INDIGENOUS PRIMARY HEALTH CARE COUNCIL

TOOLS OF RESILIENCY: ADDRESSING THE WELLBEING NEEDS OF INDIGENOUS PEOPLE BY HONOURING CULTURE AS TREATMENT

2020

CONTENTS

INTRODUCTION

In 2018/19 the Ministry of Health and Long-Term Care provided one-time Mental Health and Addictions (MHA) funding to the Indigenous Primary Health Care Council (IPHCC) to support the collection and analysis of data to provide a better understanding of Indigenous community-governed MHA programs and services in Ontario.

These programs and services are provided across Ontario at ten Aboriginal Health Access Centres (AHACs) and three Indigenous-governed Community Health Centres (CHCs). At least fifteen additional Indigenous Interprofessional Primary Care Teams (IIPCTs) are in development or have recently opened their doors (Appendix 1). As of 2016, AHACs and Indigenous-governed CHCs provided care to 66,000 individuals, encompassing more than 25% of the First Nations, Inuit, and Metis population in Ontario. This number is expected to more than double once the IIPCTs are fully established.

Indigenous health centres share a common Model of Wholistic Health and Wellbeing. This model focuses on the restoration and rebalancing of the physical, mental, emotional and spiritual wellbeing of Indigenous peoples, families, communities and nations. Consequently, Indigenous health organizations do not see themselves as providing stand-alone mental health and addictions services. Instead, MHA services are part of an integrated model of care in which all programs and services promote wellbeing across all aspects of the self.

For the purpose of this report, a western construct of a 'continuum of care' is used to explore the range of services Indigenous health centres provide to clients with MHA challenges. Although this construct greatly simplifies the complexity inherent in the Model of Wholistic Health and Wellbeing, it is useful because it can be used to identify critical service gaps.

Evidence gathered for this report indicate that programs and services rooted in Indigenous cultures and ways of healing are the most effective way to support Indigenous clients with MHA challenges. Indigenous health centres are ideally positioned to provide these programs and services. However, they currently do not receive sufficient funding to provide a full continuum of care for clients with MHA challenges. This causes clients with severe MHA challenges to go without necessary care. Indigenous health centres need to be funded in a manner that enables them to provide a complete continuum of culturally safe, culture-based MHA care.

A substantial number of Indigenous people with MHA challenges still need to seek care from mainstream healthcare institutions—places where anti-Indigenous racism is endemic (Matthews, 2017; Wylie & McConkey, 2019). Leadership teams and front-line service providers of all publicly-funded organizations that provide MHA programs and services need to be trained on how to address and eliminate anti-Indigenous racism.

The Indigenous Primary Health Care Council (IPHCC) is an Indigenous-governed, culture-based and Indigenous-informed organization. It supports the advancement of Indigenous primary health care provision and planning throughout Ontario through partnerships, education, and advocacy. The IPHCC takes a coordinated approach to enhance Indigenous health care by ensuring the delivery of culturally safe, effective health services in a manner that respects the diversity, languages, and strengths of Indigenous peoples. This population-level, needs-based approach to health care planning, evaluation, and scaling-up leading practices drives excellence in Indigenous health.

BACKGROUND: MENTAL WELLBEING AND INDIGENOUS HEALTH CENTRES

Indigenous health centres utilize the Model of Wholistic Health and Wellbeing, which conceptualizes wellbeing as balance across physical, spiritual, emotional, and mental aspects of the self (Appendix 2).

Culture—that is, Indigenous ways of knowing and being—lies at the centre of wholistic wellbeing, as it provides the means of re-establishing balance across all areas of the self. In practice, this means that care is not divided into separate silos for physical health, traditional healing, mental health, health promotion, etc. Instead, services provided by Indigenous health centres simultaneously address clients' physical, spiritual, emotional, and mental needs.

The First Nations Mental Wellness Continuum Framework identifies purpose, hope for the future, belonging to family and community, and connection to history and Creation as elements that support the type of balance necessary for mental wellness (Chiefs of Ontario, n.d.). For Indigenous clients with MHA challenges, culture is treatment.

Colonialism, racism, and self-determination are all distal determinants of Indigenous health, including mental health (Reading & Wien, 2009). Federal government policies have resulted in a loss of language, culture, family structures, and connection to the land. These policies have impacted the education, employment, income, and housing opportunities available to Indigenous people and nations. Inter-generational trauma created by these policies results in unique MHA challenges for Indigenous clients.

> "Indigenous peoples have the right to physical and mental integrity, as well as the right to equal enjoyment of the highest attainable standard of physical and mental health."

When Indigenous clients with MHA challenges seek care from mainstream health institutions they often experience interpersonal and structural racism (Matthews, 2017; Wylie & McConkey, 2019). Instead of promoting healing, such encounters further exacerbate challenges faced by Indigenous clients.

As the Truth and Reconciliation Commission (TRC, 2015: 160) observes, "Indigenous peoples have the right to physical and mental integrity, as well as the right to equal enjoyment of the highest attainable standard of physical and mental health." In order to ameliorate health disparities, it is necessary that "Indigenous peoples have the right to be actively involved in developing, determining, and administering health programs that affect them. Indigenous peoples also have the right to traditional medicines and to maintain their traditional practices" (TRC, 2015: 160).

Indigenous health centres in Ontario aim to fulfill these rights by providing comprehensive primary health care, including MHA services. Because of their accountability to the Indigenous communities they serve, only Indigenous-governed health centres are able to provide care that is culturally safe. They create environments where clients feel comfortable, respected, and supported. However, in order to fully actualize this vision of self-determination in health care, Indigenous health centres need to be able to provide a full continuum of programs and services for clients with MHA challenges.

METHODS AND DATA SOURCES

Data and information for this report were collected from AHACs, Indigenous CHCs, and IIPCTs. Multiple sources of information were utilized in order to provide a comprehensive overview of existing MHA programs and to identify gaps in services.

Information in this report was drawn from:

- A survey administered in early 2019 by the Alliance for Healthier Communities, which solicited information about MHA services provided by member health centres; nine AHACs and all three Indigenous CHCs responded to the survey. IIPCTs were not included as they are mostly in development.
- Thirty-seven key informant interviews, representing a total of nineteen AHACs, Indigenous CHCs, and IIPCTs, conducted specifically for this report.
- MHA prevalence data from urban Indigenous populations, drawn from the Our Health Counts study.
- Mortality statistics reported by the TRC.

Data on utilization of existing services provided by the AHACs is not included in this report due to concerns over data completeness. To address this concern, the IPHCC has placed strategic importance on the improvement of its performance measurement and management systems. In 2019, the IPHCC created an Evaluation Framework to guide its performance management and to create a rationale for the collection and analysis of data. Using an improvement lens, a sub-group of AHACs will begin in early 2020 to address data completeness by identifying the root causes for incomplete data and creating customized solutions to those issues. Insight from the "We Ask Because We Care" literature will be incorporated into the improvement work.

PREVALENCE OF MENTAL HEALTH AND ADDICTIONS CHALLENGES

Our Health Counts is an ongoing community-based research project that began in 2009 as a partnership between Well Living House at St. Michael's Hospital in Toronto and De dwa da dehs nye>s AHAC in Hamilton. This project fills in gaps in health information by surveying urban Indigenous people.

To date, surveys have been completed in Hamilton, Toronto, London, Ottawa and Thunder Bay. Data collection in Kenora is ongoing. Our Health Counts MHA data for Toronto and London are included in this report to provide insight into the needs of Indigenous people in select communities in Ontario. Data from Our Health Counts illustrate distinct disparities in the prevalence of MHA conditions among Indigenous people relative to the general Canadian population. Indigenous adults report experiencing mental illnesses, including anxiety disorders, major depression, post-traumatic stress disorder, and bipolar disorder, more frequently than adults from the Canadian population as a whole (Table 1). Researchers from Our Health Counts caution that the actual rate of mental illness may be higher than reported due to barriers accessing mental health professionals who can make diagnoses. Compared to the general Canadian population, Indigenous adults more frequently report substance use (Table 2).

Table 1: Prevalence of mental health disorders among Indigenous populations compared to the Canadian population			
Adults who have been told by a health care provider* at some point in their lives that they have the following:	**Toronto OHC**	**London OHC**	**Canada**
Anxiety disorder	24%	12%	8%
Major depression	23%	14%	11%
Post-traumatic stress disorder	11%	4%	2%
Bipolar disorder	9%	4%	3%
Personality disorder	6%	1%	0%
Schizophrenia	4%	4%	2%
Eating Disorder	2%	1%	1%
It is important to note that DSM-5 diagnostic criteria are not reflective of Indigenous understandings of mental wellness. Application of diagnostic criteria that are culturally irrelevant – and culturally unsafe – can propagate the harm experienced by Indigenous clients with MHA challenges.			
Sources: (O'Brien, Xavier, Maddox, Laliberte, Wolfe, & Smylie, 2018; O'Brian et al., n.d.)			

Table 2: Prevalence of substance use in urban Indigenous populations compared to the general Canadian population			
Percentage of adults who:	**Toronto OHC**	**London OHC**	**Canada**
Smoke	63%	67%	37%
Used cannabis in the past year	63%	58%	12%
Did not drink any alcohol in the past month	32%	33%	37%
Used prescription opioids in the last year without a prescription or out of keeping with how they were prescribed	18%	17%	n/a
Have used crack/cocaine in the past 12 months	22%	8%	1.6%
Sources: (Maddox et al, 2018; Maddox et al., n.d.)			

Mortality statistics reported by the TRC (2015) illustrate how Indigenous people are more likely to die from MHA complications than the general Canadian population. First Nations people in Canada are:

- 6 times more likely than the general population to suffer alcohol related deaths
- 3 times more likely to suffer drug-induced deaths
- Twice as likely to die by suicide

And:

- Indigenous youth between the ages of 10 and 29 who are living on reserves are 5-6 times more likely to die by suicide than non-Indigenous youth.

Data from key informant interviews conducted with representatives from AHACs, Indigenous CHCs, and IIPCTs corroborate the statistics published by Our Health Counts and the TRC. When asked to describe the most prevalent MHA conditions presenting at their centres, key informants identified the following:

- Anxiety
- Depression
- Trauma
- Addictions and substance use
- Relationship and family problems
- Grief and loss

Key informants described these conditions as widespread in client populations. They also reported a high incidence of post-traumatic stress disorder and psychotic disorders, such as bipolar disorder and schizophrenia. According to informants, instances of substance use or addiction most often present as one or more of the following behaviours: use of prescription medication outside of how it was prescribed, alcohol use, gambling, or opioid use.

The following statement from one of the key informants summarizes the extent of the MHA challenges in their client population:

> *"I think that it has to be noted that whenever our primary care team sees an individual for a physical need, what they will often say is that a very significant number of those clients that they see are coming in with some kind of mental health issue."*

The key informants described, based on their work in the field, how inter-generational trauma caused by colonial practices leads to additional social problems including domestic violence, assault, and interactions with the justice system.

The statistics from Our Health Counts and the TRC, coupled with insights from key informant interviews, demonstrate two key findings. First, Indigenous people experience disproportionately high rates of MHA challenges. Second, these MHA challenges are often caused and/or exacerbated by inter-generational trauma, which in turn is a consequence of colonial policies that broke apart Indigenous families and criminalized Indigenous cultures.

TRADITIONAL HEALING, CULTURAL SAFETY, AND THE MENTAL HEALTH AND ADDICTIONS SERVICES CONTINUUM

A broad continuum of services is necessary to address the complex MHA needs of Indigenous clients (Figure 1).

It is important to note that this continuum of care is a western simplification of how Indigenous health centres actually support clients with mental health and addictions challenges. As discussed above, the Model of Wholistic Health and Wellbeing prescribes an integrated approach in which mental, physical, emotional, and spiritual wellbeing are nurtured concurrently. This continuum is used in this report in order to clearly identify and explore gaps in care. It does not indicate that Indigenous health centres provide care in typical western silos.

All twelve of the Indigenous health centres that responded to the 2019 survey provide mental health services and ten provide addictions services. All centres receive designated funding for MHA services: six receive funding from federal ministries, eleven are funded through Local Health Integration Networks or the Ministry of Health and Long-Term Care, nine receive funding from other provincial ministries, three are funded by municipalities, and one receives money from another source (IFN Life Promotions).

It is challenging for individual Indigenous health centres to provide all services across the continuum. Consequentially, some services are provided through formal partnerships, some through collaboration and integrated planning, and some by other health care institutions in the community (i.e. hospitals, the Canadian Mental Health Association). In some cases, services are simply not available; or, if they do exist, are largely inaccessible to Indigenous clients.

Care is deemed to be culturally safe when the person receiving care feels comfortable, understood, respected, and in control of their healing journey (Wepa, 2015). The importance and efficacy of traditional healing programs are described below, followed by a discussion of cultural safety. Subsequent sections describe the types of MHA services provided across the continuum of care.

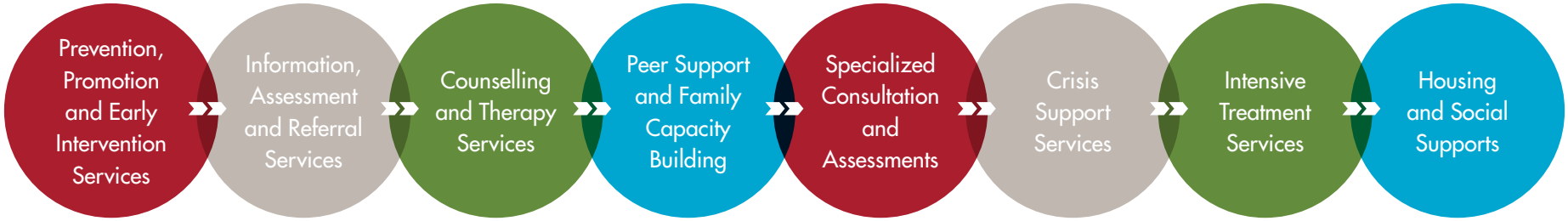

Figure 1. Continuum of Mental Health and Addictions Services

THE IMPORTANCE AND IMPACT OF TRADITIONAL HEALING PROGRAMS

Every one of the Indigenous health centres that responded to the 2019 survey reported that they offer culture-based MHA programs and services at every possible step along the continuum of care. Traditional Healing "is wholistic, based on an understanding of the interconnectedness of all life and the importance of balance and harmony in Creation" (Anishnawbe Health Toronto, n.d.). It is also egalitarian, meaning that "everyone has the ability to heal, whether it's the mother who tends the scrapes of her child, a friend who eases pain by kind words or a Healer who heals sickness" (Anishnawbe Health Toronto, n.d.).

Traditional Healing re-connects clients with community, culture, and all of Creation, thereby addressing the root causes of MHA challenges in Indigenous populations.

Call to Action #22 from the TRC requires policymakers to recognize the value of Indigenous healing practices and to ensure they are available to Indigenous patients. Indigenous health centres, which integrate Traditional Healing practices across all aspects of care, have been actualizing this Call to Action for over twenty years. These centres offer services provided by—and in partnership with—Elders, Traditional Healers, Medicine People, and Traditional Teachers (Table 5). Half of the centres who responded to the survey reported having access to a Traditional Healing Lodge.

Key informants provided details of the breadth of Traditional Healing programs and services provided by Indigenous health centres. Example include, but are not limited to:

- The Southern Ontario Aboriginal Health Access Centre (SOAHAC) offers sweetgrass turtle making that teaches people about sweetgrass as a medicine using an activity that promotes calm and relaxation. Participants form relationships and share their stories.
- Waasegiizhig Nanaandawe'iyewigamig AHAC (WNHAC) brings in Traditional Healers to run medicine picking sessions and share tobacco teachings.
- The Wasauksing First Nation Inter-professional Care Team runs sweat lodge building events and teaches sessions on sweat lodges once per month. They also provide traditional language classes to their clients and the broader community.
- Akwesasne Health Centre offers teachings and workshops throughout the year according to the ceremony cycle, medicine walks with Elders, and

Table 5: Number of Centres with Traditional Healers as staff or contracted through a purchase of Service

	# of Centres out of twelve that have Traditional Providers on staff	# of Centres out of twelve that access Traditional Providers through a Purchase of Service
Elders	5	3
Medicine People	5	1
Traditional Healers	5	4
Traditional Teachers	1	4

monthly tobacco burning for both clients and the community.

- Noojmowin Teg AHAC provides access to a Fire Keeper and Harvester who travel to local communities and provide land-based programming to youth.

Counselling services must be rooted in Indigenous values and approaches, but can also incorporate elements of western therapeutic practices. Key informants provided the following examples:

- WNHAC offers the Grief Pathway to Healing program, which pairs cognitive behavioural therapy with Indigenous ceremony and counselling practices.
- Anishnawbe Health Toronto, a CHC, provides western-based group therapy that is provided by both a western practitioner and a Traditional Medicine person.
- Wabano AHAC offers an addictions circle led by a Traditional Knowledge Keeper as part of their 12-step Wellbriety program that incorporates a pain clinic and provides care based on the Seven Grandfather teachings.
- SOAHAC offers group support programs, such as Wellness Support Circles based on White Bison Teachings and Traditional Healing.
- Misiway Milopemahtesewin CHC's Healing Trauma workshops are making good connections with participants. Registration fills up quickly and they are drawing individuals from as far north as the James Bay Coast as well as nearby First Nation communities.

The following story about an AHAC client illustrates the importance of Traditional Healing practices:

A young woman in her early 30s came to the centre looking for treatment for her addiction to alcohol. She had been in and out of the criminal justice system for many years and had been referred to the centre from that system. Coming to the Lodge the first time was a big step for her because she was not sure if it was really the right place for her. She wanted addiction treatment and when told our Healing Lodge was technically not a treatment center but that it was for trauma, she struggled with figuring out if it was the place that she wanted to go. She did not know anything about her culture, and she was afraid that she would do things incorrectly or not say the right things. We just encouraged her and let her know that there is really no wrong way to do things and that people come to the Lodge to learn; about themselves, about their culture, what culture means for them and how it can help them in their healing journey.

She was very timid at first but began to learn a little bit about a ribbon skirt and how to make one. Every day there are different cultural teachings and throughout the 27-day program she became more and more sure of herself. She learned how to prepare a sweat lodge and how to start a sacred fire. When we had some new staff start at the centre who did not know the culture, she taught them how to set up the sweat lodge ceremony. She later told us how she found an eagle feather and how she went to ceremony and learned how to dress her eagle feather. She got herself a smudge bowl and started teaching people at the new house she is living at what culture means to her. During follow-up we found that she has not gone back to jail and she has not been drinking alcohol. She continues to go to additional psychotherapy to help with her other trauma. She was able to set that up on her own without the help of our wellness worker by advocating for herself. She says she can now navigate the bus system herself to get to her therapy and wants to continue to go to the lodge. In just 27 days of the program she has learned about her culture and has grown in many ways.

(Source: key informant interview, WNHAC Healing Services Manager)

THE NECESSITY OF CULTURALLY SAFE CARE

Key informants emphasized the necessity of culturally safe care. Cultural safety is not the same as cultural competency. Culturally competent providers are expected to be familiar with cultural differences and adjust the care they provide accordingly; by contrast, cultural safety is determined by whether or not clients actually feel comfortable, understood, respected, and in control of their healing journey (Wepa, 2015). All Indigenous health centres are staffed with providers and employees who are Indigenous or who have been trained in culturally safe practices. Only Indigenous health centres can be culturally safe.

Shkagamik-Kwe Health Centre's (SKHC) Woven Blanket Model of Care is just one example of how Indigenous health centres provide culturally safe care. The Woven Blanket model calls for an environment that respects traditional values and embraces an individual's unique needs within the context of their family and community. Similar to other primary care models, clients have a principal primary care provider (e.g. nurse practitioner, physician assistant or physician); however, providers collaborate and share care responsibilities, so that there is always someone available to provide care if the principal care provider is away. Client navigators coordinate patient care and regular team meetings involving clinical, mental wellness, and traditional care staff are conducted in a case management fashion (SKHC, 2017).

SKHC's Traditional and Mental Health Programs are essential components of the model, ensuring patients and families receive wholistic and comprehensive care. One such program is the Nanda-Gikendan Program (NGP). The NGP is a culture-based program that incorporates traditional practices—such as fasting, monthly sweats, Elder knowledge transfer, and Traditional Healing from community-sanctioned healers and helpers—alongside talk therapy provided by western psychotherapists as well as cultural counsellors. The NGP team works within the Woven Blanket Model of Care to provide culturally safe and relevant programming to support the wholistic mental wellbeing of individuals, families, and community as a whole.

When culturally safe care is not available, Indigenous clients are at risk of experiencing harm. Anti-Indigenous racism is a pervasive problem in mainstream healthcare institutions (Matthews, 2017; Wylie & McConkey, 2018). As a result, Indigenous clients have reason to distrust mainstream healthcare, and may avoid receiving medically-necessary care as a consequence

(Browne & Fiske, 2001). As a key informant from an Indigenous health centre put it:

> *"Well, people, there is still racism in the system and Indigenous people do not trust the non-Indigenous service providers. When they see us for a cold, we get child welfare. When anybody presents with a simple problem that everyone experiences, it gets exaggerated in the mainstream system. I think there is no trust in the system. But here they feel trust right away and they feel like it is a place of belonging for them the minute they enter."*

Indigenous Cultural Safety (ICS) training helps make mainstream healthcare institutions safer for Indigenous clients by helping service providers explore their own biases and understand the legacies of colonization. These biases and legacies continue to negatively affect service accessibility and health outcomes for Indigenous people. ICS education addresses anti-Indigenous racism through the use of coordinated, evidence-informed training practices. Greater uptake of this anti-Indigenous racism training by mainstream healthcare institutions is necessary in order for them to provide safer care. Although mainstream organizations cannot achieve Indigenous cultural safety, they continue to have Indigenous clients and therefore are morally obligated to provide care that is free from anti-Indigenous racism. As of April 1, 2020, the ICS program will operate as part of the IPHCC.

MENTAL HEALTH AND ADDICTIONS SERVICES PROVIDED BY INDIGENOUS HEALTH CENTRES

In practice, MHA services provided by Indigenous health centres do not exist in silos; instead, all aspects of care—whether specifically targeted towards MHA challenges or not—are designed and implemented with the goal of promoting wholistic mental, emotional, spiritual, and physical wellbeing.

PREVENTION, PROMOTION AND EARLY INTERVENTION SERVICES

The first section of the continuum of MHA services includes universal promotion, universal prevention, targeted prevention and early intervention services. Universal promotion involves those activities that enhance the capacity of individuals and communities to take control over their lives and improve their mental wellbeing. Universal prevention involves those activities that focus on reducing the risk factors and enhancing the protective factors associated with mental illness and addictions. Targeted prevention are those activities focused on changing views and behaviours, building skills and competencies and/or creating awareness and resiliency through the provision of information, education and programming to defined at risk populations. Early intervention services are those that respond early in life or early in the course of a mental illness or episode to reduce the risk of escalation and thus minimize the harmful impact on individuals, their families and the wider community.

All respondents to the 2019 survey stated that their centre provides prevention, promotion and early intervention services in-house. Four of the respondents indicated that these services are also provided through a partnership and three replied that other community agencies also provide the service. Despite reporting they provide the service, three respondents stated that a gap in prevention, promotion and early intervention services still exists. This suggests that the need for these programs outstrips the capacity of some Indigenous health centres. Mainstream early intervention resources, like BounceBack or Big White Wall, target adults with mild to moderate mental health challenges; however, these resources do not address the complexities of MHA challenges caused by intergenerational trauma and so are of minimal relevance to Indigenous clients.

Targeted prevention are those activities focused on changing views and behaviours, building skills and competencies and/or creating awareness and resiliency through the provision of information, education and programming to defined at risk populations.

Examples of prevention, promotion and early intervention services were provided in the key informant interviews. These include, but are not limited to:

- Gizhewaadiziwin AHAC partners with the Ontario Provincial Police to deliver a program for youth on how to live off the land and make good choices. Using experiential learning, the goal of the program is to prevent substance use by offering alternatives with a traditional focus.
- SKHC hosts medicine walks, medicine camps, beading groups and monthly workshops on various mental health topics.
- Chigamik CHC runs monthly beading circles and smoking cessation programs.
- SOAHAC partners and engages with Knowledge Keepers and Elders to provide a variety of prevention and promotion activities for children and youth including plant walks, fishing trips and wholistic arts programs for those with fetal alcohol spectrum disorder and attention-deficit hyperactivity disorder.

INFORMATION, ASSESSMENT, AND REFERRAL SERVICES

Information services involve providing up-to-date, evidence-based information to clients and families about MHA and the core services that are available to them. Assessment services are when providers ask clients questions and do a physical exam in order to understand their health needs and provide appropriate services. Referral services are when the provider recommends a client be seen by another health professional or another organization.

Nine of the twelve survey respondents stated that their centre provides information, assessment and referral services. Three respondents stated that these services are also provided through a partnership and two stated that this remains a gap.

COUNSELLING AND THERAPY SERVICES

Counseling services focus on treating the emotional, social and mental challenges experienced by clients. Counseling often focuses on stressors and issues of grief, depression and the need for someone with whom to talk.

Ten of the twelve survey respondents stated that they provide counseling and therapy services at their centre. Three respondents stated that counseling is provided through partnerships and two respondents stated that this is a service gap.

The types of counselling and therapy services offered by Indigenous health centres differentiates them from mainstream service provision because they integrate Indigenous cultures and Traditional Healing. Key informant interviews provided examples of unique counselling and therapy programs:

- Equine therapy at SOAHAC
- Art therapy at De dwa da dehs nye>s AHAC
- A sexual assault/domestic violence therapy program at Noojmowin Teg AHAC

PEER SUPPORT AND FAMILY CAPACITY-BUILDING

Family support services facilitate emotional and practical support and information exchange between people with common lived experience. Culture-based community engagement programs, such as traditional ceremonies and teaching, develop a sense of belonging and connectedness. Strengthened social networks enhance community resiliency. Peer support is a naturally-occurring, mutually beneficial support process, in which people with lived experience meet as equals, sharing skills, strengths and hope.

Nine of twelve survey respondents identified peer support and family capacity-building as a gap in service. Five reported that they provide peer support and family capacity-building at their centre and three indicated that they provide this service through a partnership.

Examples of peer led programs were shared in the key informant interviews:

- De dwa da dehs nye>s AHAC has a peer-led program for people experiencing MHA challenges. The peer support program assists with service navigation, runs recovery groups, and provides one-on-one sessions for those not yet comfortable with 'official' counselling
- Akwesasne Health Centre has a peer-led program that includes recovered MHA clients hosting intergenerational teachings of traditional practices in schools.

Peer support is a naturally-occurring, mutually beneficial support process, in which people with lived experience meet as equals, sharing skills, strengths and hope.

SPECIALIZED CONSULTATION AND ASSESSMENTS

Specialized consultations and assessments are designed to provide advice on the assessment, diagnosis, prognosis and/or treatment of an individual with an identified mental health or addiction need.

Five of twelve survey respondents stated that they provide specialized consultation and assessments at their centre, three stated these services are provided through a partnership, and one stated they are provided by another community agency. Five respondents stated that this is a gap in service provision.

It was mentioned in the key informant interviews that providing specialty care in one place is helpful, enabling "one stop shopping." This increases the ease with which clients can access specialists and provides an opportunity to provide case management.

CRISIS SUPPORT SERVICES

Crisis support services offer treatment to individuals experiencing a crisis. They provide immediate relief from symptoms, prevent the condition from worsening, and resolve the crisis as soon as possible. Crisis support services provide timely access to care in a variety of settings or modalities, such as telephone crisis support, walk-in services, mobile crisis outreach, crisis residential services, and psychiatric emergency/medical crisis services.

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These services reduce unnecessary hospitalizations and improve quality of life for individuals experiencing a mental health crisis by alleviating symptoms and connecting them to on-going support.

Five of twelve survey respondents stated that they provide crisis support services at their centre, one stated the service is provided through a partnership, and five respondents reported that crisis support services are provided by other community agencies. Five respondents stated that crisis support services are an identified gap.

When asked whether they have access to a Crisis Services network and/or 1-800 number, three of twelve respondents stated they have access to a crisis service, six stated they have access to a 1-800 number and the remaining four stated they do not have access to a Crisis Service or a 1-800 number.

One centre reported having an ACT team and six stated they have access to one in the community. However, key informant interviews revealed that access to mainstream ACT teams is tenuous. As one key informant put it:

> *"There is a funded ACT team in our region. During my 11 years working in Indigenous community mental health, our team has only ever been able to successfully refer and enroll one community member in this program. The application and intake process are not aligned with Indigenous concepts and needs. There are systemic barriers to getting access to this program."*

Mainstream ACT teams require clients to have psychiatric diagnosis in order to access services. This is a significant barrier for Indigenous clients as many do not have a diagnosis. Key informants explained that Indigenous clients often do not have access to a psychiatrist, avoid mainstream mental health services because of systemic anti-Indigneous racism, or find Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic labels to be culturally irrelevant and unhelpful for their healing journey. There is a need for intensive crisis support services that meet the particular needs of Indigenous clients.

INTENSIVE TREATMENT SERVICES

Intensive treatment services are targeted to those with severe and/or complex mental illnesses and/or addictions that limit functioning in areas such as employment, parenting, schooling, housing, and other activities of daily life.

Ten of the twelve survey respondents identified intensive treatment services as a gap in the continuum of care. Only three stated that their centre provides intensive treatment services, while four reported that intensive treatment services are provided by another community agency. Centres with intensive treatment services are reporting positive outcomes, highlighting the need for these services to be more available across Indigenous health centres.

Rapid Access Addiction Medicine (RAAM) Clinics are an example of an intensive treatment service. The De dwa da dehs nye>s AHAC is part of a RAAM Clinic. The survey respondent from the centre provided the following description:

> *"Our organization felt strongly about being part of the Brantford Rapid Access Addiction Medicine (RAAM) Clinic as we anticipated a high percentage of clients would be Indigenous. We wanted to be available on site to provide supportive counselling and connection to other community services such as primary care, Traditional Healing, long-term mental health counselling, and any other services they may need. The [RAAM] clinic has been operational for 5 months as of February 28, 2019 and approximately 20% of patients self-identify as Indigenous and ask to speak with our Indigenous counsellor. We offer short-term counselling, case management, culture approaches, medicine teachings and medicine bundles, on-site in the clinic 2 days each week. This offers patients a safe space within an institutional-like clinic and culturally appropriate services for individuals who would otherwise not have taken the initiative to seek out these kinds of supports. The RAAM clinic has seen remarkable outcomes with respect to connection to primary care and an example of how multiple community partners can work together in a way that is better for the patient."*

Social and environmental factors, such as homelessness, can exacerbate or significantly limit recovery from MHA disorders. Housing and social supports thus address the social determinants of health, including economic security.

This collaborative model is dependent on willing partners. It also pre-supposes that Indigenous health centres have the resources to augment the RAAM clinic programming. Smaller health centres may not have the personnel and financial resources to partner effectively with RAAM clinics. Therefore, Indigenous health centres should be funded to collaborate with the RAAM clinics.

Naandwe Noojimowin was identified by key informants as an additional example of an intensive treatment program. Offered by N'Mninoeyaa AHAC, this 5-day residential program assists adults who have experienced childhood trauma such as domestic violence, sexual abuse, child abuse/neglect, family dysfunction, and/or inter-generational trauma. This land-based program helps participants understand their own behaviours and build healthier relationships with both themselves and their communities, and its effectiveness has recently been demonstrated in a comprehensive program evaluation.

HOUSING AND SOCIAL SUPPORTS

Housing and social supports consist of a range of non-therapeutic and non-medical services aimed at facilitating the recovery and well-being of clients at home, school, and work.

Social and environmental factors, such as homelessness, can exacerbate or significantly limit recovery from MHA disorders. Housing and social supports thus address the social determinants of health, including economic security.

According to the results of the 2019 survey, three centres directly provide housing and social supports. Two centres have access to supportive housing services through a community partnership. Three others reported that housing and social supports are provided by separate community agency. Seven respondents identified housing and social supports as a gap in the continuum of care.

Key informants described a successful housing and social support program at De dwa da dehs nye>s AHAC in Hamilton. The Our Health Counts Hamilton study reported that 13% of Indigenous people living in Hamilton are homeless. This prompted De dwa da dehs nye>s to initiate a collaborative homeless program. They also became involved with Hamilton's 20,000 Homes Campaign and collaborated with municipal, provincial, and federal partners to offer the Homeward Bound program to the Indigenous community in Hamilton. Staff in the program work collaboratively with the centre's outreach team, wellness and cultural workers, and clients to collectively work towards meeting client needs.

Other centres, including Gizhewaadiziwin AHAC and Wabano AHAC, provide coordination of services for mental health clients who are in need of housing by advocating on the client's behalf.

PROVISION OF MENTAL HEALTH AND ADDICTIONS SERVICES ACROSS THE CONTINUUM

Indigenous health centres provide many of the services on the MHA continuum, with all or most of them providing prevention, promotion and early intervention services; information, assessment and referral services; and counselling and therapy services at their centres. Figure 2 illustrates the number of organizations providing each of the services on the continuum, and also whether the services are provided by the centre alone, in partnership with another agency, or solely by another agency.

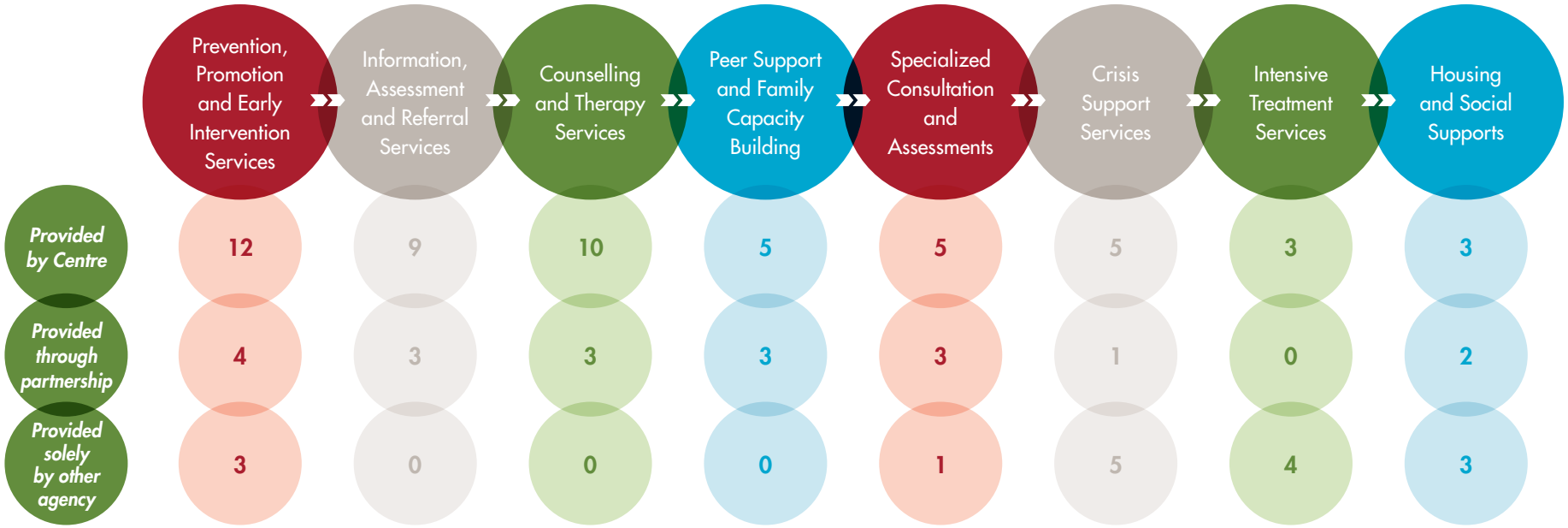

Figure 2. Continuum of Mental Health and Addictions Services Provided by Indigenous-Governed Health Centres

Across the continuum, Indigenous health centres more frequently provide services by themselves instead of partnering with other organizations. When asked about barriers to community partnerships, survey respondents observed that mainstream health organizations lack the background knowledge necessary to readily support Indigenous health and wellbeing:

> *"As an Indigenous organization, we are very often in 'teaching mode' when we work with community partners. Our primary focus is to support our clients; however, it takes a significant amount of additional time to educate non-Indigenous partners before we can effectively work together for the health and well-being of our shared clients. This additional time is not often accounted for where funding and performance targets are concerned. Recognition of the additional work placed on Indigenous organizations by mainstream/non-Indigenous agencies is overlooked."*

> *"Having a strong knowledge, awareness, understanding and appreciation among other health and wellness providers for the history of Indigenous peoples in Canada and how this has impacted mental health and addictions impacts is required to build partnerships."*

> *"A lack of staff training on Indigenous peoples' health is a barrier to partnering. It is challenging and very time consuming to work with partners with limited to no knowledge of the history of Indigenous peoples in Canada and how that has impacted health and wellness, in particular mental health and addictions."*

This lack of knowledge within mainstream organizations about colonialism and ongoing structural racism contributes to Indigenous clients receiving unsafe care. Indigenous health centres provide much of the MHA continuum of care themselves in order to ensure that their clients receive culturally safe care.

The following quote from a key informant provides additional insight into the challenges of working with mainstream health agencies:

> *"I am always cautious … we try to partner when we can, we partner with other Indigenous community members but the mainstream agencies, I am always cautious because of the cultural competency part. I am just worried that it is always going to be the mainstream approach because I do not see any other way right now. Until they get used to us being there, how we do things, I am a bit protective of how much we connect. I work with our partners and I go to the tables, I do the planning and I will work with them, but I am cautious."*

Indigenous health centres often need to provide in-house care because of the challenges associated with creating partnerships with mainstream organizations. This places additional financial pressure on Indigenous health centres as they do not receive sufficient funding to provide the full continuum of MHA care.

MENTAL HEALTH AND ADDICTIONS SERVICE PROVIDERS

Indigenous health centres provide MHA services by employing and contracting service providers. Table 3 illustrates the provider types utilized by AHACs and Indigenous CHCs, as provided by survey respondents. Table 4 illustrates those centres that provide care through a purchase of service as reported by the survey respondents (denoted by a check mark).

Table 3: Employees per centre by provider type

FTE Employees	Waas-egi-izhig AHAC	Nooj-mowin Teg AHAC	SO-AHAC	De dwa da dehs nye>s AHAC	Akwe-sasne Health Centre	N'Mninoeyaa AHAC	Anish-nawbe Health Toronto CHC	Misi-way CHC	Chigamik CHC	Anish-nawbe Mush-kiki AHAC	Wabano AHAC	SKHC
Counselors	2	2	8	4	1	8.5	7	4	4	1	6	
Harm Reduction		2				5.5	3				3	
MH Nurses							1					
NPs	7	5	11*		1		1		0.5			4
Outreach/ Community Workers	4		3	2	2		3				4	
Peer Workers							5	1				
Physicians	3		4*			2**			0.2			2
Psychiatrist							4			0.2		1
Psychologists		2		0.2-0.4**		.13	1					
Reg. Nurses	2	1 (CNS)	2*		5							2
Social Work	2	1	6	2	1		2		1	0.5	6	7
Volunteers							4					
Other		2***									3****	1

**Not fully dedicated to MHA but work significant portions of their time with clients with a MHA*
***Fee for service physicians*
****Addiction Workers*
*****2 FTE Program Coordinators, 1 FTE Program Assistant*

Table 4: Centres that provide specific service through a purchase of service												
FTE Employees	**Waas-egi-izhig AHAC**	**Nooj-mowin Teg AHAC**	**SO-AHAC**	**De dwa da dehs nye>s AHAC**	**Akwe-sasne Health Centre**	**N'Mninoeyaa AHAC**	**Anish-nawbe Health Toronto CHC**	**Misi-way CHC**	**Chigamik CHC**	**Anish-nawbe Mush-kiki AHAC**	**Wabano AHAC**	**SKHC**
Counselors										✓		
Harm Reduction												
MH Nurses												
NPs		✓										
Outreach/ Community Workers												
Peer Workers												
Physicians					✓							
Psychiatrist			✓		✓		✓			✓	✓	
Psychologists					✓		✓		✓	✓		
Reg. Nurses												
Social Work												
Volunteers												
Other											✓*	

***ADR Facilitators**

Psychologist and psychiatrist services remain a challenge for Indigenous- governed health centres. There is a high level of need and these services are not available in many of the communities served. Five of twelve survey respondents stated they currently have access to psychologists and eight indicated they have access to a psychiatrist.

Partnerships with hospitals in southern Ontario exist; partners specifically mentioned by survey respondents were the Centre for Addiction and Mental Health, Sick Kids, and London Health Sciences.

When asked whether their centre would benefit from having more access to psychologists and psychiatrists, nine replied yes. When asked why they needed improved access to psychologists and psychiatrists, four centres indicated they need assistance with treatment planning, particularly for complex cases. Psychological assessments were an identified need for three centres. Three centres also indicated that they had unacceptably long wait times for psychological services because of high demand. Other needs identified by respondents include assistance with medication management and a desire to increase the types of therapy offered at their centre.

Psychologist and psychiatrist services remain a challenge for Indigenous-governed health centres. There is a high level of need and these services are not available in many of the communities served.

GAPS IN MENTAL HEALTH AND ADDICTIONS SERVICES

Gaps were identified by survey respondents for each of the seven core elements of the continuum of MHA services. In Figure 3, the number above each of the elements represents the number of survey respondents who stated this was a gap. Since all but one survey respondent rated their knowledge of MHA services in their community as good or extensive, there can be confidence that these gaps were not identified due to a lack of knowledge of service availability.

Figure 3. Gaps in the Continuum of Mental Health and Addictions Services Provided by Indigenous-Governed Health Centres

Fewer gaps were reported at the left end of the continuum where the core elements are most often provided by the centres. However, three centres identify prevention and early intervention as a service gap even though they offer those services, suggesting that they do not have sufficient resources to meet community needs. Peer support and family capacity-building, another service area with preventative functions, were identified as a gap by nine survey respondents.

Intensive treatment services were also identified as gaps by a large majority of survey respondents, while crisis support services were identified by five. Programs currently being offered by Indigenous health centres report positive results, indicating

the importance of expanding access to intensive treatment and crisis support services.

Seven of twelve survey respondents identified housing and social supports as a gap in care. This is indicative of how the wellbeing of Indigenous communities and nations is influenced by the broader social policy context. Indigenous health centres—despite a paucity of resources—are striving to fix gaps in the social security net and promote economic security.

Survey respondents were invited to identify additional gaps that may fall outside the MHA continuum of care. Multiple respondents identified system-wide challenges related to the paucity of culturally safe mental health care and the need for more system navigators.

Key informants explained that these gaps in services are due to a long-standing problem of scarcity of both human and financial resources. Geographic location, the need to travel, and the volume and complexity of clients result in unfilled positions, thus making it harder for Indigenous health centres to meet the needs of their clients. Insufficient funding makes it impossible for Indigenous health centres to provide the full range of MHA services. As one key informant put it:

> *"I could go on and on about the gaps. But I just think of all the services that non-indigenous organizations have access to, and I look at our tiny wee budget and everything that we are trying to do for eight communities."*

Survey respondents were asked whether they would benefit from additional staff to provide MHA-focused initiatives and what staffing roles/services and/or programs are needed. Interestingly, although only one centre identified counselling and therapy services as a gap in the MHA service continuum, eight centres stated that they need more counsellors. This indicates that the overall need for Indigenous-specific MHA services is so great that even relatively well-developed services are unable to keep up with demand. Respondents indicated that high demand results in clients being placed on waitlists.

Seven centres reported that they need additional support staff to run MHA programs and services. Examples of such staff include intake workers, system navigators, outreach workers, peer support workers, and social support workers. Support staff are also needed to run specific services related to abuse, grief, and capacity-building. Again, this illustrates how the demand for the MHA services offered by Indigenous health centres exceeds their human and financial resources.

Four centres indicated that they need additional resources to support Traditional Healing programs, such as the ability to hire additional Traditional Healers or securing access to a Traditional Healing Lodge. Culture lies at the centre of the Model of Wholistic Health and Wellbeing, and traditional practices—which re-connect clients to themselves, their communities, and their cultures—is a well-established and effective treatment for MHA challenges among Indigenous clients.

Adversity in early life can have negative impacts that last a lifetime. Four centres reported that they need additional support for pediatric MHA services, especially for young children and those involved with Child and Family Services.

Technological gaps, including having an operational electronic medical record (EMR), were also mentioned by some key informants. Currently, all AHACs and Indigenous CHCs are either using or transitioning to a common EMR, a process that will be completed by the middle of 2020. Some of the new IIPCTs will also use the new EMR. While work needs to be undertaken to ensure data completeness, in the future all Indigenous health centres will be able to use their data to reflect on the care they are providing and use data for improvement.

SUCCESS STORIES

The progress being made at Indigenous health centres is testament to the efficacy of care that is culture-based and culturally safe. Even with inadequate resources, Indigenous health centres are working hard to maximize their impact on the wellbeing of the nations and communities they serve. Near the end of the interviews, key informants were asked about their most significant successes in MHA programming in the past five years. Their responses include, but are not limited to:

"Our healing trauma workshops have been a real success. The numbers that are going through and the fact that people are sticking with the program. They have to be here for 5 days and we have had a 100% graduation rate for women and an 80% graduation rate for men. Men are a little harder to draw out but those who graduate actually do quite well. We have been working with a facilitator up until now. He is coming one more time but my team are going to do the workshop themselves and he is going to sit back and just support my team and provide daily debriefs. And if the team is comfortable then we are going to be able to fly on our own. This is a really significant milestone for us to be able to deliver the program locally as we will be able to offer it more often and not have the additional cost of the facilitator."

"Our smoking cessation program has been successful. We just pulled the data at the end of December [2018]. We have had over 400 Indigenous people go through our program over the last five years. I think that is really great and our success rate is 44%, which means that a year after attending the program, people are still reporting that they are smoke-free."

"The interdisciplinary programs we have created are a success; like the art therapy and the family art therapy. It is a collaboration between two or three programs; it is not just mental health. Mental health cannot be a stand-alone program; one service provider cannot do it alone, can never carry the brunt of what people are coming in with. It has to be a team approach and it has to be interdisciplinary. It has to have an Elder or a Traditional Knowledge Keeper integrated to develop the program, contribute the teachings, lay the foundation, do the teaching, all of it. We had done that."

SUMMARY AND RECOMMENDATIONS

This report provides a summary of the MHA programs and services provided by Indigenous health centres in Ontario. Indigenous health centres are striving to provide the full continuum of MHA services according to the principles of the Model of Wholistic Health and Wellbeing.

Their efforts are limited by insufficient resources, resulting in significant gaps in care. Even well-developed MHA programs and services are strained by inadequate numbers of Traditional Healers, support staff, and psychotherapists.

In summary, the evidence showed:

- There is a high need for culturally safe MHA services due to the high prevalence of mental illnesses and addictions challenges in Indigenous populations.
- This disproportionality of MHA challenges is a consequence of historical trauma stemming from colonial legacies and ongoing structural and interpersonal racism.
- Anti-Indigenous racism continues to be endemic in mainstream healthcare institutions, resulting in additional harm to Indigenous clients with MHA challenges.
- Indigenous cultural safety (ICS) training is an effective means of mitigating anti-Indigenous racism and helping ensure that Indigenous clients feel comfortable, understood, respected, and in control of their healing journey.
- Indigenous health centres are the only institutions that can be culturally safe.
- Culture-based care, including Traditional Healing, addresses the root causes of historical trauma and is the most appropriate and effective means of treating MHA challenges in Indigenous populations.
- Indigenous health centres provide integrated, culture-based MHA services that promote wholistic health and wellbeing; however, their efforts are being limited by inadequate financial and human resources.
- These limitations result in gaps in the MHA continuum of care, particularly in the areas of crisis support services, intensive treatment services, peer support and capacity-building, and housing and social supports.
- As a consequence, Indigenous health centres need additional resources in order to provide culturally safe crisis support services, hire more counsellors and support staff, and expand culture-based capacity-building and prevention programs.

AS A RESULT OF THESE FINDINGS, THE FOLLOWING TWO RECOMMENDATIONS ARE MADE:

1. Given the necessity that Indigenous clients with MHA challenges receive care that is both culture-based and culturally safe, it is recommended that Indigenous health centres be funded at a level that enables them to provide the full span of MHA programs and services.

   a. It is further recommended that this increase in funding covers the costs associated with:

      i. Implementing and/or expanding culture-based crisis support services and intensive treatment services;

      ii. Enhancing prevention, early intervention and capacity-building programs and services, especially for children and youth; and

      iii. Hiring sufficient numbers of psychotherapists and other staff.

   b. It is recommended that a separate Indigenous-designed and funded psychotherapy program also be provided within the pending psychotherapy program to be rolled out in Ontario.

2. Given the pervasiveness of structural and interpersonal anti-Indigenous racism in mainstream healthcare institutions, coupled with the inevitability that Indigenous people will still need to receive some MHA care in such institutions, it is recommended that all Boards of Directors, leaders and front-line providers of government-funded organizations that offer MHA programs and services be required to take a course on addressing anti-Indigenous racism that is developed and delivered by Indigenous experts.

   Cultural safety can only be achieved by Indigenous-governed health centres; however, mainstream organizations have a moral obligation to eliminate anti-Indigenous racism and provide care that is as safe as possible.

This report began by acknowledging that Indigenous communities and nations have the right to the best possible physical and mental health. They also have the right to exercise self-determination over the healthcare they receive.

Indigenous health centres have the unique experience and expertise necessary to provide MHA care that is culture-based, culturally safe, and of the highest quality.

Implementing these recommendations would support reconciliation and promote wholistic health and wellbeing for Indigenous people with MHA challenges.

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APPENDIX 1

INDIGENOUS COMMUNITY GOVERNED AND PROVINCIALLY FUNDED PRIMARY HEALTH CARE CENTRES

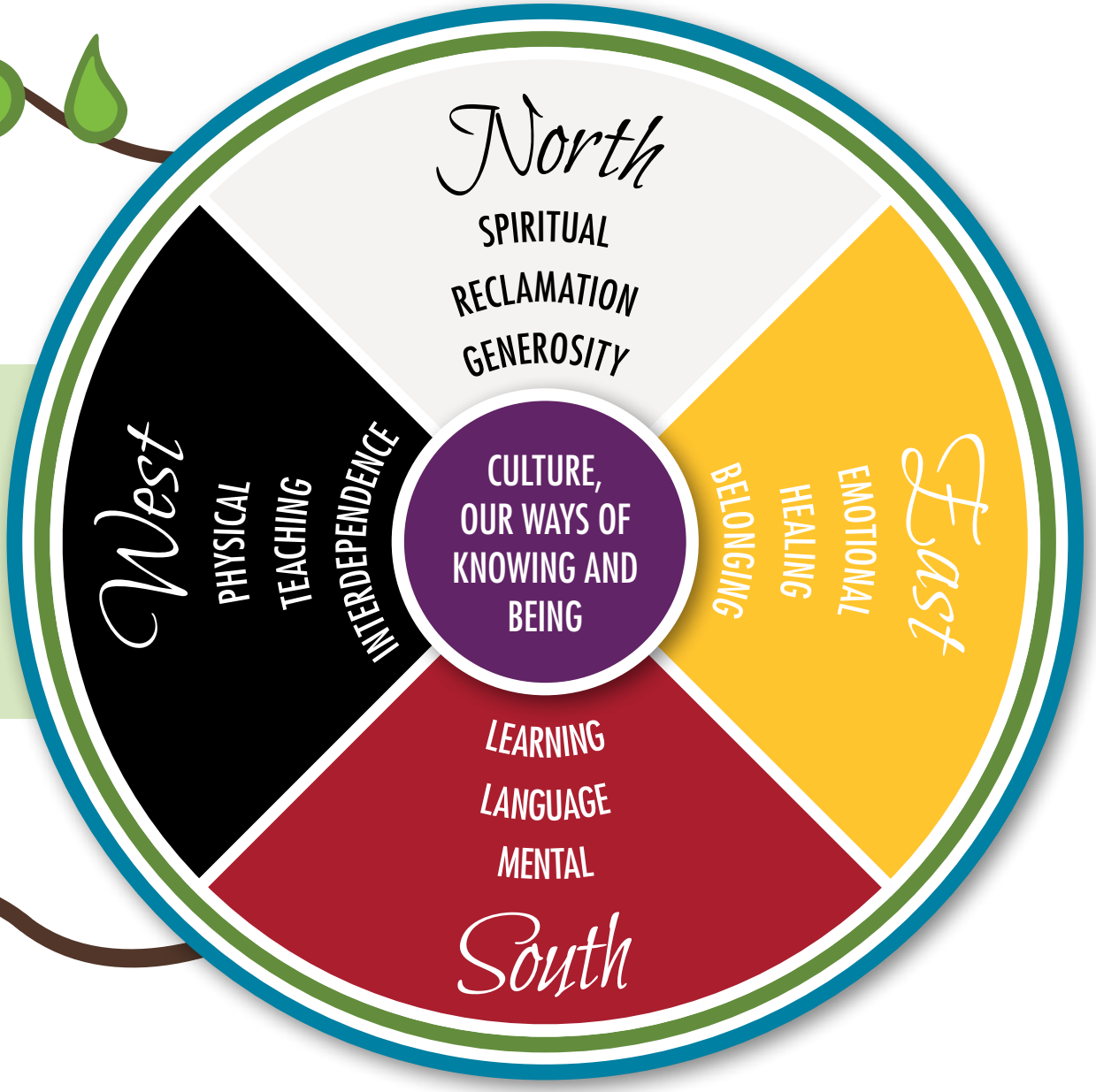
Note: This map is incomplete because it does not include the names and locations of Indigenous Interprofessional Primary Care Teams that have recently opened or are currently in development: Mamaway Wiidokdaadwin Primary Health Care Team (North Simcoe - Muskoka), Matawa Health Co-operative (9 communities in Northwestern Ontario), Tsi nonwe Aetewa'nikonriyoh-stahkwake Healing Centre (Tyendinaga Mohawk Territory), Mushkegowuk Council Area Primary Care Team (Northeastern Ontario), North Bay Indigenous Hub (North Bay), Temiskaming Mino M'shki-ki Indigenous Health Team (Temiskaming Shores), and Wasauksing First Nation (Parry Sound).

APPENDIX 2

MODEL OF WHOLISTIC HEALTH AND WELLBEING

A Time for Reconciliation

Cultural teachings and traditional practices vary between nations and regions. All are recognized and respected. The value systems represented by this Model of Wholistic Health and Wellbeing are the common ones that frame the work of the Indigenous primary health care organizations toward healthy communities.



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Chi-Miigwetch!

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