NE LHIN
ABORIGINAL/FIRST NATION AND MÉTIS
MENTAL HEALTH AND ADDICTIONS FRAMEWORK

January 2011
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Executive Summary

In 2009, the NE LHIN published its 2010-2013 Integrated Health Services Plan (IHSP). Major priorities identified in the IHSP included **Aboriginal First Nations and Métis Health Services** as well as **Mental Health and Addictions Services**.

Subsequently in 2010 the NE LHIN initiated the development of an **Aboriginal, First Nations and Métis Mental Health and Addiction Framework Strategy** to provide direction for improving the access to and the quality of mental health and addiction services for Aboriginal, First Nation and Métis people across the lifespan.

Although there are considerable deficits in Aboriginal mental health and addictions data, there are significant health inequities making the need for this framework compelling: Mental health issues are more common in northern Ontario but fewer people have access to mental health services. Ontario’s recent **10 Year Mental Health and Addictions Strategy** and the **Select Committee on Mental Health and Addictions** have identified significant gaps in the mental health and addictions services sector and called for a core basket of services among many other improvements.

But Aboriginal people face additional challenges. The Aboriginal population in the NE LHIN is estimated to be 55,172 people, approximately 10% of the total population. Compared with the general population, Aboriginal people rate their health less frequently as excellent or very good (66.1 % versus 75.1 %); report higher rates of excessive alcohol use (23.3 % versus16.3 %); higher rates of prescription and illicit drug use; and the negative multi generational mental health effects of residential school attendance touch the lives of many. Furthermore, there are significant inequalities in the social determinants of health: The unemployment rate for First Nations people in the NE LHIN is double that of the overall population, and their average yearly income is approximately $10,000 lower. Consequently, a high proportion of Aboriginal people live below the low-income cut off. Especially disadvantaged are the youngest children: 38.7% of Aboriginal children under age 6 live below the low-income cut-off in the NE LHIN.

During the development of this framework there was a strong commitment to respect Aboriginal self-determination and Aboriginal cultural perspectives in health. Aboriginal, First Nations and Métis people were invited to participate at the grass roots level throughout the framework development, through community engagement sessions and collaboration with a community partnership and the Local Aboriginal Health Committee. Stakeholders provided community perspectives on mental health and addictions priority issues, which included:

- **Historical trauma, including Indian Residential Schools effects and Post Traumatic Stress Disorder**
- **Unresolved intergenerational grief due to historical trauma**
• Suicide and suicidal ideation
• Depression
• Low self esteem, hopelessness and learned dependency
• Elder abuse, especially financial abuse
• Substance abuse of all forms
• Addictions, including prescription drug abuse, illicit drug abuse and concurrent disorders
• Chemical induced psychosis
• Dual disorders
• Child and youth mental health

Participants in the James Bay region highlighted the following additional mental health and addictions issues:
• Crisis proportions in suicide and suicidal ideation amongst youth
• Solvent abuse, especially gasoline inhaling amongst youth
• Isolation

At present the addictions and mental health needs of Aboriginal people in the NE LHIN are served by a small handful of Aboriginal health and social service organizations augmented by (mainly paraprofessional) workers at the First Nation community level. Services are available through the following organizations
• 8 Indian Friendship Centres
• 3 Aboriginal Health Access Centres (AHAC)
• 1 Aboriginal Community Health Centre (CHC)
• 2 Addictions Treatment facilities
• 3 Regional mental health service providers
• 3 First Nation community based mental health clinics

These programs or services may represent as few as 1 or 2 FTEs per organization with the exception of Aboriginal Health Access Centres and larger First Nation mental health clinics which may comprise 4 or 5 FTE in mental health or addictions services. The services do not represent a comprehensive mental health and addictions services infrastructure to serve the often profound and complex mental health and addictions needs of Aboriginal communities. Stakeholders cited numerous gaps in the mental health and addictions services available to Aboriginal people. These are summarized in Table 1.

A continuum of care does not exist within Aboriginal health organizations or communities. It is very encouraging to see that several excellent and innovative programs have been developed in communities using limited funding, including community development initiatives, youth resilience programs and integrated traditional healing/clinical health programs. However, given the many gaps in services, the high mental illness burden and complex disorders in communities, a core basket of services (as recommended by Ontario’s 10 year strategy) is especially urgently required for Aboriginal, First Nations and Métis people.
### Table 1 Gaps and deficits in mental health and addictions care

<table>
<thead>
<tr>
<th>Mental health services gaps</th>
<th>Addictions services gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry services</td>
<td>Knowledge, skills, services to address prescription drug abuse and concurrent disorders</td>
</tr>
<tr>
<td>Respite care</td>
<td>Withdrawal management</td>
</tr>
<tr>
<td>Capacity to deal with dual diagnosis</td>
<td>Methadone treatment, linkages, support and aftercare</td>
</tr>
<tr>
<td>Crisis response services</td>
<td>Alternatives to pain management</td>
</tr>
<tr>
<td>Children’s mental health services (12 – 17)</td>
<td>Youth assessment and treatment</td>
</tr>
<tr>
<td>Family based interventions</td>
<td>Youth treatment services for prescription drugs</td>
</tr>
<tr>
<td>FASD assessment and diagnosis services</td>
<td>Youth solvent abuse program</td>
</tr>
<tr>
<td>Speech and language services for children</td>
<td></td>
</tr>
<tr>
<td>Skilled workers/capacity to deliver prevention and promotion for youth</td>
<td></td>
</tr>
</tbody>
</table>

### Gaps affecting both mental health and addictions

- Relapse prevention support
- Supportive and transitional housing
- Capacity to deal with concurrent disorders

### System gaps and impediments

- Transportation support to access services and care
- Increased complexities and costs in serving northern and remote communities
- Interjurisdictional barriers between program and funding mandates
- Comprehensive evidence base and data sets to inform planning
- Cultural safety in mainstream services
- Lack of access to and integration with primary care
- Human resources and capacity

Beyond simply funding programs and services to address these gaps and deficits, there is a need to support a climate conducive to maximizing the efficiency and effectiveness of new and existing programs and services by reducing fragmentation and lack of coordination. Integration efforts across several dimensions of mental health and addictions care are a key factor to achieve this. Recommendations addressing the layers of integration are provided in section 1; supportive processes are provided in recommendations section 2.
1.0 Recommendations Related to Improved Integration of Services

Recommendation 1.0: Create seamless, integrated Aboriginal mental health and addictions services
Facilitate the development of service and systems integration as the foundation to comprehensive, culturally safe, effective, timely, proactive and population-based services. To achieve this, service integration must be improved in the areas of Traditional Aboriginal healing, mental health and addictions, primary care, provincial and federal services and between Aboriginal and non-Aboriginal service organizations.

Recommendation 1.1: Improve integration of Traditional Aboriginal and clinical approaches
Traditional Aboriginal healing approaches address mental and emotional health and wellbeing, yet they can carry less of a stigma than might be associated with visiting a mental health clinician. Not all Aboriginal people chose a traditional approach, however research does show that traditional Aboriginal healing is an important part of health and wellness for many and is often used concurrently with clinical services. Mechanisms to support integration of traditional and clinical approaches should be encouraged, supported and designed as appropriate and in partnership with Aboriginal communities and service organizations.

Recommendation 1.2: Improve integration of addictions and mental health services
Integration of mental health and addictions services is necessary in order to address the complex, inter-generational issues faced by many individuals. This approach is congruent with Aboriginal concepts of wholistic health. Integrating mental health and addictions services within Aboriginal communities and service settings should therefore be encouraged and supported. The NE LHIN has taken a leadership position in emphasizing the integration of addictions and mental health as a goal outlined in the 2008-2011 Integrated Health Service Plan. This direction is in line with Ontario’s 10 Year Mental Health and Addictions Strategy. A cornerstone of this approach is to ensure that those who present with mental health disorders are offered screening and care for addictions and vice versa. This assessment process should unfold over a number of encounters as the provider/client relationship develops.

Recommendation 1.3: Improve integration of addictions and mental health services with primary care
Ontario’s Aboriginal health policies as well as international research have underscored the importance of ensuring that Aboriginal clients receive health services addressing all four dimensions of their health - mental, emotional, spiritual, physical - because of the beneficial impact on their wellbeing. Engaging the primary care sector is particularly important because:

- Many people with a mental illness or a substance abuse problem do not
seek help for these problems from mental health and addictions providers.

- Up to 40% of presenting concerns in primary care physician offices are related to mental health, and nurse practitioners’ experiences are similar.
- Strategies for decreasing prescription drug abuse can only be effective by involving primary care providers who prescribe them as stakeholders.
- Chronic illness can be risk factors for mental disorders and addictions.

**Recommendation 1.4: Improve integration between mental health and addictions and social/justice sectors including housing, policing, education and child welfare**

Mental health and addictions services are not well integrated with social services. People with SMI or addictions often require housing, income support, parenting, court support, education and employment programs in order to support their recovery.

**Recommendation 1.5: Improve integration between services located on and off reserve**

The health information, systems linkages and resources to allow Aboriginal people to move seamlessly from provider to provider, setting to setting or community to community are not in place. This is a particular challenge for the Aboriginal population which can be transient between First Nation communities or urban settings and those who need specialized services only accessible off reserve.

**Recommendation 1.6: Improve integration between Aboriginal and non-Aboriginal services**

Mental health and addictions workers in urban as well as First Nations health organizations face often great difficulty connecting their clients with the necessary specialized services in the mainstream systems. Once the right services are identified, clients are placed on waiting list which can be detrimental to continuity of care for clients. For individual who have received mainstream services, there is limited discharge planning and communications and no information sharing to support any form of aftercare once they return to their community. In short, care is fragmented.

2.0 Recommendations Related to the Strengthening of the Regional, Community and Systems Foundations for Effective Services

**Recommendation 2.0: Support the development of high quality, effective, culturally safe services**

In concert with the support for integration, there is a need to build supports aimed at improving the effective provision of services. These can organized into three areas:

- Knowledge: enhance knowledge exchange and access to information
Recommendation 2.1: Enhance knowledge exchange and access to information through the development of an agenda for Aboriginal, First Nation and Métis health information and data

There is a lack of consistent and reliable health information on Aboriginal, First Nations and Métis people, which is preventing accurate monitoring of mental health and addictions health status, services and effectiveness. Data sharing agreements with Political Territorial Organizations (PTOs), communities and governmental sectors are needed to extract information from existing data sets and potentially develop new data bases.

Recommendation 2.2: Enhance knowledge exchange and access to information through formal opportunities of information sharing between the communities of practice

There is still little information on effective, culturally safe approaches to Aboriginal mental health and addictions. Exchange of promising practices within the communities of practice can be an important aspect of improving care and supporting Aboriginal self-determination in health.

Recommendation 2.3: Enhance knowledge exchange and access to information through the development of culturally appropriate assessment and evaluation tools

Our knowledge and understanding of appropriate, culturally safe assessment tools and effective mental health services and programs for Aboriginal communities is still quite limited. Mental health and addictions assessment instruments and evaluation tools are based on mainstream populations and culture. They are often culturally and ideologically incompatible with Aboriginal worldviews.

Recommendation 2.4: Support the enhancement of skills of providers in traditional wellness approaches

Traditional approaches to health are needed by many Aboriginal people and this is supported by Aboriginal policies. Therefore it is necessary to improve access to local traditional approaches and the development of knowledge of traditional approaches to mental wellness within mental health and addictions workers.

Recommendation 2.5: Support the enhancement of skills of providers by cultivating an Aboriginal workforce that has competencies in both clinical and traditional approaches

There is a shortage of Aboriginal mental health and addictions workers. They are urgently required in order to provide more culturally safe care and a choice of traditional approaches to mental health and addictions.
**Recommendation 2.6: Support the enhancement of skills of providers through the creation of standards for cultural safety training of all service providers**

Many mental health and addictions providers have no undergraduate or continuing education related to cultural safety and Aboriginal health issues. Although some schools (e.g.: the Northern Ontario School of Medicine) has integrated this into their core curriculum, most have not accomplished this as of yet.

**Recommendation 2.6: Support the development of appropriate planning mechanisms by demonstrating leadership on an intergovernmental planning table**

Federal/ Provincial/ Regional jurisdictional barriers continue to be a major impediment to mental health and addictions service provision to Aboriginal, First Nations and Métis people; individuals moving between reserve and urban residences are particularly affected.

**Recommendation 2.7: Support the development of appropriate planning mechanisms by establishing a NE LHIN Aboriginal mental health and addictions planning table**

A coordinated effort is required to create and monitor systems and service integration of Aboriginal, First Nations and Métis mental health and addictions services.

**Recommendation 2.8: Support the development of greater equity in NE LHIN funded programs**

Existing health inequities are the result of health influences that operate at all system levels, and across sectors and geographic borders. As Aboriginal people represent over 10% of the total population in the NE LHIN it is imperative that there are pathways to promote Aboriginal health equity.

**Recommendation 2.9: Support the development of appropriate reporting requirements and service accountability agreements**

To create culturally safe service environments, all organizations should be encouraged to provide evidence of cultural safety training.
Introduction to the Framework

About the NE LHIN

The North East LHIN region is one that is distinct and vibrant both culturally and linguistically. It has the highest number of French-speaking communities in the province, with Francophones comprising 24 per cent of the region’s population. Aboriginal and First Nation communities make up 10 per cent of the North East region. The North East LHIN works closely with Northeaster Ontario citizens, health service providers and partners to determine the health care priorities and services for the region.

The North East LHIN coordinates services among more than 200 health care service providers, including a community care access centre, community health centres, community mental health and addiction services, community support services, hospitals, and long-term care homes.

The NE LHIN is focused on building meaningful relations with Aboriginal/First Nation/Métis communities to help improve the health status and services of Aboriginal/First Nation/Métis. This task is complex as health services for Aboriginal people are under multiple jurisdictions. Aboriginal peoples in Ontario, including members of First Nations and citizens of the Métis Nation receive physician services and hospital care through provincially funded programs and services. Specialized federal and provincial programs and services dedicated to First Nations and Métis people respectively also exist. Involving Aboriginal communities and organizations in the planning of Aboriginal services is therefore paramount in order to ensure that provincial programs and services serve Aboriginal peoples in a culturally appropriate manner.

The NE LHIN has made significant strides to develop a strategy to identify and engage Aboriginal communities in its region and produced a document entitled: North East Local Health Integration Network: Integrated health service plan. Engaging Aboriginal Peoples in 2006.

In 2007, the NE LHIN established an Aboriginal Health Planning Group, now called the Local Aboriginal Health Committee. The group meets on a regular basis to advise on priorities and allocations within the Aging at Home Strategy for the Aboriginal/First Nation/Métis communities, and health planning priorities in general. The group is chaired by a NE LHIN board member, who in turn provides a direct link back to the LHIN decision makers.

1 Adapted from NE LHIN Website accessible at http://www.nelhin.on.ca/page_about.aspx?id=108&ekmensel=e2f22c9a_72_184_btnlink

2 Adapted from NE LHIN Website accessible at http://www.nelhin.on.ca/page_about.aspx?id=1308&ekmensel=e2f22c9a_414_426_btnlink
On November 30 2009, the NE LHIN published its 2010-2013 Integrated Health Services Plan. The IHSP outlines the region’s health care priorities (a total of nine) for the next three years. It was developed with the input of people from all across the NE LHIN region\(^3\). The priorities for the NE LHIN include Aboriginal First Nations and Métis Health Services as well as Mental Health and Addictions Services.

In order to take action on these two IHSP priorities, an Aboriginal, First Nations and Métis Mental Health and Addiction Framework Strategy was clearly needed.

**Development of this Framework**

In 2010 the NE LHIN initiated the development of an Aboriginal, First Nations and Métis Mental Health and Addiction Framework Strategy designed to outline:

- a) functional integration and future development opportunities across sectors, and
- b) culturally appropriate and sustainable options for improved service delivery structures.

The overall goal of this initiative was to provide direction to improving the access to and the quality of Mental Health and Addiction care for Aboriginal/First Nation and Métis people across the lifespan.

The development of this framework has been inclusive and participatory, with a focus on respecting Aboriginal community and health provider knowledge. To invite contribution from the grass roots level into the development of this framework, a total of six community engagement sessions with key stakeholders in Aboriginal mental health and addictions were conducted in the NE LHIN geographic area during the summer of 2010. Aboriginal stakeholders included rural and urban First Nations as well as Métis Nation of Ontario service providers. Participants included Aboriginal, First Nations and Métis health program managers and directors, Friendship Centre Executive Directors, representatives from the Ontario Federation of Indian Friendship Centres, political representatives and staff as well as frontline mental health service providers.

Ongoing direction for the process of development was provided through regular meetings with (a) a Community Partnership Committee acting as steering committee and composed of experts in Aboriginal mental health and addictions; as well as (b) Aboriginal health leaders who form the Local Aboriginal Health Committee.

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\(^3\) The IHSP is accessible at [http://www.nelhin.on.ca/page_ihsp.aspx?id=4020&ekmensel=e2f22c9a_72_204_btnlink](http://www.nelhin.on.ca/page_ihsp.aspx?id=4020&ekmensel=e2f22c9a_72_204_btnlink)
For the final framework development the community and health provider knowledge was augmented with national and international Aboriginal mental health and addictions literature, provincial administrative health datasets and then situated with current provincial and federal policy environments.
Towards an Understanding of Mental Health and Addictions in Aboriginal Communities

A Note on Terminology

Prior to discussing statistics related to Aboriginal people it is important to clearly define the terminology used in this report. First it is important to note that the terms “Aboriginal” and “First Nations” are not used interchangeably. The term “Aboriginal” is defined in the Canadian Constitution Act and includes all people of indigenous descent: First Nations, Inuit, and Métis. The term "Indians," is considered to be offensive by many Aboriginal people, when used by non-Aboriginal people. The legal term “Status Indians” is therefore replaced by “First Nations people”, a term which however is not legally defined. Nevertheless, it commonly refers to both Status and Non-Status Indian people in Canada⁴.

Statistical Overview of the Aboriginal Population in the NE LHIN

2006 Census figures estimate the population in the NE LHIN to be 545,040 people. Based on the same census figures, the NE LHIN is the LHIN with the highest number of people who identify as Aboriginal, with 51,910 people (9.5% of the population). Of these, 29,835 (5.5% of the total population) identified as North American Indian (presumably First Nations) and 20,700 (3.8% of the total population) identified as Métis.

However, census figures underestimate the First Nations population on reserve as this group is incompletely enumerated in the census. More accurate, adjusted population counts can be calculated by updating census data with INAC registration numbers for on reserve registered Indians for incompletely enumerated reserves. Furthermore an additional estimate is added to account for incomplete enumeration in the INAC population count. Based on these adjustments, the Aboriginal population in the NE LHIN is estimated to be 55,172 people [1], which amounts to just over 10% of the total population.

There are 56 First Nations communities in the NE LHIN. INAC data shows that approximately 51% of First Nations people live off reserve in either rural or urban areas. In addition, Métis people do not have a geographically-defined land base and therefore also live commonly in mainstream rural and urban areas.

⁴ For more information, see Government of Canada. Indian and Northern Affairs Canada. Definitions. Available at: http://www.ainc-inac.gc.ca/ai/mr/is/info106-eng.asp.
Access to Aboriginal Mental Health and Addictions Data

Comprehensive and consistent Aboriginal health and mental health data sources are currently still lacking in Canada. There are two main reasons for that:

- a) administrative datasets generally do not capture Aboriginal status
- b) governmental health surveys do not include populations on reserve

Several administrative data sets are however collected by First Nations and Inuit Health Branch (FNIHB) of Health Canada on First Nations and Inuit people. On the other hand, the major provincial administrative datasets, that capture health information for most individuals, do not include Aboriginal identifiers. FNIHB data sets that capture First Nations population living on reserve as well as Inuit people comprise therefore the most complete data sets. There is little information on Métis and other Aboriginal people living off reserve [2].

The Canadian Community Health Survey does not include First Nations. The First Nations Regional Health Survey (RHS), which is conducted in five year intervals, captures self reported health data in a sample of reserves across Canada. Data are aggregated at a national level and however there is currently no access to Ontario or LHIN level data.

As such, there are no data sources currently available to describe Aboriginal mental health accurately at the NE LHIN level. However some First Nations specific data (based on residence on reserve) can be extracted from existing health information data sets collected by the Ministry of Health and Long-Term Care (MOHLTC).

A major limitation to the compilation of Aboriginal health and mental health status profile from administrative data sets held by the MOHLTC is the fact that Aboriginal status or identity is not consistently collected by health services providers in Ontario. Aboriginal status is also not included in OHIP cards. Some administrative data sets include residence codes which can be used to extract some data such as hospital utilization for people living on reserve. Different federal, provincial and Aboriginal health organizations collect additional types of health data, but these data sets are not collected for the specific purpose of Aboriginal health surveillance and no data sharing agreements have been developed at this point to allow for aggregation of these data sets. Their usefulness as secondary data sets to estimate the mental health status profile of Aboriginal population in the NE LHIN is considerably compromised by

- a) the lack of consistent identifiers for Aboriginal status and
- b) the lack of data sharing agreements and processes.

These factors in turn lead to “a serious health data deficit in the Ne LHIN planning area”.[3]
**Aboriginal Mental Health and Addictions in Canada**

Accessible information on the mental health of Aboriginal people living in the NE LHIN is quite limited at this point. In order to begin to provide a picture of Aboriginal mental health and addictions it is useful to identify mental health issues generally experienced by Aboriginal people in Canada.

While there are thriving Aboriginal communities, many Aboriginal communities nevertheless experience overall poor health and mental health status, isolation, socioeconomic inequality, and marginalization. Although data sources are incomplete and exist only for First Nations people living on reserve and Inuit people, mental illness and disorders are serious health issues in most Aboriginal communities, often compounded by a lack of access to appropriate services.[4]

Patterns of mental health and addictions issues in the Aboriginal population are similar to those found in other Indigenous populations who share a history of colonization. [5] The causal connection between colonialization and mental illness is supported by a large body of research. [6-9] It is therefore imperative that mental health, mental illness and addictions in Aboriginal communities be approached with an understanding of the impact of colonialization and marginalization by the dominant society. The consequences of colonialization have been dramatic and include (but are not limited to) loss of language, loss of traditional lands and economies, and the long standing historical exposure to governmental assimilation policies.

These forces have had devastating effects on many Aboriginal families and communities. The negative, multi-generational impact of colonialization is a well-established risk factor for mental disorder, substance use and suicide in Aboriginal communities. The residential school system exacerbated the problem by subjecting generations of Aboriginal people to mental, physical and sexual abuse, and by weakened family relationships through the forced removal of young children from their families. [2, 7, 10] Research indicates that up to 98 percent of residential school survivors may be afflicted (or were afflicted) with a mental health disorder, including substance abuse problems, Post Traumatic Stress Disorder, major depression and chronic depression. [11, 12] A fact sheet produced by the Canadian Psychiatric Association states that suicide is the leading cause of death for Aboriginal persons under the age of 45. [11]

Results from the 2002/03 First Nations Regional Longitudinal Health Survey (RHS) on the use of alcohol and substances by First Nations people on reserve indicate that rates for both abstinence from alcohol and the frequency of drinking were lower among First Nations compared with the general population. For example only 65.6% of participants reported to have consumed alcohol in the past year compared to 79.3% of the general Canadian population. However, there are higher rates of heavy drinkers (defined as those who have five or more drinks on one occasion) as well as a greater proportion of drug users.
RHS findings indicate that more than double the proportion of First Nations adults (16.0%) are engaged in heavy drinking on a weekly basis compared with the general population.[13] A total of 26.7% of respondents reported using marijuana over the past year, compared to only 14.1% in the general population (the highest frequency of users were males aged 18 to 29). Prescription drug use was reported by 12.2% of participants over the past year including codeine, morphine and opiates. The usage rate of other illicit substances was found to be 7.3% over the past year, a rate about double that found in the general population.[13]

**Statistical Data on Aboriginal Mental Health and Addictions in the NE LHIN**

While good comparative data for Aboriginal people do not exist, a data analysis of secondary sources has from time to time been conducted by the MOHLTC for Northern Ontario.

One such analysis of a subset of data from the Canadian Community Health Survey (CCHS) was conducted for the development of this framework. It includes Aboriginal people’s data, collected from self-identified, Aboriginal people living off reserve. In this case it was necessary to combine two cycles (2005 and 2007/08) of data to get a large enough sample of Aboriginal vs. non-Aboriginal data to provide meaningful data. These CCHS results show that Aboriginal people in Ontario rate their mental health as poorer. In addition, they also report more risk factors for mental health and addictions than non-Aboriginal people in Ontario (see Table 1). The differences were statistically significant.

A further analysis of CCHS data reveals that higher prevalence of low income, low education and poor mental well-being are reported in Northern Ontario and especially in the NE LHIN [14]. An analysis of Northern Ontario Aboriginal people is not available, however there is every indication the Aboriginal data would reveal even poorer conditions.

**Table 1: Select Mental Health Risk Factors, Ontario**

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Aboriginal Respondents</th>
<th>Non-Aboriginal Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived mental health - very good or excellent</td>
<td>66.1 %</td>
<td>75.1 %</td>
</tr>
<tr>
<td>Heavy Drinking</td>
<td>23.3 %</td>
<td>16.3 %</td>
</tr>
<tr>
<td>Smoking (daily or occasional)</td>
<td>40.3 %</td>
<td>20.2 %</td>
</tr>
</tbody>
</table>
The CCHS results point to high needs for mental health and addictions services in Northern Ontario. Despite this high need, mental health resource utilization rates are quite low, possibly as a result of a combination of stigma and access difficulties. Perhaps, in part as a consequence of the low utilization of mental health services, individuals with mental health issues experience acute mental illness more frequently than in Southern Ontario. Statistics show that Northern Ontario hospitalization rate related to mental health issues is significantly higher than that of the province. Furthermore, suicide hospitalizations rates are more than double the provincial rate (8.3 vs. 19.2 per 10,000). [14]

Working closely with NE LHIN data analysts during the development of this framework, additional customized analyses of administrative data sets were completed. An analysis of provincial data set on Schedule 1 psychiatric facilities revealed the most common diagnoses for reason for admission for people living in First Nations communities in the NE LHIN (see Table 2)

Table 2: Top SMI Diagnoses at Discharge for First Nations

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mood Disorders</td>
</tr>
<tr>
<td>2</td>
<td>Schizophrenia And Other Psychotic Disorders</td>
</tr>
<tr>
<td>3</td>
<td>Substance-related Disorders</td>
</tr>
<tr>
<td>4</td>
<td>Adjustment Disorders</td>
</tr>
<tr>
<td>5</td>
<td>Anxiety Disorders</td>
</tr>
</tbody>
</table>

While this list can serve as a general indicator of the most common mental illnesses in First Nations, it is important to note that access difficulties exist for Aboriginal people and in some regions these are quite severe as will be demonstrated in this framework. It is therefore important to remember that a significant portion of those requiring hospitalization are likely not receiving hospital care.

Community mental health programs funded by MOHLTC enter basic service information into the Common Data Set (CDS) for mental health. There are several Aboriginal mental health and addictions programs contributing to the CDS. They include programs: B’saanibamaadsiwin (Muskoka, Parry Sound), Alemotaeta (James Bay Comm Mental Health Program), N’Mninoeyaa: Community Health Access Centre (north shore of Lake Huron and in Sault Ste. Marie), Noojmowin Teg Health Centre (Manitoulin Island), and Shkagamik Kwe Aboriginal Health Access Centre (Sudbury).

A special data analysis of the CDS of these programs covering the fiscal year 2009 was conducted. The data is provided in Table 3. The total number of disorders is much higher than the total number of service recipients, since many recipients have multiple disorders. The low number of child hood disorder related services is an indication of the lack of child and youth services provided.
Furthermore, a review of the service data clearly indicates that there is a strong emphasis on treatment whereas early intervention services are scarce. This leads to more severe morbidity for those who are in need of interventions as well as increased treatment and specialized service needs “downstream”.

Table 3 Service Provided by Aboriginal Programs as reported in the Common Data Set Mental Health

<table>
<thead>
<tr>
<th>Type of Service:</th>
<th>Concurrent Disorders</th>
<th>Counselling &amp; Treatment</th>
<th>Diversion &amp; Court Support</th>
<th>Early Intervention</th>
<th>Mental Health Case Management</th>
<th>Mental Health Crisis Intervention</th>
<th>Total of Prog. Reported</th>
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</thead>
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<td>Total Service Recipients (SR’s)</td>
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<td>1989</td>
<td>124</td>
<td>100</td>
<td>2301</td>
<td>78</td>
<td>5144</td>
</tr>
<tr>
<td>Unknown / SR Declined / Missing</td>
<td>384</td>
<td>822</td>
<td>56</td>
<td>32</td>
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<tr>
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<td>68</td>
<td>68</td>
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<td>76</td>
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<td>433</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>12</td>
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<td>Personality Disorders</td>
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<td>0</td>
<td>8</td>
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<td>47</td>
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<td>32</td>
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<td>Substance Related Disorders</td>
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<td>4</td>
<td>0</td>
<td>76</td>
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<td>193</td>
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<tr>
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<td>19</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>27</td>
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<tr>
<td>Other*</td>
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<td>16</td>
<td>116</td>
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<td>276</td>
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<td>12</td>
<td>96</td>
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<tr>
<td>Other Chronic illnesses and/or physical disabilities</td>
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<td>0</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>48</td>
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Aboriginal Stakeholder Perceptions of Mental Health and Addictions in Communities in the NE LHIN Region

Given the lack of Aboriginal specific mental health and addictions data, grass roots information from those who work in the area of Aboriginal mental health and addictions becomes crucial for the development of a framework for services. During the community engagement sessions, stakeholders perceived mental health and addictions services as equally important as services to prevent and treat obesity, diabetes, heart disease and other chronic illnesses.

They also noted that many of these concerns had been highlighted in other consultations, studies, needs assessments, and reports shared with government over the past several years and expressed their hope that the framework would finally propose meaningful action to be taken to address these.

Based on observations of stakeholders, the main mental health and addictions issues are as follows:

- Historical trauma, including Indian Residential Schools effects and Post Traumatic Stress Disorder
- Unresolved intergenerational grief due to historical trauma
- Suicide and suicidal ideation
- Depression
- Low self esteem, hopelessness and learned dependency
- Elder abuse, especially financial abuse
- Substance abuse of all forms
- Addictions, including prescription drug abuse, illicit drug abuse and concurrent disorders
- Chemical induced psychosis
- Dual disorders
- Child and youth mental health

In addition to the above noted concerns, participants from the James Bay region highlighted the following mental health and addictions issues:

- Crisis proportions in suicide and suicidal ideation amongst youth
- Solvent abuse, especially gasoline inhaling amongst youth
- Isolation

Many of the issues described by stakeholders are interlinked. For example, an increase in violent confrontations can be attributed to the increase in those addicted to and trafficking in prescription drugs, which is further linked to an increase in youth involvement in the court systems.
Similarly, over-representation of Aboriginal children in the care of Children’s Aid Society case are linked with parenting issues and substance use which in turn are linked to PTSD, intergenerational trauma and the legacy of the residential school systems. In general, stakeholders understand addictions as a symptom of underlying pervasive pain, unresolved grief, abuse history or other mental health issue. Those with mental health issues are in turn at greater risk of addictions and concurrent disorders.

Stakeholders discussed these complex and interrelated mental health and addictions issues which are commonly seen among their clients as “Matrix Disorder”. They use this term to describe the symptoms of individuals with several complex and interlinked issues which may include suicidal ideation, addictions, abuse history, and others.

**Statistical Data on the Determinants of Health in the NE LHIN**

The Public Health Agency of Canada lists twelve determinants of health - income and social status; social support networks; education and literacy; employment and working conditions; physical environments; social environments; biology and genetic endowment; personal health practices and coping skills; healthy child development; health services; gender; and culture[15].

While regional data on the social determinants is not easily accessible, Statistics Canada has, in collaboration with the Ontario Trillium Foundation prepared a profile of the Aboriginal population in northeastern Ontario (within the NE LHIN region), including the combined area of Algoma, Cochrane, Manitoulin and Sudbury (ACMS). They report on the following determinants of health: [16]

**Growth rate and age structure:** The Aboriginal community is growing at a much faster rate than the total population. In ACMS, the Aboriginal community increased by 20% between 2001 and 2006. Contributing to this increase in numbers are higher birth rates, greater numbers of people self-identifying as Aboriginal (particularly in the Métis population), as well as increased enumeration of First Nations communities. The Aboriginal population is younger than the population at large with children and youth making up 42.7% versus 29.8% in the total population.

**Education, Employment and Income:** The younger Aboriginal generation is becoming better educated, however still 43.3% of First Nations people had either no certificate or completed post secondary education.

**Employment:** The unemployment rate for First Nations people was double that of the overall ACMS population. Aboriginal people in ACMS are more likely to have part-time or seasonal work than full-time employment and their average yearly income is approximately $10,000 lower than the yearly income of the overall population.
Poverty and its impact on Early Childhood: A high proportion of Aboriginal people in ACMS live below the low-income cut off. Especially disadvantaged are the youngest children—38.7% of Aboriginal children under 6 live below the low-income cut-off.

Research shows that improved employment, education and economic status are associated with better health and mental health. Poorer health and mental health are associated with disadvantages in employment, education and economic status. The long-term impact of poverty on children’s health and mental health is particularly detrimental.

Aboriginal Stakeholder Perceptions of the Determinants of Health in the NE LHIN

Mental health and addictions were seen by stakeholders to be particularly closely linked with income and social hierarchy. Within Aboriginal communities, low income levels, poverty, wage gaps and the inability to develop a viable economic base within communities is linked to many adverse impacts on health, well-being and mental health. These conditions are closely linked to hopelessness especially in youth who are lacking opportunities; addictions in youth and adults; and family violence and numerous other issues.

Low educational attainment including high school dropouts, teen pregnancies, single parent homes and low income levels within Aboriginal communities are strong contributors to many of the societal ills and consequent mental health issues. One participant shared their viewpoint as follows:

“Domestic violence is also an issue that it is closely related to addictions and poverty, because basic needs are not being met in the family and that ultimately feeds into violence.”

Participant quote.

Many felt that addressing social determinants of health in concert with prevention and promotion efforts at the community level would need to be a part of the mental health and addictions framework if efforts are to be successfully aimed at overcoming mental health and addictions issues in communities.
Mental Health and Addictions Policy Directions and Aboriginal, First Nations and Métis People

Aboriginal Mental Health and Addictions Health Policies in Canada

Despite the high rates of mental health disorders in Aboriginal populations, comprehensive national Aboriginal mental health and addictions services to address this issue are still lacking. Health Canada’s First Nations and Inuit Health Branch (FNIHB) provides two main types of mental health services to First Nations people only:

a) the National Native Alcohol and Drug Abuse Program which provides funding for community-based paraprofessionals and regional treatment centres (Health Canada, 2006); and,
b) short term crisis intervention clinical treatment for a limited list of presenting issues (Health Canada, 2005).

These services are not adequate to address the complexity of mental health issues in Aboriginal communities and there are serious gaps in services for most Aboriginal communities. Consequently crises related to mental health, addictions and suicide are relatively common.

At times, ‘outside’ interventions are provided in response to community crises, such as youth suicide waves. Yet, the utilization of these services is often poor as these services provided by mainstream mental health and addictions services are not culturally safe. Correspondingly, parachuted programs lack community connection, cultural understanding and cultural safety[17]. These interventions also lack long-terms sustainability and typically are removed once the most immediate community crisis signs have subsided. It is a short term “band aid” response.

Clearly, solutions must be based on long-term partnerships with Aboriginal communities and local mental health and other service organizations. The notion that a collaborative approach is crucial to successful Aboriginal mental health and addictions programs is not new and was strongly endorsed by the 1996 Royal Commission on Aboriginal Peoples [18]. There is also emerging evidence that community-driven mental health care that involves both clinical as well as traditional Aboriginal healing services are essential for community acceptance and cultural relevance. While the mental health literature on effective culturally-based mental health and addictions services is still in its infancy, there are some early indications of the success of community-driven, collaborative approaches. A brief overview of some of these programs and their underlying approach is provided in the following sections.
Aboriginal Mental Health and Addictions Policies in Canada

In 2005, the First Nations and Inuit Mental Wellness Advisory Committee (MWAC) was formed with partners from the Assembly of First Nations, Inuit Tapiriit Kanatami, federal/provincial/territorial networks, non-governmental and Aboriginal organizations. Representatives included individuals with specialized expertise in the mental health and addictions fields and other key partners. The purpose of MWAC was to provide strategic direction to Health Canada on issues related to mental wellness, which includes mental health, mental illness, suicide prevention, and substance abuse/addictions. As part of its strategy development the committee developed five goals for a First Nations and Inuit Mental Wellness Strategic Action Plan:

- To support the development of a coordinated continuum of mental wellness services for and by First Nations and Inuit that includes traditional, cultural and mainstream approaches.
- To disseminate and share knowledge about promising traditional, cultural and mainstream approaches to mental wellness.
- To support and recognize the community as its own best resource by acknowledging diverse ways of knowing and by developing community capacity to improve mental wellness.
- To enhance the knowledge, skills, recruitment and retention of a mental wellness and allied services workforce able to provide effective and culturally safe services and supports for First Nations and Inuit.
- To clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal, provincial, territorial and First Nations and Inuit delivered programs and services.

A proposed national strategy, presented as a First Nations and Inuit Mental Wellness Strategic Action Plan would address core issues in the lives of First Nations and Inuit in ways that build on their strengths, experience, and abilities to take and apply the best of their cultures. It is acknowledged that effective community-based practices require on-going support to allow the paths to mental wellness to evolve in a culturally congruent way.

Pilot initiatives are currently in the implementation stage in several Aboriginal communities across the country. They are in line with the strategic goals of the MWAC, including the development of Mental Wellness Teams. A primary goal is the integration of these programs with provincial services. An evaluation of the outcomes of these new initiatives and their integration will however require time. More comprehensive services are currently not provided under this initiative.

5 The strategic plan document can be found on the website of Indigenous Mental Health http://www.indigenous-mental-health.ca/index.php?option=com_content&view=article&id=24&Itemid=38
In Ontario, the pilot project, entitled “Raising the Spirit” Mental Wellness Team comprises an interdisciplinary, centralized, consultative team embracing both traditional and western approaches. Based in Sudbury, it services 10 First Nations in northeastern Ontario.

Some provinces have taken steps to develop Aboriginal mental health strategies informed by consultations with Aboriginal stakeholders. The province of Alberta for example completed a framework in 2006. The document recommends the creation of culturally appropriate options for the full range of mental health services; it affirms that planning and management of effective Aboriginal mental health services requires both formal and informal inter-governmental and inter-Ministerial, Health Canada and Aboriginal collaboration; and Health Canada and Aboriginal governments need to be engaged “without abrogating or derogating from Treaty and Aboriginal rights” in providing services to First Nations people.[19]

The Assembly of First Nations (AFN) has incorporated mental health and suicide in its health policy work. The AFN focuses on reducing “the unacceptably high rate of suicide among First Nations…. This will be achieved through establishing internal and external linkages with suicide prevention programs; and examining the accessibility of mental health services for First Nations as a means to identify gaps in services and resources in suicide prevention. The AFN has also test-piloted a Cultural, Economic, Political, Social (CEPS) training program for youth leadership and empowerment.”[6]

In the area of addictions, the Chiefs of Ontario (COO), in collaboration with FNIH–Ontario Region and First Nations Stakeholders will develop and prepare for negotiation a Regional Prescription Drug Abuse Strategy[7].

Ontario Policy Directions on Aboriginal Health and Mental Health

Ontario has made significant progress over the past two decades in engaging Aboriginal communities and supporting a collaborative approach to Aboriginal health planning that is affirming of Aboriginal worldviews. Early in the 1990s, the Ontario government began a nearly three year process to collaborate with Aboriginal, First Nations and Métis leaders and organizations to develop a new relationship between Aboriginal people and the health care system in Ontario. This collaboration involved nearly 7000 Aboriginal people form 250 communities in Ontario and lead to the development of Ontario’s first Aboriginal health policy. The vision statement is provided below:

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6 See AFN website at http://www.afn.ca/article.asp?id=1647
7 See website of the Chiefs of Ontario at http://chiefs-of-ontario.org/PageContent/Default.aspx?SectionID=2&SectionHeadlineID=29
Aboriginal health is wholistic and includes the physical, mental, emotional, spiritual and cultural aspects of life. Through this understanding of self, a vision of wellness which balances body, mind and spirit is promoted throughout the healing continuum. Committed partnerships of First Nation/Aboriginal and non-Aboriginal people and governments will recognize and respect the diversities in lifestyles and traditions of Aboriginal people regardless of residency and status.

The goal of the Aboriginal Health Policy is to improve the health of Aboriginal individuals, families, communities and nations through equitable access to health care, First Nation/Aboriginal health care facilities, improved standards of care, the provision of culturally appropriate health services, and promotion of a healthy environment. Self-determination in health will be supported by appropriate levels of financial and human resources for Aboriginal-designed, -developed and -delivered programs and services that respect and promote community responsibility, autonomy and local control.

The Aboriginal health policy was created to facilitate improvements in Aboriginal health through better access to care, better standards of care and more culturally appropriate care. This policy, which is still in use today,\(^8\) was the beginning of a commitment to health services designed, developed and delivered in partnership with Aboriginal people[20].

In 1994 the province created the **Aboriginal Healing and Wellness Strategy**, which consists of various community-based services to address Aboriginal health status as well as family healing.

Both the policy and the strategy orientation have been strongly focused on Aboriginal world views, a wholistic Aboriginal understanding of health, traditional Aboriginal healing and community partnerships in the creation of programs.

An Aboriginal mental health and addictions specific policy direction however does currently not exist.

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\(^8\) See the website of the Aboriginal Healing and Wellness Strategy accessible at http://www.ahwsontario.ca/about/healthpolicy.html
Ontario Policy Directions on Mental Health and Addictions

In 2008, the Ontario government made a commitment to improve mental health and addiction services, including (a) the reduction of wait times in emergency departments for people presenting with mental illnesses and addictions and (b) provision of better care for people with eating disorders or early psychosis, and (c) the development of comprehensive mental health and addiction strategy that would lead to better services for Ontarians. A Minister’s Advisory Group on mental health and addictions was established to develop a strategy to transform mental health and addictions services.

In 2009 a consultation paper was developed by the Minister's Advisory Group on mental health and addictions to provide a framework for a 10-year strategy to transform mental health and addiction services in Ontario. [21]

The goals of this initiative are:

- Improve health and well-being for all Ontarians.
- Reduce incidence of mental illnesses and addictions.
- Identify mental illnesses and addictions early and intervene appropriately.
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex symptoms of mental illnesses and/or addictions and their families.

The Strategy provides a comprehensive overview of the current system and recommendations to improve the provision of mental health and addictions care. It should be noted however, that that the MOHLTC completed little engagement with the Aboriginal community in the development of this strategy and therefore the unique and compelling needs of the Aboriginal population in Ontario have been overlooked. The notion of ‘Aboriginal self-determination’ in relation to Aboriginal mental health and addictions supported by provincial and federal governments has not been accommodated.

The Select Committee on Mental Health and Addictions has recently provided the legislative assembly of Ontario with recommendations to address the current crisis in the mental health and addictions field. The main problem identified by the committee based on extensive hearings, is that there is in fact no coherent system and as a consequence many people fall through the cracks. Their recommendations are therefore far reaching and include the creation of a new provincial organization responsible for overseeing the mental health and addictions system.

The committee also recommended that a core basket of mental health and addictions services be made available in all regions of Ontario.[22] Strategic goals of the proposed Mental Health and Addictions Ontario are as follows:
- **System Design:** To develop the provincial and regional framework for the delivery of mental health and addictions services.
- **System Management:** To plan, organize, manage, and oversee the delivery of mental health and addictions services.
- **Service Delivery:** To ensure timely and equitable access to assessment and treatment for all Ontarians.
- **Supportive Care:** To ensure seamless navigation to housing, income, employment, peer support, and other social services.
- **Improved Outcomes:** To improve client outcomes through research and best practice guidelines.
- **Promotion, Prevention, Early Identification and Intervention:** To reduce the incidence, severity and mortality of mental illness and addictions through promotion, prevention, and early identification and intervention, from early childhood to the senior years.
- **Reduce Stigma:** To reduce stigma and the harm it causes.

In their final report the committee acknowledges that there is a “lack of access to even basic mental health services for aboriginal Canadians in many parts of Ontario”.

A notable flaw in the development of the report is that the Select Committee only engaged with a handful of First Nations (on-reserve) and did not actively engage with off-reserve Aboriginal people. Feedback that was provided about the mental health and addiction issues of urban Aboriginal people by the Ontario Federation of Indian Friendship Centres and other off-reserve Aboriginal organizations was not incorporated in the Select Committee’s final report.

This urban Aboriginal perspective is outlined in the following section, based on research conducted by the OFIFC.

*“Good Mind” Ontario Federation of Indian Friendship Centres (OFIFC) Mental Health Strategy 2006*

The Ontario Federation of Indian Friendship Centres developed a Mental Health Strategy entitled “Good Mind” in response to the increased demand for mental health services in urban Aboriginal communities and the fragmented medically focused approach predominant in existing mental health services. The strategy described the need for both clinically based mental health and addictions programs and services and traditional healing and culturally specific approaches. It also outlined that there is currently, no capacity within the Friendship Centres to provide comprehensive, culturally appropriate mental health services and

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9 “Good Mind” Ontario Federation of Indian Friendship Centres, Mental Health Strategy, September 2006
training. Many of the issues, barriers and gaps described are similar to those we heard during the information gathering phase of this framework’s development. In addition, many of the principles and strategic approaches are aligned with the recommendations in this framework. These are described in further detail in Appendix B along with specific recommendations arising from the Leaders for Change Aboriginal Mental Health and Wellness Conference held in November 2007 in Toronto.

The Métis Nation of Ontario conducted a Métis Nation Health Needs Assessment in 2005. Table 4 provides an overview of the mental and emotional health services needs, based on this research project.

International Policy Approaches to Improving Indigenous Mental Health

In New Zealand, Māori mental health is integrated into the national mental health framework as one of several strategic priorities. There has been significant growth and development of Māori mental health and addictions services over the past decade, including the development of human resources and research and evaluation. To improve Māori mental health the Ministry of Health is proposing to "continue to broaden the range, quality and choice of mental health and addiction services for Māori – with immediate emphasis on: (a) enabling Māori to present earlier to mental health and addiction services, (b) promoting choice by supporting the implementation of kaupapa Māori models of practice (c) increasing Māori participation in the planning and delivery of mental health and addiction services for Māori.”[23]

In 2008, the Council of Australian Governments (COAG) made large-scale funding commitments to improve Indigenous child health and close the gap in life expectancy between Aboriginal and non-Aboriginal peoples within one generation [24]. The “Close the Gap” initiative is based on a human rights framework, focusing on health equality for Indigenous Australians. To achieve its goal, the approach for this initiative is (a) to plan, implement and deliver services in partnership with Indigenous people, communities and organizations, (b) to proceed proactively and ambitiously and (c) to develop targets and benchmarks to keep track of progress. Furthermore, the plan will include an expansion of the Aboriginal controlled health services as well as increased access to mainstream services [25].

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10 Kaupapa Māori models of practice are traditional models of practice
Table 4: Métis Mental and emotional health services needs, 2005

<table>
<thead>
<tr>
<th>Health Domain</th>
<th>Need Category</th>
<th>Experiences Expressed by Métis Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual health</td>
<td>Culturally appropriate and/or personally meaningful spiritual activities</td>
<td>Insufficient opportunities for traditional spiritual activities and health care approaches</td>
</tr>
</tbody>
</table>
| Mental/cognitive health        | Mental activity and challenges that uses personal cognitive strengths | Need for Métis language taught in schools  
Need for education, training and jobs | |
| Emotional health and well-being| Emotional health and well-being       | Insufficient counselors and mental health professionals  
Insufficient workshops or education for dealing with anger, depression, suicide, stress.  
**Need for all basic mental health and addictions services** |
|                                | Self-esteem and esteem by others      | Racist practices of health care providers  
Perceived inadequate and apparently uncaring treatment by health care providers  
**Need for culturally safe services** |
|                                | Love and belongingness (meaningful association and communication with people who share culture and values) | Insufficient social opportunities with other Métis |
| Domestic Violence              | Safety                                | **Need for:**  
Counselling circles, Addictions counselling, Women’s shelters, Violence education awareness sessions/workshops, and Men’s circles. |

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Insights from Communities and the Literature: Approaches to Mental Health and Addictions and Related Services

Community Development

Self-determination is one of the defining characteristics of Aboriginal-specific health policies in Canada today and the immediate effect of self-determination is on the culture of health services: Aboriginal controlled services are generally designed to welcome and celebrate Aboriginal culture and heritage and improve cultural safety. However the broader determinants of health, such as poverty, housing, environmental contamination and life style practices are much more difficult to improve [26] and require an additional focus on health equality as well as community development.

Community development has an important role to play in Aboriginal mental wellness, prevention of mental health disorders as well as mental health service provisions.

Research shows that Aboriginal communities that have taken active steps to preserve and revive their culture and have more control over their services have dramatically lower rates of suicide. Community level indicators of cultural continuity identified include community control over education, police and fire services and health services Researchers suggest that the experience of cultural continuity allows youth to understand themselves, connect to their own past and build a future.[27]

The vitality of social networks and community functioning also has an important influence on mental health. “Some children grow up in communities with extended family networks, a sense of collective responsibility, connections to ancestors and elders, and services to assist those with problems. Others grow up in communities that are fragmented, without hope, and that lack basic health services. Communities with high problematic substance use leads to fetal alcohol syndrome and fetal alcohol effects that influences learning ability and illegal behaviour that results in time in prison.” [4] Strong social networks are clearly linked to good mental health.

Furthermore, Aboriginal community development and community connectedness has been shown to be a promising approach to counteract feelings of hopelessness, depression and suicidal ideation in Aboriginal youth.[28]

Community development in the area of Aboriginal control over mental health services provision is also a promising approach to address child and youth mental health issues from a culturally competent and wholistic perspective which
includes a focus on the individual, the family as well as the community services. [29] Some Aboriginal communities have proactively focused on community development. Sagomok Anishnabek is one of these communities and their chosen process is described below.

**Case Study in NE Ontario: The Sagamok Anishnabek Community Story Process**

The process of gathering information for the Sagamok Anishnabek Community Story has been going on since 2001. At that time, small groups within the community began meeting and thinking about the challenges the community faces, the strengths and resources it has to overcome these obstacles, and the steps that they can take to start making a difference. As well, a series of meetings and workshops were held in the community (with youth, community leaders, and other community members) and a wide variety of small group and individual interviews provided additional information. These sessions helped prepare people for a comprehensive consultation process that was designed to produce a Community Story document. The Community Story document was understood to be an important step in the process of developing a long-term community healing and development plan.

Building on the rich source of information about the community contained in the 2003 Community Story, a *Ten-Year Action Plan* was produced. This plan focused on two primary lines of action: healing and community development. The progress towards the goals of the Action Plan were reviewed in a 2006 Community Story Process. The process provided focused information on progress and remaining issues affecting children, youth, women, men, families, social environment, economics, politics, culture, spirituality as well as lands and resources.

The Community Story Framework has become a tool for Sagamok Anishnabek to explore what is really happening and what is needed to make life better for everyone. The Community Story Framework has proven to be a very powerful tool for getting community members involved in thinking about and taking action on their own for the improvement of the quality of life for all.

**Integration of Traditional Wellness Approaches**

Mental health services are still stigmatized, which is one reason why those who require care may not seek services. Therefore it is particularly important that
appropriate services are accessible when clients overcome the hurdle of stigma and seek help.

Traditional Aboriginal approaches, including “traditional medicines and healers are a part of culturally appropriate care for many Aboriginal peoples”. It is therefore important that mental health and addictions service providers respect traditional approaches and find ways to integrate them in mainstream or clinical approaches.[30]

Traditional Aboriginal healing approaches often address the mental and emotional health and wellbeing, yet they can carry less of a stigma than might be associated with visiting a mental health clinician. Not all Aboriginal people chose a traditional approach, however research does show that traditional Aboriginal healing is an important part of health and wellness for many and is often used concurrently with clinical services.[30]

Emerging evidence suggests an integrated approach to mental health and addictions holds promise. Traditional healing approaches reaffirm and strengthen Aboriginal cultural identity, which in turn has been shown to promote good mental health in Aboriginal youth and adults.[31]

Traditional approaches are also important since some clinicians have found limitations of clinical approaches with Aboriginal patients because psychiatry and psychology are mainstream traditions embodying non-Aboriginal cultural values and practices. Several Aboriginal organizations have begun to integrate Traditional healing in their mental health programs. One of these efforts is well documented and described in the following section.

**Case Study in NE Ontario: Collaboration between Western and Traditional Care Providers**

In northeastern Ontario, Mnaamodzawin Health Services Inc. and Noojmowin Teg Health Access Centre have collaborated on a model of Aboriginal community-based shared mental health care. Their collaboration has had significant progress in integrating traditional Aboriginal healing approaches with clinical services such as counselling, psychology, psychiatry and long-term care. Research shows that the service model has very high levels of client and provider satisfaction. In addition, clients rated the cultural competence of providers and cultural safety in this service environment as very high.

However, it is important to stress that this level of collaboration did not evolve spontaneously. Instead, health care professionals and leaders worked with a group of elders over several years to ensure supportive programs and policies were in place. Health professionals needed ongoing opportunities to learn how to bridge these two approaches to health and how practitioners of the two healing
In summary, the following conditions were seen as essential for the development of successful integration:

- In depth community consultations regarding the healing traditions and cultural protocols for healing within the local Aboriginal cultural (i.e. steer clear of pan-Aboriginal approaches)

- Written protocols or guidelines for traditional healing services in an interdisciplinary or clinical service environment rooted in and respectful of local healing traditions

- Ongoing opportunities for inter-professional education and collaboration with knowledge exchange between clinical and traditional service providers—these include opportunities for clinical staff to learn about Aboriginal culture and healing traditions and attend healing sessions as appropriate; clinical education should also be available

- Formal opportunities for collaborative care and case management

- Ongoing opportunities for community education regarding mental health as well as traditional approaches to health

- A focus on enabling client access to traditional healing.[29]

Integration of Federal, Provincial, Municipal and First Nations Primary Care and Health Services

Primary care is the first place of contact with the health care system. Providers in that setting frequently co-ordinate patient access to specialized sectors such as mental health care and it often takes place in physician offices. The family physician is frequently the first contact patients approach for mental health issues. Up to 40% of visits to family physicians are mental health related.[33] However primary care varies in many First Nations communities, where there is limited or no direct access to physicians or hospital services. The first contact for Aboriginal people living on reserve who are seeking services for mental health issues within the on-reserve health care system is usually a nursing station or First Nations health centre. These organizations are typically staffed by nurses and paraprofessionals with no, or infrequent access to physician services. These differences in primary care services are the result of many factors, including: the federal government’s fiduciary responsibility to provide First Nations health
services on reserve; the historic governmental neglect and under-funding of Aboriginal health services; their historic separation from mainstream health services; and geographic and demographic factors which impact on the primary health care for small rural and remote communities in general. [2, 34]

Integrating these various services for First Nations people on reserve poses considerable challenges, including overcoming institutional inertia and cross jurisdictional barriers, to encourage systems that have traditionally operated in isolation to collaborate. Furthermore, changing systems is a lengthy process that requires significant staff time to develop collaborative relationships and protocols or agreements for integrative care. There can be significant rewards for clients, including a improved continuum of care.[35] An example of one such major initiative to integrate various levels of previously silo-ed services is currently taking place in the James Bay region.

Case Study in NE Ontario: The Weeneebayko Area Health Integration Framework

After a three-year process, historic resolutions were signed on July 15, 2010 in Moosonee, Ontario confirming commitment to integrate the provincial James Bay General Hospital and the federal Weeneebayko Health Ahtuskaywin into the new Weeneebayko Area Health Authority (WAHA).

This event involved cooperation and collaboration among leadership of the NE LHIN, the Boards, the Chiefs of the Hudson and James Bay communities as well as the Federal, Provincial and Municipal government.

Resolutions by the three hospital boards – Weeneebayko Health Ahtuskaywin, James Bay General Hospital, and WAHA – confirmed their commitment to proceed with integration by way of the North East LHIN’s Voluntary Integration process. The goal is to have the integration completed by October 1, 2010.

It is hoped that this integration of hospital programs and services will improve the quality, accessibility, delivery, effectiveness, efficiency and cultural appropriateness of health care services in communities along the Hudson and James Bay Coast.

The new WAHA will ensure better coordination of federal and provincial programs and services, as well as improve the utilization of health professionals, facilities and equipment. WAHA will serve a vast geography with hundreds of kilometers between the area’s communities, many accessible only by air or water.[36]
Promoting Aboriginal Youth Mental Health: Strengthening Resilience

Although there is much variation in suicide rates, suicide, in particular youth suicide, is an urgent issue for many Aboriginal communities in Canada. Overall suicide rates are five to seven times higher for First Nations and Métis people when compared with mainstream Canadians. Suicide in small close-knit communities touch virtually everyone and the ripple effect of this kind of trauma can be long-lasting and powerful.

Resiliency refers to the ability to maintain hope, mental wellness and positive coping during difficult times. Resilient people may even become stronger after overcoming difficult periods in their life as they increase their confidence and learn new ways of coping. Current research shows that many factors that promote resilience originate with the family, community and within the individual’s culture. [37] There is evidence that resilience is a protective factor for youth suicide. [38] Given the higher rates of youth suicide as well as depression, intervention programs for Aboriginal youth that are based on Aboriginal culture and focus on strengthening resilience are a promising practice.

Case study in NE Ontario: The Outdoor Adventure Leadership Experience (OALE)

The Wikwemikong Outdoor Adventure Leadership Experience is a youth leadership training program designed to promote resilience and well-being of First Nations youth. It is delivered while youth participate in a 10-day wilderness canoe expedition. The program contains training modules developed collaboratively by Wikwemikong community leaders and Laurentian University researchers over a three year time period with the help of talking circles, focus groups and community meetings. The training modules have a strong cultural component.

The OALE is currently focused on promoting resilience and well-being for co-ed youth ages 14-18, however youth as young as 12 years old have participated.

Having just completed its second season of operation, an evaluation of the OALE program has demonstrated that the program is an effective short-term intervention for promoting resilience among youth in the Wikwemikong community. Additional research is planned to determine the long-term impact on participating youth.

The Outdoor Adventure Leadership Experience is a mental health intervention program that could be adapted to other Aboriginal communities. [39]
Access to Aboriginal Mental Health Information

Research on effective mental health services and programs for Aboriginal communities is still quite limited, which is in part due to the fact that Aboriginal mental health information is currently virtually inaccessible. Provincial administrative data sets that are commonly used as the basis for planning mainstream services do not capture Aboriginal specific data. Even basic information such as rates of mental health disorders can only be estimated, mainly based on various small scale studies. Tracking the impact of mental health programs and interventions is therefore equally challenging.

Dr. Cornelia Weiman, a First Nations psychiatrist, suggests that community-based research with robust findings is currently one way to research and evaluate the impact of mental health programs and policies for Aboriginal people. However, Weiman concludes that compared with mainstream and clinical evaluations, frameworks for Aboriginal wellness teams must include a broader perspective than emphasis on individuals and problem-based measures.

Access to regional mental health information is a critical prerequisite to the development of effective mental health programs for Aboriginal communities. Some communities are working on establishing local Electronic Medical Records in order to ensure better access to patient and population health information. Federal/provincial cross jurisdictional issues again provide major hurdles, however some organizations are taking on the challenge:

Case study in NE Ontario: The Giwednong Health Link (GHL)

Giwednong Health Link (GHL) represents a collective of health care organizations that are establishing a centre of excellence to use technology to support holistic health care services to First Nation community members in the Manitoulin Island/North Shore region. The GHL is a complex project involving the development of broadband network capacity, applications and software, capacity development, information management policy and governance framework involving 14 First Nations communities in the NE LHIN geographic area.

In 2006 the key health organizations began a formalized process to develop this Health Information Management project, while progress has been made, many challenges still have to be overcome before the communities can realize their goal of administrating their own health information.

There are currently four major areas issues that require resolutions before GHL...
NE LHIN Aboriginal First Nations Métis Mental Health and Addictions Framework

can become operational:

- A cost-effective and sustainable means to collect, store, and manage health data that complies with the needs of the health organizations
- A secure managed broadband health network to support applications and share health data and information
- Sustainable funding beyond the scope of the immediate project.
- Political and data governance issues relating to First Nations, federal and provincial jurisdictional issues, and strategies and agendas of First Nations, national and regional organizations

Once established GHL will support the integration of federal and provincial services, establish baseline health information and improve the ability to track chronic care, health promotion and intervention activities and their impact.

Family Based Approaches

There is growing research evidence supporting the effectiveness of Aboriginal approaches to mental health. Wholistic approaches to treatment and interventions that focus on healthy families and communities are increasingly shown to be effective. Mental health programs that are broadly based, emphasizing youth and community empowerment are most likely to impact on mental health status in Aboriginal communities. [31] Research shows that services are required not just for the individual, the child or youth or parent, but the whole family. Successful functioning of Aboriginal youth is closely linked to healthy family relationships [41]. For example, there is a strong relationship between female caretaker depression and alcohol abuse and a child’s mental health, therefore caretakers of children with severe emotional and behavioural problems may themselves be in need of treatment. [42] Programs for that group should include intervention programs for high-risk parents to reduce the risk for mental health disorders in their children.

The Strengthening American Indians for the Future is a 14-session life-skills program designed to increase resilience and reduce risk factors for behavioural, emotional, academic and social problems. The program is intended for families with children of various ages. The focus of the program is on improving Parenting Skills; Child/Teen Life-Skills and Family Life-Skills. The Courses build protective factors by improving family relationships, improving the life skills of every member in the family. The program has been successfully implemented by several First Nations in the NE LHIN region.
Case study in NE Ontario: Strengthening Aboriginal families

The Strengthening Families program was implemented by M’Chigeeng Health Services on Manitoulin Island in partnership with other First Nations health organizations. The program was adapted to incorporate the local Anishnaabe culture, including the Seven grandfather teachings, traditional medicines, smudging, songs, drums, medicine wheel teachings. Train the trainer session were held for front line workers and 33 group leaders successfully completed facilitator training! Over the following 3 years 55 families completed the program.

“'The STRENGTHENING FAMILIES PROGRAM is one of the most powerful programs for family change, because it involves not just the parents or the children alone, BUT THE WHOLE FAMILY!’” (quote, mental health worker)

Trauma Informed Approaches

In the Ontario discussion paper “Every door is the right door” the importance of integrating evidence based, person directed approaches such as a “trauma informed approach” are identified as central to transforming the mental health and addictions system and to supporting new approaches to care and support. [21] Many people with mental illnesses, problematic substance abuse and harmful gambling – particularly women – have experienced trauma, physical and/or sexual abuse, and need a trauma informed approach to help them on their healing journey.[43] Women who receive integrated care that includes trauma-informed practice experience significantly more reductions in mental illness symptoms and in alcohol and drug use than women in conventional services with no difference in cost.[44]

Trauma-informed approaches take into account knowledge of the impact of trauma and integrate this knowledge into all aspects of service delivery. [45] From a trauma-informed perspective, “problem behaviours” are understood as attempts to cope with abusive experiences. Disorders become responses, and symptoms become adaptations.[46] The question shifts from “What is wrong with this woman?” to “What happened to this woman?”.[47] Working in a trauma-informed way does not require disclosure of trauma nor treatment of trauma, it is about working in ways that accept where the woman is at and to not retraumatize.

Trauma-specific services directly address the impact of trauma and facilitate trauma recovery and healing. Initial stages of treatment emphasize safety, identified by Herman in 1992 as the critical first stage of recovery. Seeking
Safety\textsuperscript{13} and Beyond Trauma\textsuperscript{14} are two evidence-based program examples that take an integrated approach to supporting women with trauma and substance use concerns. The recognition of the importance of trauma in Aboriginal women’s healing has been identified in Canadian research and practice.

Trauma informed approaches represent a promising avenue in the effective provision of mental health and addictions care for Aboriginal people given the complexities introduced by experiences of residential school and historical trauma.

\textsuperscript{14} Covington, S., Beyond Trauma: A Healing Journey for Women. 2003, Center City, Minnesota: Hazeldon.
An Inventory of Aboriginal, First Nations and Métis Mental Health and Addictions Services in the NE LHIN

An inventory containing brief descriptions of the Aboriginal mental health and addictions services provided for each planning region in the NE LHIN is presented in this section based on information gathered from secondary sources. More complete program descriptions are provided in Appendix A.

The following on-line inventories available through Connex Ontario were used:

- The Drug and Alcohol Registry of Treatment (DART)
- Mental Health Service Information Ontario (MHSIO)
- Ontario Problem Gambling Help Line.

The architecture and information categories in these three inventories are nearly identical, although in some instances the information may be outdated or not completely accurate.

An electronic listing of NE LHIN health service providers and Za-geh-do-win information Clearinghouse’s Aboriginal Mental Health Services/Support Directory entitled “The Key” were also used to develop this inventory.

The NE LHIN health service provider data base shows that there are 21 Aboriginal organizations which provide mental health or addiction services in the NE LHIN. Table 5 provides an overview of these services by planning area.

As listed in the table, along with federally funded mental health and addictions programs available in the 56 First Nations in the NE LHIN, Aboriginal addictions and mental health services are provided by the following types of organizations:

8 Indian Friendship Centres
3 Aboriginal Health Access Centres (AHAC)
1 Aboriginal Community Health Centre (CHC)
2 Addictions Treatment facilities
3 regional mental health service providers
3 First Nation community based mental health clinics

The locations of these organizations are depicted in Figure 1.
### Table 5: Aboriginal mental health and addictions service organizations by planning area

<table>
<thead>
<tr>
<th>Planning Area</th>
<th>Organization or service</th>
<th>LHIN funded program?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Algoma</strong></td>
<td>Anishnabe Naadmaagi Gamig Substance Abuse Treatment Centre</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mamaweswen North Shore Tribal Council</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Sault Ste. Marie Indian Friendship Centre (IFC)</td>
<td></td>
</tr>
<tr>
<td><strong>Cochrane</strong></td>
<td>Timmins Native Friendship Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ininew Friendship Centre (Cochrane)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kapuskasing Friendship Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Misiway Milopemahtesewin Community Health Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minto Counselling (1 Aboriginal worker)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>James Bay and Hudson Coasts</strong></td>
<td>Aleotaeta – James Bay Community Mental Health Program</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Moosonee Native Friendship Centre</td>
<td></td>
</tr>
<tr>
<td><strong>Manitoulin Sudbury</strong></td>
<td>Shkagamik-kwe Health Centre (Aboriginal Community-based non-residential service)</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>N’S’wakamok Native Friendship Centre (Drug and Alcohol Program)</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>Noojmowin Teg Health Centre</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>Nadmadwin Mental Health Clinic (Wikwemikong)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mnaamodzawin Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M’nendamowin Health Services (M’Chigeeng)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ngwaagan Gamig Rainbow Lodge Treatment Centre (Wikwemikong)</td>
<td></td>
</tr>
<tr>
<td><strong>Nipissing</strong></td>
<td>Giyak Moseng - Right Path Counselling and Prevention Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>North Bay Indian Friendship Centre</td>
<td></td>
</tr>
<tr>
<td><strong>Parry Sound</strong></td>
<td>B’saani-bamaadsiwin – Muskoka Parry Sound Community Mental Health Service</td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>Parry Sound Friendship Centre</td>
<td></td>
</tr>
<tr>
<td><strong>Timiskaming</strong></td>
<td>none</td>
<td></td>
</tr>
</tbody>
</table>

As noted in the table, urban Aboriginal populations may also be served by the Ontario Federation of Indian Friendship Centres (OFIFC), an Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres located in towns and cities throughout Ontario. The OFIFC administers a number of programs delivered by Friendship Centres in areas such as health, justice, family support, and employment and training. Friendship Centres also design and deliver local initiatives in areas such as education, economic development, children’s and youth initiatives and cultural awareness. A detailed description of the mental health and addictions related services, programs and initiatives undertaken by Friendship Centres in the NE LHIN is provided in the inventory in Appendix A.
Métis locals in Timmins, North Bay, Sudbury and Sault Ste. Marie offer services focused on prevention, promotion, and referral coordination. However, in terms of specific services available for the Métis, the Ministry of Health and Long Term Care and the LHINs take the position that funded health services are available to all Ontarians including Métis and status Indians living on-reserve. While there may not be any Métis-specific funded programs via the LHINs, the Métis can and do access mainstream LHIN-funded services (as do most Aboriginal people) and receive some Métis-specific funding from the MOHLTC through AHWS.
Two regionally based services, the Northeast Mental Health Centre Regional Aboriginal Mental Health Service and the “Raising the Spirit” Mental Wellness Team are also operating in the NE LHIN. Both are described in further detail in Appendix A. Appendix A also provides an overview of federally funded mental health and addictions programs operational in First Nations across the NE LHIN followed by provincially funded services; regional service teams and finally a description of mental health and addictions services and programs in each of the seven planning areas.

It is important to note that despite the seemingly long list of providers enumerated, these programs or services often only represent 1 or 2 dedicated FTE per organization with the exception of AHACs and larger First Nation mental health clinics which may comprise 4 or 5 FTE in mental health or addictions services. The inventory of services therefore does not represent a comprehensive mental health and addictions services infrastructure to serve the often profound and complex mental health and addictions needs of Aboriginal communities.

Figure 2 depicts the necessary continuum of care (adapted from “Every Door is the Right Door” [21] which is currently not available to aboriginal people.

Within First Nation communities, Métis and urban Aboriginal organizations, there is a pool of mental health oriented paraprofessional positions, including Community Wellness Workers, NNADAP workers and Brighter Futures/ Building Healthy Communities workers which are dedicated and skilled in the area of community prevention, promotion and referrals. However clinical or specialized mental health and addictions services are sparse or completely lacking. In those cases where they are available, they are usually located within regional health service provider organizations like treatment centres AHACs, CHCs or larger First Nation community based health services, where a small number of workers are providing services to a large client population. Specialized intensive tertiary services such as psychiatric hospital services are only available within the mainstream system where cultural safety and continuity of care are not assured and mostly lacking.

A comprehensive continuum of care as depicted in Figure 1 clearly does not exist within Aboriginal health care communities and organizations. Recent strategy documents by provincial taskforces and advisory councils call for a "core basket of coordinated services" for all of Ontario [21, 22]. Given the many gaps in services, the high mental illness burden and complex disorders in communities, a core basket is especially urgently required for Aboriginal, First Nations and Métis people.
Figure 2: A Continuum of Mental Health and Addictions Services

Continuum of Care

- Specialized, intensive services or tertiary care
- Mental health and addiction treatment services
- Community based addictions/mental health promotion and prevention
- Assessment, treatment planning, supports & crisis management
- Early identification and intervention
Gaps in the Aboriginal Mental Health and Addictions Service System

As recently described by the Select Committee on Mental Health and Addictions and the Minister's Advisory Committee on Mental Health and Addictions, there are significant gaps in the Ontario’s mental health and addictions services. [21, 22] The gaps experienced in the mainstream sector also affect Aboriginal people. However in addition there are First Nations on reserve and urban specific as well as Métis specific gaps which Aboriginal stakeholders discussed during the community engagement sessions. These issues are discussed in this section.

Lack of a Comprehensive Mental Health and Addictions Infrastructure

As outlined in the inventory description, the availability of Aboriginal specific services and programs in mental health and addictions is very limited. There are few resources. As one participant provided the following analogy of services provided by Aboriginal health organizations to Aboriginal people:

“It is like going to your grandma’s house. You get a great meal although there is nothing in the cupboard. People are having to be really creative with scarce resources.”

Participant quote

Most First Nation communities employ one or two mental health or addictions paraprofessional workers whose activities are aimed at promotion, prevention and referrals for community members. In urban areas, a small number of AHWS funded community wellness workers may provide a variety of social, recreational and health related group activities in Friendship Centres or Métis locals to a large target population but delivery of mental health and addictions services are outside of their capabilities. Off reserve band members may find their way to mainstream and walk in services which often lack cultural safety.

Those on reserve who do access off reserve services, find there is no connection back to their local community health services. There is no continuity of care, especially for those with chronic mental illness or co-morbidities. Similarly, there is some support for those seriously mental ill amongst mainstream services but there is no coordinating link or support services once they return to their First Nation. Services like Assertive Community Treatment teams seem to have been caught in the quandary of cross-jurisdictional wrangling.
Specialized services such as children’s mental health, youth addictions or psychogeriatric care for First Nation clients residing at home are non-existent. Such gaps will be elaborated in greater detail later in this section.

**Transportation**

Stakeholders described medical transportation as a challenge to helping clients get to appointments and services. The First Nations and Inuit Health medical transportation policy is becoming increasingly restrictive resulting in clients being denied transportation access to various specialized services such as treatment for gambling addictions.

The situation for the Métis is especially difficult as there are no program funds to support their members’ medical transportation costs.

**Northern Realities**

Stakeholders in the James Bay Coast area noted that program policies and funding models do not recognize the true transportation and operational costs of remote regions. For example, psychiatric beds are funded at the same levels as in southern Ontario although the operational costs are much higher in a remote, northern setting. Similarly, funded initiatives to improve the Information Communications Technology platform needed for services such as a CAT Scan neglect the ongoing operational and maintenance costs which are high in remote communities due to extra travel expenditures for technical service. Furthermore, telephone consults are common for coastal communities however there are no applicable billing codes for this service.

**Interjurisdictional Barriers**

Participants expressed the need to begin working on reducing “silos” and cross jurisdictional barriers as it makes it very difficult to provide services. Collaboration between federal and provincial services and Aboriginal stakeholders need to be urgently improved so that service delivery is coordinated, as opposed to the current piecemeal approach. In the words of one participant:

> Cross jurisdictional issues mean we are dividing up Aboriginal people for the provision of services….you can provide services to this person but not that person.....

> Participant quote

Mainstream service providers and organizations are often unclear whether or not their mandate extends to providing services on reserve. Often once they do
determine that their mandate does extend to include on reserve clients, the funds are not available to support this or have been allocated to other activities. As an example, Assertive Community Treatment teams could be instrumental in servicing the SMI populations within First Nations communities, however they do not currently provide services in these communities.

Other jurisdictional issues arise from the fact that Aboriginal health service organizations such as Friendship Centres or the Weeneebayko Hospital are not eligible as health service providers for the purposes of NE LHIN’s funding thereby limiting their access to and abilities to contribute to mental health and addictions service delivery for their constituents.

**Lack of a Comprehensive, Evidence Base and Data Sets to Inform Service Planning**

There are no regional mental health and addictions status and health services data for Aboriginal people.

This is in part caused by the digital divide: typically Aboriginal service organizations are underfunded and unable to purchase electronic medical records, although they are increasingly used by mainstream providers. Furthermore, many communities are lacking the appropriate broadband connectivity, human resources and infrastructure to implement health information systems which are however urgently needed to inform service planning. Organizations need support to build local capacity, including infrastructure and software to undertake data collection and analysis on an ongoing basis.

The lack of reliable, high quality and consistent health data is negatively impacting on health services. In the absence of reliable data, it is difficult to assess community health needs, allocate appropriate resources and determine if health programs are effective. Data would also help to identify where specialized training is necessary for Aboriginal mental health and addictions service providers and ensure effective services.

Although there are various health data collection processes being undertaken by the Union of Ontario Indians and Chiefs of Ontario for First Nations people, for example, regional access to these data sources is at this point not possible.

Data sharing agreements are necessary with these and other mainstream bodies which honour the principles of Aboriginal self-determination and respect Aboriginal interests in data collection and research, before aggregated health information can be accessed and analyzed on a regular basis.

Stakeholders shared the view that long term goals for data collection and analysis should be developed and acted upon. This would include analyzing Aboriginal/First Nations data from existing administrative data sets as well as
collecting new data as necessary. There is also a need to standardize data collection to avoid incompatible information gathering in the diverse Aboriginal healthcare settings, such as First Nations health centres, hospitals, doctors’ offices and other service providers. In order to support integrated care, a system of standardized information and health information sharing agreements must be developed. First Nations and Métis representatives must be part of these discussions.

Participants also described a need for more of a focus on research and ongoing evaluation of programming as well as mechanisms to share and disseminate this information amongst communities.

**Health Human Resource Gaps**

An increase in Aboriginal professionals in the field of mental health and addictions would greatly improve services. However, their numbers are very low and efforts to promote this career path are sorely lacking. This is coupled with the fact that there are disincentives to pursuing these careers including lack of wage parity, lack of support, and greater potential for burnout in these high stress and demanding jobs.

Clearly efforts are needed to increase the number of Aboriginal workers in mental health and addictions and address these systemic issues. A promising development includes the establishment of interdisciplinary shared care teams such as those within Family Health Teams and Aboriginal Health Access Centres.

**Cultural Safety in Mental Health and Addictions Services for Aboriginal People**

Participants expressed concerns with the lack of cultural safety for Aboriginal people who access mainstream services.

Although cultural safety is an evolving concept the Indigenous Physicians Association of Canada (IPAC) has adopted the following definition:

> "Cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities...Self-reflection in this case is underpinned by an understanding of power differentials. For First Nations, Inuit and Métis communities this power imbalance is unequal and can be seen as a residual element of colonization and act as a barrier to facilitating the health and healing for First Nations, Inuit and Métis citizens of Canada. Providers should be able to understand their own biases and prejudices and how racism might play a role while providing care to these diverse communities." [48]
For Aboriginal people with complex mental health and addictions issues, it can be especially difficult to access specialized services which are culturally safe, especially for psychological or psychiatric assessments. Most clinicians have not been educated in historical trauma, residential school syndrome or even how to work with Aboriginal clients, although the Northern Ontario School of Medicine has incorporated this into their curriculum. Furthermore, the Indigenous Physicians Association of Canada, in collaboration with the Canadian Faculties of Medicine, have developed core competencies in Aboriginal health care.

Training on cultural safety and Aboriginal issues is needed in all health education institutions, and continuing education for health professionals. Participants also suggested that Non Insured Health Benefit therapists who offer crisis counseling provide evidence of their cultural competence.

Access and Linkages with Primary Care

For many Aboriginal people in urban settings even when serviced by Indian Friendship Centres or Métis locals, there is a lack of access to physicians. This has an impact on an individual’s access to treatment centres as a physical assessment is a requirement of the application package. Nurse practitioners within the system can play an important role, however are in short supply as well.

Access to addiction-trained physicians and nurses for First Nations clients is also poor. Professional services are needed to help serve people with mild to moderate mental health illnesses and to monitor associated medical conditions.

The situation is exacerbated in the James Bay region where sometimes a community’s only access to a doctor is by telephone. There is a severe lack of onsite health professionals in all disciplines within these communities.

Service Gaps in the Continuum of Care

As noted earlier there is no comprehensive or consistent basket of services or programs in place to serve Aboriginal needs in mental health and addictions care. Further those that exist are severely underfunded to meet service level demands.

The current service spectrum is not sufficiently supporting clients and their families. Clients are sent from one place to the next. Community workers have difficulty connecting their clients with outside services and mainstream systems. Once the client is finally connected, there is often a waiting list which can be detrimental to continuity of care for clients. With mental health and addictions

15 Accessible at the website of the Association of the Faculties of Medicine of Canada at http://www.afmc.ca/social-aboriginal-health-e.php
there is often an urgent need for immediate services i.e. a set window when services are most effective.

For individuals who access services externally, there is no effective transition between services and settings as there is limited discharge planning and no information sharing to support aftercare. In short, there is no seamless continuum of care.

**Psychiatry Services**

Participants described a lack of specialized mental health services such as early psychosis intervention and in particular, psychiatry services.

Psychiatrists are unavailable in many communities, or at best only available for few hours each month at community clinics. Wait times are typically a matter of months, and clients will often go into crisis before a referral visit is scheduled.

Individuals in correctional facilities also have difficulties in accessing psychiatric services.

In the James Bay region, a psychiatrist visits once every six months. Most telehealth services utilized are for telepsychiatry (child, family, individual), however the service has not been evaluated to determine whether this is effective or not. There is a clear need for psychiatric beds in this region but these are capped at ten though a need has been expressed for an additional 8 mental health beds. Individuals who need consistent psychiatric care are often sent out of the region for service. When they return there is limited support. Schedule 1 (acute adult psychiatric) beds must be part of the new integrated structure.

**Need for respite care**

Closely linked with psychiatry services and associated aftercare support services within the James Bay region is the need for mental health respite for those caring for the severely mentally ill.

**Relapse Prevention Support**

Basic community aftercare is insufficient or completely lacking. Frequently clients with SMI or addictions are stabilized in hospitals or in treatment centres respectively. They are then typically returned to the community with little or no local supports to sustain their recovery efforts. Without aftercare or local support systems, the chance of relapse is very high. Participants see this as a revolving door of addictions, mental health and corrections due to lack of follow up resources or aftercare for people who have received treatment for their addictions and mental health issues. As expressed by one participant:
Despite all the services there is a cycle: like the winter roads they spend thousands of dollars on it in order to construct them but they melt in the spring. This is what the SMI service is like. We send them out for hospitalization so they can get better but then they are returned to our communities without follow up.

Participant quote

In addition there is a lack of communications, discharge planning and coordination amongst external providers and community health centres or services. As an example, for clients in the James Bay region for whom acute mental health is an issue, services and beds are not always available locally. Clients are sent to Kingston however, there is little in terms of collaboration with local teams and aftercare supports are not available for the clients upon their return to the area.

Offenders who have been involved in the corrections system’s institutions face a similar issue when they are released. There are no aftercare services available to support their mental health and addictions needs. Recidivism is high.

As noted under continuum of care, information is not shared, in large part due to privacy laws. Consequently the only time the hospital, health centre or mental health services learns that a client has returned to the community is when the client presents in crisis again.

Communities also shared concerns about follow up for clients who access the short term crisis counseling through FNIH providers.

Follow up services for SMI patients is very much a concern. These clients may do well in hospital but once discharged flounder without support. There is a need for at least a psychiatric nurse to follow these clients as well as case managers or Assertive Community Treatment teams. (ACT teams which are operational in several areas across the NE LHIN do not service clients on First Nations.)

Addictions services could be enhanced through the development of a Relapse Prevention Program to create awareness of relapse signs and symptoms and suggest strategies to avert this.
Supportive and Transitional Housing

Housing for those dealing with mental health or addictions both on and off reserve is a real challenge. Poverty and housing shortages lead to conditions of overcrowding in Aboriginal communities.

Supportive housing is needed for people with mental health issues or those who have returned from institutional care whether in treatment centres or hospital. Transition homes and aftercare support services are needed where people can live in supportive environments for up to a year so that they can continue to follow their healing path during the “after treatment” phase.

Currently however, halfway houses, relapse prevention programs, supportive housing and other similar initiatives are non-existent or in short supply within Aboriginal communities in the NE LHIN.

Prescription Drug Abuse, Concurrent Disorders and Dual Diagnosis

Prescription drug abuse, concurrent disorders and dual diagnosis were seen as among the most critical emerging issues. However most existing services and programs were not designed to address these specific addictions and complex disorders. Most workers and service providers do not have the knowledge, skills or expertise to serve individuals with these needs. Information and capacities to address identification, assessments and recommended interventions are needed.

Some communities have begun to coordinate strategies specifically around the issue of prescription drug abuse and have implemented protocols with the physician community to closely monitors and limit the prescription of narcotics.

Housing as well as appropriate intervention techniques, skills and strategies for those individuals with dual diagnosis (individuals with both a developmental disability and mental illness) are required.

Withdrawal Management

Withdrawal management services represent a gap as they are in short supply. There is also a need for withdrawal management beds for the James Bay region.

Currently, there are no withdrawal management programs located on First Nations. There is an urgent need for beds within communities along with training of front line community workers so that community based withdrawal management programs or services can be offered closer to home and lessen dependence on bed availability in external programs.
Methadone Treatment, Linkages, Supports and Aftercare

The percentage of Aboriginal clients receiving methadone clinic and harm reduction services is alarming high. It is critically important to link these services with multiple supports, aftercare and traditional healing services. One First Nation community representative cited a tenfold increase in methadone treatment over the course of one year. This has significant implications for medical transportation costs as clients must attend the clinic daily.

Methadone is useful in the treatment of opioid dependence but is not intended to reduce the use of non-narcotic drugs such as cocaine, methamphetamine, alcohol. Participants and communities are struggling to understand the methadone treatment course, its efficacy as well as long term client outcomes and impacts on services. More information is needed to guide mental health and addictions service providers, closer linkages must be forged with communities and appropriate services developed to support these clients.

Alternatives to Pain Management

There appears to be growing numbers of individuals who are being treated pharmacologically for management of pain. As individuals often seek out a physician for pain management it is important that they also have access to mental health and social workers who may be in a position to assist with other needs (emotional, mental, spiritual) of these clients. There is significant literature which demonstrates that the root cause of physical pain is emotional in nature and that at times, an individual cannot tell the difference between physical and emotional pain. Primary care providers cannot adequately determine if a person's pain is emotional or physical and it is treated the same way. This could mean that many of individuals are being treated for emotional pain with narcotics which is not appropriate or effective. As the treatment of choice is narcotics this greatly increases the risk of Aboriginal individuals becoming addicted due to overall increased vulnerability as a result of historical trauma.

Integrated care between mental health and addictions and primary care is needed to better support individuals with pain issues.

Information about and linkages to other alternative therapies for pain management should also be explored.

Crisis Response Services

Participants described crisis response as a pressing gap. Currently there are no Aboriginal workers available in area hospitals to respond to crisis and though there have been sporadic attempts to implement crisis response teams or plans
for after hours services, many flounder without adequate resources, ongoing coordination and personnel (most rely on volunteers).

One example of a crisis response team was a recent endeavor funded through the Union of Ontario Indians in partnership with the Northshore Tribal Council and based in Mississaugi First Nation. Critical response, CISM debriefing sessions and grief management training was provided to a group of volunteer providers. Although this project has not been evaluated as yet, it holds promise as a potential way to build crisis response capacity in communities.

Crisis response in the James Bay region is a critical and urgent need in light of the suicide epidemic faced within some of the communities. Amongst numerous other recommendations, the “Choose life-love life-honour life” Final Report on the Emergency Summit on the Suicide Crisis, Mushkegowuk Council, June 3, 2010 called for the establishment of a regional crisis response and protocol to support communities, emergency services and community workers.

**Children’s and Youth Mental Health and Addictions Treatment and Services**

There is a lack of children’s mental health services. There is no programming or services for early intervention and those that can be accessed in mainstream are generally not culturally appropriate. There is a need to focus on responding to children’s needs in the communities in culturally appropriate and safe ways.

Numerous gaps were described in this area including the following:

- Children’s mental health services (ages 12 – 17)
- Youth assessment and treatment, specialized services for teenagers, services for student populations especially those from Northern communities
- Child or family based programs or interventions as well as providers for child care while in treatment
- Youth treatment centre for prescription drugs. The closest youth treatment centre is in southwestern Ontario (Oneida). Priority clients are drawn from the southern Ontario catchment area. Consequently, there are long waiting lists with the client often losing interest and momentum or relapsing while waiting.
- Youth solvent abuse program
- FASD assessment and diagnosis
Speech and language services as most therapists who are available will not service First Nations because of provincial jurisdictional issues.

Skilled workers and prevention/promotion programming for youth

Improved linkages with Child Welfare Initiatives and less adversarial relations with Children’s Aid Societies were also identified as a need. Some participants noted that “there are a lot of children in care and there is little sensitivity to cultural issues and differences. They are keen to apprehend but they don’t want to work with you here.”

Participants called for a new approach built around “family mental health” as opposed to just children’s mental health.

**Formal Coordination, Case Management and Linkages to Other Services and Sectors**

Participants cited one of the biggest gaps or impediments to effective care and services as a lack of supportive processes and linkages to allow them to network, case management and share information with other services and sectors such as housing, welfare, policing or education.

For example, a housing department in a First Nation may identify a “problem” tenant when really this may be an individual who is in need of mental health or addictions services. The link between services and clients is not possible however without mechanisms in place to support this. Consistent and comprehensive case management services are not available.

**Traditional Aboriginal Healing Services**

One of the more serious gaps identified in the participant roundtable discussions centered around the lack of funds dedicated to traditional services such as healing or elders’ services. Despite the fact (a) that provincial and federal policies affirm the value of traditional healing and. (b) cultural approaches to mental health and addictions are promising practices for Aboriginal clients, there is very little funding for these services or transportation to these services.

This theme will be explored in detail in the recommendations section.
Culturally Safe Mental Health and Addictions Assessment Tools and Processes

Culturally appropriate assessment or diagnostic tools which take into consideration cultural norms, historical and intergenerational trauma, community dynamics and lifestyle realities of Aboriginal peoples are needed.

Cultural issues are very real. For example, one stakeholder told a story of a person who burned her dead fathers belonging as is the custom in Cree culture, but she was then charged with arson. Another told the story of a women who was diagnosed with social anxiety disorder for not leaving her house, but she lived next door to a sexual abuser, which was the real reason for her reluctance to leave her home.

For those living in the James Bay region, isolation is a common contributing factor to their presenting concern, but is often not included on assessment tools in use.

Similarly, language barriers and misinterpretation can be an issue not recognized in the assessment process.

Apart from these types of incongruencies, assessment tools as they exist now focus on deficits and diagnosis of a problem. These tools do not accurately reflect Aboriginal worldview on healing that comes from a strengths based approach. Tools that are more culturally relevant may also consider assessing resiliency and focusing on strengths. Such a tool would have better applicability to Aboriginal programming and be more effective in highlighting Aboriginal programming that would be considered a promising practice.
Context to the Recommendations

How Can Approaches to Aboriginal Mental Health and Addictions be Enhanced or Strengthened?

The purpose of this Framework is to provide guidance and direction to the NE LHIN to support their planning of appropriate programs and services, strategies and supports to address mental health and addictions in Aboriginal communities. Specifically, this document and its recommendations were designed to:

- Present background information and describe why an Aboriginal framework is needed;
- Frame appropriate responses to the unique and complex mental health and addictions needs and circumstances of Aboriginal people in the Northeast LHIN;
- Ensure alignment, where possible, with Ontario policy and programming directions in mental health and addictions;
- Suggest mechanisms to better coordinate with partners at the federal, provincial and community level which can support improved service planning, service delivery, capacity building and create new avenues to gather much needed information and share knowledge.

Specific objectives in the development of the Framework entailed the design of information gathering activities which:

- Considered all existing programs and services responding to the needs of the Aboriginal population across the region;
- Outlined functional integration and service development opportunities across sectors;
- Provided culturally appropriate, evidence-based sustainable options for enhanced service delivery structures that will improve access and quality of Mental Health and Addiction care for Aboriginal/First Nation and Métis people across the lifespan;
- Identified local opportunities and challenges for Mental Health and Addictions service development, integration and the overall elimination of unnecessary system fragmentation.

Participants at the six community engagement sessions were key informants to help in:

- Identifying local opportunities and challenges for correcting health information deficits for health planning purposes;
• Sharing ideas for local solutions that will support current initiatives to improve the general health, mental health and well being of Aboriginal/First Nation/Métis people;
• Identifying local opportunities and challenges for service development, integration and the overall elimination of unnecessary system fragmentation across Mental Health and Addictions sectors.

As a starting point in the discussions, participants shared their views as to how approaches to Aboriginal mental health and addictions could be strengthened. These perspectives provided guidance for concepts, values and principles on which the Framework should be based and provided the necessary underpinning to the recommendations. Participants shared freely and passionately a number of key cornerstones without which any strategies, recommendations, indeed the Framework, would fail. These included:

**Build on strengths of identity, spirituality, wholism, traditional ways**

• Mental health and addictions cannot be approached using only western individual disease oriented models. Approaches which recognize wholistic health and interconnectedness with family and community must be made a central focus.

• There must be a focus on identity and spirituality as a starting point in order to begin addressing mental health and addictions.

• Our own traditional practices, knowledge and approaches must be rekindled through teaching in schools, including the language.

• There is a need to develop best practices for Aboriginal programs and services that are rooted in Aboriginal issues, culture and worldview rather than trying to adapt best practices based on existing mainstream models. Aboriginal people, knowledge, practices and approaches are credible resources. We can help our own people and others with our traditional wellness approaches and treatment methods.

**Reinforce community control, community based and culturally appropriate approaches**

• There must be recognition of Aboriginal people’s desire to take back the control over their health system and incorporate traditional healing.

• Communities must look inward for solutions rather than to others outside or external providers who are “coming out to fix us”.

• Any programs, services, initiatives or solutions must be community controlled and designed.
Community programs and services in mental health and addictions must be culturally appropriate, service providers must be culturally competent, and mainstream services must be culturally safe.

Rather than treating symptoms, focus on providing health services which approach mental health and addictions problems from their roots e.g. address Indian Residential School, intergenerational trauma, multiple issues.

Individuals and families who use mental health and addictions services must be given a voice in any planning or design of programs and services.

Communities should have the opportunity to develop programs and fit them into their service environment in a way that makes sense from a local perspective.

Programs and services must be made locally accessible within First Nation communities and within familiar Aboriginal environments within urban settings.

Framework Principles

All stakeholders are implicated and must be included in an ongoing dialogue with Aboriginal people including provincial and federal departments, provincial and territorial treaty organizations, professional bodies and others.

The Framework’s timeframe must not be constrained by 3 year planning cycles but rather extend to 10 to 20 years.

Many Aboriginal communities and stakeholders have contributed to documents and policies which have been put together but are sitting on shelves, these contributions must not be overlooked.

Appropriate resources and funds must be sourced to implement the Framework.

There must be flexibility in the Framework to allow for emergent and unforeseen issues.
Recommendations for an Aboriginal Mental Health and Addictions Framework

1.0 Recommendations Related to Improved Integration of Services

**Recommendation 1.0:**
Create seamless, integrated Aboriginal mental health and addictions services

Facilitate the development of service and systems integration as the foundation to comprehensive, culturally safe, effective, timely, proactive and population-based services.

To achieve this, service integration must be improved in the areas of Traditional Aboriginal healing, mental health and addictions, primary care, provincial and federal services and between Aboriginal and non-Aboriginal service organizations.

**Rationale for recommendation # 1.0**

Figure 3 depicts multiple layers of necessary service integration and their inter-relationships. The blue, **innermost circle** requires effecting the integration of services hampered by inter-jurisdictional barriers to ensure that individuals regardless of Aboriginal status and residence on or off-reserve or transient between healthcare settings, receive the same access and quality of services.

The **second layer** depicts integration between mental health and addictions services which currently operate as two disparate systems of care although individuals are often presenting with co-occurring disorders. Another important **dimension** of service integration involves mental health and addictions services and other social sectors such as housing, income support, child welfare, education, policing and justice. The **fourth layer** entails the integration or “braiding” of mental health or addictions services with traditional wellness approaches as appropriate and of interest to individuals and communities. A **fifth** and equally important integration opportunity involves the integration of primary care and mental health and addictions services to ensure that all aspects of a person’s health are addressed.

The **final layer** of integration needed to complete the circle of care is between Aboriginal specific services and the mainstream service system to ensure continuity of care and cultural safety for Aboriginal clients.
Detailed recommendations how these levels of integration can be achieved are provided in sections 1.1 to 1.6.

Figure 3: Integration of services required to complete the circle of care
**Recommendation 1.1**

**Improve integration of Traditional Aboriginal and clinical approaches**

Traditional Aboriginal healing approaches address mental and emotional health and wellbeing, yet they can carry less of a stigma than might be associated with visiting a mental health clinician. Not all Aboriginal people chose a traditional approach, however research does show that traditional Aboriginal healing is an important part of health and wellness for many and is often used concurrently with clinical services.[21]

Mechanisms to support integration of traditional and clinical approaches should be encouraged, supported and designed as appropriate and in partnership with Aboriginal communities and service organizations.

**Rationale for recommendation # 1.1:**

Emerging evidence suggests an integrated approach to mental health and addictions holds promise. Traditional healing approaches reaffirm and strengthen Aboriginal cultural identity, which in turn has been shown to promote good mental health in Aboriginal youth and adults.[22] Research shows that collaboration and service integration between Traditional and clinical providers requires specific conditions to succeed. [23] The following processes should be supported:

- Community consultations regarding the healing traditions and cultural protocols for healing within the local Aboriginal cultural (i.e. steer clear of pan-Aboriginal approaches);
- Written protocols or guidelines for traditional healing services in an interdisciplinary or clinical service environment rooted in and respectful of local healing traditions;
- Ongoing opportunities for inter-professional education and collaboration with knowledge exchange between clinical and traditional service providers—these include opportunities for clinical staff to learn about Aboriginal culture and healing traditions and attend healing sessions as appropriate; clinical education should also be available;
- Formal opportunities for collaborative care and case management;
- Ongoing opportunities for community education regarding mental health as well as traditional approaches to health;
- A focus on enabling client access to traditional healing via intake processes and other means.[24]
Recommendation 1.2

Improve integration of addictions and mental health services

Integration of mental health and addictions services is necessary in order to address the complex, inter-generational issues faced by many individuals. This approach is congruent with Aboriginal concepts of wholistic health. Integrating mental health and addictions services within Aboriginal communities and service settings should therefore be encouraged and supported.

The NE LHIN has taken a leadership position in emphasizing the integration of addictions and mental health as a goal outlined in the 2008-2011 Integrated Health Service Plan. This direction is congruent with Ontario’s 10 Year Mental Health and Addictions Strategy. A corner stone of this approach is to ensure that those who present with mental health disorders are offered screening and care for addictions and vice versa. This assessment process should unfold over a number of encounters as the provider/client relationship develops. [21]

Rationale for recommendation # 1.2:

Approximately three in every ten people with a mental illness also have a substance abuse issue or dependency. About four in every ten people who use alcohol in a harmful way and over half of people who use other substances in a harmful way have a mental illness at some point in their lives.16 About three in ten people who entered problem gambling programs in Ontario in 2004/2005 also reported problems with substance abuse.17

Yet, mental health services and addictions services are commonly delivered in silos, making it very difficult for individuals with a mental illness, an addiction or both to receive the care they need to recover. Most service organizations provide addictions or mental health services but not both. Treatment is most frequently offered sequentially meaning that individuals with concurrent disorders (i.e. co-occurring Mental Illness, Drug Addiction and/or Alcoholism) receive one form of treatment (either mental health or substance abuse) followed by the other treatment with another agency. Some mental health services require people to be addiction free before they can access services and some addictions services will not provide treatment to people with a serious mental illness.

A national review of mental health and addictions service in the U.S identified many problems encountered by people with concurrent disorders when treatment

is provided across the two systems of care. Recommendations called for the integration of mental health and substance abuse treatment. While there are different ways in which treatment integration can be operationalized, the following best captures the concept: “mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.”

Comprehensive integrated program models include common mental health interventions, such as individual, group and family counseling, assertive outreach, intensive case management, medication management and support services and, on occasion, intensive day or residential components. Some of these features such as assertive outreach and intensive case management are also features of Assertive Community Treatment (ACT) teams which conceivably could expand to include substance abuse counselors. Recent models incorporate interventions tailored to the person’s stage of recovery, motivational interviewing and a range of other service activities.

Recommendation 1.3

Improve integration of addictions and mental health services with primary care

Ontario’s Aboriginal health policies as well as international research have underscored the importance of ensuring that Aboriginal clients receive health services addressing all four dimensions of their health - mental, emotional, spiritual, physical - because of the beneficial impact on their wellbeing. Engaging the primary care sector is particularly important because:

- Many people with a mental illness or a substance abuse problem do not seek help for these problems from mental health and addictions providers.
- Up to 40% of presenting concerns in primary care physician offices are related to mental health, and nurse practitioners likely have a similar experience.
- Strategies for decreasing prescription drug abuse can only be effective by involving primary care providers who prescribe them as stakeholders.
- Chronic illness can be risk factors for mental disorders and addictions. Each condition has the potential to exacerbate the other, and may actually be linked to disease development. Conditions that are particularly involved include diabetes, obesity, depression, schizophrenia and addiction to pain medications.
Rationale for recommendation # 1.3:

**Benefits of Collaborative Care**

Many people with a mental disorders or a substance abuse problem do not seek help for these problems from mental health and addictions providers, but they frequently do see family health providers for medical or mental health related reasons. In Canada, family physicians already play a significant role in handling mental health problems and up to 40% of physician visits are related to mental health issues and 35% of people with mental health issues see only a family physician for their condition [51]. Improvements in mental health and addictions services are therefore linked to improved levels of integration and collaborative care between mental health and primary care services. Research shows that collaborative care results in improved health systems. For example, physicians with access to collaborative care reported greater knowledge, better skills, and more comfort in managing psychiatric disorders and greater satisfaction with mental health services. [52] Despite inherent challenges, the shared care programs have been well received by practitioners and are resulting in better patient care.[29, 52-54]

Collaborative care models allow primary care providers such as physicians, nurse practitioner and community health nurses to fulfill a more effective role in early identification, intervention and disease management. However, it is important to note that many primary care providers require continuing medical education on appropriate screening tools, culturally safe application of these tools as well as information on referral services and programs. [51, 54, 55]

Other factors are also important for favorable outcomes for patients and clients: “These include delivery of interventions in primary care settings by providers who have met face-to-face and/or have pre-existing clinical relationships. In the case of depression, good outcomes are particularly associated with approaches that combined collaborative care with treatment guidelines and systematic follow-up, especially for those with more severe illness...Perceived medico-legal barriers to collaborative care can be addressed by adequate personal professional liability protection on the part of each practitioner, and ensuring that other health care professionals with whom they work collaboratively are similarly covered.” [56]

Integrated models of care offer the potential to improve access to treatment and improve quality. Integration can work in both directions: (1) mental health care introduced into primary care settings, or (2) primary health care introduced into mental health settings.

**Linking chronic illness and mental health and addictions**

**Mental health and Diabetes**

Aboriginal populations suffer from epidemic rates of diabetes and related complications such as heart disease, kidney failure, nerve damage and blindness
Biomedical treatment approaches have typically emphasized the physical aspects of the disease. These aspects include a focus on acute care and lifestyle. Non-physical aspects of diabetes have in the past been treated as peripheral or ignored. However, Aboriginal worldviews perceive health and well-being as a balancing of physical, mental, emotional, and spiritual aspects of the body. Many Aboriginal people see a strong connection between the occurrence of diabetes in First Nations and loss of spirituality, colonial history, power imbalances, stress, racism, intergenerational trauma, and overall community wellness. A sole focus on the physical aspects of diseases is therefore insufficient.

Similarly, MOHLTC has engaged in an initiative to change the health care system to shift chronic illness care away from acute care towards chronic disease prevention and management (CDPM). Ontario’s new CDPM framework focuses on “the distinct needs of clients with chronic conditions as it aims to provide multifaceted, planned, pro-active seamless care in which the clients are full participants in managing their care and are supported to do this at all points by the system”. Figure 4 depicts some of the linkages between risk factors for chronic illnesses, addictions, and mental health issues.

Figure 4: Chronic Disease Risk Factor Linkages (from The Ontario Framework for Preventing and Managing Chronic Disease)

[Image of a diagram showing various risk factors and their linkages.]

Reference: Adapted from literature, FHP Unit, MOHLTC | Dec 2005

COPT: Chronic obstructive pulmonary disease

Recent research has found important relationships between diabetes, obesity and mental health problems such as depression and schizophrenia. For example, a national study of adults showed that obesity was associated with a 30% increase in depression. Young women and children are particularly strongly affected. These findings emphasize the importance of addressing their common elements of risk associated with common chronic diseases and mental health disorders through integrated care.

However there are many barriers to integrated care. Financial barriers are an impediment, primarily because many activities associated with integrated care, such as case management functions, consultations and other communication activities between providers, and telephone consultation with patients, are not traditionally reimbursed under typical physician fee-for-service care.

Organizational barriers to integrated care include both issues related to change and the process of care. Resistance to change, new staff and new roles, and balancing competing demands are difficult to overcome without strong leadership that is committed to integrated care and champions the program. These challenges were aptly described in the community engagement sessions conducted during the development of this Framework:

“Some of the success in our services is that there is an integrative approach to services, e.g.: mental health has an integrative approach, with physicians, nurse practitioners and nurses. It is an evolving and growing approach, including with diabetes and hypertension, it is not there yet, but it is evolving. Some of the barriers are around information sharing as well as needed support to learn how to collaborate inter-professionally.

We are still struggling with an integrative model.... There is a reluctance to work in an integrative model. Workers are very resistant to work in collaboration. Can we get people on the same chart? Can the doctors connect with the workers, such as health promoters? The promoters can then be doing some things with the clients that is actually tailored to their needs.”

Participant quote

Nonetheless such barriers must be addressed to achieve improvements in medical care, quality of care, and patient outcomes. There is a growing policy environment (such as Ontario’s CDPM) supportive of such models of care which could be supported by NE LHIN. Pilot or demonstration projects are necessary to develop effective practices in Aboriginal communities that are likely to result in
both improved patient outcomes and (as predicted by Ontario’s framework for CDPM) savings to the health care system.

**One such example of a demonstration project could entail the development of an Aboriginal inter-disciplinary family health team** reflective of the integration opportunities outlined earlier and designed in concert with communities with ample flexibility to create integrated and interdisciplinary services that deal with issues holistically and correspond with Aboriginal vision and aspirations.

Furthermore, **Indian Friendship Centres** and **Aboriginal Health Access Centres** are well received environments for a range of interlinked health and social supports, services, and activities and strive to ensure that their members find all that they need in one location.

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**Recommendation 1.4**

**Improve integration between mental health and addictions and social/justice sectors including housing, policing, education and child welfare**

Mental health and addictions services are not well integrated with social services. People with SMI or addictions often require housing, income support, parenting, court support, education and employment programs in order to support their recovery.

**Rationale for recommendation # 1.4:**

During the community engagement sessions stakeholders described a need to provide “wrap around services” for people with addictions and mental illness encompassing a variety of services, including hygiene, housing, early intervention, treatment and rehabilitation.

Participants also described how effective interdisciplinary services are helping parents to make changes in their lives which allow them to become reunited with children in care of CAS. They also expressed that there is a need for collaboration to address the lack of children’s mental health services. This would involve the addictions programs, treatment centers, mental health programs, health services, child welfare agencies as well as education sectors to address this gap of lack of services. More importantly, they advised that in treating the children, there is also a need to treat the parents and care-providing adults as
part of family based interventions. A lack of funding and coordination support makes it difficult to keep the momentum going however.

Ontario’s Mental Health and Addictions Strategy echoes this advice. It suggests that the people who are already working with children and youth such as parents, teachers, community service providers, child care providers, recreation program workers, children’s aid workers and probation officers are in the best position to identify problems early and together provide appropriate interventions or referrals. Student Support Leadership, a joint initiative between the ministries of Child and Youth Services and Education is designed to enhance partnerships between school boards and community mental health agencies and ensure students quicker access to appropriate services.

Stronger links must be built with other sectors including social services, education, employment, seniors services, housing, policing and justice. Court diversion programs funded by the MOHLTC, the mental health courts and programs operated through the Ministry of the Attorney General, federally funded Aboriginal court workers (who can help clients by directing them to various counseling services available, such as programs involving Aboriginal elders or alcohol and drug abuse counseling), the Addictions Services Initiatives offered through Ontario Works in partnership with addictions service providers are examples of cross-sectoral initiatives that address the needs of those with mental health and addictions concerns. Child Welfare Initiatives offering parenting support programs are also an example. More integration efforts are needed however in this regard and in relation to supportive housing and seniors’ mental health care.

Movement in this direction is in keeping with the Aboriginal wholistic model which bases health services on the interconnected determinants of health such as social services, education, housing, economic development, the criminal justice system and others.

People working in all sectors need ongoing education and information about mental health and addictions as well as the services and supports which are available. Leadership must be engaged to drive integration efforts and support partnerships. Coordination support and incentives must be put in place in recognition of new administrative and collaborative management costs.

Participants cited one of the biggest impediments to effective care and services as a lack of supportive processes and linkages to allow them to network, case management and share information with other services and sectors such as housing, welfare, policing or education.

For example, a housing department in a First Nation may identify a “problem” tenant when really this may be an individual who is in need of mental health or addictions services. The link between services and clients is not possible however without mechanisms in place to support this. Consistent and
comprehensive case management services must be made available.

As described in our earlier case study, Sagamok Anishnawbek has been proactive in developing a Community Story and Strategic Action Plan to mobilize its efforts around a number of issues in addressing its vision of community wellness. Inter-departmental collaboration and community ownership and mobilization has been catalyzed as a result of this development work. The community’s alcohol and drug strategy arose from the development of this action plan. Such efforts should be explored and promising practices shared with others.

**Recommendation 1.5**

**Improve integration between services located on and off reserve**

The health information, systems linkages and resources to allow Aboriginal people to move seamlessly from provider to provider, setting to setting or community to community are not in place. This is a particular challenge for the Aboriginal population which can be transient between First Nation communities or urban settings and those who need specialized services only accessible off reserve.

**Rationale for recommendation # 1.5:**

Aboriginal mental health and addictions services are not integrated. Individuals seeking mental health or addictions services are having to “tell their story” again and again as they access a service.

The Ontario Common Assessment of Needs (OCAN) Initiative being piloted amongst providers in the North East LHIN is one avenue for ensuring that a client’s information is gathered once and follows them from setting to setting. Similar to other assessment tools, the OCAN requires modifications in order that it can be used with cultural safety in an Aboriginal service environment. Only a small handful of First Nations organizations are involved in the pilot at this point but it offers potential as an information sharing tool to better link Aboriginal people with mainstream services and across settings (once adapted to Aboriginal clients).

Indian Friendship Centres and Aboriginal Health Access Centres in urban settings serve Aboriginal clients regardless of their status or place of residence. Frequently they may service clients who are in urban settings for school or work but who also receive services from First Nation health service providers as well. A mechanism for sharing information, referral and transition between services is needed for such instances.
In its December 2006 document entitled “Engaging Aboriginal Peoples” the NE LHIN described the need to ensure continuity of care for First Nations members who move between urban centres and their home reserve as an important issue that must be addressed and planned for.

In planning programs and services for the Aboriginal population in the NE LHIN, efforts should be made to resist the usual demarcation between off reserve and on reserve populations, status or non-status and Métis and ensure that incentives are in place to support expanded circles of care, information sharing, referral and case management protocols between the off reserve and on reserve health service providers.

Recommendation 1.6
Improve integration between Aboriginal and non-Aboriginal services

Mental health and addictions workers in urban as well as First Nations health organizations face often great difficulty connecting their clients with the necessary specialized services in the mainstream systems. Once the right services are identified, clients are placed on waiting list which can be detrimental to continuity of care for clients. For individual who have received mainstream services, there is limited discharge planning and communications and no information sharing to support any form of aftercare once they return to their community. In short, care is fragmented.

Rationale for recommendation # 1.6:

As noted earlier, participants have highlighted the frequent disconnect between Aboriginal services whether provided on reserve or off and non-Aboriginal or mainstream services. Continuity of care is comprised due to lack of cultural safety, jurisdictional constraints and a lack of information about available services and programs both Aboriginal and non-Aboriginal.

Some progress at improving the linkage between mainstream and Aboriginal programs has been made in the area of addictions where First Nations or Aboriginal service providers are partnering with mainstream organizations for addictions assessments and to access training to assist Aboriginal providers in acquiring this credential. However, these instances are the exception and not the norm.

In order to facilitate improved integration between Aboriginal and non-Aboriginal
services, there is a need to establish regular processes for communications and information sharing, networking, referral and discharge planning. Some participants have suggested that resources and mentoring be provided to allow Aboriginal and non-Aboriginal agencies to showcase their facilities and services and vice versa as well as allow for in-services to facilitate the sharing of any best practices such as documentation, information/data gathering and case management.

Program and service inventories both mainstream and Aboriginal have been prepared which should be widely shared. Navigation and or information brokerage supports are also needed to assist Aboriginal service providers. An example of one such service is 310-CCAC operated by the NE CCAC as well as other CCACs province-wide with its professional pool of “Care Connectors”. The service provides system, service and program navigation information and referrals to callers to help them find a health care provider or service.

Equally important, is the need to ensure that mainstream services and service providers are culturally safe or competent. Training of this nature should be provided at every opportunity including through educational institutions, professional colleges and association conferences and the medical school.

Any integration requires time and effort on the part of service providers. Despite the eventual payoff, the real challenge is to what degree can time and attention be diverted from direct services to coordination, networking, linking, information sharing and training. This is perhaps well illustrated by a participant comment:

_for mental health it is more of an issue of having everyone connecting – it takes time to create the right connections and relationships._

*Participant quote*

**Summary of Integration Issues**

Although the benefits of the integration opportunities described are many, it is important to both recognize and support the effort, coordination and potential impact on direct services that developing such relationships, communications and processes could cost at the outset. Each organization or service provider must determine for themselves, which of these integration opportunities could make the most sense in terms of improving access, continuity of care and quality of services for their clients.
2.0 Recommendations Related to the Strengthening of the Regional, Community and Systems Foundations for Effective Services

Recommendation 2.0:
Support the development of high quality, effective, culturally safe services

In concert with the support for integration, there is a need to build supports aimed at improving the effective provision of services. These can organized into three areas:

- Knowledge: enhance knowledge exchange and access to information
- People: enhance skills of providers
- Support effective planning, governance and accountability

Rationale for recommendation # 2.0:

While service fragmentation is one of the major issues that impede quality of care and access to services, there are additional prerequisites to an improved Aboriginal mental health and addictions system. The components of the framework discussed in this section are believed to work synergistically with service integration.

Recommendation 2.1:
Enhance knowledge exchange and access to information through the development of an agenda for Aboriginal, First Nation and Métis health information and data

There is a lack of consistent and reliable health information on Aboriginal, First Nations and Métis people, which is preventing accurate monitoring of mental health and addictions health status, services and effectiveness. Data sharing agreements with Political Territorial Organizations, communities and governmental sectors are needed to extract information from existing data sets and potentially develop new data bases.

Rationale for recommendation # 2.1:

The lack of comprehensive data available concerning Aboriginal populations within the NE LHIN has been documented in a previous report prepared for the NE LHIN. [3] Administrative data sets do include Aboriginal identifiers and other data collection processes are incompletely rolled out in Aboriginal communities.
or regional data is not accessible due to community privacy issues. As previously described, there is a pressing need for coordinated efforts involving the Political Territorial Organizations (PTOs) which are part of the NE LHIN, Health Canada's FNIH branch, the MOHLTC, INAC and other holders of data pertaining to the LHIN’s catchment area to address health information deficits.

Processes and data sharing agreements need to be developed to analyze Aboriginal/First Nations data from existing administrative data sets as well as to collect new data if necessary. There is also a need to standardize data collection to avoid incompatible information gathering in the diverse Aboriginal healthcare settings, such as First Nations health centres, hospitals, doctors' offices and other service providers. In order to support integrated care, a system of standardized information and health information sharing agreements must be developed. First Nations and Métis representatives must be part of these discussions.

Areas of focus would include mechanisms for defining, collecting, analyzing, storing and sharing of health data and ultimately crafting data sharing protocols and agreements.

Recommendation 2.2:

Enhance knowledge exchange and access to information through formal opportunities of information sharing between the communities of practice

There is still little information on effective, culturally safe approaches to Aboriginal mental health and addictions. Exchange of promising practices within the communities of practice can be an important aspect of improving care and supporting Aboriginal self-determination in health.

Rationale for recommendation # 2.2:

Participants described a number of knowledge transfer activities within their respective regions which have been instrumental in supporting their collective capacity building and networking. For example, the Native Mental Health Conference is a multi-partner collaborative effort held every 2 years within the NE LHIN region involving the Centre for Addictions and Mental Health, Shkagamik-Kwe Health Centre, Za-geh-do-win Information Clearinghouse, Laurentian University Native Student Affairs, Mamaweswen North Shore Tribal Council, Noojmowin-Teg Health Access Centre, Union of Ontario Indians, Northeast Mental Health Centre, Nog-da-win-da-min, and Mnaamodzawin Health Services Inc. The conference is a well designed, collaborative forum for sharing, joint
planning and networking. Similarly the national Native Mental Health Association of Canada conference represents an important knowledge and skill building forum for the sharing promising practices and approaches from the field.

More opportunities of this nature should be afforded to allow communities and organizations to share promising practices and initiatives amongst each other.

Further, an annual forum should be organized to allow for sharing of information between and amongst LHIN representatives and the Aboriginal community which would complement the activities of the Aboriginal engagement strategy.

**Recommendation 2.3:**

**Enhance knowledge exchange and access to information through the development of culturally appropriate assessment and evaluation tools**

Our knowledge and understanding of appropriate, culturally safe assessment tools and effective mental health services and programs for Aboriginal communities is still quite limited.

Mental health and addictions assessment instruments and evaluation tools are based on mainstream populations and culture. They are often culturally and ideologically incompatible with Aboriginal worldviews. [58]

**Rationale for recommendation # 2.3:**

There is a need for the development of new approaches to Aboriginal mental health and addictions assessment instruments and evaluation tools.

Such tools should take into account Aboriginal cultural norms, language, spiritual belief systems, dimensions of wholistic health, geographic and socioeconomic realities. In addition, the tools needs to reflect the historical and colonial impacts on Aboriginal people, Aboriginal community dynamics and culture as well as social determinants of health which have an impact on mental health and addictions.

Community workers explained that assessment tools as they exist now focus on deficits and diagnosis of a problem. These tools do not accurately reflect an Aboriginal worldview on healing nor a strengths-based or recovery-based approach. Tools that are more culturally relevant should consider assessing resiliency and focusing on strengths. Research partnerships are needed to begin research and development of Aboriginal specific instruments and tools.
Recommendation 2.4:
Support the enhancement of skills of providers in traditional wellness approaches

Traditional approaches to health are needed by many Aboriginal people and this is supported by Aboriginal policies.

Therefore it is necessary to improve access to local traditional approaches and the development of knowledge of traditional approaches to mental wellness within mental health and addictions workers.

Rationale for recommendation # 2.4:

An explicit and integrated focus on wholistic and traditional healing approaches and the recognition and validation of these services through funded programs such as financial support for healer visits and elders counseling is needed. Traditional healing programs and services should be accessible to all Aboriginal clients within all mental health and addictions services.

Local cultural resource people, elders, grandmothers and grandfathers, natural helpers and other knowledge keepers which exist within each community should be recognized and supported so that they can play their rightful roles in addressing community wellness in concert with funded services. The following strategies are recommended:

- Provide information and supports to the informal pool of “natural helpers” within communities to cultivate and expand their skills.

- Ensure the teaching of a wholistic approach which recognizes the determinants of health and acknowledges the four aspects of health and addresses the whole person in health encounters in health care education

- Provide funding for traditional services
Recommendation 2.5:
Support the enhancement of skills of providers by cultivating an Aboriginal workforce that has competencies in both clinical and traditional approaches

There is a shortage of Aboriginal mental health and addictions workers. They are urgently required in order to provide more culturally safe care and a choice of traditional approaches to mental health and addictions.

Rationale for recommendation # 2.5:

Cultivate Human Resources

Cultivating an Aboriginal workforce that has competencies in both western/clinical and traditional approaches is a key priority. A number of different recommendations were made in this regard:

- Increase the number of Aboriginal mental health workers; increase efforts to promote these important career paths
- Develop a pool of Aboriginal therapists with cultural safety training to provide culturally safe services through FNIHB’s NIHB program
- Provide creative knowledge exchange and training opportunities to the existing Aboriginal and First Nations workers in both mainstream and traditional wellness approaches
- Provide a system of ‘Care for the Caregivers’ within all mental health and addictions programs including strategies such as: crisis debriefing sessions, ongoing case reviews, regularly scheduled leaves, supported educational opportunities, meaningful recognition and supportive backup.

Any initiative supported by the NE LHIN must be aligned with existing provincial and federal Aboriginal Health Human Resource strategies as outlined in the NELHIN’s project charter around health human resources planning. However, this must be made explicit and should be monitored and encouraged to support excellence in this area.
Recommendation 2.6:
Support the enhancement of skills of providers through the creation of standards for cultural safety training of all service providers

Many mental health and addictions providers have no undergraduate or continuing education related to cultural safety and Aboriginal health issues.

Although some schools (e.g.: the Northern Ontario School of Medicine) has integrated this into their core curriculum, most have not accomplished this as of yet.

Rationale for recommendation # 2.6:

Ensuring cultural competence and safety in all healthcare settings will require that all new and existing health professionals must prove ongoing professional development in this area. Northeastern Ontario should demonstrate leadership and strive for the same standard as New Zealand where new professionals must pass the culturally safety portion of their licensing exam in order to qualify to practice and work with Indigenous people. Not setting the bar at this level will otherwise leave this standard as a choice and not a requisite or expectation in health care training.

One of the mechanisms suggested for monitoring and tracking progress in this area was in the area of Service Accountability Agreements. It is recommended that the NE LHIN require health service providers to provide an annual accounting of their service activities with Aboriginal populations including their efforts to institute training on cultural safety for their employees. Organization that provide culturally safe service go beyond the provision of cultural spaces, such as rooms for smudging. Instead, cultural safety must be embedded in all service levels, interactions between providers and clients, human resources, policies, governance, evaluation and reporting. As a starting point, the core competencies in Aboriginal health, developed by the Indigenous Physicians Association of Canada should be used to guide educational activities\(^{19}\).

\(^{19}\) See website: [http://www.afmc.ca/social-aboriginal-health-e.php](http://www.afmc.ca/social-aboriginal-health-e.php)
Recommendation 2.6:
Support the development of appropriate planning mechanisms by demonstrating leadership on an intergovernmental planning table

Federal/ Provincial/ Regional jurisdictional barriers continue to be a major impediment to mental health and addictions service provision to Aboriginal, First Nations and Métis people; individuals moving between reserve and urban residences are particularly affected.

Rationale for recommendation # 2.6:

The NE LHIN should organize an intergovernmental planning table to ensure coordination and collaboration between provincial and federally funded departments and community. In particular, the NELHIN should partner with the Ministry of Aboriginal Affairs (MAA) and the Aboriginal Strategy Unit and the MOHLTC in leading the intergovernmental table. The MAA and MOHLTC have formal established relationships and accountability to First Nation, Métis and urban Aboriginal leadership whereas the LHINs do not. At a provincial level, the LHIN’s lack of formal, official relationship with First Nation, urban Aboriginal and Métis health leadership is stalling progress and improvements in the Aboriginal health field. This jurisdictional gap must be addressed to ensure the development of effective mental health and addictions services.

Further, it is recommended that the NE LHIN align its efforts with existing local, regional, provincial and federal First Nation, urban Aboriginal and Métis health strategies and investigate the potential for taking the lead to bring local mental health and addictions services, currently managed by other sectors, ministries and levels of government, under one management within the NE LHIN. This is in keeping with the proposal outlined in the report from the Select Committee concerning the establishment of a provincial Mental Health and Addictions Ontario body. [22] Within the NE LHIN and with the endorsement and support of community leadership, this level of integration, coordination and collaboration is greatly needed and has the potential to improve the quality of care, quality of life and ultimately save lives.
Recommendation 2.7:
Support the development of appropriate planning mechanisms by establishing a NE LHIN Aboriginal mental health and addictions planning table

A coordinated effort is required to create and monitor systems and service integration of Aboriginal, First Nations and Métis mental health and addictions services.

Rationale for recommendation # 2.7:

To establish a focus on mental health and addictions and to provide recommendations to both the Local Aboriginal Health Committee and the NE LHIN Board, a mental health and addictions specific planning table is needed to bring together Aboriginal service providers and other stakeholders with expertise in mental health and addictions.

This planning group would provide ongoing insight and advice and provide informed recommendations concerning policies and programming and service priorities as well as serve as an information and communications channel back to communities, organizations and other stakeholders. The intent is to ensure that there is an ongoing dialogue to support implementation of this framework.

In particular, this table would be responsible for prioritizing the numerous service continuum gaps identified earlier in this report and recommending ways in which such gaps could be addressed.

This group would also ensure that orientation is provided to NE LHIN senior staff, board, committees and taskforces concerning the unique needs and priorities of Aboriginal people. It was also recommended that the NE LHIN continue to maintain an openness and presence in communities by continuing to consult with health service organizations, tribal councils, PTOs and others.
Recommendation 2.8:
Support the development of greater equity in NE LHIN funded programs

Existing health inequities are the result of health influences that operate at all system levels, and across sectors and geographic borders. As Aboriginal people represent over 10% of the total population in the NE LHIN it is imperative that there are pathways to promote Aboriginal health equity.

Rationale for recommendation # 2.8:

Given the poorer mental health and addictions status of Aboriginal populations and reduced access to services it is clear that serious health inequalities exist in the NE LHIN. Participants proposed that the NE LHIN focuses on decreasing health inequalities in its region through a variety of strategies, most of which have already been outlined in previous recommendations.

A first goal would be to establish equity and accountability in funding, ensuring that funding is proportional to the Aboriginal population size (i.e. approximately 10% of the NE LHIN population). An additional aim would be to ensure that there is equity in service provision based not solely on population but on the complexity of issues and disparities in health status. In this regard it was recommended that the NE LHIN establish a health equality strategy to achieve equity in mental health and addiction program areas.

Recommendation 2.9:
Support the development of appropriate reporting requirements and service accountability agreements

To create culturally safe service environments, all organizations should be encouraged to provide evidence of cultural safety training.

Rationale for recommendation # 2.9:

In keeping with the LHIN's legislated requirement to report on services to Aboriginal people, it was recommended that the NE LHIN require health service providers to provide an annual accounting of their service activities with
Aboriginal populations including their efforts to institute training on cultural safety for their employees.

Whether an agency, organization or service is culturally safe, implies more than just “window dressing” or token activities. This effort must be embedded in service levels and quality of provider/client interactions, human resources, policies, governance, evaluation and reporting. Core requirements for cultural safety should be developed with Aboriginal partners.

The reporting requirements for all organizations whether Aboriginal or non-Aboriginal are rigorous and prescribed. Participants at engagements sessions reported that Aboriginal organizations which report to the NE LHIN require more flexibility with respect to reporting mechanisms to better reflect the traditional programming undertaken as currently the reporting mechanism do not capture the nature and scope of this work.
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Appendix A: An Inventory of Aboriginal Mental Health & Addictions Programs & Services in the NE LHIN
INVENTORY OF ABORIGINAL MENTAL HEALTH & ADDICTIONS PROGRAMS & SERVICES IN THE NE LHIN

August 2010

Brief descriptions of Aboriginal Mental Health and Addictions Programs in the North East Local Health Integration Network

Prepared by:

Mariette Sutherland, B.Eng.
Whitefish River First Nation
Birch Island, Ontario, P0P 1A0
and
Marion Maar, PhD
Faculty of Medicine, Human Sciences Division
Northern Ontario School of Medicine, Sudbury, Ontario
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<th>Service Area</th>
<th>Organizations</th>
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<td>North East LHIN</td>
<td>Mnaamodzawin Health Services and Noojmowin Teg Health Centre’s Mental Health Team</td>
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<td></td>
<td>Ngwaagan Gamig Recovery Centre Inc.</td>
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<td></td>
<td>Nadmadwin Mental Health Clinic (Wikwemikong)</td>
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<td></td>
<td>M’Nendamowin Health Services (M’Chigeeng)</td>
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<td></td>
<td>Kina Gbezhgomi Child and Family Services</td>
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<td></td>
<td>Foster Care Program</td>
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<td>Child and Family Services Program</td>
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<td></td>
<td>Community Support Program</td>
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<td></td>
<td>Kinoondidaagamig (a place of talking) Treatment Home</td>
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<td></td>
<td>Timiskaming</td>
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<td></td>
<td>Algoma</td>
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<td></td>
<td>N’Mninoeyaa Aboriginal Health Access Centre</td>
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<td></td>
<td>Anishnabe Naadmaagi Gamig Treatment Centre</td>
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<td></td>
<td>Nog-da-win-da-min Family and Community Service</td>
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<td>Educational Groups/Programs</td>
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<td>Family support and advocacy</td>
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<td>Native Foster Care</td>
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<td>In-home Support</td>
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<td>Parry Sound</td>
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<td>B’saanibamaadsiwin Native Mental Health Service</td>
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<td>Nipissing</td>
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<td></td>
<td>“Giyak Moseng” The Right Path Counseling and Prevention Services</td>
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<td></td>
<td>Community Counseling Centre of Nipissing</td>
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</table>

Appendix 1 – some demographic information related to the 7 planning areas
Inventory of Aboriginal Mental Health and Addictions Services

A brief summary of Aboriginal mental health and addictions services and programs in the NE LHIN

Introduction

This inventory provides brief descriptions of the Aboriginal mental health and addictions services within each planning region in the NE LHIN. Information contained in this inventory has been gathered from secondary sources.

The following on-line inventories available through Connex Ontario were used:

- The Drug and Alcohol Registry of Treatment (DART)
- Mental Health Service Information Ontario (MHSIO)
- Ontario Problem Gambling Help Line.

The architecture and information categories in these three inventories are nearly identical, although in some instances the information may be outdated or not completely accurate.

An electronic listing of NE LHIN health service providers and Za-geh-do-win information Clearinghouse’s Aboriginal Mental Health Services/Support Directory entitled “The Key” were also used to develop this inventory.

The NE LHIN health service provider data base shows that there are 21 Aboriginal organizations which provide mental health or addiction services in the NE LHIN. Table 1 provides an overview of these services by planning area.

As listed in the table, along with federally funded mental health and addictions programs available in the 56 First Nations in the NE LHIN, Aboriginal addictions and mental health services are provided by the following types of organizations:

- 8 Indian Friendship Centres
- 3 Aboriginal Health Access Centres (AHAC)
- 1 Aboriginal Community Health Centre (CHC)
- 2 Addictions Treatment facilities
- 3 regional mental health service providers
- 3 First Nation community based mental health clinics

The locations of these organizations are depicted in Figure 1.
### Table 1: Aboriginal mental health and addictions service organizations by planning area

<table>
<thead>
<tr>
<th>Planning Area</th>
<th>Organization or service</th>
<th>LHIN funded program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algoma</td>
<td>Anishnabe Naadmaagi Gamig Substance Abuse Treatment Centre</td>
<td>Yes</td>
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<td></td>
<td>Mamaweswen North Shore Tribal Council</td>
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<td></td>
<td>Sault Ste. Marie Indian Friendship Centre (IFC)</td>
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<td>Cochrane</td>
<td>Timmins Native Friendship Centre</td>
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<td></td>
<td>Ininew Friendship Centre (Cochrane)</td>
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<td>Misiway Milopemahtesewin Community Health Centre</td>
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<td></td>
<td>Minto Counselling (1 Aboriginal worker)</td>
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<tr>
<td>James Bay and Hudson Coasts</td>
<td>Aleotaeta – James Bay Community Mental Health Program</td>
<td>Yes</td>
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<td>Moosonee Native Friendship Centre</td>
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<td>Manitoulin Sudbury</td>
<td>Shkagamik-kwe Health Centre (Aboriginal Community-based non-residential service)</td>
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<td>N’Swakamok Native Friendship Centre (Drug and Alcohol Program)</td>
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<td>Noojmowin Teg Health Centre</td>
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<td>Nadmadwin Mental Health Clinic (Wikwemikong)</td>
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<td>Mnaamodzawin Health Services</td>
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<td>Ngwaagan Gamig Rainbow Lodge Treatment Centre (Wikwemikong)</td>
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<td>Giyak Moseng - Right Path Counselling and Prevention Service</td>
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<td>Parry Sound</td>
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<tr>
<td>Timiskaming</td>
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</table>

As noted in the table, urban Aboriginal populations may also be served by member Friendship Centres of the Ontario Federation of Indian Friendship Centres (OFIFC), an Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres located in towns and cities throughout Ontario. The OFIFC administers a number of programs delivered by Friendship Centres in areas such as health, justice, family support, and employment and training. Friendship Centres also design and deliver local initiatives in areas such as education, economic development, children’s and youth initiatives and cultural awareness. A detailed description of the mental health and addictions related services, programs and initiatives undertaken by Friendship Centres in the NE LHIN is provided in a later section of this inventory.
Métis locals in Timmins, North Bay, Sudbury and Sault Ste. Marie offer services focused on prevention, promotion, and referral coordination. However, in terms of specific services available for the Métis, the Ministry of Health and Long Term Care and the LHINs take the position that funded health services are available to all Ontarians including Métis and status Indians living on-reserve.

While there may not be any Métis-specific funded programs via the LHINs, the Métis can and do access mainstream LHIN-funded services (as do most Aboriginal people) and
receive some Métis-specific funding from the MOHLTC through AHWS.

Two regional based services, the Northeast Mental Health Centre Regional Aboriginal Mental Health Service and the “Raising the Spirit” Mental Wellness Team are also operating in the NE LHIN. Both are described in further detail in this inventory. We begin with an overview of federally funded mental health and addictions programs operational in First Nations across the NE LHIN followed by provincially funded services; regional service teams and finally a description of mental health and addictions services and programs in each of the seven planning areas.

Federal Programs Operating in First Nations

**Brighter Futures**

The Brighter Futures program is a community-based health promotion and ill-health prevention program for First Nations and Inuit communities. The program typically offers learning-related activities that strive to increase awareness, change attitudes, build knowledge and enhance skills. Communities have the flexibility to build their programs from amongst its five components listed below:

**Program Components**

**Mental Health**
The goal of this component is to promote the development of healthy communities through community-based mental health programs, services and/or activities. Information and awareness activities on a variety of topics (ex.: depression, family violence and stress management), counseling services and wellness activities (ex.: a course in traditional shawl making and recreational activities) are some of the ways communities have promoted the health of their community.

**Child Development**
This component aims to ensure that children receive the nurturing they need to reach their full potential. A wide variety of community-based programs and activities have been funded under this component, such as school breakfast programs, a math learning program, a parent-child crafts program, after-school programs (ex.: a drama club and a computer club), school-based "Stop Bullying" sessions, cultural heritage activities (ex.: teaching of traditional throat singing) and toy lending libraries.

**Parenting**
The aim of this component is to promote culturally sensitive parenting skills. Health Canada funds a variety of activities through this component and includes parenting workshops, parenting training programs (for example, the “Nobody’s Perfect”

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parenting program) and a support group for parents of children with Attention Deficit Hyperactivity Disorder.

Healthy Babies
The aim of this component is to improve the health and well-being of mothers and babies. A variety of activities are eligible for funding, such as pre- and post-pregnancy services and pregnancy-related education such as education about breastfeeding, the importance of healthy eating, regular medical examinations and the avoidance of drugs, alcohol and tobacco during pregnancy.

Injury Prevention
As the title suggests, the goal of this component is to prevent injuries. Examples of activities funded include first aid and CPR training, water, fire and bicycle safety workshops, awareness campaigns and promotion of the use of seat belts and car seats.

Building Healthy Communities
The Building Healthy Communities program was designed to assist First Nations and Inuit communities to develop community-based approaches to youth solvent abuse and mental health crises, the two components of the program. First Nations and Inuit communities have the flexibility to determine which program component(s) to provide community-based programs, services and/or activities.

Solvent Abuse
The solvent abuse component enables First Nations and Inuit communities to develop local programs aimed at preventing the abuse of solvents and to intervene as needed, which could involve residential treatment. Training-related activities for community workers are also eligible for funding.

Mental Health Crisis Management
This component complements the mental health promotion and prevention activities of the Brighter Futures program. It enables First Nations and Inuit communities to respond to crises, such as suicide, as well as to heal from them. It also enables communities to receive crisis-related training, such as suicide prevention training.

National Native Alcohol and Drug Abuse Program & National Youth Solvent Abuse Program

The goal of the National Native Alcohol and Drug Abuse Program (NNADAP) has been to help First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations.

NNADAP supports a national network of 52 residential treatment centres, with some 700-treatment beds. In the NE LHIN there are three (3) treatment centres funded by NNADAP.

NNADAP workers employed by First Nations initiate program activities based on the size and needs of each community which generally fall into three key areas:

**Prevention activities**, aimed at preventing serious alcohol and other drug abuse problems, include:

- Public awareness campaigns;
- Public meetings;
- Public speaking;
- Developing content for schools on alcohol and drug abuse;
- School programs;
- News media work; and
- Cultural and spiritual events.

**Intervention activities**, aimed at dealing with existing abuse problems at the earliest possible stage, include:

- Recreation activities for youths;
- Discussion groups and social programs; and
- Native spiritual and cultural programs.

**Aftercare activities**, aimed at preventing alcohol and drug abuse problems from reoccurring, include:

- Counseling;
- Sharing circles;
- Support groups;
- Crisis intervention;
- Support visits;
- Outreach visits;
- Treatment referrals;
- Detox referrals;
- Social service referrals;
- Medical referrals; and
- Band services referrals.

**Health Support Services for Former Indian Residential School Students and their Families**

Former students of Indian Residential Schools as well as their family members may be eligible to receive health support services, as follows:

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• Counseling
• Emotional Support
• Cultural Support
• Transportation

Through this funding, the Weeneebayko Area Health Authority has created a Traditional Healers Program, which operates two weeks a month in each community. The mostly Cree healers working within the program offer the following traditional health services;

• Traditional counseling for individuals, youth, couples, families and community groups
• Various sweat lodge, seasonal and rites of passage Ceremonies
• Grief counseling and debriefing
• Traditional Cree Knowledge recovery

Within the Sudbury, Manitoulin planning region, the Noojmowin Teg has used this funding to develop an art therapy program for community groups of residential school survivors. Eight week group sharing and art therapy sessions are supplemented by one on one counseling with a professional therapist.

**Crisis Counseling Benefits – Non-Insured Health Benefits**

A recognized professional mental health therapist may provide short-term crisis intervention mental health counseling when no other services are available to the recipient.

**What is covered?**

- The initial assessment;
- Development of a treatment plan; and
- Fees and associated travel costs for the professional mental health therapist when it is deemed cost-effective to provide such services in a community.

**Who can provide crisis intervention mental health counseling?**

Therapists registered with a regulatory body from the disciplines of clinical psychology or clinical social work can provide crisis intervention mental health counseling, in the province or territory in which they provide the service.

In exceptional circumstances, service providers from disciplines other than clinical psychology or clinical social work may be considered.

**Communities in Crisis and One Time Consultations**

This is service provided by First Nations and Inuit Health Branch of Health Canada when communities have optimized the existing capacity, to fill remaining gaps when

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communities are dealing with crisis. It is on a request basis only and is usually coordinated with other regional, provincial and local programs, services and resources.

**National Aboriginal Youth Suicide Prevention Strategy (2005-2010)**

One of Health Canada’s priorities is the development and implementation of a National Aboriginal Youth Suicide Prevention Strategy that aims to increase resiliency and protective factors, and reduce risk factors associated with Aboriginal youth suicide.

Health Canada, in collaboration with national Aboriginal organizations has been working on an evidence-based national strategy to address suicide prevention. A key element of the strategy is to support community-based solutions to youth suicide, which are rooted in the evidence regarding what is most likely to be effective in preventing Aboriginal youth suicide.

**OBJECTIVES:**

- increase awareness and understanding of Aboriginal youth suicide prevention;
- strengthen key protective factors such as a strong sense of identity, meaning and purpose, and resilience;
- strengthen and facilitate collaborative approaches and linkages with in and across governments, agencies and organizations;
- develop and implement locally-driven suicide prevention plans in First Nations and Inuit communities;
- improve and increase crisis response efforts to intervene more effectively in preventing suicide and suicide clusters following a suicide-related crisis in First Nations communities;
- enhance knowledge development regarding what is known about what works in preventing Aboriginal youth suicide; and
- gather First Nation youth to discuss, educate, ad raise awareness of suicide prevention and healthy lifestyles.

A renewal of this initiative was announced in the March 4, 2010 budget and it has been extended to March 31 2012.

Implementation of the funding allocations within Ontario region has been determined by the Chiefs in Ontario in collaboration with Health Canada, First Nation and Inuit Health, Ontario Region. A call for proposals was issued originally in 2007 for one year with a subsequent call in 2008 for the period 2008-2010.

Funding to the established projects has been extended for the remainder of the 2 year extension of the initiative ($1 million per year for 14 projects) dispersed amongst a combination of communities ($50,000 per) and tribal councils ($100,000 per).

In the NELHIN the following communities have been invited to send in a proposal for review and renewal of the funding for the period 2010-2012:

- Wasauksing First Nation
- Moose Cree FN
- Kashechewan FN
- Wabun Tribal Council
Provincially funded Programs

Ontario Mental Health Demonstration Project/Telemental Health Initiative

An initiative involving the Métis Nation of Ontario, the Ontario Mental Health Demonstration Project/Telemental Health Initiative provides community based, non-residential activities and services to individuals and families dealing with mental health issues. The services are culturally appropriate, culturally competent and complement and link to existing services or programs that continue to build service capacity at the community level.

An important component of the program is the use of video-conferencing. It allows for the timely delivery of Mental Health Assessments and increases access to psychiatric care in communities where care is not available or wait times are prolonged. One of the Project partnerships is between the MNO and Providence Care Centre (PCC) in Kingston, Ontario.

The agreement between the two includes the provision of clinical services to Métis citizens and families and increased access to Mental Health Professionals. The agreement also includes provisions for PCC to provide training to the MNO Health Branch. The agreement will also facilitate research on Métis Mental Health and will help to identify Best Practices in this area.

The range of services and programming available to those coping with mental health issues through the Demonstration Project includes screening and assessment, intake, early intervention, referrals, case management and aftercare (post-treatment) support using contemporary and traditional therapeutic interventions, such as healing circles and individual/group counselling. Mental wellness promotion and peer support, both integral to the delivery of a comprehensive Mental Health program are also available.

Although the Project was developed for Métis people and family members throughout the province, the services are available to all Aboriginal people in Fort Frances, Kenora, Dryden, Thunder Bay, Timmins, Sault Ste. Marie, Sudbury, North Bay, Midland/Port McNicol, Bancroft/ Maynooth, Ottawa, Hamilton and Windsor. Four of these communities are in the NE LHIN. There is a plan to add service in other communities in the near future.

Addictions Services Initiative, Ontario Works

The Addictions Services Initiative is a targeted employment assistance activity designed to help participants whose substance abuse is a barrier to participation in Ontario Works and employment.
The three components of the ASI are:

- a screening test for substance abuse;
- participation in an assessment of substance abuse;
- participation in a program for the treatment of substance abuse.

There are two primary ways that a participant would start on the service path for ASI:

- Self-disclosure: participants who come forward on their own to say that they have a substance abuse problem which is a barrier to participation and employment.
- Identification by staff: participants whose participation record/history may indicate that substance abuse is impairing their ability to participate in Ontario Works or to obtain and keep employment.

**Screening Test for Substance Abuse**

Ontario Works participants may be referred for a screening test for substance abuse when there are reasonable grounds to believe that their repeated substance abuse may be or may become a barrier to participation in employment. The results of the screening test are not equivalent to a diagnosis or confirmation that a substance abuse problem exists; however, the results of the test can be used in making a determination about next steps for the participant.

The screening process involves the use of the CAGE-AID tool, or other approved screening tool and may also involve motivational interviewing techniques to establish a positive trusting relationship with the applicant or participant to ascertain barriers and next steps for treatment.

**Assessment of Substance Abuse**

If screening indicates that a participant has a substance abuse problem that is a barrier to employment, the participant is referred for assessment to a Ministry of Health and Long-term Care (MOHLTC) funded addiction program. This program administers the MOHLTC-mandated standardized assessment tools required for a participant's entry into all MOHLTC-funded addiction programs.

Some participants require "pre-assessment readiness" and stabilization work (i.e., intensive case management) prior to taking the assessment.

The assessment process provides insight into what treatment will be appropriate and effective for each individual. The Ontario Works ASI case manager and the participant may be consulted in the treatment planning process in order to determine what additional supports might be helpful.

The majority of First Nation communities do not have access to agencies using the MOHLTC standardized assessment tools.

**Program for Treatment of Substance Abuse**
The treatment program to which a participant is referred will be the least restrictive and least intrusive as is appropriate, in accordance with the Admission and Discharge Criteria of the MOHLTC. Treatments can range from individual counselling to self-help groups to residential services, and may also include programs for friends and family members. The treatment plan should include a plan for continued care, for a period of up to one year after completion of treatment.

A number of First Nation communities and organizations have implemented the Addictions Services Initiative within the NE LHIN in collaboration with their communities’ mental health and addictions services.

**Aboriginal Healing and Wellness Strategy**

The Aboriginal Healing and Wellness Strategy (AHWS) is a provincial policy and service initiative that brings together Aboriginal people and the Government of Ontario in a unique partnership to promote health and healing among Aboriginal people. In 1990, Aboriginal organizations and the government ministries that developed this Strategy expressed a commitment to combat the alarming conditions of poor health and family violence that Aboriginal People in Ontario have endured.

The goal of the Aboriginal Healing and Wellness Strategy (AHWS) is to foster improvements in the health and well being of Aboriginal individuals, families, communities and Nations through:

- provision of equitable access to primary health and healing services and programs, including prevention, treatment and support, that are culturally appropriate and culturally competent;
- building on the strengths and enhancing the capacities of Aboriginal communities; and,
- promotion of equitable, violence-free relationships and healthy environments.

AHWS is managed by the Joint Management Committee (JMC), a unique consensus decision making model with both Aboriginal and government representation. The following Provincial Ministries have representatives on the JMC: Ministry of Community and Social Services, Ministry of Children and Youth Services, Ministry of Health and Long-term Care, Ministry of Aboriginal Affairs and Ontario Women’s Directorate of the Ministry of Citizenship and Immigration.

Aboriginal partners include:

- Association of Iroquois and Allies Indians (AIAI)
- Grand Council Treaty #3 (GCT#3)
- Independent First Nations (IFN)
- Métis Nation of Ontario (MNO)
- Nishnawbe-Aski Nation (NAN)
- Ontario Federation of Indian Friendship Centres (OFIFC)
- Ontario Native Women’s Association
- Union of Ontario Indians (UOI)
With the exceptions of Grand Council Treaty 3 and Independent First Nations, these Aboriginal partners are important provincial/territorial organizations within the NE LHIN.

With a budget of $48 million annually, the Strategy funds 275 initiatives in 18 different types of health and wellness programs, projects and organizations.

**Community Wellness Workers**

The AHWS funds Community Wellness Workers based in First Nations, Métis and urban communities to provide family violence services, referrals, support and case management to clients to address existing and emerging health, healing and wellness. They assist clients to develop action plans to address the identified concerns. Community Wellness Workers share information with health and social agencies; organize and facilitate community events (e.g., cultural awareness, education, illness prevention and crisis intervention workshops, as well as promotion programming for school age and other youth, seniors and other identified populations); and undertake outreach (e.g., health and wellness fairs). Aboriginal cultural approaches will be reflected or used as a part of the activities and services.

The primary responsibilities of these community-based workers are to develop, provide, facilitate and/or co-ordinate a variety of local programming relating to reducing or preventing family and community violence, including community-based family violence awareness and prevention education campaigns or activities in local settings (e.g., schools) or at local community events (e.g., powwows and health fairs). In addition, some Community Wellness Workers also facilitate or provide:

- Local co-ordination of existing crisis or "first response" services, including community patrols, search and rescue, suicide prevention/intervention and disaster response, as well as access to required health, policing and social services; and
- Referrals to/service co-ordination of counselling, legal and/or treatment services for individuals and families experiencing a crisis or trauma, including liaison with non-Aboriginal services to facilitate case management.

**The Union of Ontario Indians (UOI)** Community Wellness Workers are located in 40 First Nation communities throughout the UOI territory, 17 of which are located within the NE LHIN. For more information on the Community Wellness Workers sponsored by the UOI please contact:

**Union of Ontario Indians**
Curve Lake First Nation
Curve Lake, ON
K0L 1R0
Tel: (705) 657-9383
Fax: (705) 657-2341
[http://www.anishinabek.ca/uoi](http://www.anishinabek.ca/uoi)

**The Ontario Federation of Indian Friendship Centres (OFIFC)**
The OFIFC sponsors Community Wellness Workers (commonly known in the Friendship Centres as Healing and Wellness Coordinators) located in 26 Friendship Centres throughout Ontario. In the NE LHIN, these include:

- Sault Ste. Marie Indian Friendship Centre (IFC)
- Ininew Friendship Centre (Cochrane)
- Kapuskasing Friendship Centre
- Moosonee Native Friendship Centre
- North Bay Indian Friendship Centre
- N'Swakamok Friendship Centre (Sudbury)
- Parry Sound Friendship Centre
- Timmins Native Friendship Centre

For more information on Community Wellness Workers sponsored by the OFIFC please contact:

**Ontario Federation of Indian Friendship Centres**

219 Front Street East  
Toronto, ON  
M5A 1E8  
Tel: (416) 956-7575  
Fax: (416) 956-7577  
[http://www.ofifc.org](http://www.ofifc.org)

**The Métis Nation of Ontario (MNO)**

The Métis Nation of Ontario sponsors AHWS funded Community Wellness Workers in 12 MNO Community Councils, four (4) of which are in the NE LHIN. They include:

- North Bay  
- Sudbury  
- Timmins  
- Sault Ste. Marie

The MNO also sponsors CWWs at 6 OFIFC Friendship Centres including N'Swakamok Friendship Centre, Sudbury located in the NE LHIN.

For more information on Community Wellness Workers sponsored by the MNO, please contact:

**Métis Nation of Ontario**

500 Old Patrick Street, Unit 3  
Ottawa, ON  
K1N 9G4  
Tel: (613) 798-1488  
Fax: (613)722-4225  
Toll Free: 1-888-463-4889  
In addition to the services provided by the Community Wellness Workers, the Metis Nation of Ontario employs Community AHWS Coordinators who provide client-based services like:

- Assisting clients to access services
- Providing advocacy to support the securing of medical assistance services
- Providing referrals to emergency shelters or transitional housing
- Providing referrals to anger-management or treatment programs.
- Providing referrals to the MNO Mental Health Program.
- Providing advocacy for those dealing with the court system.

The Coordinators also provide participant-based services related to reducing family violence through fitness and recreation, walking groups, nutrition or foot-care clinics/workshops as well as Healthy Eating/Community Gardens. Holistic approaches to good health also include traditional ceremonies that promote stress-relief and gatherings such as the Harvest Meal that promote traditional family activities and promotes healthy eating.

The Coordinators also promote information sharing between Aboriginal and non-Aboriginal organizations like mental health centres, shelters, and treatment centres to increase client access to local services.

**Aboriginal Health Access Centres**

The AHWS funds 10 Aboriginal Health Access Centres provincially which are similar to Community Health Centres. They offer a blend of traditional Aboriginal approaches to health and wellness and contemporary primary health care in a culturally appropriate setting. Programs may include: pre and post-natal care, nutrition, health education, disease prevention, and mental health counseling.

The three Aboriginal Health Access Centres operating in the NE LHIN provide holistic culturally based services on and off reserve in rural Northeastern Ontario.

N’Mninoeyaa Aboriginal Mental Health Services provides mental health services to the communities of the North Shore Tribal Council located between Sault Ste Marie and Sudbury on the northern shore of Lake Huron. Noojmowin Teg Health Access Centre’s mental health team provides services to island communities in the Manitoulin District. Shkagmik-kwe Health Centre provides services to the Aboriginal people of Greater Sudbury and surrounding First Nations.

These three Aboriginal Health Access Centres are located within the NE LHIN’s boundaries as follows:

**N’Mninoeyaa: Community Health Access**

49 Indian Road, P.O. Box 28
Cutler, ON
P0P 1B0
Tel: (705) 844-2021
Fax: (705) 844-2844
website: [http://www.mamaweswen.ca](http://www.mamaweswen.ca)
Noojmowin Teg Health Access Centre
Aundeck Omni Kaning
48 Hillside Road, Hwy 540, Bag 2002
Little Current, ON
P0P 1K0
Tel: (705) 368-2182 ext. 204
Fax: (705) 368-2229
http://www.noojmowin-teg.ca

Shkagamik-Kwe Health Centre
161 Applegrove Street
Sudbury, ON
P3C 1N2
Tel: (705) 675-1596
Fax: (705) 675-8040
http://www.shkagamik-kwe.org/

These are described in more detail in the respective planning area descriptions.

Healing Lodges

AHWS also funds healing lodges in various locations across the province. These facilities offer Traditional Healing approaches to address the underlying impacts of sexual assault, physical, mental and emotional abuse, and family dysfunction. The primary focus is on client-based activities that are provided through residential programs. There is one AHWS funded healing lodge within the NE LHIN area.

Shawanaga First Nation Healing Centre
R.R.#1
Nobel, ON
POG 1G0
Tel: (705) 366-2378
Fax: (705) 366-2496
website: http://www.shawanaga.ca

Ontario Federation of Indian Friendship Centres

The Ontario Federation of Indian Friendship Centres (OFIFC) is an Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres located in towns and cities throughout Ontario. The OFIFC administers a number of programs delivered by Friendship Centres in areas such as health, justice, family support, and employment and training. Friendship Centres also design and deliver local initiatives in areas such as education, economic development, children’s and youth initiatives and cultural awareness.

In addition to some services and programs, the OFIFC has been working in mental
health through planning, research, coordination and demonstration projects including:

1. The preparation of the Mental Health and Addiction OFIFC Consultation Report, 1995
3. The development of “Good Mind” OFIFC Mental Health Strategy, 2006
4. Coordination of “Leaders for Change: Aboriginal Mental Health and Wellness Conference, November 2007” in partnership with other Aboriginal stakeholders
5. “Ascertaining the Urban Aboriginal Landscape for Children and Youth Mental Health Services” in partnership with the Metis Nation of Ontario and Ontario Native Women’s Association, 2008
6. Demonstration projects: the third phase of AHWS identified mental health as a priority and as a result the OFIFC Children’s Mental Health Program is housed in three member Friendship Centres. The focus is to mitigate high risk behaviour amongst youth ages 7 – 15.

Along with the demonstration project the OFIFC administers an Aboriginal Alcohol and Drug Worker Program in 10 Friendship Centres, the AHWS Community Wellness Worker program in 27 Friendship Centres as noted earlier and Akwe:go a children’s program targeting at risk Aboriginal children ages 7 – 12 in all of its member Friendship Centres.

In the NE LHIN some of these programs are operated by the following Friendship Centres:

<table>
<thead>
<tr>
<th>Friendship Centre</th>
<th>Children’s Mental Health Demonstration Project</th>
<th>Addictions Program</th>
<th>Mental Health Program</th>
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<tbody>
<tr>
<td>N’Swakamok Friendship Centre (Sudbury)</td>
<td>X (for 7 – 15 yr olds)</td>
<td>X</td>
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<tr>
<td>Parry Sound Friendship Centre</td>
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<td></td>
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<tr>
<td>North Bay Indian Friendship Centre</td>
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<tr>
<td>Ininew Friendship Centre</td>
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<tr>
<td>Sault Ste.,Marie Indian Friendship Centre</td>
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<td>Aboriginal community mental health program</td>
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<tr>
<td>Timmins Native Friendship Centre, Kapuskasing Friendship Centre and Moosonee Native Friendship</td>
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</tbody>
</table>
The Métis Nation of Ontario

The Métis Nation of Ontario Health and Wellness Branch facilitates and coordinates activities to address the holistic needs of the Métis Nation in Ontario at the provincial, regional and local levels. Holistic Aboriginal health includes the physical, mental, emotional, spiritual and cultural aspects of life.

The Branch actively seeks to partner with Aboriginal and non-Aboriginal people and governments that recognize and respect the diverse lifestyles and traditions of Aboriginal people regardless of residency and status.

Appropriate levels of financial and human resources will be secured for Aboriginal-designed, developed and delivered programs and services that respect and promote community responsibility, autonomy and local control.

Health programs and services administered include:

- Aboriginal Healing and Wellness Strategy – Community Wellness Workers
- Aboriginal Healthy Babies/Healthy Children
- Responsible Gambling
- Pre/Post Natal Nutrition
- Community Action Plan
- Diabetes Awareness Strategy
- Health Research Initiatives
- Long Term Care Program
- Mental Health Demonstration Project

In terms of specific services available for the Métis, the Ministry of Health and Long Term Care and the LHINs take the position that funded health services are available to all Ontarians including Métis and status Indians living on-reserve. The Ministry provides Métis-specific funding for a number of programs and the Ministry also provides Métis-specific funding through AHWS. There are no Metis-specific programs funded by the LHINs.

Union of Ontario Indians

The Anishinabek Nation incorporated the Union of Ontario Indians (UOI) as its secretariat in 1949. The UOI represents 40 First Nations throughout the province of Ontario from Golden Lake in the east, Sarnia in the south, Thunder Bay and Lake Nipigon in the north. The 40 First Nations have an approximate combined population of 55,000 citizens, one third of the province of Ontario’s aboriginal population.
The Union of Ontario Indians delivers a variety of programs and services, such as Health, Social Services, Education, Intergovernmental Affairs and Treaty Research with a staffing complement of approximately 70 members.

**Aboriginal Healing and Wellness Programs**

As noted earlier, 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 unique partnership to promote health and healing among Aboriginal people. In 1990, Aboriginal organizations and the government ministries that developed this Strategy expressed a commitment to combat the alarming conditions of poor health and family violence that Aboriginal People in Ontario have endured.

The Union of Ontario Indians is one of the nine Aboriginal partners within Aboriginal Healing and Wellness Strategy. In addition to participating in the policy work that occurs at the Joint Management Committee level, the Union of Ontario Indians administers programs funded by AHWS.

In addition to the programs and services listed below, often there are one-time grant opportunities that arise and the Union of Ontario Indians Health Secretariat strives to ensure that member First Nations have access to and participate in these initiatives.

**PROGRAMS AND SERVICES**

**Community Wellness Workers**

The primary responsibilities of these community-based workers are to develop, provide, facilitate and/or co-ordinate a variety of local programming relating to reducing or preventing family and community violence, including community-based family violence awareness and prevention education campaigns or activities in local settings (e.g., schools) or at local community events (e.g., powwows and health fairs). In addition, some Community Wellness Workers also facilitate or provide:

- Local co-ordination of existing crisis or "first response" services, including community patrols, search and rescue, suicide prevention/intervention and disaster response, as well as access to required health, policing and social services; and
- Referrals to/service co-ordination of counselling, legal and/or treatment services for individuals and families experiencing a crisis or trauma, including liaison with non-Aboriginal services to facilitate case management.

There is one Community Wellness Worker in each First Nation within the Union of Ontario Indians (Anishinabek Nation)

**Healing Lodges**

These facilities offer Traditional Aboriginal healing and contemporary approaches to treatment of sexual assault, addictions and family dysfunction, etc. Options include both residential and outpatient programming. UOI works in partnership with Kii Kee Wan Nii Kaan (Southwest Regional Healing Lodge), which is located on Munsee Delaware
Healthy Babies Healthy Children Program

The objective of Aboriginal Healthy Babies/Healthy Children (AHBHC) Program is to improve the long-term health prospects of children aged 0 - 6 years. The program includes pre-and post-natal screening and assessment, home visiting, service coordination and support for service integration. Each First Nation within the Anishinabek Nation participates in and/or offers the AHBHC program.

Community Development Support Program

The Union of Ontario Indians Health Secretariat provides assistance to its member Nations and their respective AHWS programs. The AHWS Community Development Support Worker provides these services.

- Assist, advise and support UOI communities as required to ensure participation in community health programs administered by the Union of Ontario Indians;
- Support the implementation and management of UOI administered community health programs to increase and maintain capacity and competence in program governance, program planning, program development, program management and administration, program evaluation and program design;
- Provide assistance in preparing accurate/complete documentation for annual submissions/work-plans and year-end reports and other tracking activities;
- Ensure that funding dollars are flowed to appropriate funded projects;
- Provide community visits to assist funded projects with reporting and meeting reporting requirements; and,
- Networking.

In addition to providing support for the AHWS funded programs, the Union of Ontario Indians Health Secretariat also provides the same service for other programs administered by the UOI including the Diabetes Education Program funded by the Ministry of Health and Long-term Care and the Aboriginal Responsible Gambling Program funded by the Ministry of Health Promotion, HIV/AIDS program, Fetal Alcohol Spectrum Disorder and the Policy Unit.

Regional programs

Northeast Mental Health Centre – Regional Aboriginal Mental Health Service (RAMHS)

RAMHS began in November 2006 to provide culturally appropriate supports to Aboriginal clients returning home after hospitalization. During its first year, RAMHS consulted with First Nations communities and Aboriginal organizations throughout the northeast, prioritizing service areas and establishing service agreements with communities and organizations wanting support from RAMHS. Service agreements
have been established with Dokis, and communities within Northshore Tribal Council First Nations including Sagamok, as well as Atikameksheng Anishnawbek.

Services offered by RAMHS are determined in consultation with the Aboriginal communities and organizations they are engaged with. Examples of current activities include:

- clinical supervision and consultation
- workshops on building specific skills
- public education
- involvement in community and professional event planning.

Additionally, RAMHS provides case management support to Aboriginal clients in the Northeast Mental Health Centre before discharge from hospital, and ongoing follow-up in their communities.

RAMHS also develops and facilitates education opportunities for NEMHC staff and board members about Aboriginal cultures and worldviews, and supports student placements from local colleges and universities.

**Northeast Mental Health Centre – Regional Aboriginal Mental Health Service (RAMHS)**

Box 3010, HWY 11N,
North Bay, ON
P1B 8L1
Tel: (705) 474-1200 ext. 2255
Fax: (705) 495-7805
Website: http://www.nemhc.on.ca/programs-services/regional-specialized/aboriginal-e.aspx

**“Raising the Spirit” Mental Wellness Team**

The “Raising the Spirit” Mental Wellness Team is a 2.5 year pilot project funded by Health Canada which involves the formation of a specialized consultative team comprised of professionals from social work, psychology, traditional knowledge and healing, concurrent disorders and psychiatry. The team has been collaborating with community mental health and addictions workers in working towards the following goals:

- Improving access to needed specialized services where gaps exist
- Enhanced knowledge, skills and capacities of community workers
- Providing support via a team approach of consultation, clinical supervision, coaching and mentoring.
- Build and/or strengthen bridges between traditional and mainstream approaches to wellness.

The overall goal of this initiative is to enhance capacity at the community level to address needs associated with addictions, mental health and concurrent disorders in ways that reflect the culture, attitudes and philosophies of the participating First Nation communities.

The following 10 First Nations in the Northeastern Ontario region are participating in this pilot project:
1. Dokis First Nation
2. Nipissing First Nation
3. Atikameksheng Anishnawbek First Nation
4. Whitefish River First Nation
5. Aundeck Omni Kaning First Nation
6. Sheguiandah First Nation
7. Wikwemikong Unceded Indian Reserve
8. M’Chigeeng First Nation
9. Sheshegwaning First Nation
10. Sagamok Anishnawbek First Nation

Specific services include knowledge transfer and capacity building of workers; crisis and team support/debriefing for workers and specialized services in psychiatry and psychology to address identified gaps.

“Raising the Spirit” Mental Wellness Team
888 Regent Street, Suite #308
Sudbury, ON
P3E 6C6
Tel: (705) 586-3071
Fax: (705) 586-3073

Student Support for Learning Initiative


The goal of the initiative is to foster relationships (“clusters”) between school boards/authorities and child and youth mental health agencies to form and enhance local partnerships and coordinate services between schools and agencies in order to improve access to youth and children’s mental health services. There are currently 29 Clusters operational with 3 in northeastern Ontario (1 based in Sudbury).

Clusters are encouraged to invite appropriate health sector partners (e.g., hospitals that offer child and youth mental health services, Family Health Teams, Community Health Centres, addictions service providers) to participate and to develop joint referral processes with schools, school boards, child and youth mental health agencies.

Clusters are also encouraged to invite representation from care, treatment, custody and correctional facilities (Section 23 education programs) to participate in Cluster planning. Leaders of school boards, schools, community agencies and health partners are being asked to work together to establish or enhance local partnerships and protocols to better meet the needs of students through collaborative planning, coordination and referrals.
Programs and Services by Planning Region

First Nation communities located in the NE LHIN generally have the following community based mental health and addictions resources as described earlier:

- a mental health worker funded through the Brighter Futures/Building Healthy Communities program
- an “Alternatives” or NNADAP worker
- often, a Community Wellness worker funded through the provincial Aboriginal Healing and Wellness Strategy.

Most of these resources emphasize promotion and prevention programming and referrals to external services.

Some of the larger First Nations offer more extensive mental health and addictions services through community-based clinics. These clinics employ various prevention and promotion workers, counselling professionals and managers.

Regional health services organizations, such as Mnaamodzawin Health Services; Noojomowin Teg Health Centre; Mamaweswen – Northshore Tribal Council; B’saanibamaadsiwin Native Mental Health Service and the Northeast Mental Health Centre – Regional Aboriginal Mental Health Service (RAMHS) may also provide access to visiting professionals such as social workers, therapists and counselors, psychiatrists and psychologists.

In this section we describe the various service providers of addictions and mental health care by planning region.

James Bay Coast

In this section, we briefly describe mental health and addictions services operating in the James Bay coast region.

The James Bay Community Mental Health Program (JBCMHP)

The James Bay Community Mental Health Program (JBCMHP) provides services to Aboriginal people who live on-reserve in five Cree communities along the western coast of James Bay as well as one off-reserve community:

1. Attawapiskat First Nation
2. Kashechewan First Nation
3. Fort Albany First Nation
4. Moose Cree First Nation (Moose Factory)
5. Peawanuck First Nation (Weenusk)
6. Moosonee (off reserve town)

24 For a current description of this program, refer to http://www.hc-sc.gc.ca/fniah-spnia/promotion/mental/brighter_grandir-eng.php
*Alemotaeta*, the James Bay Community Mental Health Program provides services in a holistic manner that recognizes the local cultures, heritages and traditions. Individuals, families and whole communities are offered ongoing support and developmental assistance to cope with aspects of their lives which impede their physical, emotional, mental and spiritual health and to develop their strengths in living a more balanced life. The program networks with other community resources and agencies within the local communities and outside area.

The program offers front-line services that are always respectful of the culture and language of the people. The service provides continuity of care for those people over the age 16 living in the James Bay area, particularly those struggling with depression, concurrent disorder, court support & diversion, follow-up and after care, grief, addiction to alcohol/drugs, effects of abuse, problems with relationships, low self-esteem, Moderate Mental Illness and Severe Mental Illness. The following service providers are available:

**Mental Health Counselor (available in all sites):** To provide a variety of appropriate client-directed counseling services.

**Regional Team Leader:** To provide counseling and professional support for program staff and community partners. To provide counseling and referral services for individuals, couples and families as appropriate.

**Regional Clinician Worker:** To provide community based counseling services to persons with mental illness which are culturally relevant, accessible, and effective in the client’s home community as part of the program’s clinical team. To provide joint clinical counseling with a Community Counselor in the coastal communities served by the James Bay Community Mental Health Program.

**Regional Concurrent Disorder Worker:** To provide culturally appropriate assessment, crisis management, supportive counseling and referral services in their language of choice in home community for clients with SMI (Serious Mental Health Illness) and/or CD (Concurrent Disorders - a major mental illness in combination with addictions issues and substance misuse).

**Regional Court Worker/Case Manager:** The primary goal of the program is to divert people with mental illness away from or out of the criminal justice system to more appropriate community mental health services.

**Regional Crisis Intervention/Early Episode Clinician:** Provides comprehensive case management and crisis services to clients that are experiencing early psychosis.

**Addictions Worker:** The program provides intake, assessment, referral, community treatment, group intervention, public education and community awareness to adults, youth, family members and Problem Gamblers.

The **head office** is located in Moosonee and regional specialized workers fly into the coastal communities to provide outreach services; workers also provide sessions to clients over the phone. Larger coastal communities have, a full time worker in the community in addition to the visiting workers. Telehealth/telepsychiatry facilities are accessible in Moosonee and Moose Factory. There is no telemedicine within the coast communities as internet access is unreliable with slow connections when it is working.

The services are geared to address the broad range of need of the client population, including: family issues, crisis, court referrals for anger management, suicidal ideation, mood disorders, depression, trauma, Post Traumatic Stress Disorder and anxiety.
Disorders. These presenting concerns are in most cases complicated by intergenerational trauma, that may include residential school trauma, physical and sexual abuse and other issues. Substance use is mostly confined to alcohol. Suicidal ideation is a major concern and suicide waves have occurred in some communities in the recent past.

The current client case load for J BCMHS is approximately 600-700 clients, however many more contact this team for brief mental health services and these clients often return for further brief services after a period of time.

Common presenting concerns according to staff are: family issues, crisis, court referrals (e.g.: for anger management) mood disorders, depression, anxiety disorder, trauma, complicated trauma, Post Traumatic Stress Disorder, suicidal ideation is a major issue as well as addictions to alcohol. The need for services and travel demands are overwhelming in this region.

Services provided by the James Bay Community Mental Health program can be summarized as follows:

- Case management
- Community support
- Dual diagnosis
- Court support and diversion
- Public education
- Follow-up and after care for persons discharged from hospital
- Self-help initiatives to meet the needs of individuals with a serious/persistent mental illness
- Parenting Support
- Grief Outreach Counseling
- Individual, couples and Family Counseling
- Critical Incident Counseling
- Anger Management
- Substance Abuse and Aftercare
- Clinical Services for People with Mental Disorders
- Focusing Therapy
- Psychology Services

The program extends services to the communities of Attawapiskat, Fort Albany, Kashechewan, Moosonee, Moose Factory, and Peawanuck. J BCMHP has a Mental Health Worker stationed at each First Nation community except for Moose Factory. However, a regional clinical coordinator and regional clinician provide services at Weeneebayko General Hospital located at Moose Factory. The Ontario Psychiatric Outreach Program at McMaster University provides psychiatry services on a monthly basis.

**James Bay Community Mental Health Program (JBCMHP)**

34 Revillion Road  
PO Box 370  
Moosonee, ON  
P0L 1Y0  
Tel: (705) 336-2164
**Weeneebayko Health Ahtuskaywin/Weeneebayko General Hospital**

Weeneebayko Health Ahtuskaywin is the regional health authority representing the eight First Nations of the six communities: Moose Factory, Moosonee, Attawapiskat, Fort Albany, Kashechewan and Peawanuck and the southerly First Nation communities of Taykwa Tagamou (formerly New Post), Missanabie Cree and Chapleau Cree, this region is also known as the Mushkegowuk Territory. WHA is dedicated to the continually enhancing the provision of health care services to the people of the Mushkegowuk Territory.

Weeneebayko General Hospital is the regional provider of adult psychiatric beds and withdrawal management beds. Many clients present at the emergency department in crisis.

**Weeneebayko General Hospital /Weeneebayko Health Ahtuskaywin**

PO Box 34
Moose Factory, ON
P0L 1W0
Tel: (705) 658-4544
Fax: (705) 658-4917
Website: http://www.wha.on.ca

**Payukotayno – Child and Family Services**

Payukotayno is a mandated Native Child Welfare Agency within the Nishnawbe Aski Nation territory, providing services to both native and non-native residents in the communities along the west coast of James Bay. These communities include Moosonee, Moose Factory, Fort Albany, Kashechewan, Attawapiskat and Peawanuck. The main goal of Payukotayno is to become actively involved in strengthening the communities by providing support and intervention services to families. Their objective is to help in “building healthy communities” which can only be achieved through strong partnerships with Chiefs and Councils.

**Tele-psychiatry**

In conjunction with the Division of Child Psychiatry at the University of Toronto, this program provides access to psychiatric consultation with 75 child psychiatrists. Children from birth to eighteen years of age can be seen by specialist via video line. The Division of Child Psychiatry at the University of Toronto also provides follow-up consultation if required. They also provide the Agency and other partners with Educational Seminars, program consultation for special needs clients and a trauma program started in August 2010.

**Child and Family Intervention and Early Intervention**

These services are provided in Peawanuck, Attawapiskat, Fort Albany, Kashechewan, Moosonee and Moose Factory. The workers make assessments based on established assessment models, refer to other regional and local services, and provide advocacy. The service assigns one worker to the Awashishuk Centre.
Early Intervention
(0-6 program)
Early intervention provides assessment and intervention services for children, from newborn to six years of age. It is implemented in community settings in Moosonee, Moose Factory and the coastal communities. It is linked to Child Care Centres, Early Years, Healthy Babies, Residential Programs, Schools and other community programs. They assist the child, caregivers, teen mothers and other high-risk pregnant clientele to these resources.

Special Needs Program
The special needs program provides counseling and hands-on services, aimed at promoting wholeness of life and the emotional wellbeing of children with special needs. There are four clinical programs serving Moosonee, Moose Factory, with the inclusion of Moose Cree, Fort Albany, Kashechewan and Attawapiskat. The four programs are Intensive Child and Family, 0-6 Program, Special Needs Program and the Community Support Program.

Counseling Unit
This unit provides a variety of counseling services including:
- Anger Management
- Witnesses and Survivors of physical, sexual, emotional abuse
- Grief and bereavement counseling
- Stress and anxiety management
- Behavioral management
- Therapeutic Group Work
- Play and Art Therapy

Community Support Worker/Family Support Worker/Prevention Worker
The Native Child Welfare Prevention Program is designed to support families and children by helping to address the community needs. The philosophy behind the development of the Prevention Program identifies the families and children who may require services that will prevent the need for more intrusive services in the future. This is a direct service position with responsibility for the delivery of a range of community prevention programs and family support activities designed to strengthen families and respond to emerging community needs. There are (3) Community Support Workers that cover the James Bay area: one in Peawanuck, Attawapiskat and Kashechewan. The Community Support Workers work closely with the following organizations; schools in their communities, Mental Health Workers, Traditional Elders, National Alcohol and Drug Addiction Programs, Receiving Homes, Foster/Child Care Department, Protection/Intake Unit, and Moosonee Native Friendship Centre and other service providers within their perspective communities.

Community Care Program
The goal of The Community Program is to enhance family well being, so that they will be able to strive to their fullest potential in meeting their emotional, physical, mental and spiritual needs; taking into consideration each families cultural uniqueness and stimulation in enriching their holistic needs in body and in mind, Thus, strengthening the family as one.
Vision
To strengthen the family as one.

Mandate
To assess, formulate and implement treatment plans to address the needs of children, youth and adults within communities, which include Moosonee, Moose Factory, Fort Albany, Kashechewan, Attawapiskat and Peawanuck.

Services Provided
The Community Care Program is committed to bringing respect, honesty, trust and confidentiality to their clientele in all areas of service. Services include:

- Crisis Response
- Crisis Intervention
- Crisis Prevention
- One on One counseling
- Healthy Choices
- Referrals to appropriate agencies
- Resource material
- Coping skills
- Family Violence

Family Service Worker(s)
The Family Service Worker Program is offered by Payukotayno: James & Hudson’s Bay Family Services. The service is available in Moose Factory @ Moose Cree Health Services, MoCreebec Health Services and Fort Albany @ Peetabeck Health Services.

Goal
The primary purpose is to provide the necessary services to achieve and maintain good mental health for children and their families.

Services Provided
- Counseling for children and adolescents up to and including age 16 and their families, on a voluntary basis
- Arranging for behavioral or psychiatric assessments for children and adolescents referred to the service
- Evaluation and facilitation of recommendations from the assessment
- Recommendations to families, courts, schools or other professional regarding appropriate treatment plans
- Group sessions for children with similar difficulties
- Mental health consultation to teachers, public health nurses, social workers, physicians, and other health professionals
- Workshops to promote community awareness on topics related to Children’s Mental Health
- Close co-operation with Prevention Workers in the communities
- Follow-up on referrals from the Children’s Aid Society for counseling

Payukotayno Child and Family Services
50 Bay Road
P.O. Box 189
Nishnawbe Aski Nation Crisis Teams

The Crisis Team Program is a First Nation/community based program that receives additional coordination and intervention support from the Tribal Council Crisis Intervention Coordinator and Nishnawbe Aski Nation (NAN).

The Crisis Team Program provides an effective, coordinated response to people who are experiencing incident related trauma, with a primary focus on suicide and family violence. The vision and goal is that over time, the services provided through the Program will reduce the incidence of family violence and suicide.

The Crisis Team Coordinator is responsible for coordination of a well-organized, well-trained, well-equipped crisis team that can intervene efficiently and effectively to traumatic incidents with a primary focus on suicide and family violence. The Crisis Team will work to lessen the impact of traumatic stress, prevent suicide and family violence within their communities and promote healing for individuals who experience any traumatic incident.

The NAN Chief has passed a Resolution in 94/95 directing the NAN to use the AHWS funds to build and maintain Crisis Teams in NAN communities. The teams – mostly volunteers – go through many difficulties – similar to volunteer fire departments or Emergency First Response Teams in rural areas in the rest of Ontario. Each Tribal Council and community is unique. However, NAN utilizes the following ‘Objectives’ as a simple base.

NAN Crisis Team Objectives

- To ensure that each First Nation maintains its designated and organized Crisis Team and that there is a designated Crisis Team Coordinator for each Team. The Tribal Council will designate a Regional Crisis Intervention Coordinator to support the Crisis Team Coordinators and Teams within their territory.

- To build a Crisis Team, communities can choose Crisis Team members from the Front Line Team, the Emergency First Response Team, the Peacekeepers, the Canadian Rangers or any grouping of workers/community members, which the community feels, is appropriate. There should be clear protocols and communications between separate groups providing emergency services.

- To ensure that each First Nation’s Crisis Team Coordinator and Crisis Team receive ongoing basic training in First Aid and CPR, Suicide Prevention, Critical Incident Stress Debriefing and Nonviolent Crisis Intervention. Teams may also choose other types of training as they deem appropriate providing that they can link training to intervention and prevention of traumatic stress due to suicide, family violence and other types of severe trauma.
To ensure that every First Nation has a crisis response plan that is part of a larger Community Emergency Response Plan and that the community reviews its plans annually. Communities must submit its plans to NAN.

To ensure that every First Nation maintains and upgrades the communications and crisis response equipment that it needs to operate effectively.

To support the ongoing operations of Crisis Teams.

NAN is the flow-through funding agent. They have Letters of Agreement with the Tribal Councils and First Nations who are ultimately responsible for the team or worker in their community. As a political organization, NAN is an administrator in this situation. They do not have front-line work staff. NAN’s role generally is to try to find additional funds and resources during a crisis once the local system is overwhelmed.

Sagashtawao Healing Lodge

The Sagashtawao Healing Lodge is a community based residential treatment program for alcohol and drug dependent persons designed to strengthen the client in the area of mental, emotional, spiritual and physical development, family relationships, life skills and native culture awareness.

**Number of beds**: NNADAP funded: 12; Total overall: 12  
**Languages offered**: First Nation (Cree); English  
**Target age**: 18 and over  
**Treatment cycle**: 6 weeks; 3 week relapse prevention  
**Intake frequency**: Once per cycle  
**Type of treatment program**: Adults, men and women  
**Special services**: Intake screening; Interpretation services; Dual addiction  
**Treatment for substances**: Alcohol; Narcotics; Hallucinogens  
**Treatment components**:  
- Assessment  
- Alcohol and drug education  
- Case management  
- Client orientation  
- Crisis intervention  
- Professional consultation  
- Cultural activities  
- Individual counseling  
- Individual and aftercare planning  
- Life skills/personal development  
- Group counseling  
- Individual treatment planning  
- Intake  
- Referral  
- Recreation therapy  
- Reports and record keeping
Sagashtawao Healing Lodge  
Box 99  
Moosonee, ON  
P0L 1Y0  
Tel: (705) 336-3450  
Fax: (705) 336-3452  
Email: office@shlodge.com

Health Support Services for Former Indian Residential School Students and their Families

Former students of Indian Residential Schools as well as their family members may be eligible to receive health support services, as follows:

- Counseling
- Emotional Support
- Cultural Support
- Transportation

Through this funding, the Weeneebayko Area Health Authority has created a Traditional Healers Program, which operates two weeks a month in each community. The mostly Cree healers working within the program offer the following traditional health services:

- Traditional counseling for individuals, youth, couples, families and community groups
- Various sweat lodge, seasonal and rites of passage Ceremonies
- Greif counseling and debriefing
- Traditional Cree Knowledge recovery

Cochrane

Within the Cochrane planning region, Timmins and District Hospital has a community mental health program, called Next Step, which has both in patient and out patient services (day program). Day programs also allow for follow up with psychiatrist or social worker although there are very few psychiatrists (some are locum.) Individuals who are prescribed medications may also be followed by a visiting psychiatrist in Cochrane who also does some consultation with staff.

Addictions assessments are done by North Cochrane and some are also done at Misiway Community Health Centre. Referrals are also done by the Ininew Indian Friendship Centre.

Misiway Milopemahtesewin Community Health Centre (Timmins)
The Misiway Community Health Centre is one of two Aboriginal Community Health Centres funded by the Ontario Ministry of Health and Longterm Care. Misiway CHC was established to provide quality programs and services that honour, respect and support Aboriginal culture, values and healing practices, complemented by western approaches to primary health care. Through education, promotion and service delivery, the Misiway CHC encourages individuals, families and communities to integrate and balance their physical, mental, emotional and spiritual needs.

The Misiway Health Centre offers culturally competent counseling for individuals, couples and families. The mental health services and programs incorporate the unique values, beliefs and traditions of the Aboriginal culture. A self-empowerment approach towards the balance of physical, mental, emotional, and spiritual needs is nurtured. Misiway's counsellor is a registered member of a regulated body qualified to deliver various therapeutic techniques.

Services offered include:
- Individual, couple and family counseling
- Stress and anxiety management
- Crisis intervention
- Assertiveness training
- Anger management
- Self-esteem therapy
- Addiction intervention
- Critical incident stress debriefing

A Traditional Healing Program provides access to Traditional Healers on a monthly basis to provide services to clients.

**Misiway Milopemahtesewin Community Health Centre**
130 Wilson Street
Timmins, ON
P4N 2SY
Tel: (705) 264-2200
Fax: (705) 264-2243
Website: http://www.misiway.ca

**Minto Counselling Centre**

Minto Counselling Centre based in Cochrane, provides services to those who 16 years and older presenting with serious mental health issues. Services include therapy, assessment, case management, social and recreational rehabilitation programs, individual counseling and group treatment for survivors of sexual abuse, crisis (after hours available through emergency room of local hospital) and coordination of psychiatric clinics.

It offers an Aboriginal services program comprised of one worker who endeavors to provide more effective outreach and networking to the area First Nations including New Post, educational presentations on topics such as concurrent disorders and one on one counseling.
Minto Counselling Centre
233 8th Street, P.O.Box 2298
Cochrane, ON
P0L 1C0
Tel: (705) 272-4245
Fax: (705) 272-6737
Email: mcc@puc.net

Sudbury/Manitoulin

Shkagamik-kwe Health Centre

Shkagamik-Kwe Health Centre is an Aboriginal Health Access Centre based in Sudbury and funded by the Aboriginal Healing and Wellness Strategy. Programs and services are provided in a culturally-appropriate manner to Aboriginal people within the City of Greater Sudbury and associate First Nations. Shkagamik-Kwe Health Centre is a culturally based Wholistic Health Centre dedicated to balanced and healthy lifestyles. Programs and Services support Traditional Aboriginal values encompassing the connectedness of Emotional, Spiritual, Physical and Mental well being. Mental health services include mental health support, counseling and treatment, crisis intervention services to individuals 18 years of age and over, practical & emotional client support, group interventions, home/hospital visits, case management, referrals, and advocacy and participates in community development. The organization has a focus on family violence and supports/participates in community development initiatives.

Shkagamik-kwe Health Centre
161 Applegrove Street
Sudbury, ON
P3C 1N2
Tel: (705) 675-1596
Fax: (705) 675-8040

Noojmowin Teg Health Access Centre

Noojmowin Teg Health Access Centre provides services to seven First Nations on Manitoulin Island, as well as the off reserve Aboriginal population in the Manitoulin District. The communities include:

1. Aundeck Omni Kaning
2. M’Chigeeng First Nation
3. Sheguiandah First Nation
4. Sheshegwaning First Nation
5. Whitefish River First Nation
6. Wikwemikong Unceded Indian Reserve
7. Zhiibaahaasing First Nation
8. Off reserve population in the Manitoulin District

Noojmowin Teg Health Access Centre offers a blend of traditional Aboriginal approaches to health and wellness along with contemporary primary and mental health care in a culturally appropriate setting. Services are provided through outreach to seven First Nations communities as well as the off-reserve Aboriginal population in the Manitoulin district. Services are provided in partnership with six federally funded community health centres and two federally funded health services organizations within the First Nation communities. Each centre is visited regularly by this agency’s team of health practitioners.

Noojmowin Teg provides mental health services through integrated services with Mnaamodzawin Health Services (MHS), a second regional Aboriginal health organization. MHS is a regional provider of First Nations community health services funded by Health Canada’s First Nations and Inuit Health Branch. Both organizations emphasize community-based Aboriginal approaches to mental health care and share a home office. Service integration in mental health, such as common intake, case coordination and seamless services is a common goal and was initiated with the formation of an interdisciplinary mental health care group, known as the Knaaw Chi Ge Win (New Beginnings) team. Services are provided to clients with a variety of issues ranging from addictions, mood disorders and anxiety, depression, bipolar, eating disorder, SMI as well as domestic violence, intergenerational abuse, residential school abuse. Three providers have individual specialty areas:

- One psychologist who provides treatment and cognitive behavioural therapy with a focus parenting issues with adults and children.
- One psychologist with a focus on personality disorder
- One psychological associate focusing on cognitive behavioural therapy and supportive counseling.

A recent addition to the services includes art therapy and traditional counseling services through the Indian Residential Students Support initiative.

**Noojmowin Teg Health Centre**
Postal Bag 2002, Hwy 540
48 Hillside Rd., Aundeck Omni Kaning
Little Current, ON
P0P 1K0

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26 Information about Noojmowin Teg Health Access Centre is adapted from the Noojmowin Teg Website accessible at [www.noojmowin-teg.ca](http://www.noojmowin-teg.ca)

Mnaamodzawin Health Services

Mnaamodzawin Health Services (MHS) Inc. is a regional provider of First Nations health services for the following five First Nation communities on Manitoulin Island.

- Whitefish River
- Sheguiandah
- Aundeck Omni Kaning
- Sheshegwaning
- Zhiibaahaasing

MHS is funded through a federal transfer agreement. Services have been built in partnership with the First Nation communities since 1995.

Mnaamodzawin Health Services and Noojmowin Teg Health Centre’s Mental Health Team

These two separate agencies practice shared care with a significant traditional approach. The shared care model of Mnaadmodzawin Health Services and Noojmowin Teg Health Centre offers services and consultation to all seven First Nations and off reserve Aboriginal populations as well and has been demonstrated as a positive model for training and interventions at the community level.28

The shared mental health team is comprised of full-time staff including a Team Lead (on a six month rotational basis); (1) Adult Mental Health Case Manager (RN), (0.75FTE) Child Case Manager, (1) Mental Health Counsellor, (1) Maternal Child Health Coordinator (MSW), (1) Healthy Babies and Healthy Children lay support worker; (1) Traditional Coordinator and many traditional helpers, (1) psychologist (PhD), and (1) Psychological Associate. Contracted consultants include a psychiatrist, a licensed child psychiatrist, psychologist and traditional healer who visit on a monthly basis. Nurse practitioners and nursing staff (many of whom are Aboriginal) including Community Nurses, mental health nurses, home care nurses and the diabetes specialist are an important support and linkage to the mental health team as they are in the communities interacting closely with clients and front line workers on a daily basis.

In response to recommendations outlined in a 2007 mental health research project29, Mnaamodzawin Health Services have further enriched the communities with several modalities in parenting and childhood development services over the past four years. MHS has also implemented a number of funded programs under the Aboriginal Healing Foundation. Similarly, the team, through Noojmowin Teg Health Centre’s leadership

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29 Ibid
have been providing services to Indian Residential School survivors and their relatives through the Indian Residential Schools Resolution Health Support Program. An Art Therapy initiative for residential school survivors has been established comprised of 8 week cycles involving group art therapy sessions and one-on-one counseling.

Ngwaagan Gamig Recovery Centre Inc.

"NgwaaganGamig substance abuse treatment centre provides "A culturally based program 12 Step Foundation and Life Skills approach for its clientele which encourages spiritual, physical and emotional well-being."

Mission

“Ngwaagan Gamig Recovery Centre Inc. is dedicated to the cultural sensitivity of the Anishnaabe nations by promoting healthy lifestyles in the areas of prevention, treatment of addictions, and aftercare.”

Vision Statement (Niigaan Naab Daa)

- To empower individuals and families toward a healthy lifestyle, healing and wellness, through education utilizing cultural holistic approaches.
- To help individuals develop the skills to deal with the effects of substance abuse
- To assist individuals, families and the community to understand the impact that alcohol and drugs have on their lives through a public information system.
- To work with youth to develop problem solving and social skills as well as culturally related self-esteem goals in order to assist them in living a drug free life.
- To enhance the understanding of the community of the way in which traditional values and beliefs can help build a healthy family and a stronger community.
- To encourage individuals, agencies and community groups to actively work together to define and implement programs in the community which lead to healthier families and communities.
- To encourage the continued health of individuals through creation of an aftercare and follow-up program.

Number of beds: NNADAP funded: 8; Total overall: 8
Languages offered: First Nation (Ojibway); English
Target age: 18 and over
Treatment cycle: 4 weeks
Intake frequency: Once Per Cycle
Type of treatment program: Adults; Pregnant clients
Special services: Detoxification; Intake screening; Walk-in crisis; Dual addiction; Interpretation services; Follow-up/aftercare; Outpatient services; Prevention program
Treatment for substances: Alcohol; Narcotics; Prescription; Hallucinogens
Treatment components:
- Assessment
- Alcohol and drug education
- Case management
- Client orientation
- Crisis intervention
• Professional consultation
• Cultural activities
• Individual counseling
• Individual and aftercare planning
• Life skills/personal development
• Group counseling
• Individual treatment planning
• Intake
• Referral
• Recreation therapy
• Reports and record keeping

Ngwaagan Gamig Recovery Centre Inc.
Box 81, 56 Pitawanakat Street
Wikwemikong, ON
P0P 2J0
Tel: (705) 859-2324
Fax: (705) 859-2325
Email: rainbowlodge@amtelecom.net

Nadmadwin Mental Health Clinic (Wikwemikong)

The Nadmadwin Mental Health Clinic provides services to the band membership of Wikwemikong and employs native staff to ensure culturally appropriate services.

A variety of mental health services are offered which may include, but are not limited to:
• Relationship issues
• Parent/child issues
• Child behavior problems
• Abuse issues
• Grief and loss
• Trauma
• Anxieties
• Phobias
• Dealing with suicidal ideation
• Suicide prevention and intervention
• Depression
• Anger management
• Parental support
• Advocacy for developmentally challenged individuals and their families

Services provided include:
• Counseling and therapy for individuals, couples and families
• Assessment and consultation from a visiting psychiatrist
• Community development and public education services
• Coordination with other agencies to ensure continuity of care
• Support and advocacy for the developmentally challenged
Clinic staff include a Program Manager; two clinicians; a youth mental health worker, psychological associate (Noojmowin Teg) and administrative support. Referral sources include: individuals/self-referral; family members; doctors/nurses; hospitals; community programs and police.

**Nadamadwin Mental Health Clinic**
16 Complex Drive  
PO Box 101  
Wikwemikong ON  
P0P 2J0  
Tel: (705) 859-2330  
Fax: (705) 859-2035

**M’Nendamowin Health Services (M’Chigeeng)**
M’Nendamowin Health Services provides mental health and addictions services to community members of M’Chigeeng First Nation. Services include both direct and indirect mental health and addictions services. Direct services are provided through clinical interventions and indirect services include mental health promotion, prevention and public education. Our service delivery model includes both western and traditional forms of intervention.

**Clinic Staff**
- Part-time Clinic Manager– 3 days/week
- Mental Health Worker
- Mental Health Worker
- Alternatives Program Worker (NNADAP)
- Program Support Worker
- Psychiatric Consultant – 6 days/year
- Psychological Associate from Noojmowin Teg -6 days/month

**Clinical Intervention:**
The two Mental Health Workers and Alternatives Program Worker provide clinical assessments, treatment planning, counseling, advocacy and support, and referrals to more specialized treatment services. The staff are supervised by the Clinic Manager and have access to psychiatric and psychological consultation services from visiting professionals.

**Psychiatric consultation services**
A visiting psychiatrist provides psychiatric consultation services to M’Nendamowin Health Services.

**Psychological services**
Noojmowin Teg Health Centre provides Psychological Services to M’Nendamowin Health Services through the services of a psychological associate. This service is provided six days/month and the service provision is of a direct clinical intervention as well as providing consultation to M’Nendamowin Health Services staff. The Psychological Associate has provided in-service training to program staff in the area of treatment planning in order to enhance their skills in this area. Due to funding restrictions
from the MOHLTC the Psychological Associate is unable to provide services to children. Plans are in place to enhance psychological services for children. Presently the Psychological Associate has a waiting list.

**Community development & mental health promotion**

Program staff deliver or coordinate mental health and addictions awareness and skill building workshops/programs. Public educational sessions on mental health and addictions issues are promoted on a regular bases throughout the year, especially during Mental Health Week, Mental Illness Awareness Week and NAAW week.

M’Chigeeng Health Services in partnership with Kina Gbezhagomi Child and Family Services and Wikwemikong Health Services and with $20,000 in funding from First Nation and Inuit Health collaborated to deliver Strengthening Families for the Future Program. A total of three 14-session Strengthening Families for the Future programs were delivered within the First Nation communities on Manitoulin Island.

**M’Nendamowin Health Services**
689A Hwy 551
M’Chigeeng, ON
P0P 1G0
Tel: (705-377-5090
Fax: (705) 377-4485

**Kina Gbezhgomi Child and Family Services**
Kina Gbezhgomi Child and Family Services is a not-profit Aboriginal child and family service organization servicing seven First Nations in the District of Manitoulin Island. The First Nations communities include:

Wikwemikong
M’Chigeeng
Aundeck Omni Kaning
Sheguianah
Sheshegwaning
ZhiibaahaGaing
Whitefish River

The organization has “agency status” with the Ministry of Child and Youth Services meaning it provides services under Part II of the Child and Family Services Act (Voluntary Services).

The purpose of Native Child Welfare Prevention Services are to provide a wide range of culturally appropriate healing services to remedy, prevent and arrest further social, emotional or behavioral difficulties experienced within families of the seven Member First Nation communities.

Vision:
“Kina Gbezhgomi Child and Family Services providing family preservation services to the members of the seven First Nations based on their traditions, values, beliefs and customs.”

Mission:
Kina Gbezhgomi Child and Family Services provides quality prevention services that recognize Anishinaabek peoples’ inherent authority, right and responsibility to honour and care for their children.

Families are able to access the services and programs on a “voluntary” basis. Kina Gbezhgomi’s focus is to support children and strengthen families and communities to prevent the need for child welfare interventions including the apprehension of our children. Prevention and community development services are intended to create healthy caring and sharing families where family breakdown, child neglect and abuse would not flourish. Instead of problems being addressed after they have become evident, community health and strengths are focused on beforehand.

Kina Gbezhgomi focuses on three main areas:

- Intervention with families as specified in the plan of care process developed with the Children’s Aid Society;
- Primary prevention programs to create healthy and safe environments for each child on the seven First Nations communities served, thereby lowering the risk of child welfare intervention;
- Expansion of the foster care program in concert with the Children’s Aid Society in order to maximize utilization of these resources.

Kina Gbezhgomi delivers three (3) child and family based programs and services to its member First Nation communities. The programs are as follows:

**Foster Care Program**

Kina Gbezhgomi Child and Family Services is licensed to provide foster care services under the Child and Family Services Act. The agency is responsible for recruiting foster parents; conducting home studies; approving and supervising foster homes; providing support to foster parents; receiving referrals for placements from CAS; and matching placement requests with available foster care resources. The Foster Care Program provides temporary family-based care within the First Nations Membership of the United Chiefs and Council of Manitoulin and Wikwemikong Unceded Indian Reserve. The Foster Care Program continually reinforces Native values, customs and traditions by maintaining and supporting the cultural bond between the child in care and his/her community. The Foster Care Programs primary functions are to recruit, screen and train a pool of foster parent applicants: to approve foster homes, to provide supervision and support to foster parents and to maintain the necessary links with the placing agency and partner agencies to ensure that the needs of the child(ren) and foster parent are met, while the child(ren) are in care.

**Child and Family Services Program**

The Child and Family Services program encompasses supportive counseling services for children and their families with the objective of preventing the need for child welfare interventions. The intent is to support families at risk and provide individual / family counseling on a mutually consensual basis. The Child and Family Services program
assists with problem solving, encouragement and empowerment of family units that will facilitate making healthy choices for their families. The role of the Child and Family Service Workers is to create a climate of trust and respect in which individuals can feel safe and supported when dealing with issues. Workers will also encourage support systems that exist in the community by providing advocacy and essential services that will prevent and/or reduce the necessity of protection services

**Networking Collaborative Services**
The Child and Family Service Workers (CFSW) assess, develop and implement a plan for service with families, based on the strengths and needs of the family. As well, the CFSWs assist and collaborate with Band Representatives, Community Support Workers, Mental Health Workers, Educators, Tribal Police and other Native service providers by facilitating the development of appropriate plans of care with the Manitoulin/Sudbury Children’s Aid Society.

**Assessment and Referrals**
Assessments are completed with individuals and/or family members in a culturally appropriate, respectful and timely manner. Services are developed based on the medicine wheel on the strengths and needs of the family; services that will educate, encourage, support and empower the individual/family to retain a measure of balance over their lives. Alternate additional services are linked upon consent of the client.

**Advocacy and Liaison**
CFSWs promote and affirm the endeavors and development/growth of the family, either in writing or verbally, in order to support the respective Band Representative during the child welfare court process. Workers interpret, explain and liaise between the clients and court workers, lawyers, tribal police, and be supportive during actual court proceedings.

**Supportive Services**
Emotional support, guidance, information, advice, encouragement, understanding and feedback are offered before, during, and after the crisis situations and interventions involving protection services.

**Education and Life Skills**
Services delivered concentrate on the early life stages, formative and adult years in all four areas of the Anishnaabe way of life — emotional, spiritual, physical and mental. Relationship building, parenting skills and pro-active life skills are also emphasized.

**Tangible Support Services**
Temporary/emergency measures act to stabilize a crisis situation and reduce the risk of child protection services.

**Emergency After Hours**
This service are available after every business day, weekend and holiday to children and families with the objective of stabilizing a crisis situation. The After Hours Worker is available to assist the family at the onset of a child protection investigation, apprehension and placement. In the instance an apprehension occurs the worker will align themselves with the implementation of the agency’s Foster Care Program. The After Hours Worker ensures that the children’s immediate needs are met —physically and emotionally.
Community Support Program

The Community Support Program is geared to early intervention with the purpose of prevention in providing assistance for families and children with educational programs, public relation and awareness, networking and collaborating with other service providers, life skills, budgeting, social and recreational programs, cultural and traditional teachings, healing circles, advocacy, referrals and case management for family support.

Kina Gbezhgomi Child and Family Services
98 Pottawatomi Ave
Wikwemikong, ON
P0P 2J0
Tel: (705) 859-2100
Fax: (705) 859-2195

Kinoondidaagamig (a place of talking) Treatment Home

Kinoondidaagamig Treatment Home based on and operated by Aundeck Omni Kaning First Nation is a 5 bed, co-ed, residential MCYS licensed facility for Anishnabek youth aged 12-18 years of age. The treatment home is a unique program using evidence based mental health treatment practices while incorporating the cultural, spiritual teachings and values common amongst Anishnabek people.

Services include:
- Psycho-social assessments
- Residential placement
- 24 hour supervision for hard to serve youth
- in house counseling and treatment services
- psycho-educational groups
- cultural programming
- offsite educational and extra-curricular activities

Youth come from across Ontario and are admitted through planned and emergency intake processes in collaboration with the CAS and child and family service organizations. Criteria for admission are as follows:

- 12-18 years of age
- in need of residential placement
- no other opportunities for placement in the home community or family setting
- presenting with social, emotional, mental or behavioral challenges that can be addressed through mental health treatment
- discharge plan in place for the youth
- First Nations children and youth given a priority

Kinoondidaagamig Treatment Home
2027 Hwy 540
Aundeck Omni Kaning First Nation
NE LHIN Aboriginal First Nations Métis Mental Health and Addictions Framework

RR #1, Comp #311
Little Current, ON
PO P 1K0
Tel: (705) 368-0435
Fax: (705) 368-0011

Timiskaming

No Aboriginal services noted.

Algoma

N’Mninoeyaa Aboriginal Health Access Centre

N’Mninoeyaa Aboriginal Mental Health Services, Mamaweswen/NSTC provides services to seven First Nations of the North Shore Tribal Council as well as at the Indian Friendship Centre in the town of Sault Ste. Marie. The communities are located along highway 17:

1. Batchewana First Nation
2. Garden River First Nation
3. Thessalon First Nation
4. Mississauga First Nation
5. Serpent River First Nation
6. Sagamok Anishnawbek
7. Atikameksheng Anishnawbek (Whitefish Lake First Nation)
8. Sault Ste. Marie Indian Friendship Centre

N’Mninoeyaa Aboriginal Mental Health Services provide both traditional and contemporary mental health counseling and treatment services to adult individuals (18 and over) with significant mental health challenges. Services are provided by outreach to communities. A Mental Health Program Coordinator works with an Aboriginal Mental Health Sub-committee, made up of one representative from each community including the Indian Friendship Centre, to provide program support, planning and guidance in implementing the regional mental health program.  

Outreach services are provided at the community level, where other, less specialized (mainly federal), services also exist, such as the NNADAP and community mental health workers. Generally, the local workers provide brief services as well as referrals to outside services and visiting professionals.

The visiting mental health staff complement includes a psychologist for Garden River, Batchewana, and the Indian Friendship Centre of Sault Ste. Marie on a purchased service contract, 3 hours per week per community; a purchased service Mental Health Therapist working in Atikameksheng Anishnawbek (4 hours per week); and a full time

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employee, Mental Health Case Worker for Sagamok Anishnawbek, Serpent River, Mississauga and Thessalon First Nations, providing services one day per week in each community.

The Mental Health Case Worker also facilitates groups such as men’s and youth circles on a monthly basis. This mental health worker receives clinical supervision and advice through a protocol arrangement with the Northeast Mental Health Centre’s Regional Aboriginal Mental Health Service. The contracted consultant services (psychologist and therapist) are funded through the Northeast Local Health Integration Network. To facilitate planning and coordination of these mental health services, the North Shore Tribal Council employs a mental health administrator. The administrator works with a mental health sub-committee comprised of representatives from each of the NSTC’s member communities to identify and address mental health needs.

**N’Mninoeyaa Community Health Access Centre**
Hwy. 17, Serpent River First Nation
Cutler, ON
PO0 1B0
Tel: (705) 844-2021
Fax: (705) 844-2844

**Anishnabe Naadmaagi Gamig Treatment Centre**

- **Number of beds:** NNADAP funded: 16; Total overall: 16
- **Languages offered:** First Nation (Ojibway); English
- **Target age:** 18 and over
- **Treatment cycle:** 4 weeks
- **Intake frequency:** Bi-Weekly
- **Type of treatment program:** Adults; Pregnant clients
- **Special services:** Intake screening; Interpretation services; Dual addiction; Outpatient services; Follow-up/aftercare
- **Treatment for substances:** Alcohol; Narcotics; Prescription; Hallucinogens

**Treatment components:**
- Assessment
- Alcohol and drug education
- Case management
- Client orientation
- Crisis intervention
- Professional consultation
- Cultural activities
- Individual counseling
- Individual and aftercare planning
- Life skills/personal development
- Group counseling
- Individual treatment planning
- Intake
- Referral
- Recreation therapy
- Reports and record keeping
Anishnabe Naadmaagi Gamig Treatment Centre
Box 568
Blind River, ON
P0R 1B0
Tel: (705) 356-1681
Fax: (705) 356-1684
Email: Janicl@bellnet.ca

Nog-da-win-da-min Family and Community Service

Nog-da-win-da-min Family and Community Services is a Native Child Welfare Prevention service agency that works in collaboration with seven First Nations in ensuring that children, youth and families receive culturally appropriate services. Nog-da-win-da-min offers various services and programs to the children, youth and families who are members of the following First Nation communities:

- Batchewana First Nation
- Garden River First Nation
- Thessalon First Nation
- Mississauga First Nation
- Serpent River First Nation
- Sagamok Anishnawbek
- Atikameksheng Anishnawbek (Whitefish Lake First Nation)

Educational Groups/Programs

Several culturally based education programs are available to youth and adults. Topics include domestic violence, parenting, anger management, life skills, and self-esteem.

**Creating Healthy Family Relationships - Impact of Domestic Violence on Communities**

This is a 4 week culturally based program that will allow community members to learn how domestic violence impacts our communities. This program will also allow members to look at healthy and unhealthy relationships. The members will look at historical issues and how these may influence their behaviours.

**Reflecting on our Pasts for Future Generations - Parenting Program**

This is a six week program that allows parents to learn and discuss how history has impacted their parenting. Through discussion and sharing they will learn alternative ways to parenting their children. They will discuss some of their challenges of parenting their children in today's society and learn different ways of dealing with inappropriate behaviour.

**"Anger What's That About" - Anger Management**

This twelve week program assists people in looking at anger and where it comes from. The participants are required to attend at least 10 sessions to achieve their certificate.
Some topics are discussion on feelings, triggers and alternative ways of dealing with anger in a healthy way.

**Life Skills**

This program is facilitated by a Certified Life Skills Coach who facilitates various sessions either one on one or as a group. Some of the topics covered are problem solving, leadership skills, cooperation, identifying and describing our feelings. The programs that are developed are six weeks in length.

**Mino Madzwin**

Mino Madzwin is a culturally sensitive program for at risk Aboriginal youth. The areas that are addressed are anger management, substance abuse, family & community relationships and pro-social skills. This program is a recognized alternative for youth justice program.

**“Honouring Each Other through Bravery and Respect” - Youth and Family Violence**

The youth will learn about family violence and how it impacts their lives. They will learn types of abuse and effective ways of communicating. Through sharing they will learn about culture and how to apply our teachings to live healthier lives. This is a 4 week program that is designed for youth between the ages 11 to 18 years of age.

**Care for Kids**

This program aims to teach children about healthy sexuality as a sexual abuse prevention program. This program is designed for children between the ages of 10 -13 years of age. It is a 6 week program that includes an information session for the parents. Some of the information that the children will learn about are about Bodies, Babies, Feelings, Bedtime, Touching and Secret and Surprises.

**“It’s OK to Be me Anishnabe” - Self-Esteem Program for Kids**

This is a program that is designed to facilitate healthy self-esteem in children from ages 7-12 years. They will learn about their culture and history to assist in having a healthy identity as an Anishnabe. The children will learn through participating in activities in a safe environment.

**Family support and advocacy**

Workers attend child welfare investigations on-reserve with the Children's Aid Society. They provide assistance and support to children and families to resolve child welfare crises. They also co-operatively plan and carry out actions designed to divert similar crises in the future. All services are voluntary.

**Native Foster Care**

Native foster parents provide a nurturing healthy and safe environment for a child to grow and develop. A child may be separated from their own parents for various reasons. Native foster care is intended to be temporary and is for children of all ages.

**In-home Support**

This program is based on the premise that it is best for children to grow up in their own
families. In families where there is child maltreatment, skilled professionals can assist families to learn more appropriate ways to raise their children. The program provides more intensive in-home support to immediate and their extended families living in one of the First Nation communities.

**Nog-da-win-da-min Family and Community Service**

405 Gran Street  
Batchawana First Nation  
Batchewana, ON  
P6A 5K9  
Tel: (705) 946-3600  
Fax: (705) 946-3717

**Parry Sound**

**B’saanibamaadsiwin Native Mental Health Service**

B’saanibamaadsiwin is an Aboriginal mental health program that provides culturally relevant and community specific mental health services to the First Nations communities of the Parry Sound and Muskoka districts.

Direction for the design, development and delivery of B’saanibamaadsiwin services is provided by the Program Advisory Committee which represents the First Nations communities of the two districts. A staff of four provides services including:

- assessment and referral
- 24/7 crisis service for individuals in the urban Aboriginal population and First Nation communities in the Parry Sound area
- counselling, aimed at providing culturally appropriate support and treatment for individuals, families and the community
- community development (i.e., to develop the capability of improving First Nations mental health and resources to deal with mental health issues) in each community and across communities
- consultation to non-Aboriginal service providers, communities and community workers on Aboriginal mental health-related issues
- capacity building by providing resources and workshops to the community on an as requested basis.

B’saanibamaadsiwin Native Mental Health Service  
26 James Street  
Parry Sound, ON  
P2A 1T5  
Tel: (705) 746-2512  
Fax: (705) 746-9590
Nipissing

“Giyak Moseng” The Right Path Counseling and Prevention Services

The Right Path provides professional mental health and addictions counseling, assessment, consultation, education and prevention services to all members of Nipissing First Nation.

Mental Health Services include:

**Individual, couple and family counseling to address:**
- Stress and coping
- Grief
- Anger
- Abuse
- Addictions
- Mood disorders
- Mental health disorders (eg depression)

**Referrals to psychologists and psychiatrists**

**Group sessions concerning the topics of:**
- Self esteem
- Abuse and violence
- Grief and loss

**Addictions counseling/Alcohol and Drug Prevention Services**

A psychologist is onsite on a part time basis to offer clinical consultation, psychological assessments and treatment. A coordinator of traditional healing is available as well for those who wish to access traditional services in their healing journey.

“Giyak Moseng” The Right Path Counseling and Prevention Services
58 Semo Road
Garden Village, ON
P2B 3K2
Tel: (705) 753-1375
Fax: (705) 753-087

**Community Counseling Centre of Nipissing**

Community Counselling Centre is a non-profit organization providing professional counselling services and community programs to individuals, couples, and families. The Centre also has public education and consulting services available to community organizations and industry.

Along with an Employee Assistance Program, the Centre offers community services including the following:
- Addictions services
- Community Integration and Advocacy Program
- Counselling for men who are abusive
- Counselling for women who have been abused
- Counselling for women who have been sexually abused
- Individual, couple and family counseling
- Credit Counselling
- Fetal Alcohol Spectrum Disorder
- Post partum mood disorder program

Within the context of the Addictions Services Program, the Centre offers Native Assessment and Referral.

Clients preferring Aboriginal specific services have access to complete their comprehensive substance use assessment with an Aboriginal assessment referral addictions counsellor. Aboriginal specific programming including individual & group counselling and support is also available

**Community Counseling Centre of Nipissing**
361 McIntyre Street East
North Bay, ON
P1B 1C9
Tel: (705) 472-6515
Fax: (705) 472-4852
Appendix 1 – some demographic information related to the 7 planning areas

According to 2001 Census data there are 42,500 Aboriginal people residing in the NE LHIN. “Aboriginal” is a term used to describe three distinct groups of people as recognized under the Constitution Act of 1982. These groups are the Indian, Inuit and Métis people of Canada. The term “Indian” is now commonly referred to as First Nations. First Nations and Métis make up essentially all Aboriginal people in the North East LHIN. The Métis are primarily urban based while First Nations live both on-reserve and off-reserve in various communities throughout the NE LHIN.

Table 1 Aboriginal population in the NE LHIN, Census 2001

<table>
<thead>
<tr>
<th>Category</th>
<th>Ontario</th>
<th>NE LHIN</th>
</tr>
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<tbody>
<tr>
<td>Total Aboriginal Population</td>
<td>188,315</td>
<td>42,500</td>
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<tr>
<td>North American Indian (single response)</td>
<td>131,560</td>
<td>26,520</td>
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<tr>
<td>Métis (single response)</td>
<td>48,340</td>
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<tr>
<td>Inuit (single response)</td>
<td>1,375</td>
<td>45</td>
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<tr>
<td>Multiple Aboriginal responses</td>
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<tr>
<td>Aboriginal responses not included elsewhere</td>
<td>5,345</td>
<td>890</td>
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</table>

First Nations people in the NE LHIN live in 42 First Nation communities as well as in off-reserve settings such as towns and cities. It is important to note that off-reserve members may be living anywhere and may not necessarily localized within the NE LHIN’s boundaries. For the purposes of effective community engagement, the NE LHIN divides its region into 7 distinct planning areas. These are noted below in Table 2 along with the associated First Nation communities.

Table 2 summarizes the registered population of each First Nation community in the NE LHIN’s planning areas.

Table 2 First Nation Population in the NE LHIN by community

<table>
<thead>
<tr>
<th>NE LHIN Planning Area</th>
<th>First Nations Total Registered Population</th>
<th>Registered On-Reserve (own or other)</th>
<th>Registered Off Reserve</th>
<th>On Crown Land (Band or other)</th>
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<tbody>
<tr>
<td>Location</td>
<td>Attawapiskat</td>
<td>Fort Albany Kashechewan</td>
<td>Moose Cree</td>
<td>Marten Falls</td>
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<tr>
<td>------------------</td>
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<td>-------------------------</td>
<td>-----------</td>
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<tr>
<td>James Bay Coast</td>
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<td>Cochrane</td>
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<td>Constance Lake</td>
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<td>Flying Post</td>
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<td>Sudbury Manitoulin</td>
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<td>Sheshegwaning</td>
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<td>Aundeck Omni</td>
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<td>M'Chigeeng</td>
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<td>Timiskaming</td>
<td>Beaverhouse**</td>
<td>554</td>
<td>135</td>
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<td>Matachawan</td>
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<td>Algoma</td>
<td>Hornepaye</td>
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<td>Location</td>
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<td>1,061</td>
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<td>Mississauga</td>
<td>1,009</td>
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<tr>
<td>Sagamok Anishnawbek</td>
<td>2,308</td>
<td>1,366</td>
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<td>Serpent River</td>
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<td>Thessalon</td>
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<td>Atikameksheng Anishnabek</td>
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<td>Missanabie Cree***</td>
<td>187</td>
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<td>187</td>
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<tr>
<td>Parry Sound</td>
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<td>Dokis</td>
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<td>Nipissing</td>
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<td>Temagami</td>
<td>647</td>
<td>224</td>
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<td>Totals</td>
<td>28,995</td>
<td>12,279</td>
<td>16,430</td>
<td>286</td>
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</tbody>
</table>

Source: Indian and Northern Affairs First Nations Profiles; ** NAN Community statistics (100); *** from community website
Appendix B: The OFIFC “Good Mind” Strategy & “Leaders for Change”

“Good Mind” Ontario Federation of Indian Friendship Centres (OFIFC) Mental Health Strategy 2006

The Ontario Federation of Indian Friendship Centres developed a Mental Health Strategy entitled “Good Mind” in response to the increased demand for mental health services in urban Aboriginal communities and the fragmented medically focused approach predominant in existing mental health services. The strategy described the need for both clinically based mental health and addictions programs and services and traditional healing and culturally specific approaches. It also outlined that there is currently, no capacity within the Friendship Centres to provide comprehensive, culturally appropriate mental health services and training. Many of the issues, barriers and gaps described are similar to those we heard during the information gathering phase of this framework’s development. In addition, many of the principles and strategic approaches are aligned with the recommendations in this framework.

The Good Mind Mental Health Strategy is based on the following key principles:

1. Self-Determination is fundamental and thus Aboriginal people must be involved in all aspects of mental health care delivery including research, planning and development, implementation and evaluation. Aboriginal people must have full involvement at all levels of decision making.

2. It is the right of Aboriginal people to choose different models of mental health care based on the varying needs and priorities identified by different communities and based on specifications of an individual client.

3. A wholistic framework addresses the physical, mental, emotional, spiritual, cultural and social well-being of individuals and the whole community. Within a wholistic framework, both traditional Aboriginal healing methods and modern medical modalities are applied to contribute to the improved mental health of Aboriginal people.

4. Socio-economic issues have resulted in significant negative impacts on the mental health of Aboriginal people. Higher levels of poverty and unemployment, low educational status, inadequate or unaffordable housing, food insecurity and shared historical experiences resulting in some loss of cultural identity have had a negative impact on the mental health of Aboriginal people. Improving the social, economic and physical environments will contribute to improved Aboriginal mental health.

5. Mental health care services must be culturally appropriate and accessible to all Aboriginal people in Ontario, regardless of residency. There are numerous factors currently affecting access to mental health care including jurisdictional wrangling, systemic racism, attitudes of medical professionals, distance, lack of transportation, financial resources, employment and unresponsive mental health

31 “Good Mind” Ontario Federation of Indian Friendship Centres, Mental Health Strategy, September 2006
care programs. Barriers to accessibility are further exacerbated by the refusal or reluctance to accommodate, recognize and include traditional and alternative therapies.

6. Mental health services must be provided in a culturally secure environment and manner. Services must be reflective of Aboriginal cultural rights, views, values and expectations.

7. A coordinated and collaborative inter-sectoral approach is required. Service delivery needs to be better coordinated within the mental health care system between primary and secondary services.

8. Guaranteed funding and political willingness and commitment are central to a mental health strategy for Aboriginal people.

The overall strategic approach described in the “Good Mind” Mental Health Strategy includes the following:

1. Strengthen OFIFC commitment to the urban Aboriginal population throughout the province by incorporating mental health programming within the Friendship Centres.

2. Implement mental health programs and services to include prevention, care and treatment, education, research and coordination.

3. Approach mental well-being as part of the healing continuum which includes the physical, mental, emotional and spiritual elements applied to all the life cycle stages.

4. Ensure that Aboriginal mental health services are available which network and support Aboriginal community agencies.

5. Ensure that Aboriginal mental health services are accountable to and endorsed by the community.

6. Establish an Aboriginal-designed system of referrals.

7. Increase the number of trained and available Aboriginal traditional healers/therapists.

8. Provide ongoing training and professional development in the area of mental health for Friendship Centre staff.

In addition, the OFIFC outlined three key strategic directions which are aligned with Ontario’s Aboriginal Health Policy and other important policies guiding the development of health programs and services for Aboriginal people in Ontario. These three strategic directions include:

**Strategic Direction #1 – Planning and Representation**

**Goal: To ensure Aboriginal mental health programs and services are designed, developed and delivered by Aboriginal people in partnership with appropriate mental health stakeholders.**

Specific approaches identified included having the OFIFC involved in the development of an Ontario Aboriginal Mental Health Strategy and ensuring Aboriginal representation within all provincial and federal mental health planning environments, institutions and agencies.

**Strategic Direction #2 – Mental Health Status**
Goal: To improve the mental health status of Aboriginal people and bring mental health disorders and addictions to manageable levels through direct involvement in the design, development and delivery of Aboriginal specific mental health programs and services.

In keeping with integrative approaches to ensure quality and access to care, strategic partnerships will be developed to facilitate cooperation and collaboration amongst health professionals and design, develop and deliver Aboriginal specific mental health programs and services. The OFIFC will also promote the utilization of Aboriginal healing lodges and treatment centres as effective mental health and wellness alternatives.

Strategic Direction #3 – Access to programs and services

Goal: To ensure improved equitable access to quality, culture based and culturally appropriate mental health programs and services.

Approaches will include the provision and promotion of client advocacy through training, education and resource development, cross cultural education for health care professionals, institutions and other significant mental health stakeholders and human resource development to address the shortage of Aboriginal nurses, doctors, psychiatrists, psychologists, therapists, multidisciplinary teams, addictions counselors and community mental health workers. An emphasis will also be place on ensuring recognition, inclusion, quality development and integration of traditional healers, medicine people, natural counselors and other traditional community based workers.

The OFIFC believes that a combination of these strategic directions and approaches will foster and create much needed systemic change as it continues to create programs, services, resources, information and capacity building to address the multitude of challenges facing urban Aboriginal people in the management of mental health and the complex issues that arise as a result.

Recommendations from Leaders for Change: Aboriginal Mental Health and Wellness Conference, November 6 – 8, 2007, Toronto

The Ontario Federation of Indian Friendship Centres in partnership with the Association of Iroquois and Allied Indians, the Independent First Nations Forum, the Métis Nation of Ontario and the Ontario Native Women’s Association hosted in November, 2007, a three day conference entitled: Leaders for Change: Aboriginal Mental Health and Wellness Conference. The conference was intended to create a forum for dialogue amongst all stakeholders on needs, gaps in service and best practices in Aboriginal mental health. From this dialogue a framework for a strategic plan to address Aboriginal concerns in mental health could be developed. Recommendations intended to inform the framework flowed from both the workshops and working group discussions held over the three day conference.

Recommendations arising from the workshops included:

1. Supportive community resources need to be available to reconnect people with

their Aboriginal history, culture, language and ceremonies etc.

2. Reconnection with Elders and Traditional people must be a priority for all communities.

3. Bullying (violence), concurrent disorders, dementia, aging, and suicide (youth) are priority areas that must be addressed immediately.

4. Networking and partnerships with key community and health service providers is necessary.

5. Education and training opportunities for Aboriginal front line workers must address the needs of an Aboriginal population who is increasing in age and having longer life expectancy.

6. Community programs and services must include culturally relevant assessment and evaluation tools, (spiritual) supports and a long term commitment to address a holistic continuum of care for mental health and wellness.

7. Communities need to actively participate and set priorities for research and development of mental health and wellness strategies and capacity building.

8. Mental health and wellness for children and youth must be a priority.

9. Children, youth and parents need to work together within a family centred mental health support system.

10. Federal and provincial governments must approve a “child first” policy in regards to providing essential services to Aboriginal children.

11. Communities can make a significant difference by supporting Jordan’s Principle: an agreement between the Provincial and Federal government to provide service first and settle the question of who should pay for costs later. (communities can go online to register support for Jordan’s Principle at www.fncaringsociety.com)

12. Communities need to develop alternatives to mainstream justice system, especially for youth, because it isn’t working for Aboriginal people.

Recommendations arising from the working group discussions included:

1. A “holistic” approach that includes programs and services that are family centred, and that is integrated with existing programs and services rather than creating a separate “system” in isolation.

2. Grass roots inclusion in the research and development of community based programs and services for Aboriginal peoples that recognizes the diversity among Nations.

3. Networking and coordination including support by an on and off reserve/urban and rural Leadership, including working on a comprehensive strategy built from the community up.

4. Programs and services that are supportive and address a continuum of care with less focus on crisis intervention.

5. More involvement and support by leadership to set mental health as a priority and a commitment to long-term community planning and development to address community needs.

6. Community education and outreach needs to include cultural sensitivity training and an Aboriginal defined mental health focus to address stigmatization and create a positive vision for future endeavours.

7. Poverty and violence against women and children as a contributing factor to poor mental health need to be addressed.

8. A culturally appropriate diagnostic tool for Aboriginal people that recognizes Aboriginal approaches to mental health ie. Spiritual practices, is needed.
9. Communities need to have the financial and human resources to address gaps in programs and services and increase accessibility, such as Elders, children, youth, low income families, transportation, alter-able persons, translators, traditional healers, etc.

10. Aboriginal knowledge needs to be recognized as legitimate knowledge and recognition of Elders/Traditional peoples’ practices as competent approaches for addressing mental health issues.

11. Continued need for conferences/gatherings/training sessions for workers to build their knowledge and skills base with a strong focus on cultural approaches.

12. Policy changes that incorporate need for front-line workers ‘self care’, as prevention for burn-out, chronic stress, fatigue, high staff turnover, etc.

13. Coordination of programs and services is essential including family case management and data management for effective collaboration.

14. Front-line workers need to be recognized as “experts” in their community and as a feasible resource for community development and change.

15. Racism needs to be addressed on all levels internally and externally.

16. Client confidentiality needs to be addressed including building trust among community members and program service providers.

17. Programs and services need to be culturally relevant and integrate cultural appropriateness and community responsiveness.

18. Programs and services need to address concurrent mental health issues.