIFC). These include:

- AKWE:GO & Wasa-Nabin programs – youth programming provided by the Ontario Federation of Indian Friendship Centres (OFIFC) from funding from the Ontario Ministry of Children and Youth Services
- Aboriginal Family Support Worker Program
- Aboriginal Healing and Wellness Coordinators Program
- Health Outreach Workers Program
- Life Long Care Program
- Urban Multipurpose Aboriginal Youth Centre

Aboriginal Programs Delivered through Other Agencies

Other agencies, such as agencies working with or for Tribal Councils or Aboriginal Health Planning Authorities, may also deliver programs in a number of communities. Details vary from region to region. These generally are programs such as:

- Mental Health programming or counseling services (e.g. Nodin, Anishinaabeg Counseling)
- Diabetes prevention or treatment programming (e.g. delivered either within First Nations communities on a rotating basis, or that provided within other health centers)
- Addictions treatments
- Crisis Intervention and Prevention
- Health planning and coordination
- Programs delivered within the mainstream healthcare industry that are Aboriginal-specific (e.g. those at the Sioux Lookout Meno Ya Win Health Centre such as traditional foods)

5.2.2.3 Out of Province Programs

Some community members are also accessing programs available out of province. Many community members access programs in Manitoba, instead of travelling to Thunder Bay or other urban centres in Ontario. These were not included within the Program Inventory Database; however they may provide alternatives to health care and services for Aboriginal people in western communities.

Examples of service providers being accessed within Manitoba may include: Hospitals and Treatment Centers. Some of the Health Services located in Manitoba include:

- **Eyaa-Keen Centre**, Winnipeg MB – Treatment centre which includes a variety of services including intake, one-on-one counseling, healing circles (www.eyaa-keen.org)
- **Aboriginal Health & Wellness Centre**, Winnipeg MB – part of the Aboriginal Centre of Winnipeg, Inc. (http://www.abcentre.org)
- **Winnipeg Regional Health Authority, Aboriginal Health Services** (http://www.wrha.mb.ca/aboriginalhealth/services.php)
- **Cancer Care Manitoba, Aboriginal Services** (http://www.cancercare.mb.ca/home/patients_and_family/patient_and_family_support_services/aboriginal_services/)
- **Manitoba Association of Friendship Centers** (http://www.mac.mb.ca/site/) – there are two Friendship Centers near communities within Ontario
- Selkirk Friendship Centre - Selkirk, Manitoba (http://www.selkirkfriendshipcentre.ca)
- The Indian Metis Friendship Centre of Winnipeg (http://www.imfc.net)
- **Manitoba Métis Federation** (www.mmf.mb.ca/)
- **Four Arrows Regional Health Authority** (http://www.fourarrowsrha.ca/)
- **Ma Mawi Wi Chi Itata Centre** – Family support centre (http://www.mamawi.com/)
- **Native Addictions Council of Manitoba** (http://www.mts.net/~nacm/)
- **Nine Circles Community Health Centre** – HIV/AIDS care (http://www.ninecircles.ca/)
- **Circle of Life Thunderbird House** – traditional healing and wellness / gathering place (http://www.thunderbirdhouse.com/)

5.2.3 UTILIZATION PATTERNS

Information on utilization patterns of programs by Aboriginal people within the NW LHIN was not available. The limitations on health information records and treatment of Aboriginal people are detailed elsewhere (Section 3.2). Briefly, as most hospitals and health care providers do not record patients by ethnicity or culture (self-identified or otherwise), it is difficult to delineate Aboriginal patients.

In addition, Aboriginal providers canvassed for this project were not forthcoming with this type of information. Providers contacted were unsure as to the purpose and intentions of the project. Some providers did not understand why the LHIN was collecting the information or how the information was going to be used; thus were not willing to provide the data to DPRA. One stakeholder did mention that NIHB gathers utilization information. NIHB reports at the regional level (Atlantic, QC, ON, MB, SK, AB, BC, YK, NU, NWT) on utilization rates and expenditures with respect to transportation, pharmacy, dental, other health care (primarily refers to short-term crisis intervention and mental health counseling), premiums and vision care.

5.2.4 REFERRAL PATTERNS AND WAIT TIMES FOR ACCESS

For Aboriginal programs, there is very little accessible information available on referral patterns and wait times. Many service providers noted they received referrals from various agencies and referred to other programs, however numbers of referrals and clients was unavailable. Community front-line staff in remote communities often expressed concern with wait times for required treatment programs approved by NIHB. Patients have been known to wait eight to 10 months for an available bed in a treatment centre.

Stakeholders spoke about long wait times for health care services focused on obstetrics, heart disease, hypertension, arthritis and diabetes. One stakeholder noted that the overuse of emergency services by Aboriginal people creates longer wait times for primary care appointments because of the limited supply of doctors (i.e., doctors have to cover emergency and deliver primary care). There was also mention of long wait lists for seniors who are going to the emergency department and walk-in clinics to obtain care. There is no continuity of care, which becomes especially problematic with severe chronic illnesses.

The process of undergoing an assessment and obtaining a referral to access programs was also a challenge for many community members. Stakeholder also noted the long wait times associated with travel to get to programs for an assessment. The use of technology to carry out assessments has, however, improved the process. Some communities have also encouraged community staff to obtain further training to gain the knowledge required to more appropriately assess and refer to the required programs.

5.3 GAPS IN ABORIGINAL PROGRAMS AND SERVICES

The SLFNHA 2006 Anishinabe Health Plan reveals that 47.8% of survey participants reported being satisfied with currently available health programs and services, while 46.2% reported being unsatisfied with the services (the remainder of participants were either partially satisfied, ambivalent or nonresponsive). Some of the physician service issues that were mentioned included: lack of physician services; lack of permanent doctors; health care visits too short or too rushed; and wait times too long[63].

Project participants were asked if the health programs and services available were meeting the health needs and priorities of Aboriginal people residing in the NW LHIN region with respect to addictions, disease (chronic and acute), accidents and injuries through the life course. Participants were also asked to identify any gaps in programs and services offered to Aboriginal people residing in the NW LHIN.

[63] SLFNHA. (2006). The Anishinabe Health Plan. July 31, 2006.

The following section presents the findings, including health related needs and priorities, and a summary of gaps in programs and services available to Aboriginal people in the NW LHIN region.

Most of the participants felt that the health programs and services available in the NW LHIN Region were not adequately meeting the needs of the Aboriginal population. Participants indicated that the programs and services available on-reserve and outside of the communities were not accessible or effectively delivered to meet the needs of the people seeking treatment.

Gaps in health programs and service were indentified in the areas of:

- Mental Health and Addictions
- Chronic Disease Diagnosis and Management
- Acute Diseases / Accidents and Injuries
- Active and Engaged Parenting
- Children Programs and Services
- Youth Programs and Services
- Seniors Programs and Services
- Continuity of Care / Provision of Essential Services and Specialized Care
- Infrastructure
- Culturally appropriate services
- Transitional assistance
- Wellness Education and Preventative Health Care

5.3.1 MENTAL HEALTH AND ADDICTIONS

Mental health and addictions was identified during community engagement sessions and telephone interviews held throughout the NW LHIN Region, as pressing concerns within First Nations communities. Mental health issues are considered to be the root cause of poor health status of Aboriginal people living in the NW LHIN Region. Some of the mental health conditions mentioned include:

- Addictions to drugs, alcohol and gambling
- Depression
- Dementia
- Psychiatric disorders (bi-polar, schizophrenia)
- Suicide
- Family Violence

The 2009 Aboriginal Health Forum – Pathway for Collaboration Summary Report corroborates these findings and identifies some additional mental health and addictions issues mentioned by Aboriginal people that are affecting their communities: residential school trauma; grief; stress; Alzheimer's disease; FASD; and the stigma attached to mental health issues. Forum participants went on to identify a number of limitations in current mental health and addictions services: lack of youth focused programs and services; limited number of treatment centres; lack of 24-hour mental health services; long wait lists for programs; lack of culturally appropriate services as well as racism and discrimination; stigma; lack of relationship between regional services and Aboriginal communities; inadequate funding for services; lack of follow-up support; and inequitable difference with services such as reimbursement of transportation costs[64].

The 2008 Aboriginal Health Forum – Elements of Change Summary Report also discusses gaps/limitations in mental health and addictions services. Forum participants mentioned: lack of coordinated services; poor after-care supports; lack of support for youth/adults with suicidal behaviour; poor community supports for Aboriginal women; lack of community-based facilities for youth with

[64] NW LHIN. (2009). 2009 Aboriginal Health Forum – Pathway for Collaboration Summary Report. March 4-5, 2009, Valhalla Inn, Thunder Bay.

addictions; lack of trained staff; poor reintegration programs; lack of coordination; and lack of sufficient funding[65].

Many of the issues noted during the 2008 and 2009 forums were also mention by project participants and are discussed in greater detail below.

Many project participants felt that the programs and services available for treating mental health issues were limited to specific programs for such issues as addictions, family violence, depression or mental illnesses.

While mental health and addiction services are currently offered by various providers in the NW LHIN, including services through on reserve counselors (NNADAP), off-reserve treatment centres, and acute and primary care systems, many individuals remarked on the limited availability of programs and services addressing all of the above noted mental health needs and priorities.

More specifically, the following gaps were identified:

- Resources and Capacity / Community Supports and Counseling
- Programs and services for addictions
- Suicide Prevention
- Traditional and Holistic approach to healing
- Adequate and timely diagnosis

5.3.1.1 Resources and Capacity / Community Supports and Counseling

Many participants felt that certain communities in the NW LHIN region were challenged by a lack of trained human resources available to meet the needs of community members suffering from mental illnesses and related mental health issues. While some communities do have a mental health worker in-situ, they often carry a heavy case load and are not able to provide the support and counseling required. Some of the mental health workers also expressed concern that they were often dealing with cases beyond their comfort and skill level. They expressed the need for additional support and training to help ensure the adequate delivery of programs to their community members. While other communities had visiting mental health counsellors, it was noted that these visits were infrequent and support was not always available when required.

Most participants indicated that additional supports were required for aftercare; ensuring that community members have adequate support within their home community after returning from treatment centres or receiving counseling. Some participants suggested encouraging the development of support groups; similar to Alcohol Anonymous (AA) that would encourage people to share their experiences.

5.3.1.2 Programs and Services for Addictions

Most participants expressed the need for additional programs and services to meet the needs of community members dealing with addictions, including solvent abuse, gambling, prescription drugs and alcohol. The majority of community participants indicated that prescription drug abuse was a major health-related concern in the community. Most felt that additional services were required to sufficiently support community members suffering from addictions. In particular, the need for follow-up care was mentioned. Many noted that community members who sought treatment for their addictions would return home and ‘fall back to their old ways’ because of a lack of after care. Community members recognized the long-term healing journey required to deal with addictive behaviours. Some participants suggested locating detoxification centres or safe places to access care and support within their communities in an effort to ensure services are being offered when and where they are needed.

[65] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay.

There was some criticism of methadone programs as a treatment for the dependence on opioid drugs. Some community members believe that Aboriginal residents receiving treatment via methadone clinics are not always recovering fully from their addictions, nor are they being encouraged to eventually discontinue the methadone regimen. The use of methadone to prevent opioid withdrawal and reduce or eliminate drug cravings is a treatment method for the withdrawal symptoms; however it is not a cure for the addiction and thus patients require other social and medical supports to stabilize and improve their lifestyles.

5.3.1.3 Suicide Prevention

Participants noted that additional programs and services were required to meet the health needs of Aboriginal people affected by suicide and trauma. In particular, programs and services aimed at suicide prevention in youth and young adults were suggested. Gaps in suicide prevention and awareness were also concerns expressed by stakeholders in urban areas where an increase in suicide among youth has occurred. Youth who move to urban locations to go to school are challenged with adapting to the new environment, the new social pressures and the resulting depression associated with leaving their home community. Consequently, there is a recognized need for suicide prevention activities aimed at these transitional youth.

It was also noted that Aboriginal people affected by suicidal tendencies may be institutionalized for short-periods, in either a hospital or a detention centre. These individuals are often released upon ‘sobering up’ and ‘return to life as they know it’. Many people remarked on the need for enhanced supports aimed at encouraging people to remain in care and acquire the services needed to address the roots of the problem.

5.3.1.4 Traditional or Holistic Approach to Healing

Some community members noted that National Child Benefit Reinvestment (NCBR) funding was being used for cultural enrichment through traditional healing and cultural camps. NCBR funding brings healers into the community, who then provide spiritual counseling. A positive cultural identity helps to produce resiliency in the community and an ability to “bounce back” from adversity. Most participants felt that cultural programs for children and youth are very important and that more programs are required. By reconnecting with traditional practices, members noted that children’s self-esteem has improved.

Individuals mentioned the lack of a case management or holistic approach to healing, specifically healing related to mental health and addictions. It was indicated that more holistic, community-based models should be developed and implemented. These models should incorporate training and capacity building in healing. While reliance on “professional” healers within this model was acknowledged, so to was a dependence on healers with lived experience and cultural knowledge.

The termination of AHF funding in the recent federal budget means the end of numerous community-based healing projects (as of March 31, 2010). This will have a significant impact on the healing journey of Aboriginal people living within the NW LHIN region. The objective of the AHF was to address the healing needs of Aboriginal people affected by the legacy of Indian Residential Schools, including the intergenerational impacts, by supporting holistic and community-based healing to address needs of individuals, families and communities. The long term goal of the AHF was to break the cycle of physical and sexual abuse that is a consequence of the residential school legacy, and to create sustainable well-being for individuals and communities. The AHF model was emphasized as a holistic, community-based approach that emphasized training and capacity building in healing; and reliance not only on “professional” healers, but healers with lived experience and cultural knowledge. One of the conclusions reached by the AHF after several years of research, was that “culture is good medicine”[66].

Some participants felt that more traditional supports should be provided (i.e. sweat lodges) so that community members could access care for mental illnesses more appropriate to their culture and traditions.

[66] The Aboriginal Healing Foundation. 2006. A Healing Journey: Final Report

5.3.1.5 Adequate and Timely Diagnosis

Many of the participants indicated that Aboriginal people were not receiving or accessing the services to ensure an adequate or timely diagnosis of mental health related diseases. Many mental health issues may go undiagnosed for reasons such as a lack of trust toward community health workers, uncertainty as to whom to turn to, and embarrassment (these concerns were also identified by community health workers during community engagement sessions).

Furthermore, Western categories of depression do not necessarily capture the Aboriginal experience, which includes trauma linked to sexual abuse and IRS experience. Aboriginal people may not be seeking the care required from the appropriate service providers to completely health from the residential school experience / intergenerational impacts.

5.3.2 CHRONIC DISEASE DIAGNOSIS AND MANAGEMENT

Chronic disease refers to conditions that persist over long periods of time. Participants suggested a number of chronic diseases impacting the Aboriginal population, including:

- Diabetes
- Cancer
- Circulatory conditions
- Obesity
- Arthritis
- Asthma
- Disabilities

The 2008 Aboriginal Health Forum – Elements of Change Summary Report highlights unmet needs with respect to chronic disease prevention management. Forum participants mentioned a lack of education and resources such as advanced foot care training, respite and rehabilitation training as well as limited access to Aboriginal health care workers and physician services. Moreover, forum participants identified the following gaps/limitations: interrupted services; lack of culturally appropriates services, lack of knowledge about chronic disease; and, poor communication between the client and provider and between remote and urban centres[67].

The largest gap with respect to chronic diseases mentioned by project participants was adequate care and support within the communities for residents affected by diseases, such as diabetes, arthritis, hypertension and cardiovascular disease, dementia and asthma.

Individuals remarked that Aboriginal people were often diagnosed with a chronic illness but were not provided with sufficient information about the requisite rehabilitation and/or how to "live comfortably" (manage) with the chronic disease.

Gaps were identified in the following areas:

- Diabetes management
- Prevention and control of respiratory illnesses
- Health promotion
- Consistency in care
- Palliative care

[67] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p. 10-11.

5.3.2.1 Diabetes Management

The most common chronic disease mentioned during community engagement sessions (in-person and by telephone) was diabetes and its related health conditions (e.g., foot lesions requiring care, obesity). Many participants indicated that diabetics were challenged with understanding how to live comfortably with the disease and prevent further declines in health as a result of insufficient treatment. Community participants expressed concern that communities were lacking consistent and satisfactory diabetes care. It was noted that additional counselling in the areas of nutrition/healthy eating and healthy lifestyles would help to reduce the impact of diabetes and encourage improved lifestyles. Some communities suggested more frequent visits by foot care specialists and health promotion consultants in the areas of nutrition and exercise.

The need for dialysis in home communities or closer to home was identified by a number of participants. At present, members have to leave the community to access this care. Some of the communities spoke about having to relocate community members to urban centers in order for them to access dialysis. This creates individual and family hardship. Some participants felt that the governments should do more to encourage home dialysis units within the NW LHIN so community members are not required to relocate to obtain their care.

5.3.2.2 Prevention and Control of Respiratory Illnesses

Poor housing conditions were suggested by some communities as the cause of increased asthma and respiratory illnesses in both the young and old. Homes were described as often being over-crowded and/or infested with mould. Enhancing community awareness about the impacts of these conditions and encouraging improved home maintenance as well as improved home construction has the potential to positively influence the health and well-being of community members.

5.3.2.3 Health Promotion

Health promotion and public health on-reserve within the NW LHIN is encouraged through various programs offered by Health Canada. Social and environmental conditions in the communities can affect people's ability to achieve a healthy lifestyle and maintain good health. Healthy environments include the availability of healthy foods, clean and safe water, properly designed and adequate housing.

Nurses and health staff in some of the communities expressed concern with the lack of health promotion initiatives in the communities, including programs offered to encourage healthy living and eating healthy foods as well as proper maintenance of homes.

Health promotion activities would encourage proper immunization, healthy eating and adequate exercise. Although some services are offered in communities, participants felt there were only a limited number of adequately trained staff to encourage and deliver health promotion activities. Many of the nurses in remote and rural communities are often relief nurses (not full-time) and are forced to deal with acute situations and often don’t have the time, commitment or training to promote public health education.

5.3.2.4 Consistency in Care

Some health care providers interviewed indicated that Aboriginal people were more likely to access emergency rooms for acute care, accidents and injuries as well as more general symptoms that could be treated by a primary care physician or nurse practitioner. Consistent care was limited for chronic diseases because many Aboriginal residents lack family physicians or nurse practitioners. Those living close to urban centers were told to access emergency care services instead of waiting for an appointment with a family physician (if available). Members of remote communities were limited to appointments with physicians or nurse practitioners when (or if) they visited the community. Cases are often not well managed as emergency services do not provide the follow-up care that a consistent family physician or nurse practitioners would provide.

5.3.2.5 Palliative Care

Individuals noted that palliative care is not always available for Aboriginal people in their own home, community or culturally acceptable location. For First Nation patients from distant communities, dying in a hospital means being far from home and family, and being in an unfamiliar cultural milieu. Some participants noted that some hospitals/palliative care centres did not provide patients receiving palliative care the respect, level of communication, or culturally appropriate environments required to meet the needs of the Aboriginal population.

Some participants indicated that palliative care should be an 'extended family experience' but in many cases community members are forced to leave their community (and their family supports) during this 'end of life journey'. Some participants stated that at times, community members refuse to accept palliative care services and instead choose to remain in their community (thereby not receiving adequate end of life care and possibly suffering as a result). For Aboriginal people remaining in their communities and with the limited supports provided, care was often limited to family members and friends. This management of care by family members and friends leads to high levels of stress on these individuals.

Some suggested that with the aid of physicians providing palliative care and the assistance of community health staff, Aboriginal people be allowed to securely return to their communities to be with their family and friends as they pass on.

Community members living close to palliative care providers were able to receive this care with the support from family and friends. The Meno Ya Win Health Centre in Sioux Lookout has been designated as a centre of excellence for Aboriginal care with the mission based on culturally responsive values, providing traditional healing options, interpreter services, and traditional foods including the development of a palliative care area large enough for extended family.

5.3.3 Acute Disease / Accidents and Injuries

Aboriginal people living within close proximity to urban centre are able to access acute care through emergency rooms, health centres and/or the primary care system. Gaps were identified with respect to:

- Accessing care in a timely manner
- Limited acute care services
- Lack of preventative and pro-active measures
- Limited resources

5.3.3.1 Accessing care in a timely manner

Individuals noted that Aboriginal people are not always accessing care for acute diseases, accidents and injuries in a timely manner. Even Aboriginal people living in communities in close proximity to care often face transportation challenges. Many Aboriginal people do not have vehicles to transport themselves or their family members to health care facilities. Some community members in rural and remote locations are reliant on air travel, including scheduled flights or medevac options. Consequently, additional options for accessing medical care are required.

Information suggests that Aboriginal people have a higher rate of accidents and injuries as a result of substance misuse. Moreover, Aboriginal people injured while under the influence of alcohol, drugs or other stimulants are less likely to access care until they "sober up". This delay in treatment could result in more acute situations.

5.3.3.2 Limited acute care services

Acute care in rural and remote communities is often limited to services provided by nursing stations and is not always available 24-hours a day. Aboriginal people residing in these communities must wait until nursing staff is available (or nursing staff must make themselves available after hours – many of these communities employ nurses with experience in acute care and will provide the services required for the

community members in a timely and effective manner based on the resources that they have) and/or more acute care services can be arranged.

5.3.3.3 Lack of preventative and pro-active measures

Many of the participants indicated that 'band-aid' solutions were being provided to deal with health care needs and priorities in the communities. Community health staff are forced to react to issues as they arise instead of creating solutions (health promotion and disease prevention) that will help reduce the need for the services.

Many felt that there was a lack of preventative and pro-active measures to assist with providing and encouraging healthy lifestyles for Aboriginal people in the NW LHIN. Many suggested the need for more prevention and awareness programs to encourage healthy lifestyles, to assist with the management of disease and to reduce the number of accidents and injuries within the communities.

Some communities have been proactive in developing strategies to guide health and social programming in areas such as diabetes, tobacco use and more recently, prescription drug abuse. Many respondents indicated the need for more of these community-based strategies to ensure that programs and services are being developed to meet the needs of their members.

5.3.3.4 Limited Resources

Many individuals remarked that limited resources on-reserve prevented adequate care in the area of the public health. Some suggested that the nurses stationed in the community are not always trained in public health and are often too preoccupied with day-to-day tasks to focus on health promotion and disease prevention activities.

While some communities benefit from regular visits from a public health nurse, many others do not have access to public health services. Participants suggested the need for more public health nurses or someone who could focus on public health issues.

Community participants also spoke generally about the limited health care human resources available in the communities to effectively deliver health programs and services. They noted that many of their staff members are '"wearing two hats" (i.e., some services are being delivered by the same individual). The limited human resources were associated with limited program funding, higher salary expectations on the part of staff and the need for qualified staff.

5.3.4 ACTIVE AND ENGAGED PARENTING

Learning and providing supportive parenting skills is essential for long-term health and well-being. Some participants suggested that Aboriginal people were faced with challenges in meeting the needs of their children.

Some participants suggested that the challenge associated with active and engaged parenting is an intergenerational impact of the residential school experience. The effects of residential schools are far more widespread than first realized, including third and fourth generation family members. Inadequate parenting skills, addictions, and family violence are some of the most often cited social ills attributed to residential school traumas.

Many participants felt that additional programs and services were required to encourage active and engaged parenting. Some indicated concern with teen age pregnancies and felt the need for additional workshops in sex and health education.

Other services were suggested including prenatal nutrition and fetal alcohol syndrome disorder (FASD) awareness. Some remote communities indicated that prenatal support was sometimes provided but was limited to when a nurse was available to visit the community.

5.3.5 CHILDREN'S PROGRAMS AND SERVICES

Some communities indicated a gap in available day care services. Individuals commented that they could benefit from more support for an organized pre-school program for children under six years old. Some respondents also indicated that limitations with respect to on-reserve education create challenges to ensuring Aboriginal children receive the learning foundation required to succeed in long-term educational pursuits.

Some community respondents also indicated that Aboriginal people are not always accessing the required programs and services for children struggling with developmental and social issues. Participants identified gaps in the availability of services and challenges with accessing services not provided in the communities. Some suggestions included that there were more assessments required to assist with early intervention for FASD or learning disabilities. Some services not easily accessible included:

- Speech Therapy
- Hearing Tests
- Diagnosis of FASD and learning disabilities
- Nutrition
- Dental Health

5.3.6 YOUTH PROGRAMS AND SERVICES

Many participants suggested gaps in the availability and delivery of youth programs and services, available on reserve and in small communities as well as adequate resources that contribute to the well-being of Aboriginal youth. The gaps identified included:

- Lack of recreational and cultural programs
- Educational curriculum

5.3.6.1 Lack of Recreational Activities and Cultural Programs

Most participants felt that additional recreational and cultural programs and services should be provided to youth on-reserve, including activities that encourage active lifestyles. The youth programs suggested include programming similar to Scouts Canada, YMCA and/or wilderness camp activities, including traditional knowledge. While some community representatives indicated that they had a staff member to organize youth activities, others noted their lack of an active youth coordinator on-reserve.

Many participants indicated that youth need the programs and services to support and build awareness about the importance of language and traditional cultural events, understanding and speaking the traditional language and creating healthier family dynamics. The need for programs and services in order to “bridge the gap” between Elders and youth was also noted.

5.3.6.2 Educational Curriculum

Federally funded elementary and secondary schools within communities are the responsibility of the local First Nation Education Authority, band council or federal government. Some communities lack a set-curriculum for the students. Respondents indicated that Aboriginal students are not being provided the same education as children living off-reserve.
Some communities within the NW LHIN provide educational programming up to Grade 6 or up to Grade 8. In many communities, students must leave their communities to continue their education in provincially funded schools in urban areas. This situation creates stress for students and has the potential to influence their overall health and well-being.

According to census data, there is a significant gap between the educational attainment of Aboriginal populations and that of the non-Aboriginal population; thus leading to Aboriginal people with few employment skills and lack of academic/literacy skills needed to upgrade their qualifications.

5.3.7 Seniors Programs and Services

Aboriginal people off reserve can access long-term care services through the Community Care Access Centres (CCAC) and/or community support service agencies such as Aboriginal Health Access Centres or various Aboriginal organizations funded by the Ministry of Health and Long-Term Care.

Many of the First Nation communities in the NW LHIN manage and deliver various long-term care services on behalf of their members. The range and type of services available varies from community to community. Homemaking services are the most common and include community support services (meal programs, friendly visiting, security checks) and in a few cases professional health services.

Health Canada also provides First Nations with the Home and Community Care Program that provides basic home and community care services. The Program is delivered by trained and certified personal care/home health aide workers and often supervised by registered nurses.

The 2008 Aboriginal Health Forum – Elements of Change Summary Report notes the following unmet in senior services: lack of medical escorts; lack of meals on wheels programming; lack of translation services; and lack of friendly visiting programs. Additionally, it was noted that there needed to be more cross cultural training available to help ensure that health care providers are more culturally aware of Aboriginal needs and are able to provide culturally appropriate programs and services[68].

Many participants identified gaps in available health programs and services for seniors on- and off reserve. It was indicated that the programs and services available should more adequately reflect the aging population and their subsequent increase in medical needs. Most communities do not offer adequate health programs and services on-reserve to meet the needs of seniors, including supports to allow them to live in their own home. In addition, there is a need for more organized programming to engage Elders in recreational and cultural activities. Gaps identified included:

- Limited provisions through the Home Care Support Program
- Adequate Housing and Home Supports
- Culturally appropriate accommodations in Long Term Care Facilities

5.3.7.1 Limited provisions through the Home Care Support Program

Most participants indicated that Elders are impacted by gaps in the Home Care Support Program. Although most communities have a Home Care Support Program, services are often limited to a minimum number of hours per day and do not cover all the needs of the Elders. Many Elders are forced to move off reserve to access the required home care.

5.3.7.2 Adequate Housing and Home Supports

Participants mentioned an increase in the number of citizens living in Sioux Lookout, Thunder Bay and other urban centers because of limited care in remote communities.

An improvement in respite care and availability of housing facilities to support their needs would allow Elders to remain in their communities.

5.3.7.3 Culturally appropriate accommodations in Long Term Care Facilities

There are currently 14 long-term care homes in the NW LHIN. Many First Nation seniors are relocating to urban centers to live in long term care facilities. The seniors are faced with adjusting to a new situation away from their community and family.

Respondents indicated that for some older adults, this accommodation brings back memories of their residential school experience. Many identified a gap in culturally appropriate care in the long-term care

[68] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p. 11.

facility to ensure seniors are provided with adequate translation services so they can continue to speak their language and practice their traditions.

5.3.8 Continuity of Care / Provision of Essential Services and Specialized Care

Other gaps mentioned by participants, included continuity of care and the provision of essential services and specialized care for the Aboriginal population in the NW LHIN Region. Specific gaps were identified with respect to:

- Dental services
- First Response
- Primary Care
- Specialized Care

5.3.8.1 Dental Services

Most communities identified a shortage of adequate dental care. In remote communities, dental services are sometimes provided only on an annual or bi-annual basis. To obtain dental services most residents must leave the community to access a dentist in an urban location. For remote communities this is a financial constraint that is not entirely subsidized by Non-Insured Health Benefits (NIHB). Some communities (in remote locations) lack the space for dental services to be provided. In a few communities this has led to community members going without proper dental care.

5.3.8.2 First Response

Many participants also indicated that first response – ambulatory care and fire services – were limited or non-existent within their communities. Some communities benefited from volunteer programs, whereby trained personnel on or in close proximity to the community acted in the capacity of first responder. Other communities (more remote locations) went without the essential services altogether.

5.3.8.3 Primary Care

Infrequent visits from physicians and untrained or short-term nursing staff that were not familiar with the community were identified as important gaps to primary care access. Many participants indicated that Aboriginal people suffered as a result of limited family physicians in the NW LHIN region. Similar to regions across Ontario, primary care physicians are few in number. Long-wait lists and lengthy wait-times for appointments often discourage Aboriginal people from scheduling regular appointments or accessing care when required.

Some health care providers also expressed concern that there was no continuity of care provided to community members. There is a lack of primary care physicians for community members so many community members access local emergency rooms for acute care, accidents and injuries and symptoms that could be treated by a primary care physician or nurse practitioner. This method of treatment limits the ability for adequate follow-up care options and creates obstacles to the continuity of care.

5.3.8.4 Specialized Care

Many participants also identified specialized care as a significant gap. Examples of such services include physiotherapy, eye care, psychological treatment, and speech/language pathology treatment. Community members usually had to leave the community to access these services. In more remote locations this required costly transportation, extra time to access appointments, and the need for an escort if patients were not confident in travelling alone.

5.3.9 Infrastructure

Many community respondents indicated that they often struggled with organizing health programs and meeting to meet the needs of community members because of limitations associated with infrastructure.

Many community based service providers indicated a gap in the availability of meeting space for health promotion workshops and confidential office space for counselling sessions. Many of the programs offered in the communities shared office space and consequently, have to concurrently run programs and meet with clients.

Some participants also indicated that there was no ‘safe house’ for women/men that are affected by spousal abuse or family violence. Some suggested that community members often had to leave the community to secure a safe place.

5.3.10 CULTURALLY APPROPRIATE SERVICES

Many participants noted that the programs and services provided both on- and off-reserve are not consistent with the traditions and culture of the Aboriginal populations. Some programs, such as interpretation services and Aboriginal counselors are available in some locations but not across all urban areas in the NW LHIN region.

Community-based programs, such as community-kitchens, cultural camps, language courses and seniors groups are being developed on-reserve to meet the needs of First Nations people. However, limited funding is available for traditional healing methods and approaches to well-being.

Some community health care providers suggested developing more approaches to healing that included trips to northern camps and living off the land; however, limitations in funding rarely allow for this approach to be adopted.

In off-reserve and more urban locations, gaps in translation services limit some community members from accessing available programs and services or fully understanding medical diagnosis and requirements.

5.3.11 TRANSITIONAL ASSISTANCE

The Northwest population is very mobile, moving between their home communities and the larger urban areas in the region to seek employment, education or to access health care.

Moving to a new social environment requires significant adaptation. Many participants noted gaps in transitional supports required during this stressful time. Many urban new comers are not aware of how or where to access health programs and services and do not adjust well to the new environment.

5.3.12 WELLNESS EDUCATION AND PREVENTATIVE HEALTH CARE

Many community participants noted their belief that health care providers are not providing adequate health care in the area of preventative measures. Most participants felt that there were gaps in the overall education provided to Aboriginal people for life and overall wellness. Some felt that the desire to establish a healthy lifestyle was not a priority for Aboriginal people struggling to meet their basic needs. Some suggested that leading a healthy lifestyle was dependent on available resources, such as healthy foods, employment and recreational opportunities.

Some participants suggested that more education and training should be provided for nutrition and healthy eating. Others felt that this ‘way of life’ would require a change in mentality and way of living to which many Aboriginal people were unaccustomed. Many participants identified initiatives underway in communities that encourage healthier living options, including healthy eating programs within schools to encourage a change in behavior at an earlier age.

5.4 Duplications in Aboriginal Programs and Services

Most of the participants did not indicate any major duplication in Aboriginal programs and services. Some participants indicated that there may be a few duplications in programs and services provided by Health Centres on reserve and off-reserve locations, but with access challenges (even within close proximity) these duplications were minor.

Some felt that programs and services provided by nurses in the communities may be duplicated by community-based program staff (i.e. prenatal, diabetes, nutrition), however most participants remarked that community staff worked closely with nursing staff to integrate the programs and services available and deliver workshops collaboratively.

Pre-natal care was also identified as duplication within urban centers, specifically Thunder Bay. This service is currently delivered through health care access centers and Friendship Centres; however, participants felt that this duplication provided young mothers and expectant parents with a choice in where they could access care.

With respect to duplication, many felt that clarifying roles and responsibilities, improving communication and developing a shared inventory of programs and services available within and outside of communities would assist with determining any duplications and better delivery the programs and services available.

Many also felt that duplications in programs and services allowed for multiple options as to where clients can go for health programs and services. These different access points were considered a benefit for community members.

5.5 Challenges to Delivery and Access

This section presents the challenges associated with the delivery and access to Aboriginal health programs and services both on-reserve and off-reserve.

5.5.1 Challenges Associated with the Delivery of Health Programs and Service On-Reserve

Front-line workers and health care providers, through the engagement sessions and key stakeholder interviews presented many of the challenges they face with respect to the day to day delivery of health programs and services on-reserve. The key challenges include:

- Human resources, capacity and Infrastructure
- Reporting requirements
- Financial resources
- Jurisdictional Issues

5.5.1.1 Human Resources, Capacity and Infrastructure

Respondents indicated that available resources (human, financial, material) are not sufficient to meet the needs of Aboriginal people living on many of the reserves. Often front-line staff and managers do not have the education or adequate training required to effectively implement programs. Some of the community staff also indicated that program managers are often stressed as a result of dealing with mental health issues beyond their capabilities. Many staff expressed frustration that they did not have the necessary supports to assist them with the delivery of programs and services.

Some staff suggested that they were underpaid. They indicated that higher wages would likely interest more qualified people to assist with community-based programming. It was also noted that often when staff are sufficiently trained they seek higher paid employment elsewhere.

Some community-based programs are reliant on leadership electing people to the managerial position to run programs. Often changes in leadership can result in changes in program managers. This inconsistency often created obstacles in program functions.

Many participants indicated that the community programs did not have the adequate office space to meet the needs of the clients in the communities. Many programs and one-on-one counseling sessions share space thus, privacy and confidentiality are issues.

5.5.1.2 Reporting Requirements

Many of the participants mentioned challenges with the reporting requirements for community-based programs. They often felt that the reporting requirements were time-consuming and difficult to follow. They did not feel they had the necessary support to seek additional assistance if required.

Some participants suggested that the information gathering requirements are difficult and that collaboration with nursing staff was required to gather the required data (i.e. Healthy Babies Annual Report). Other community respondents noted a lack of collaboration with nursing staff to complete the annual reporting requirements.

5.5.1.3 Financial Resources

Many of the community representatives suggested constraints associated with limited funding that affected their ability to deliver adequate health programs and services to their community members.

Many of the participants responsible for running community-based programs felt challenged by the need to have to obtain annual funding and ensure that resources are in place on a yearly basis in order to be able to continue offering the program. The lack of continuity or assurance that funding will be provided creates obstacles in planning for sustainable programs and services. It was noted that program managers are not always convinced that programming will continue the following year and as such, do not always develop plans for long-term activities.

Provincial and federal contributions to community-based and off-reserve health programs and services also create challenges for program coordinators. Many of the community representatives were not aware of contribution agreements and do not understand where and how the provincial funds and federal funds are allocated. Many were not aware of funding opportunities at the federal or provincial level or if there might be duplication in funding provided for similar programs.

5.5.1.4 Jurisdictional Issues

Participants commented on some challenges encountered due to jurisdictional issues, specifically understanding federal and provincial responsibilities. Many participants felt strongly that First Nations were the responsibility of the federal government and did not understand programs or services that were provided by the provincial government. Some service providers expressed concern that programs and services were available off reserve but certain provincial organizations (i.e. CCAC) could not provide similar services to on reserve community members. There was also concern with respect to the Aboriginal population being counted in population estimates for CCAC funding base, but yet, they do not always receive same services from the CCAC as the rest of the population.

5.5.2 Challenges Associated with the Access of Health Programs and Services On-Reserve

The NW LHIN Integrated Health Services Plan, 2010-2013, notes that challenges accessing mental health and addiction services continue to be an issue in communities (not just Aboriginal communities) across the North West region (e.g., medication management is often a problem because of the shortage

of physicians and pharmacists). Clients are often forced to leave their communities in order to access specialized care. For instance, outside of Thunder Bay and Kenora, there are a limited number of specialized treatment centres, detoxification options, withdrawal management programs, or transitional supports. In particular, access issues have been identified with respect to psychogeriatric services, transitional or supportive housing and walk-in mental health services[69].

The 2008 Aboriginal Health Forum – Elements of Change Summary Report identifies a number of barriers to accessing care that compromise the health and well-being of community members. These include: lack of networking with the broader health system; lack of specialized services; lack of translation services; lack of understanding of Aboriginal culture and traditions; insufficient funding; limited understanding of the impact that the diverse geography within the NW LHIN region has on the health of Aboriginal people; lack of knowledge about where to go for services; limited number of Aboriginal health care workers; shortage of trained staff; lack of rehabilitation services; long wait times; shortage of physicians; and, lack of telemedicine[70]. Many of these barriers also apply to Aboriginal people attempting to access care off reserve.

Front-line workers and health care providers, through the engagement sessions and key stakeholder interviews, presented many challenges associated with community members accessing programs on-reserve. The key challenges include:

- Awareness and understanding of programs
- Desire and motivation to participate
- Trust and confidentiality
- Transportation

5.5.2.1 Awareness and Understanding of Programs

Many community participants indicated that the greatest challenges for community members in accessing programs and services on-reserve is: (1) awareness that the programs exist and (2) understanding of how the program may benefit their health and well-being.

Staff indicated that many communication forums are utilized to enhance awareness about existing programs and services, including advertising workshops through radio, word-of-mouth and telephone calls as well as personally inviting participants to attend.

5.5.2.2 Desire and Motivation to Participate

Many of the participants indicated that community members have to want to participate in a program and demonstrate their motivation to participate. Some community members struggle with pride or embarrassment and do not want to accept assistance or admit that they needed assistance. For some, this means overcoming potential humiliation and opening doors that many may not want to open. Community respondents commented that some community members are addicted to their lifestyles and are not interested in accepting assistance to improve their well-being.

5.5.2.3 Trust and Confidentiality

A perceived lack of trust and confidentiality are important challenges that often deter an individual from accessing programs and services on-reserve. Respondents noted that community members are less likely to participate in community-based health programs and services if they do not trust the service provider.

[69] NW LHIN. (2009). Integrated Health Services Plan, 2010-2013. p.32.
[70] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p. 9-10.

Additionally, community members do not access care as readily if they fear that their information will not be kept confidential. This challenge is encountered on-reserve because of the limited space available to hold one-on-one meetings and counseling sessions.

5.5.2.4 Transportation

Aboriginal community members face challenges in accessing transportation that will enable them to participate in health programs (this is true for a broad spectrum of health programs and treatment). While some respondents indicated that their community had transportation options available (e.g., medical van), many others indicted a lack of alternative travel options.

5.5.3 Challenges Associated with the Delivery of Aboriginal Health Programs and Services Off-Reserve

This section presents the challenges that front-line workers and health care providers expressed during the engagement sessions and key informant interviews associated with the delivery of Aboriginal health programs and services off-reserve. The key challenges include:

- Developing and delivering culturally appropriate programs and services
- Collaborations and building strong and supportive partnerships
- Patient expectations
- Provision of aftercare and follow-up requirements

5.5.3.1 Developing and Delivering Culturally Appropriate Programs and Services

Many services providers, particularly off reserve, were challenged with developing and delivering Aboriginal appropriate health programs and services in the NW LHIN region. Some organizations indicated that they have been successful in collaborating with Aboriginal representatives to ensure that culturally sensitive programs are developed to meet the needs and traditional values of Aboriginal people.

Some participants felt that organizations could do more to ensure that Aboriginal needs are met when participating in off reserve health programs and services. Suggestions included providing Aboriginal translation services, ensuring that medical language is adequately explained to, and understood by, the client, and ensuring that Aboriginal clients are comfortable with the treatment they receive.

Many service providers outside of the communities felt that the health care system was not adequately set up to receive First Nations members, specifically with respect to language and culture. The most supportive programs identified were those that had Aboriginal people working within the organization to create a welcoming environment and to assist with client requirements (language, understanding medical language and navigating the system).

5.5.3.2 Collaboration and Building Strong and Supportive Relationships

Many of the participants indicated that there are challenges with establishing supportive relationships between off-reserve service providers and community members. They noted that off reserve programs are more successful in meeting the health needs and priorities of Aboriginal people when the participants trust the service providers and are encouraged to participate in off reserve services by community health care providers.

Health providers indicated that off reserve programs are more successful if there is collaboration with other Aboriginal programs and strong and supportive relationships developed.

Some remote community representatives did not feel that they could benefit from building formal or informal relationships with other communities or health providers. They felt strongly that their community was unique and had to deal with health issues and concerns independently.

5.5.3.3 Patient Expectations

Some service providers indicated that they often encounter challenges with what they considered to be basic patient's expectations. They described a situation in which community members arrive at the emergency department to access services that can be better provided through primary care physicians or other service providers.

Patients accessing health care are often expected to complete lengthy application forms, including medical history and additional background information. Some Aboriginal people may have limited literacy skills (i.e. language barriers, reading or comprehension) that challenge their ability to adequately complete the forms. Some patients are also not willing to provide medical information because they do not understand why it is essential or because they do not know their family history.

Health care providers also indicated challenges with ensuring patients had adequate identification and contact information for follow-up care.

5.5.3.4 Provision of After-care and Follow-up Requirements

Many off reserve service providers indicated challenges in meeting the needs of Aboriginal people accessing programs off reserve because of the limitations associated with ensuring adequate after-care and follow-up. After seeking care off reserve, many patients return to their home communities and physicians are left without contact information which allows the physician to ensure that patients are receiving adequate after-care. Some service providers felt that additional patient tracking was required to ensure that the health needs of the Aboriginal clients were being met when they returned to their home communities.

5.5.4 Challenges Associated with the Access of Aboriginal Health Programs and Services Off-Reserve

Many of the participants expressed challenges that Aboriginals face in accessing health programs and services off-reserve. The challenges include:

- Awareness of programs and services available
- Motivation and interest to participate in process
- Availability of programs and services
- Financial support and challenges with Non-Insured Health Benefits
- Transportation
- Transition and Language Barriers

5.5.4.1 Awareness of Programs and Services Available

Many community members and health staff on reserve were not always aware of the health programs and services available off reserve. There was often no clear direction or 'formula to follow' when community members on reserve needed additional support not available in their community. Respondents commented that often times they do not know where to go or how to access the available services.

Some suggested that an inventory would be helpful in allowing community health staff to be aware of the available resources. Some health staff also felt that they could benefit from understanding how other communities are delivering health programs and services to meet the needs of their community members. Some suggested building awareness of health care access centres and Friendship Centres within local communities to ensure that Aboriginal people are more aware of where they can go to access assistance with navigating the health care system.

5.5.4.2 Motivation and Interest

Many of the participants indicated that some community members do not want to attend programs and services provided outside of their community. Leaving their home community created additional stress that at time deterred them from wanting to access outside programming. Some community members struggle with pride or embarrassment and do not want to accept assistance or admit that they need help. Many community health providers struggled with the challenges of working with community members who do not want to accept the health care that is available to them. Challenges associated with literacy and a need to read and write in order to be able to participate in programs and services may have resulted in some individuals electing to not take part.

5.5.4.3 Availability of Programs and Services

Community health care providers are often challenged by wait times and limited space available for community members, specifically in respect to detoxification centres and addiction clinics. When community members seek help and are interested in participating in a program there are often wait times of eight to 12 months; by the time a bed becomes available, participants have often lost interest.

Many of the programs approved by NIHB are often the programs with lengthy wait lists. Some suggested NIHB should allow community members to participate in a wider variety of treatment programs to help reduce wait times.

5.5.4.4 Financial Support / NIHB

Health Canada's Non-Insured Health Benefits Program provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health counselling and medical transportation for eligible First Nations people.

Many participants expressed challenges with acquiring approval and financial support by NIHB to access the services required. In some situations approval for travel was a lengthy process and resulted in longer wait times to access the required services.

Many expressed concerns with NIHB and the lack of clarity surrounding the programs and services refundable by NIHB. Some respondents indicated that funding was not always approved for escorts, nor was it always approved for health needs such as orthotics or assessments to access treatment.

Many participants felt that community members face challenges associated with the application process; they did not always have the literacy levels required to fill out the application. The process of completing forms and acquiring approval for travel was dependent on the health staff and often resulted in heavy administrative functions to ensure adequate funding.

5.5.4.5 Transportation

The greatest challenges facing participants attempting to access health care programs and services off reserve are transportation limitations due to geographic constraints. Many individuals in remote communities (air access only) were limited to air travel schedules and would often have to leave the community for three days to attend medical services that may only be a one-hour appointment. This travel created issues such as time away from work, childcare requirements and financial supports for food and accommodations while out of the community.

Some were concerned with the short notice that was often provided for health appointments outside of the community that could not always be met because of challenges associated with the short-term notice and planning logistics of leaving the community.

Many community members also were frightened about leaving the community and escorts were not always provided so community members were left to make the journey on their own.

5.5.4.6 Transition and Language Barriers

Many community members moving into new communities have challenges with adapting to the new environments. Many newcomers are not aware of how or where to access health programs and services and do not adjust well to the new environments.

5.5.5 Challenges Associated with Aboriginal Health Planning

The 2008 Aboriginal Health Forum: "Elements of Change" Summary Report notes that Aboriginal health planning in the NW LHIN region is complex and requires the consideration of various community and Treaty groups as well as a the distinctive issues and approaches that exist within groups located in the North West region[71]. More specifically, challenges that influence Aboriginal health planning include:

- Vast distances between Aboriginal communities and the remoteness if northern First Nation communities
- Language barriers and the lack of translation services
- Lack of culturally sensitive and culturally appropriate services and programs
- Lack of knowledge of existing services

5.6 Health Program and Service Opportunities

5.6.1 Current and Potential Partnerships

5.6.1.1 Current Partnerships

There are many partnerships (formal and informal) that currently exist between health care professionals providing programs and services to Aboriginal people residing in the NW LHIN.

Some participants indicated formal relationships that were established through signed memoranda of understanding (MOUs) and designated roles and responsibilities. Most participants indicated that they have developed many informal relationships and work collaboratively with other health care providers when possible. This may include sharing resources (human and material) and organizing events collaboratively.

On-reserve, most health program staff work closely together, sharing resources and building successful working relationships. Some community representatives indicated that they have strong supports outside of the community with tribal councils, health authorities and/or other health care providers. On the other hand, some noted that because of their geographic location they work independently from other organizations since partnerships are difficult to establish due to the distance.

Across the NW LHIN Region, formal and informal partnerships have been established between community health program staff and the following health providers:

- Other community program managers/front line staff
- Community leadership
- Other communities
- Community and Regional Hospitals
- NW Aboriginal Health Services Advisory Committee
- Northern Ontario School of Medicine
- Health Canada

[71] NW LHIN. (2008). Aboriginal Health Forum. "Elements of Change" Summary Report. March 27 -28, 2008, Victoria Inn, Thunder Bay.

- Health Access Centers
- Dilico Anishinabek Family Care
- NW CCAC
- Community Health Centers
- Keewaytinook Okimakanak
- Family Health Teams
- Tribal Councils
- Health Planning Authorities

The 2008 Aboriginal Health Forum – Elements of Change Summary Report noted that partnerships/linkages between communities and the following programs/centre/organizations were working well:

- Lifelong Care Programs
- Community Care Access Centre
- Alcohol Drug Programs
- Dilico Programs
- Cancer Society
- Thunder Bay Regional Health Sciences Centre
- Remote diagnostics (e.g., diagnosing children in remote communities using telehealth/telemedicine) [72]

The Forum participants noted some unmet partnership needs: lack of health care professionals in the communities; lack of emergency supports in many communities; and poor communication between health care providers and First nation communities. Participants also remarked that health care politics was a barrier to the development of partnerships with the broader health care system[73].

5.6.1.2 Potential Partnerships

Many of the participants suggested that additional partnerships could be established and that some of the existing partnerships could be further developed.

One potential partnership noted includes developing relationships with other communities to help understand how health care services are provided elsewhere and sharing lessons learned to determine more effective ways to deliver the community-based programs.

Many participants felt roles and responsibilities could be clarified to better understand how the different levels of governments could work together to provide sufficient funding to meet the needs of Aboriginals.

Additionally, many participants felt that better relationships could be developed with primary health care physicians to meet the needs of community members. Many felt that Aboriginal people should establish more positive relationships with a family doctor. Some suggestions for these relationships included: more frequent visits by physicians to communities, better access of tele-health to meet regularly with patients or developing relationships with community nurses to understand the health needs and priorities of the community members.

The 2008 Aboriginal Health Forum – Elements of Change Summary Report states the need for improved cooperation and coordination between providers and communities. The reports also noted that improved communication, education and increased contact was integral to enhanced partnerships/linkages. Additionally, implementation of an Aboriginal Healthy Babies program, support programs for caregivers

[72] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p. 11-12.
[73] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p.12.

and the expansion of telehealth/telemedicine to all remote communities were identified as ways to enhance partnerships and linkages with the wider health care system[74].

5.6.2 Opportunities for Integration

Respondents noted a number of opportunities for new and/or enhanced integration between the programs and services (at all levels) offered to Aboriginal people residing in the NW LHIN.

Some suggested that all service providers should work to integrate more traditional and cultural practices into the services they provide to the Aboriginal population. It was suggested that this could be done by having service providers work more closely with community and Aboriginal representatives (e.g., having appropriate membership on boards and planning committees by Aboriginal people). This would help ensure that Aboriginal perspectives were incorporated in the planning phase as well as in the design and possibly delivery of initiatives.

Many community members suggested that health care providers throughout the NW LHIN need to acquire a better understanding of what is actually happening in rural and remote communities so as to better represent this population's needs in the development and delivery of programs. Respondents suggested that providers who are unfamiliar with these communities should make a concerted effort to spend more time visiting these communities and speaking with residents. The majority of respondents indicated that the NW LHIN had to develop a stronger working relationship with the communities, that they had to develop a better understanding of the socio-economic factors contributing to the health and well-being of rural and remote community members, and that they had to develop a strategy for integration that meets the needs of all populations with the NW LHIN.

Participants commented that the integration of services may be more effective if there was more awareness surrounding the health programs and services provided across the NW LHIN Region. Suggestions for addressing this issue included developing a more accurate directory of available health programs and services and sharing of information between health care providers located across the region.

Respondents noted that further integration of health programs and services would be a challenge due to the geographic and demographic variability that exists between communities across the NW LHIN region. Some participants indicated their belief that workshops were often too focused on the needs of southern communities and did not adequately reflect the priorities of northern remote communities.

Overall, participants felt that there was a need for increased integration of mental health and addictions programs in order to ensure adequate delivery of services and continuity of care for the Aboriginal population.

The 2008 Aboriginal Health Forum participants noted that integration would help decrease duplication and maximize resource. The highlighted the following integration opportunities:

- Integrate services targeting the same demographic population
- Combine similar/overlap services areas (e.g., health babies/early childhood development
- Combine FASD services for communities
- Integrate traditional and non-traditional healing practices for all health care providers[75]

[74] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p.12.
[75] NW LHIN. (2008). Aboriginal Health Forum – Elements of Change Summary Report. March 27-28, 2008, Victoria Inn, Thunder Bay. p.12.

5.6.3 HEALTH CARE TECHNOLOGY USAGE

The NW LHINs' Integrated Health Services Plan, 2010-2013, notes that:

> There are hundreds of studies which show that well designed Electronic Health Information and Communication Technologies (eHealth ICT) are important to making patients safer, improving quality and making healthcare more convenient and efficient[76].

KO Telemedicine (KOTM) uses videoconferencing and advanced information communication technologies to deliver clinical, educational and administrative services to 26 First Nation communities in Ontario.

The telemedicine workstations installed in the communities include videoconferencing equipment and the following peripherals: an Ear, Nose, and Throat (ENT) Scope, a Stethoscope, and a Patient Exam Camera.

The equipment provides the telemedicine coordinators (CTC) in the First Nation communities with the tools necessary to connect to nurses, community doctors, or specialists elsewhere in Ontario.

KO also provides web streaming technology that allows staff and community members in remote communities to participate in live conferences and access to training and educational materials, including videos on archived conferences and training materials in the following subject areas:

- Addictions
- CTC Training
- Community Wellness
- Diabetes Education
- Fetal Alcohol
- Health and Wellness
- Health Management
- Health Professionals
- Home and Community Care
- Language Development
- Mental Health
- Parenting
- Prenatal
- Sign Language
- Medical Translation

The Ontario Telemedicine Network (OTN) is an independent, not-for-profit organization that is funded by the Government of Ontario. OTN partners with KOTM and offers a variety of telemedicine services, including videoconferencing, webcasting, store forward and tele-homecare for clients across Ontario. Across Ontario, there are more than 925 telemedicine sites located in hospitals and health care locations and approximately 125 in the NW LHIN[77].

Each of the technologies utilized to deliver health programs and services are explained in more detail in the following sections.

Videoconferencing

Both KO and OTN provide videoconferencing to the communities and First Nations in the NW LHIN. Videoconferencing is used for three main applications, including:

- *Clinical Telemedicine*: expanding patient access to diagnosis and treatment, whereby physicians and other specialists can see patients as if they were in the room.
- *Distance Education*: Allowing participation in health education at various hospitals and other sites across Ontario and easy collaboration with peers
- *Meetings:* Allowing healthcare providers to participate in meetings without the travel expenses.

Webcasting

Webcasting is used by KOTM and OTN's to broadcast health professional events over the internet live or on-demand. Webcasting events can include optional chat options and messaging services for electronic communication between webcasting participants.

[76] NW LHIN. (2009). Integrated Health Services Plan, 2010-2013.
[77] Ontario Telemedicine Network . Retrieved from: http://www.otn.ca/otn/site-locations

Store Forward

Store forward is a service used by KOTM and OTN to electronically share information on patients. For example, a health care professional may take a digital image of the health problem and upload it to a secure server for review by another specialist to provide a diagnosis. This service provides improved and timely access for patients without unnecessary travel.

Tele-homecare

Tele-homecare uses technology to link patients in communities with health care professionals. This service is offered to patients with chronic illnesses as a way to better self-manage their illnesses. Tele-home care is currently being utilized in the homes of clients with multiple chronic diseases in the communities of Deer Lake and Sandy Lake.

Tele-Rehab

Tele-Rehab is a project being run in partnership with the Northwestern Ontario Regional Stroke Network including, KOTM, KO Home and Community Care, St. Josephs Care Group, Thunder Bay Regional Health and OTN.

This program allows patients recovering from strokes in remote First Nation communities to link up with a physiotherapist outside of the community using portable videoconferencing equipment. Without this service, community members would have to extend their stay in Thunder Bay or other urban centres in order to participate in rehabilitation, or return home without any rehabilitation care.

Tele-rehab is currently being utilized in the homes of residents in the communities of Fort Severn, Keewaywin and Sachigo Lake.

Tele-Psychiatry

Tele-Psychiatry is a program provided by Nodin (SLFNHA) that targets children ages four to 19 years of age. It is a collaboration with the University of Toronto Sick Kids Department and provides a one-time consultation with a psychiatrist to review case management and recommendations.

5.6.4 Expansion of Technology and Innovation in Aboriginal Communities

Health care providers suggested the importance of further investing in tele-medicine programs, such as Tele-rehab, Tele-home care and Tele-psychiatry to assist patients living in remote communities. These programs would allow community members to remain in their home while receiving supports through technology that assist with chronic and mental diseases. This program also has the potential to provide palliative care services and supports for people without removing them from the community.

Additionally, technology could be used by health care providers to provide patient assessments through video conferencing technologies thereby addressing long wait times. Additional training and support could also be encouraged through the use of on-line services.

The need for an integrated service delivery model and more awareness of the available programs and services could be achieved through the development of an on-line database or inventory of health care programs and services available on-reserve and off-reserve for the Aboriginal population of the NW LHIN.

5.7 Best Practices and Lessons Learned

Generally speaking, successful Aboriginal mental health and addictions programs and services while diverse are often community-based, culturally-appropriate approaches that acknowledge the long-term nature of healing as well as the connections between physical, mental, emotional and spiritual health. Successful approaches also recognize and address the historic and contemporary realities of life for Aboriginal people.

5.7.1 BEST PRACTICES / LESSONS LEARNED – THE PROJECT PARTICIPANTS

A number of best practices and/or lessons learned were mentioned by participants that could be adopted to help guide future Aboriginal mental health and addictions programs and services in the NW LHIN. Some of the best practices / lessons learned include:

- Improved planning and collaboration with Aboriginal people
- Motivation and encouragement from staff and leadership
- Provision of incentives for participation
- Increased awareness
- Incorporation of traditional values and cultural activities
- Adoption of an holistic approach to health

5.7.1.1 Improved Collaboration with Aboriginal Communities

Many participants remarked that Aboriginal people needed to be more involved and engaged in the development of Aboriginal mental health and addictions programming, planning and policy decision making. More than once the sentiment was expressed that any health policy or program involving Aboriginal people "should be lead by Aboriginal people"; that First Nations should have "ownership" of programs.

One mainstream provider noted that it would be beneficial to increase opportunities for collaboration with NW LHIN community leaders so as to better understand the type of care Aboriginal people need and are comfortable with and to help to decrease inequities in the health care system. It was noted that because a number of relationships are already in place in certain communities, enhanced collaboration focused on mental health and addictions issues may prove less of a challenge in these areas versus other regions in the NW LHIN. One interviewee also commented that part of developing partnerships is the continued need to maintain those partnerships. Specifically, it was noted that collaboration between First Nations communities and the NW LHIN may be difficult until there is a clearer understanding of the role of the LHIN and its relationship to First Nation communities. It is important to realize that forging relationships takes time and consistent effort.

Across varying types of health services, many session participants and key informant interviewees noted that it was beneficial when service providers (e.g. RNs, doctors, etc.) travelled to communities to provide service, rather than having community members go to urban centres for treatment, and that community members were "more willing to get service from specialist in their community" (as opposed to traveling elsewhere). One community representative gave the example of required travel for dialysis treatments and how it is difficult for patients (e.g., an Elder receiving dialysis wished to remain in the community, but eventually was forced to move closer to the hospital due to lack of treatment in the community).

In general, a willingness to "go to the communities" was noted as an effective engagement method and a positive way to create partnerships. It was thought to enhance non-Aboriginal awareness and understanding with respect to the fact that communities do not necessarily have the same needs and that in order for programs to be successful they must be flexible enough to meet local needs.

One identified gap that could provide an opportunity for further collaboration between NW LHIN (specifically funding) and the Aboriginal population, is the termination of financial support for the Aboriginal Healing Foundation projects on March 31, 2010. More than one session participant noted that AHF programs provide valuable healing and mental health services to community members, and they provide a model for best-practice healing programs in that AHF programming is designed, run and implemented by First Nations communities.

5.7.1.2 Motivation and Encouragement from Staff and Leadership

Respondents indicated that the success of community-based health programs was based in large part on the motivation and encouragement of dedicated human resources. Because health care staff are

responsible for health care design and delivery, they must be aware of the health needs and priorities of their community population. Both on and off reserve, qualified, dedicated and well-informed staff are important to ensuring that the programs and services are delivered in the most appropriate manner possible. Participants commented on the importance of developing trust and ensuring confidentiality between the staff and the client so as to encourage participation in programs and services, particularly those focused on mental health and addictions where there is an increased risk of stigma.

Linked to this need for staff (and staffing capacity (number and skill level)) is the realization that programming is most successful if it is consistently delivered (without gaps in accessibility) (e.g. if funding is not available or if there are staffing gaps). As a result of insufficient funding or staff, programs may not run continuously and community members may not be aware of them or may elect not to participate because of the lack of program stability. This is an important issue given the difficulty encountered at times in getting people to participate in mental health and addictions programs. It takes some people a long time to decide they are finally ready to take part in a program that will encourage them to deal with their abuse (e.g., prescription drug use) and their deep-seated issues (e.g., residential school experience). Having a program cancelled (e.g., AHF) once an individual has made the effort to ask for help can be detrimental.

Within the communities it is important that leadership actively and openly support mental health and addictions programming. In communities where leadership is overtly supportive of these programs and services, community members are more inclined to participate.

5.7.1.3 Provision of Incentives for Participation

Some communities experience difficulties in engaging community members to participate in workshops that are organized to build awareness and improve knowledge about important health issues (e.g., drug abuse, gambling, and depression). Some program managers have experienced success through the provision of incentives for participation, including healthy meals, gifts and prizes.

5.7.1.4 Increased Awareness

Some communities have been successful at organizing events in communities that build awareness of health issues and provide education to community members. One such approach is the organization of an annual Health Fair where a variety of programs and services are showcased for community members to learn about in a fun and fair-like fashion. Other events included:

- Developing health program event calendars that are distributed to all community members
- Using the radio and television to build awareness/information on key mental health issues and concerns present information on the programs and services available
- Organizing fun and informative workshops (multiple topics of interest)
- Planning events during National Awareness Week events (e.g., Mental Illness Awareness Week, National Addictions Awareness Week)
- Education on prescription drugs using resources (e.g. DVD) provided in Aboriginal languages, not only English, was noted as an effective practice.

Some communities are currently developing community-based strategies for prescription drug abuse. This process involves establishing the right contacts, and reviewing all the literature and documents available to meet the needs of drug abuse in the communities.

5.7.1.5 Incorporation of Traditional Values and Cultural Activities

Programs that incorporate traditional healing (e.g., sweats, talking circles, traditional healers) were noted as successful because they were culturally appropriate. Less formalized cultural ‘healing’ such as going on the land or participating in cultural activities such as tobacco ceremonies, were also noted as successful strategy. Traditional activities were viewed as being particularly helpful in addressing mental health issues and more generally, the holistic nature of health.

Mainstream health providers noted several programs offering culturally appropriate services as positive / best practices, including:

- Coordination between traditional healers and mainstream providers to incorporate traditional medicine
- Workers on-staff in mainstream facilities that can assist patients and doctors in understanding / communicating (cultural support as well as language)
- Increased education and understanding on cultural sensitivity and awareness (noted by several mainstream service providers as an important priority as well as by Aboriginal respondents as a challenge to program access for community members)
    - One provider noted that having First Nations artwork within the facility helped to increase cultural understandings
    - Another noted that a cultural-sensitivity workshop for mainstream staff assisted in increasing staff understandings of how to provide services appropriate and comfortable to First Nations patients at a hands-on level
- One Aboriginal health-service provider noted that it is important for non-Aboriginal health care providers to visit communities in order to develop an understanding and respect for Aboriginal culture ("has to start with mutual respect").
- It was also noted that partnerships between Aboriginal providers and mainstream providers could help address needs, and improve cultural awareness / cultural safety within mainstream institutions (but resources are not necessarily in place in order to provide this kind of partnership/network).
- Culturally-appropriate food available for people receiving care in mainstream facilities

5.7.1.6 Adoption of an Holistic Approach to Health

It was noted that an holistic approach to health is required to fully address health concerns; that there is a need to get away from addressing symptoms and instead address fundamental issues affecting health status ("roots of problems"). Associated with this view on health is that working with community members is a long-term process (e.g., 28 days of treatment off-reserve is often not adequate for people struggling with addictions); that there is a need for long-term support and guidance. Also integral to an holistic view of health is a need for prevention measures that address the broader socio-economic concerns (e.g., lack of employment) and the way that they affect health (e.g. healthy food is often not affordable for those people at risk for diabetes, which increases their risk factors).

5.7.2 Successes / Lessons Learned – The 2009 Aboriginal Health Forum

The 2009 Aboriginal Health Forum – Pathways for Collaboration Summary Report highlights successful elements and lessons learned as they relate to collaborations in mental health and addictions services[78].

The key elements that contribute to successful collaborations for mental health and addictions services include:

- Full partnership and participation in all aspects of research or program development
- Community endorsement
- Open dialogue
- Client focused approach
- Mutual support
- Collaboration occurring at multiple levels and across services

[78] NW LHIN. (2009). 2009 Aboriginal Health Forum Pathways for Collaboration Summary Report. Valhalla Inn, Thunder Bay, March 4-5, 2009.

The key lessons learned include:

- Listening to the community
- Respecting local traditions and cultural knowledge
- Understanding the political processes involved
- Internal collaboration happening in a blended agency
- Understanding that collaboration is not about competition
- There are no short term solutions
- Consistency in care and service delivery must be nurtured

Other successful elements and key lessons learned as they relate to collaborations in chronic disease prevention and management, eHealth and seniors services, highlighted in the 2009 Aboriginal Health Forum – Pathways for Collaboration Summary Report, may also be relevant to mental health and addictions program and service collaborations[79].

Table 9: Other Successful Elements from the 2009 Aboriginal Health Forum

Successful Elements		
Chronic Disease Prevention and Management	**eHealth**	**Seniors Services**
Stakeholder ownership and active involvement for change	Creating a common visions and prioritizing principles	A team approach
Communities involved in their own care	Active participation by stakeholders in the planning	Being culturally sensitive
Recognition that one size does not fit all	Implementation and evaluation of eHealth strategies	Having culturally appropriate supports
Community education and capacity building	Reducing complexity by narrowing strategies down to a manageable number of projects	Wotking with and respecting the direction of the Elders
Partnering and aligning resources		Strengthening the local team
Being accountable for community results		Developing good rapport
		Weaving the principles of culturally integrated health services into the fabric of the organization
		Having a negotiated agreement with the major stakeholders

Table 10: Other Key Lessons Learned from the 2009 Aboriginal Health Forum

Key Lessons Learned		
Chronic Disease Prevention and Management	**eHealth**	**Seniors Services**
Population based strategies and shared messaging helps to shift the role of health care providers	Building community capacity and sharing information across the region can improve access to services and save financial resources	Communication is key
Open and honest communication helps to bridge the gap of distance and culture		Programs must be easily accessible
Flexibility is extremely valuable to bridge the gap in services		More community and volunteer involvement is needed

[79] NW LHIN. (2009). 2009 Aboriginal Health Forum Pathways for Collaboration Summary Report. Valhalla Inn, Thunder Bay, March 4-5, 2009.

Co-facilitated workshops are beneficial		

The Aboriginal Health Forum "Elements of Change" Summary Report identified some NW community-based programs that provide addiction prevention and intervention services and community counselling and substance abuse centres that were considered to be working well:

- Family violence program – O.W.N. (Our Way Now)
- Methadone programs in Dryden, Kenora and Thunder Bay
- Thunder Bay Aboriginal Health Access Centre programs in life skills, anger management and violence prevention
- NODIN mental health program
- Elder traditional healing and cultural teachings (for youth)[80]

5.7.3 BEST/PROMISING PRACTICES – THE LITERATURE

A number of best/promising programs (and practices within those programs) are contained within the national, regional and community literature on mental health and addictions programming for Aboriginal people that could be adopted to help guide future programming and service delivery in the NW LHIN.

5.7.3.1 NW LHIN Region Examples

Sioux Lookout First Nations Health Authority Chiefs' Forum on Social Issues: Conference on Reducing Prescription Drug Abuse

The Sioux Lookout First Nations Health Authority hosted a three day conference on prescription drug abuse that was intended to:

> …bring together all local and regional organizations, agencies, community health and NNADAP workers, key community members, and Sioux Lookout Zone Chiefs' with the goal of developing an integrated, multi-agency, cross jurisdictional strategic plan to tackle the serious issue of community crisis due to the increased usage of manufactured intoxicants within the First Nation communities in the Sioux Lookout Zone of Northwestern Ontario.
>
> The specific goal of the Forum was to facilitate the development of an action plan reflective of the collective wisdom of the participants (Elders, community leaders and youth) to address the issue of prescription drug abuse. The intention was to develop a number of strategies that could integrate already existing community based and regional services to provide a comprehensive continuum of service delivery.
>
> The Forum goal was focused on developing workplans to address issues related to the increased usage of prescription drug abuse and to promote the development of a continuum of service delivery, thereby ensuring integration of services from the prevention aspect of care to intervention and treatment[81].

Prior to the forum, workbooks (that included questions on topics such as what activities encourage people to refrain from prescription drug abuse, what can be done in the short- and long-term to address the issue) were sent out to 36 communities with the request that three individuals complete a workbook. A total of 42 workbooks were returned prior to the forum. Within these workbooks communities identified a wide range of activities that promote freedom from substance abuse, including[82]:

[80] NW LHIN. (2008). Aboriginal Health Forum Elements of Change Summary Report. Victoria Inn, Thunder Bay, March 27-28, 2008.
[81] Legacybowesgroup. (2009). Answering the Call for Help: Reducing prescription drug abuse in our communities – Final Report. Sioux Lookout First Nations Health Authority. P. 5
[82]. Legacybowesgroup. (2009). Answering the Call for Help: Reducing prescription drug abuse in our communities – Final Report. Appendix F: P. 6. Sioux Lookout First Nations Health Authority.

- Hunting and fishing
- Pow-Wows
- Games and sports-broomball, hockey, baseball, basketball, bingo
- Gospel jamborees
- Summer festivals
- Craft nights, activity nights with children, parents
- Traditional ceremonies
- Community events-feast, social events, rummage/bake sales
- Hockey for young people
- Community gatherings and cultural events
- Community kitchens
- Pool tournament
- AA meetings, sharing groups, church meetings and prayers
- Health promotional and prevention activities that educate people on living
- healthy lifestyles and eliminating or reducing risk factor.
- Events that promote personal skills and confidence such as public speaking, singing, arts and crafts, entertainments, radio and television, etc.
- Conducting community volunteerism such as community cleanups, fundraising, support groups, leading youth and sport groups, etc.

More than 30 communities and 30 organizations participated in the Forum.

Wapakeka First Nation Survivors of Suicide Conference

An example of successful suicide intervention and prevention activities comes from the Wapakeka First Nation. Between 1989 and 1998 there were 17 suicides in a community of approximately 350. In response, "the community developed a safety net"[83] which included adopting a more proactive approach to the engagement of youth in activities (including cultural programming in school and land-based activities). It also included an annual conference for Survivors of Suicide, which has grown from five communities participating to 13. The conference includes workshops on "sexual abuse, communication, parenting, grief, residential school, substance abuse, crisis intervention, native traditions and medicines"[84]. It also includes spiritual activities and recreational activities such as sports and singing. From 1999 to 2007, there has been only one suicide in Wapakeka, speaking to the effectiveness of this type of intervention activities.

NAN Decade for Youth and Development Suicide Strategy

Another successful program approach to mental health and addictions is the NAN Decade for Youth and Development Suicide Strategy. Members of the NAN Decade Youth Council noted that suicides affect NAN communities deeply: "because our communities are small and many families are related, it's almost impossible not to be deeply affected by a suicide"[85]. Several of the NAN programs included within the Decade for Youth and Development were noted as successful community-based interventions, in particular the Girl Power Program. The Girl Power Program targets adolescent and younger Aboriginal girls, "[working] on self-esteem, life skills, nutrition, traditional teachings, violence prevention, healthy sexuality and decision making"[86]. Counselors also become role models for participants. Another successful NAN program through the Decade for Youth and Development was the Wolf Spirit program (a

[83] Masecar, D. (2007). What is Working, What is Hopeful: Supporting community-based suicide prevention strategies with Indigenous communities – and any other community that is interested. First Nations and Inuit Health Branch. P. 10. Retrieved from: http://addictions.knet.ca/node/19

[84] Masecar, D. (2007). What is Working, What is Hopeful: Supporting community-based suicide prevention strategies with Indigenous communities – and any other community that is interested. First Nations and Inuit Health Branch. P. 10. Retrieved from: http://addictions.knet.ca/node/19

[85] Masecar, D. (2007). What is Working, What is Hopeful: Supporting community-based suicide prevention strategies with Indigenous communities – and any other community that is interested. First Nations and Inuit Health Branch. P. 13. Retrieved from: http://addictions.knet.ca/node/19

[86] Masecar, D. (2007). What is Working, What is Hopeful: Supporting community-based suicide prevention strategies with Indigenous communities – and any other community that is interested. First Nations and Inuit Health Branch. P. 15. Retrieved from: http://addictions.knet.ca/node/19

new program as of 2007) for young men, similar to Girl Power. Both these programs focus on a variety of issues, and were developed with NAN youth.

5.7.3.2 Other Examples

Capacity Building for Mental Health Initiatives

The Native Mental Health Association of Canada (NMHAC) has committed to ten strategic initiatives for building capacity to support and enhance mental health of Aboriginal people across Canada:

- Establish a model for effective governance and organizational development;
- Develop a framework for action planning for a National Suicide Prevention Initiative;
- Develop a strategy for youth engagement;
- Parent the create of Centres for Family Restoration and Community Development;
- Develop and nurture partnerships and alliances that honor the spirit of mutual respect, recognition, responsibility and sharing;
- Engage in development, implementation and evaluation of policies at all levels of government that support and enhance the well-being of Indigenous families and communities;
- Develop/partner on a virtual clearinghouse capacity that brings together international, national, regional and local mental health/wellness knowledge and information;
- Through validation and sharing of Indigenous knowledge, language and practices, enhance capacity of communities;
- Develop and nurture ethical protocols related to engagement and health of Indigenous people; and
- Develop a plan to raise public awareness about NMHAC[87]

Aboriginal Healing Foundation

In the 2006 evaluation of the Aboriginal Healing Foundation, Volume III outlined a number of "promising healing practices in Aboriginal communities". The evaluation, through the use of survey responses, identified a variety of ways in which participant safety is protected and a safe healing environment was created:

- Ensuring confidentiality – the importance of confidentiality was mentioned numerous times.
- Creating a comfortable, non-judgmental atmosphere – creating a place of belonging and safety is essential to forming trusting relationships.
- Taking the necessary time – time is often required to generate community support for a new project or program.
- Working in circles and groups – Speaking out when safety is assured allows people to feel less alone.
- Building safety into the therapeutic process – Safety was sometimes addressed before any therapeutic work was undertaken through codes of ethics, standards of practice and group rules.
- Building trust through dependability – the regularity of activities, including set times and locations for circles, contributes to success, especially when working with children and youth.
- Having the right staff – Healers with the skills to guide participants through intensive healing work, and who take care of their own healing needs, make important contributions to the safety of the therapeutic process.
- Reinforcing safety through proper closure, follow-up aftercare – This is accomplished, in pat, by checking out how people are feeling before they leave to go home and by providing telephone access to counsellors after hours.
- Creating a nonthreatening environment through informal activities – Providing traditional or cultural activities within a healing program builds trust. Also, a number of organizations extolled the benefits of home visits, and having participants visit the counsellor's home.

[87] Native Mental Health Association of Canada. (2008). Charting the Future of Native Mental Health in Canada: Ten-Year Strategic Plan 2008-2018. p. 23 – 41.

- Creating a comfortable place for healing – Many organizations commented on the importance of the physical environment, including the role of quiet, warm, comfortable surroundings, a place for counselling or meeting without interruptions, often in a separate building or in a natural on-the-land setting.
- Creating cultural safety – Project activities taking place in a culturally appropriate environment range from going on medicine walks to ice fishing, spring camping and ritual cleansing in a lake or river[88]

Red Cross' Walking the Prevention Circle (mentioned during the 2009 Aboriginal Health Forum)

This workshop is offered by the Red Cross and aimed at Aboriginal people or those involved with First Nations communities. Walking the Prevention Circle "acknowledges the history, challenges and potential of Aboriginal individuals and communities as it explores issues relating to abuse, neglect and interpersonal violence. Designed for adults, this workshop empowers participants to name and reclaim the past, and begin the transition from the cycle of violence to the circle of healing, a journey that begins with awareness and moves toward prevention"[89].

TheRedPath

TheRedPath program is an educational Aboriginal-specific model that teaches practitioners in all health and wellness programs the importance of emotional health. TheRedPath model can easily be integrated into existing health and wellness programs to ensure their success. TheRedPath also has its own 28-day intervention program, blending clinical and cultural approaches that offer techniques to cultivate a healthy mind, body and spirit. The skills learned by practitioners and participants alike will continue to develop and flourish over time.

The RedPath was developed with the goal of blending clinical and cultural approaches to facilitate participants' personal development in terms of physical, emotional, psychological, and spiritual well being. The model incorporates key Aboriginal concepts - circle, creativity, balance and ceremony – to develop psychological mindedness, emotional understanding, emotional control and mindfulness. It successfully trains participants to balance all aspects of their lives, making for happy, healthy individuals capable of making a positive contribution to their communities[90].

Round Lake and Poundmaker's Lodge

Treatment centres such as Round Lake in British Columbia and Poundmaker's Lodge in Alberta are examples of addictions program models that have broken new ground in a *culture as healing* approach to addictions recovery. The culture as healing model is grounded in an understanding of the impacts of residential school abuse and colonization. Culture as healing counters these impacts through four strategies of cultural revitalization:

- Restoring a sense of belonging through pride in identity, family, community, and ancestry;
- Restoring the wisdom of traditional teachings, practices, and medicines that promote balanced health for the mind, body, heart, and spirit throughout the lifespan;
- Providing opportunities to practice new ways of thinking, behaving, and living with others who are also committed to balanced health; and
- Restoring the roles of women and Elders and strengthening the capacity of individuals, families, and communities to resolve their own problems[91].

[88] AHF. (2006). Final Report of the Aboriginal Healing Foundation. Volume III. Promising Healing Practices in Aboriginal Communities. p. 29-32.
[89] Red Cross. Walking the Prevention Circle. Retrieved from: http://www.redcross.ca/article.asp?id=22276&tid=030
[90] http://whitepathconsulting.com/theredpath.html
[91] Chansonneuve, Deborah. 2007. Addictive Behaviours Among Aboriginal People in Canada. AHF Research Series. Prepared for the Aboriginal Healing Foundation. p. 54.

"Nemi'simk, Seeing Oneself" Youth Early Intervention Program Model

The program was designed specifically to address the root causes of substance abuse and addictions among Aboriginal youth. It is based on a holistic model of "personality matched, motive-specific brief interventions" to help teens identify and move away from maladaptive coping strategies that contribute to substance abuse. The program name, *Nemi'simk, Seeing Oneself*, was chosen to convey an inner journey where personal gifts of the spirit and the power of self-healing are realized.

Interventions are based on a set of workbooks, each one aimed at a specific personality type associated with substance abuse. The stories and situations depicted in each workbook are all based on real life stories of Mi'kmaq youth; all of the artwork i s by Mi'kmaq youth and all content reflects traditional Mi'kmaq teachings, symbols, and colours that have significance to community members. Six high school guidance counsellors and eight RCMP trained as "interveners" for the program guided youth through and after completion of the pilot project[92].

Eskasoni Community Healing Movement

The following are examples of a range of addiction prevention strategies for children and youth involving numerous partners and stakeholders:

- Moose Camp was Canada's first program of its type bridging Elders, youth, and RCMP together for positively-centered activities. Fifteen youth spent a week at Moose Camp with police officers, Department of Natural Resources officers and Elders. In the context of a moose hunt, the youth learned cultural skills such as how to harvest traditional foods for the good of the community. Program activities were designed to strengthen youth's cultural identity and to increase awareness of how the actions of individuals affect the whole community. This program was nominated for an RCMP award in 2004 (Jeff Christie, key informant).
- The Sunflower Project helps youth better understand their personal life experiences by planting, growing, and harvesting sunflowers and through traditional teachings about healthy development through the life cycle. This project was developed in partnership with Cape Breton University.
- PATHS/Empathy Program targets school children aged 5–11 who engage in anti-social behaviour such as bullying, violence, and lack of interest in school. Communication skills are increased through cultural teachings, family stories, and other activities that fit an Aboriginal learning style. This program was developed through the Eskasoni School Board[93].

Hollow Water Community Holistic Circle Healing

The Hollow Water Community Holistic Circle Healing program has been in operation for more than 10 years. The program was initiated by a core of community women desiring healing and change. It began in response to the high prevalence of sexual abuse in the community, but has since broadened to other sources of trauma[94,95]. A key assumption of this program is that sexual abuse and excessive substance use are "perceived as inseparable"[96]. The program uses a "healing circle" format, which is based on principles of restorative justice. The program is process-centred, which aligns with a core Aboriginal orientation and is based on Anishnabe spirituality and values.

Since the initiation of the program, the community has experienced a recidivism rate of less than two percent, life expectancy has risen from 63 to 70 years, alcohol abuse has almost stopped in the older

[92] Chansonneuve, D. (2005). Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People. Ottawa: Aboriginal Healing Foundation. p.55
[93] Chansonneuve, Deborah. 2007. Addictive Behaviours Among Aboriginal People in Canada. AHF Research Series. Prepared for the Aboriginal Healing Foundation. p. 54.
[94] Couture,Joe; Parker,Ted; Couture,Ruth; and Patti Laboucane. 2001. A Cost-Benefit Analysis of Hollow Water's Community Holistic Circle Healing Process. Ottawa, Ontario: Ministry of the Solicitor General and the Aboriginal Healing Foundation.
[95] Lane, Phil Jr., Michael Bopp, Judie Bopp, and Julian Norris. 2002. Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Aboriginal Corrections Policy Unit. Department of the Solicitor General. Ottawa: Supply and Services Canada.
[96] Couture,Joe; Parker,Ted; Couture,Ruth; and Patti Laboucane. 2001. A Cost-Benefit Analysis of Hollow Water's Community Holistic Circle Healing Process. Ottawa, Ontario: Ministry of the Solicitor General and the Aboriginal Healing Foundation. p.15

population, youth are remaining in school longer, and the community now fosters children from other First Nations (since it is now seen as a safe community). The program has also been shown to be more cost effective than the equivalent government-run services which would have cost between $4 - $10 million more than the cost of this program[97].

Alkali Lake Community Healing Model

Esketmec (Alkali Lake, B.C.) is famous for its successful struggle to overcome community alcoholism. In the mid-1980s, the community made a dramatic shift from a situation in which virtually every man, woman and child over twelve years of age was a practicing alcoholic to one in which ninety-five percent of the population practice sobriety. The program began with a small, core group of sufferers who were dedicated to healing the community and leadership who were committed to the cause. The healing model involves the reintroduction of traditional ceremonies and the use of healing circles to tackle underlying causes of community ill-health. The program evolved to address high levels of physical and sexual abuse and many other community challenges. Much of what was learned in their struggle was incorporated into a comprehensive training program called "New Directions Training"[98].

Squamish Nation

Squamish Nation has been actively engaged in addressing residential school trauma for more than twenty years. The momentum for healing came from within. In particular, community Elders, many of whom began with their own healing, were highly instrumental in initiating change. The healing process moved from an emergency-response mode (crisis intervention) to long-term healing opportunities (including treatment, counseling, healing circles and prevention) that deal with the root causes of trauma through a social determinants of health approach. The Squamish Nation uses a combination of both traditional and western approaches[99].

[97] Joe; Parker,Ted; Couture,Ruth; and Patti Laboucane. 2001. A Cost-Benefit Analysis of Hollow Water's Community Holistic Circle Healing Process. Ottawa, Ontario: Ministry of the Solicitor General and the Aboriginal Healing Foundation. p.4.
[98] Lane, Phil Jr., Michael Bopp, Judie Bopp, and Julian Norris. 2002. Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Aboriginal Corrections Policy Unit. Department of the Solicitor General. Ottawa: Supply and Services Canada. p.31.
[99] Lane, Phil Jr., Michael Bopp, Judie Bopp, and Julian Norris. 2002. Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Aboriginal Corrections Policy Unit. Department of the Solicitor General. Ottawa: Supply and Services Canada.

6.0 CONCLUSIONS

The Final Aboriginal Health Programs and Services Analysis and Strategy Report presents a number of important findings about the health status and health needs of Aboriginal people residing in the NW LHIN region; the availability of Aboriginal health programs, services and resources; gaps/limitations in programs and services offered to Aboriginal people in the North West region; challenges associated with the delivery of and access to Aboriginal health programs and services in the North West region; potential for new and/or enhanced partnerships and opportunities for integration and enhanced health care technology practice. Moreover, the findings indicate potential best/promising practices and lessons learned with respect to mental health and addictions programs and services offered to Aboriginal people in the NW LHIN.

The findings of the report highlight the fact that the health of Aboriginal people in Canada is poorer than their non-Aboriginal counterparts on almost every measurable health indicator: life expectancy, quality of life, infant mortality, morbidity (e.g., hospitalizations), unintentional injuries, chronic disease (e.g., diabetes), and infectious disease (e.g., tuberculosis). A wide range of complex and interconnected factors, including the residential school experience, poverty, substandard housing, and limited educational attainment, are responsible for the poorer physical health as well as placing Aboriginal people at increased risk for substance and solvent abuse, suicide and family violence. Information specific to Aboriginal people residing in the North West region further supports the national picture. The primary health issues perceived to be negatively affecting the overall well-being of the North West Aboriginal population include: mental health (e.g., suicide) and addictions (e.g., prescription drug abuse) issues, diabetes, cardiovascular disease, high blood pressure, asthma, arthritis, and cancer. The health of Aboriginal communities in the region is being affected by factors such as poor housing (e.g., mould), poor diet, limited employment, high cost of living in northern and remote communities, and poor familial relationships. The findings highlight the need to address Aboriginal health using an holistic framework, one that acknowledges the role of social, cultural, economic, political, geographic and historic factors in the determining the well-being of Aboriginal people.

The provision and funding of Aboriginal health programs and services in the NW LHIN is multilayered and complex in nature. Services may be offered through a PTO to community members, through a Tribal Council or Aboriginal Health Authority, or directly by the First Nation to its members. As well, other Aboriginal organizations (e.g., Ontario Native Women's Association, Métis Nation of Ontario, Friendship Centres) offer health services to First Nation communities and the urban Aboriginal population. Moreover, programs and services are also provided to Aboriginal people in the North West region through hospitals, public health units, CCO, CCAC, and Family Health Teams. A wide variety of programs and services, many of which are funded by FNIHB, are available to Aboriginal people on and off reserve across the North West region. FNIHB funds many more health programs and services to First Nations people living on reserve than to Aboriginal people living off reserve in urban centres. For example, FNIHB offers funding for on reserve programs targeted at children and youth (e.g., FASD, CPNP, AHSOR), mental health and addictions (e.g., NNADAP, BHC, BF, YSAP, NAYSPS), chronic disease and injury (e.g., ADI), communicable disease control, and First Nations and Inuit Home and Community Care. Off reserve FNIHB funds Aboriginal Head Start in Urban and Northern Communities, CPNP and Community Action Program for Children. While more program funding may be aimed at communities, many First Nation communities struggle to effectively administer these programs on reserve as a result of limited human capacity. In some instances, one person may be responsible for delivering more than one program. This leads to high stress and early 'burn out'.

There are a limited number of specialized programs and services available in the region to address the specific mental health and addictions needs of the Aboriginal population. The loss of AHF funding for community-based healing programs was a significant loss for the region since a number of communities were delivering healing programs with AHF funds. Unless alternate sources of funding were procured, these programs will have ended as of March 31, 2010. Fortunately, the Giizhikaandag Healing Lodge will continue to receive funding until 2012. There does exist a number of traditional supports such as

teachings by Elders and cultural healing activities such as sweats and sharing circles that occur within the communities. However, these traditional approaches to healing require additional support.

While there appears to be a wide range of national, provincial, regional and community-based programs and services are available to Aboriginal people living both on and off reserve in the North West region, there exist such significant gaps/limitations in current programming that Aboriginal people feel their health needs and priorities are not being adequately or appropriately met. Project participants identified a number of deficiencies in Aboriginal programs and services in areas including: mental health and addictions; chronic disease diagnosis and management; acute diseases; accidents and injuries; health promotion and disease prevention; programming for children (e.g., speech therapy, FASD diagnosis), youth (e.g., suicide prevention), seniors (lack of medical escorts), and parents (family violence); transitional assistance; and health care infrastructure (e.g., office space for counselling services, lack of safe houses). More specifically, within these areas, participants spoke about: a lack of timely access to services (long waitlists, lack of 24-hour mental health services); a lack of a case management approach to care; interrupted services; a lack culturally appropriate services; limited community health care capacity (human and financial resources); poor integration and coordination of programs; lack of after care; lack of traditional supports; poor communication between Aboriginal clients and health care providers (thus poor knowledge transfer). These gaps are believed to compromise the overall health and well-being of the Aboriginal population since the health needs of Aboriginal people are not being fully addressed

There are a number of challenges and barriers associated with the delivery of, and access to, health programs and services offered to Aboriginal people both on- and off reserve in the NW LHIN. On-reserve program delivery is challenged by factors such as:

- Limited health care capacity (inadequate number of staff, training and education not aligned with expected roles and responsibilities);
- Insufficient infrastructure (lack of meeting space, offices); and,
- Lack of consistent funding which limits the ability of program staff to develop long-term program plans.

Off reserve, program delivery is hampered by difficulties associated with:

- Developing and administering culturally appropriate programs and services (e.g., lack of translation services); and,
- Troubles establishing supportive relationships between off-reserve health care providers and community members due to a lack of trust on the part of Aboriginal clients.

The ability of Aboriginal people to access programs and services on reserve is impeded by a number of factors including:

- Shortage of physicians to offer specialized services in the communities thus forcing individuals to seek specialized care in the urban centres;
- Lack of program awareness and understanding of program benefits; and,
- Lack of trust in health providers; and issues around confidentiality of information (related to limited infrastructure).

Off reserve, program and service access is challenged by:

- Long wait times and limited space availability (e.g., treatment centres);
- Difficulties associated with NIHB (e.g., lack of clarity around the programs and services covered by NIHB, problems acquiring approval and support by NIHB to utilize services); and,
- Lack of transportation services and language barriers (e.g., filling out forms).

These program and service delivery and access obstacles have the potential to compromise the overall health and well-being of Aboriginal people living in the North West region.

A number of formal and informal health partnerships/relationships currently exist between community health providers and health care representatives from other communities, FNIHB, hospitals, Tribal Councils, Family Health Teams, CCAC, CCO, KO, and Health Planning Authorities. These partnerships need to be constantly nurtured and new relationships with other communities and primary care physicians developed. The complexity of community health needs, and the resources and services required to meet

those needs, speaks to the need for strong partnerships and collaborative efforts. Existing and potential partnerships, at all levels, helps to ensure that resources are maximized and that programs and services are sustainable.

Additionally, improvements in Aboriginal health care may be achieved through the integration of more traditional and cultural practices with western biomedical approaches and through increased interaction between non-Aboriginal health care providers and Aboriginal community members (e.g., health providers, leaders, members). It is believed that such relationships would help to increase the overall knowledge and awareness of non-Aboriginal providers about Aboriginal health and social issues. Other opportunities for integration include:

- The integration of services targeting the same Aboriginal demographic population (e.g., children);
- Combining similar/overlapping service areas (e.g., healthy babies/early childhood development); and,
- Combining FASD services for communities.

These examples represent a more integrated system of community supports which allows for a better continuum of care, a more holistic approach to health, and the sharing of limited resources (human and financial).

Studies suggest that the use of electronic health information and communication technologies have a role to play in improved patient safety and the delivery of more opportune and efficient health care. The NW LHIN is actively using a number of health care technologies such as videoconferencing, tele-rehabilitation and tele-psychiatry that have the potential to help improve access to, and the quality of, health care services for Aboriginal people. These technologies allow people the opportunity to remain in their community while receiving specialized health care supports.

Participants identified a number of mental health and addictions programming and service best practices / lessons learned that if adopted may potentially assist with the healing process in Aboriginal communities. These included incorporating traditional values and cultural activities as well as adopting a holistic approach (physical, mental, emotional and spiritual) to mental health and addictions planning, programming and implementation. The literature identifies a number of successful programs across the country that encompass best/promising practices such as: bringing together multiple stakeholders to develop integrated, multi-agency and cross-jurisdictional strategic plans to tackle abuse issues; taking a proactive / preventative approach to addressing community issues; incorporating traditional and land-based activities (e.g., healing circles, hunting); having the sub-population (e.g., youth) most affected by a mental health issue (e.g., suicide) develop a community-based program; using peer mentors; taking a holistic approach to improved mental health and well-being (e.g., work on self-esteem, skills development, nutrition, traditional teachings); and ensuring confidentiality, cultural safety and a non-threatening environment. The most successful initiatives are those in which: communities have been consulted about their needs; culture plays a key role in healing; community capacity is enhanced (e.g., communities have the opportunity to build the skills and strengths they need to direct their own healing); and, strategies are developed collaboratively[100].

[100] Barron, M. (2004). *Culture, Capacity and Collaboration: Building on First Principles in Addressing First Nations Communities in Crisis.* A Background Paper for a Strategic Discussion by Health Canada, FNIHB Ontario Region and Topic Experts (December 8th and 9th, 2004). November 30, 2004.

7.0 RECOMMENDATIONS

"Improving access to and coordination of mental health and addictions services will improve the quality of life and care for those requiring service and decrease the exacerbation of conditions resulting in longer term medical needs and social problems"[101].

Based on the key findings and the conclusions presented, as well as the mandate of the NW LHIN, the following recommendations are presented for consideration as a means of enhancing the delivery and administration of mental health addictions programs and services offered to Aboriginal people in the NW LHIN.

The NW LHIN should take the lead in developing a broad-based strategic approach aimed at building upon existing programs/services/resources to more effectively deal with mental health and addictions issues affecting Aboriginal people in the North West region.

1. Work with federal, provincial, regional and community partners to develop a long-term and sustainable strategy that is focused upon addressing issues related to mental health and addictions in Aboriginal people in the NW LHIN.

2. Create a formal Aboriginal Mental Health and Addictions Advisory Board composed of key stakeholders representing the NW LHIN Aboriginal sub-populations/communities (Treat #9, Treaty #3, Robinson-Superior, Métis, and urban), key Aboriginal organizations (e.g., AFN, NAHO, Chiefs of Ontario, Métis Nation of Ontario, PTOs), the NW LHIN, and relevant national (e.g., FNIHB) and regional health organizations (e.g., NOSM, CCAC) to provide oversight, assist with the development of strategic objectives and priorities, and ensure community needs and perspectives are recognized.

The proposed Aboriginal Mental Health and Addictions Advisory Board should work to develop integrated and collaborative partnerships with key stakeholders with the intent of identifying Aboriginal mental health and addictions priorities and program/service best practices.

3. The NW LHIN, on behalf of the Aboriginal Mental Health and Addictions Advisory Board, should facilitate the hosting of an Aboriginal Health Forum focused specifically on Aboriginal mental health and addictions issues. The forum would be attended by Aboriginal representatives, traditional healers, non-Aboriginal health care providers and the NW LHIN. The intent of the forum is for Aboriginal representatives to identify their priorities, and to share their challenges, successes and lessons learned/best practices related to mental health and addictions issues affecting their communities. The forum would provide the opportunity for non-Aboriginal participants to listen to the experiences of Aboriginal people in attempting to deal with mental health and addictions issues. The forum would also provide an opportunity for the development of partnerships between communities, between communities and non-Aboriginal health care providers/NW LHIN, and between traditional healers and non-Aboriginal health care professionals.

4. The Aboriginal Mental Health and Addictions Advisory Board should carry out a comprehensive review of the many innovative and successful Aboriginal mental health and addictions programs, services and initiatives currently operating at the international, national, provincial/territorial, regional and community level. Rather than creating new and untested programs and services, adopting and then adapting existing successful Aboriginal mental health and addictions prevention and treatment approaches to suit specific community needs, is a relatively efficient and effective way in which to address mental health and addictions priorities across the North West region. This could be accomplished through an intensive workshop in which individuals involved in successful initiatives present their programs to interested community representatives and health care providers. The presentation would involve describing the planning, development,

[101] NW LHIN. (2009). Integrated Health Services Plan, 2010-2013. p.33.

and implementation of the program as well as discussing the challenges, successful components, and identifying any improvements made along the way. Such as approach would lead to the development of new and/or enhanced supportive networks.

The NW LHIN should support increased provision of electronic health information and communication technologies (eHealth ICT) as a means of improving access to and delivery of mental health and addictions treatment targeted at Aboriginal people in the North West region.

5. The NW LHIN should collaborate with KO and OTN to ensure that telemedicine services, generally and those focused specifically on providing mental health and addictions support (e.g., tele-psychiatry), are available in all First Nation communities located within the North West region. This service would allow Aboriginal people to access the necessary treatment while remaining in their home community. This service could also be used to provide after care support to those individuals returning to their home community after treatment. Telemedicine has the potential to improve the continuity of care for Aboriginal people in the NW LHIN.

6. The NW LHIN should work with the First Nation communities to ensure that they have the capabilities and capacity necessary to utilize telemedicine services (e.g., equipment, human resource knowledge and skills).

7. The NW LHIN should make the NW LHIN Aboriginal Health Programs and Services Inventory available on-line to increase health care provider knowledge and awareness of available mental health and addictions programs at the community, regional, provincial, and national level.

The NW LHIN should work with Aboriginal and non-Aboriginal health care providers to develop a case management approach to addressing mental health and addictions issues in the Aboriginal population.

8. Most mental health and addictions health care providers (both within and outside of communities; both Aboriginal and non-Aboriginal providers) tend to work in isolation from one another. When health care providers do interact, the relationships are often informal – based upon personal associations rather than professional designations. Thus if one of these individuals leaves the position, the relationship between the programs is often severed. The NW LHIN should work with Aboriginal and non-Aboriginal health care providers to establish more formal structures and processes to facilitate interagency mental health and addictions collaborations. Such an approach would help to address the lack of continuity of patient care that currently exists. This approach would involve regular meetings between the partners, developing a common goal and a long-term plan to move forward together.

9. The NW LHIN should work with Aboriginal representatives (communities/groups/organizations) to determine how mental health and addictions prevention and treatment can be integrated into existing Aboriginal programs. Treating mental health and addictions in the Aboriginal population requires an holistic approach. Consequently, healing should occur through a variety of avenues/programs (e.g., employment and training programs, economic development, education, justice, youth initiatives, seniors programs). An integrated system of community supports (i.e., across the sectors) is needed to assist communities in dealing with mental health and addictions. Such a system increases the reach and the impact of healing on community members.

The NW LHIN should work with Aboriginal representatives and non-Aboriginal health care providers to enhance the cultural competency of all non-Aboriginal health professionals.

10. Aboriginal people consistently noted that non-Aboriginal health professionals do not fully understand the needs of Aboriginal people; they do not understand Aboriginal culture and traditions. This in turn, limits the ability of non-Aboriginal health care providers ability to provide adequate mental health and addictions programs and services to Aboriginal people in the North West region. The NW LHIN should work with Aboriginal representatives and non-Aboriginal

health care providers to enhance the cultural competency of all non-Aboriginal health professionals.

11. The NW LHIN should encourage all non-Aboriginal health care providers (including NW LHIN representatives) to spend more time in the communities getting to know the population that they serve and the circumstances under which they deliver services.

The NW LHINs should work to develop stronger partnerships with its key stakeholders and with Aboriginal communities located within the North West region.

12. The NW LHIN should develop stronger partnerships with its key stakeholders involved in the delivery or support of mental health and addictions programs and services. Closer collaboration will improve the probability that relevant mental health and addictions knowledge and innovative technologies are disseminated (both ways), that relevant programs are integrated when appropriate and that the continuity of care available to Aboriginal people is improved.

13. The NW LHIN needs to work to develop stronger and more trusting relationships with Aboriginal leadership (e.g., Chiefs of Ontario, Métis Nation of Ontario, AFN) and with Aboriginal communities. The current lack of trust by Aboriginal people in government generally, and by extension, the NW LHIN, hampers the ability of the NW LHIN to work collaboratively with the Aboriginal population to improve the quality of life and care for those individuals requiring mental health and addictions services.

APPENDIX A: BIBLIOGRAPHY

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APPENDIX B: LIST OF KEY STAKEHOLDERS INTERVIEWED

Name	Title	Organization
Bernice Dubec	Executive Director	Anishnawbe Mushkiki Health Access Centre
Ed Yerxa	Project Coordinator	Couchiching First Nation
Marcella Kudaka	Registered Nurse	Dilico Anishinabek Family Care
Marcia Pedri	Director of Health	Dilico Anishinabek Family Care
Rose Pittis	Director of Mental Health	Dilico Anishinabek Family Care
Katherine Campbell		Dryden Area Family Health Team
Wade Petranik	CEO	Dryden Regional Health Centre
James Adams	Zone Director, Thunder Bay Zone	FNIHB
Marlis Bruyere		Fort Frances Area Family Health Team
Kurt Pristanski	CEO	Geraldton District Hospital
Edna Hodgkinson	Registered Nurse, Program Manager Health Services	Gull Bay First Nation
Marney Vermette	Home and Community Care (HCC) Nurse Supervisor	Keewatinook Okimakanak
Phyllis Chowaniec	Mental Health Therapist	Keewatinook Okimakanak
Sally Bunting	Long Term Care Nurse	Keewatinook Okimakanak
Tina Kakepetum-Schultz	Community Engagement Coordinator	KO Telemedicine
Mark Balcaen	CEO	Lake of the Woods District Hospital
Gloria Casey	Executive Director	Mary Berglund Community Health Centre
Cathy Collinson	CEO	Nipigon District Hospital
Sheila Sakchekapo-Gabrie	Health Director	North Caribou Lake First Nations Health Services
Tuija Puiras	Chief Executive Officer	Northwest Community Care Access Centre
Wendy Talbot	Executive Director	NorWest Community Health Centres
Roger Stasser	Dean	Northern Ontario School of Medicine
Orpah McKenzie	Director, Aboriginal Affairs	Northern Ontario School of Medicine
Sol Mamakwa	Director	Shibogama Health Authority
Janet Gordon	Director of Health Services	Sioux Lookout First Nations Health Authority
Douglas Semple	Acting CEO	Sioux Lookout Meno Ya Win Health Centre
Tracy Buckler	CEO	St. Joseph's Care Group
Randy Belair	Executive Director	Sunset Country Family Health Team
Ron Saddington	CEO	Thunder Bay Regional Health Science Centre
Barb Hancock	Director of Services	Tikinagan Child & Family Services
Paul Paradis	CEO	Wilson Memorial General Hospital / McCausland Hospital

APPENDIX C: COMMUNITY ENGAGEMENT SESSION INVITATION LETTER SAMPLE

February 1, 2010

Rainy River First Nation
PO Box 450 EMO ON P0W 1E0
Fax: 807-482-2603

To: Chief and Health Staff

Re: Invitation to Attend the North West Local Health Integration Network Engagement Session on Aboriginal Health Programs and Services

As a follow-up to a letter that you received on January 22, 2010 from the North West Local Health Integration Network, we would like to invite representatives from your community to attend an Engagement Session on Aboriginal Health Programs and Services.

The North West Local Health Integration Network (North West LHIN) is conducting an Environmental Scan of Aboriginal health programs and services as well as gathering information about the health status of Aboriginal people residing with the North West LHIN Region. The North West LHIN has contracted our consulting firm DPRA Canada to assist with this project.

We hope that members of your community will be available to participate in an engagement session. We are hoping that you can send 3 or 4 individuals from your community, such as:

- Community Leaders
- Health Director
- Heath program/service staff
- Nursing station staff
- Others involved in delivering health programs and services in your community

Please find below details on the Engagement Session.

Date**: Tuesday, February 9, 2010**

Time: **9:00 am to 12:00 pm**

Location: **Fort Frances**

Your participation in this project would be very much appreciated. We will contact you shortly to determine your availability to attend the session. For additional information, please contact Christina Bruce by email at Christina.bruce@dpra.com or by telephone toll-free at 1-800-661-8437 ext. 259.

Sincerely,

Christina Bruce

SAMPLE

APPENDIX D: KEY STAKEHOLDER INTERVIEW QUESTIONS

KEY STAKEHOLDER INTERVIEW QUESTIONS

Interviewee Name/Title or Position:	
Organization:	
Interview Respondent #	
Interviewer:	
Date, time and location of Interview:	
Telephone Interview:	**In-person Interview:**

Introduction:

The North West Local Health Integration Network (NW LHIN) has contracted DPRA Canada to gather information on the following topics: programs and services available to First Nation and Métis people in the NW LHIN; gaps in programming; potential for health care provider partnerships; challenges faced by First Nation and Métis people in accessing health programs and services; health status information on First Nation and Métis people residing in the region; and best practices and lessons learned with respect to future mental health and addictions programming in the NW LHIN. Information will be collected through conducting an environmental scan, reviewing pertinent literature, carrying out community engagements sessions and conducting key stakeholder interviews.

Based on your expertise, I would like to ask you a few questions about First Nation and Métis health and the availability and accessibility of health programs and services in the NW LHIN.

Confidentiality clause:

Your interview responses will not be attributed to you by name except by your express permission. Completed interviews are kept in locked files and password-protected data storage folders.

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1) Other than community-based, what programs and services are currently offered to First Nation and Métis people residing in the NW LHIN?

- Federal
- Provincial
- Regional
- PTO

2a) To what extent do you feel that all programs and services available are meeting the health needs and priorities of First Nation and Métis people residing in the NW LHIN with respect to:

- Mental Health and Addictions
- Chronic Disease
- Acute Disease
- Accidents and Injury

2b) What performance measurement data is being collected to determine the extent to which these programs and services are achieving their expected outcomes?

3a) To what extent do you feel that these programs and services are meeting the health needs and priorities of First Nation and Métis people residing in the NW LHIN throughout the life course:

- Children
- Youth
- Adults
- Elders

3b) What performance measurement data is being collected to determine the extent to which these programs and services are achieving their expected outcomes?

4a) What challenges do you think First Nation and Métis people face in accessing these programs and services?

4b) What efforts have been made to address those challenges?

5a) Are there gaps in programs and services offered to First Nation and Métis people residing in the NW LHIN? If so, in what areas?

6) Are there any duplications in programs and services offered to First Nation and Métis people residing in the NW LHIN? If so, in what areas?

7a) What partnerships/linkages (formal or informal) currently exist between health care professionals providing programs and services to Aboriginal people residing in the NW LHIN?

7b) What new partnerships/linkages (formal/informal) could be developed?

8) What is the best way for the NW LHIN to serve your organization in terms of planning, integration and community engagement?

9) What challenges does your organization face in meeting the health care needs of the First Nation and Métis population residing in the NW LHIN Region.

10) What are the priorities of your organization in meeting the health care needs of First Nation and Métis people?

11) Can you comment on any best practices and lessons learned that could be adopted to help guide future First Nation and Métis mental health and addictions programs and services in the NW LHIN?

12) Are you aware of any reports/documents/data sets/files that present information on First Nation and Métis health status/concerns/priorities, as well as service delivery, in the NW LHIN? If so, are you able to provide us with that information?

13) Is there anything else that you would like to share with us?

APPENDIX E: COMMUNITY ENGAGEMENT SESSION QUESTIONS

North West Local Health Integration Network
Aboriginal Health Programs and Services & Strategies
Community Engagement Sessions
COMMUNITY ENGAGEMENT SESSION QUESTIONS

1. Inventory of Health Programs and Services

a) What health programs and services are currently available in your community?

b) What health programs and services are currently available outside of your community that you are able to access?

2. Gaps in Programs and Services

a) Are there any health programs and services in your community that you feel should be delivered? What are they?

b) Are there any health programs and services outside of your community that you feel should be delivered? What are they?

3. Challenges Faced by Aboriginal People in Access Health Programs and Services

a) What challenges, if any, do community members face in trying to access health programs and services offered in the community?

b) What challenges, if any, do community members face in trying to access health programs and services offered outside of the community?

c) How have those challenges been addressed?

4. Community Health Programs Opportunities and Successes

a) What factors make a community health program successful? Please provide an example of a successfully delivered health program/service and explain why you feel it has been successful.

b) Are there opportunities to form additional partnerships/collaborations (formal/informal) between:
- Community health programs and services?
- Health programs and services in and outside the community?

c) Is there anything that could be done to improve current partnerships/collaborations between programs and services?