Spirit of Mino-Pimatisiwin - A Good Life

Nishnawbe Aski Nation Mental Health And Addictions Engagement Project Report
March 2016

ABSTRACT - Executive Summary, Introduction, Mental Health & Addictions Engagement Session Findings; Survey Results, Document Review Consolidated Recommendations; Programs and Services; Addressing the Three Themes - Taking Stock; Moving Forward; Shared Outcomes, Pulling It All Together

Nishnawbe Aski Nation
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First Nations, Nishnawbe Aski Nation

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Executive Summary

The Ministry of Health and Long Term Care is conducting Phase 2 of *Open Minds, Healthy Minds*, Ontario's comprehensive Mental Health and Addictions Strategy. The Ministry has indicated that it is committed to a dedicated Aboriginal engagement process.

Nishnawbe Aski Nation (NAN), a First Nations Provincial Territorial Organization (PTO) representing forty-nine Northern Ontario First Nations, has been funded to conduct the NAN Mental Health and Addictions Engagement Project, to collect NAN-specific input into Phase 2 of *Open Minds, Health Minds*. The engagement sessions are focused on three themes, *Taking Stock, Moving Forward, and Shared Outcomes.* Engagement session one was held in October 2015 with the NAN Health Advisory Committee. The committee is comprised of health directors from seven NAN tribal councils and independent First Nations. Session two was held in March 2016. The participants were front line workers, including community health directors, an addiction treatment service director, a concurrent disorders clinician, a mental health therapist, a Suboxone program coordinator, a Chief from a remote First Nation, Deputy Grand Chief of a Tribal Council (also former front line worker), and NAN Health Policy and Planning staff. Session three will take place in the fall of 2016 in the form of a NAN-wide conference where all forty-nine NAN communities will be represented. Questionnaires were also developed and distributed to First Nation community workers, and a document review was conducted.

The first two sessions focussed on Theme One. Answers to questions from Theme Two also emerged during the sessions due to the fact that the themes are inter-related. Expansion of the work on Theme Two and Theme Three will take place during the third engagement session in the fall of 2016.

The findings from the engagement sessions, survey results, and document review are contained in this report. Relevant information that arose during the NAN Special Needs Focus Group Sessions (January-March 2016) and the NAN Multi-Agency Meeting and Counselling Roundtable, which was held March 1, 2016, has also been incorporated in this report.

The Mental Health and Addictions Engagement Sessions looked at what is working for NAN First Nations in terms of programs and services, what the gaps and barriers are, and how the gaps and barriers could be addressed. The majority of the gaps and barriers identified fall into the falling categories:

Program and Service Deficits

There are not enough programs and services at the community level and not enough counsellors, clinicians and specialists visiting the communities on a regular basis. Government funded agencies do not have the resources to meet the needs of the communities. Travel to remote First nations is very expensive. Agencies that do assessment and treatment often only make visits to communities once a year. There are six to eight weeks between counselling appointments for clients, including high-risk clients.

Traditional and cultural healing practices and land-based healing programs have had success in the First Nations that have been able to develop them. Cultural and traditional healing programs need to be available to all NAN communities.

One of the most obvious deficits in community services is Suboxone aftercare. There is also a lack of programs and services for other drug addictions, including alcohol.

Workforce/Training/Capacity Deficits

The community level workforce is generally untrained to meet the needs of the complex mental health and addiction issues that clients are presenting with. There are almost no NAN First Nations that have workers trained in trauma or PSTD, even though children, youth, and adults are suffering from high levels of trauma.

There is high turn over of workers due to year-to-year funding for programs, which sometimes is not established until after the first quarter. This is especially true of the special needs tutors and assistants in the schools where there is already a critical deficit of capacity to support children with special needs and mental health issues. Many children and youth with special needs stay home from school because there are not enough support workers, to assist them.

Community worker positions often remain unfilled, sometimes for years, due to lack of capacity at the community level. Wages for community level front line workers are low compared with similar positions for other Ontario front line workers. Positions for skilled clinicians in some of the regions of NAN often remain vacant, in some cases for years.

Community members are hesitant to seek help from community workers due to fears about confidentiality. In small First Nation communities a front line worker is likely to be a relative, friend or neighbour. Non-Insure Health Benefit generally denies travel approval for service out of the community if there is a mental health worker position in the community. However, sometimes these positions are vacant or it is not appropriate for the community member to disclose information to the community worker.

Infrastructure

There is inadequate infrastructure to accommodate programs and services at the community level. Most communities lack private counselling space that supports safety, confidentiality and trust. Communities struggle to provide appropriate spaces for outside counsellors to meet with mental health clients. Some counsellors have reported that they have to meet clients in cars. There is also a lack of accommodation in many communities for the visiting counsellors.

NAN First Nations have been experiencing a housing crisis for many years. Houses are substandard and overcrowded, often with multiple families living in cramped quarters. This contributes to the stress families are already experiencing, and negatively impacts individuals with special needs and mental health issues. Poor sewer and water systems and on-going boil water advisories put added stress on community members.

Schools lack tools and equipment to support students with special needs. Many communities lack infrastructure for recreation and activities for youth, children and Elders.

Coordination/Case Management/Collaboration Issues

There is a lack of coordination between regionally based, government funded, mental health and counselling services and community level services. There is a lack of case management at the community level. Mental Health program staff work in "silos," often in different buildings, and in some cases without offices. There is little or no information sharing or communication between programs.

Community front line workers may be accountable to the health director in one community and in another they may report directly to the funder or the band manager. In some communities there is a combination of all three. There is poor communication between the mental health programs and the community nurses, and visiting doctors. Clients in remote communities who are referred by a community worker to the doctor often wait months to be seen. They get bumped down the list after emergencies and other urgent health cases. This is particularly true regarding children with special needs or behavioural issues. Unless the person is in a mental health crisis, they are not a priority. The community has so many urgent health needs and doctors may only visit the community twice a month.

At the regional level, service agencies are not coordinated with each other. An example was given that occasionally a private agency may be seeing the same clients as Nodin Child and Family Intervention Services because there is no case management at the community level. The collaboration that may be taking place at government bilateral tables is not trickling down to the operation level. Programs are developed and positions are created without knowing what the real, "on the ground" situation is in individual communities. Services and programs are created at the government level when there may be very limited capacity to implement them successfully. There is rarely adequate on-going training for workers and often no support and supervision.

Data Collection and Information Sharing

There is gap in the area of information collection and data sharing. Without actual community-by-community and service-by-service scans and data collection, it is impossible to know the specific needs of each community. Some agencies keep statistics on certain aspects of mental health, but there are huge gaps in the type and amount of data needed. It is impossible to create

a coordinated approach between the community and regional level without sharing information. There currently are no accurate statistics on the number of suicide attempts or completed suicides. According to the participants in the engagement sessions, 80% of deaths by suicide, of people eighteen years of age and older, are listed as "other" by the coroner, with only the family being told the cause of death.

The Connection Between Trauma, Special Needs and Mental Health

There are extremely high levels of trauma in NAN First Nations among community members, including children. Trauma is an urgent mental health issue that is not being addressed and is exacerbating the level of crisis happening in First Nation communities.

Special needs are not being addressed in remote NAN First Nations, which is compounding the growing mental health crisis. NIHB does not cover travel or service costs for assessment or treatment of special needs. Children and youth are falling through the cracks and not being identified.

"There are huge numbers of children in the community that I visit that need speech and language therapy, children who are seriously delayed, but there are no services. Parents can't afford the thousands of dollars it would cost to bring the children out for therapy" -Physician, Sioux Lookout Zone.

Many children are not attending school because there are not enough trained assistants in the schools to help them. When special needs are not assessed and treated, children develop concurrent and compounding mental health issues. Children and youth with special needs are experiencing trauma in First Nation communities. As the child gets older, he/she is at high risk for developing addictions, for becoming victims of violence or perpetrators of violence, for suicide, and for coming into conflict with the criminal justice system. There is an inequality in access to services between First Nations in remote locations and First Nations who are close to urban centres where the children may attend provincial schools.

Culturally Competent, Cultural Safety, and Culturally Appropriate Services

Programs and services for mental health and addictions for NAN First Nations often lack cultural competency. Workers and clinicians who come into the community to provide counselling and mental health services have limited background or understanding of First Nations. Even Aboriginal service providers sometimes do not fully understand the intergenerational impacts of colonialism, the residential school system and the resulting social issues and trauma. Programs and services lack cultural safety. Also, there is a need for culturally appropriate programs and services at the community level and the regional level.

Education and Awareness/ Outreach and Prevention

There is a need for awareness and understanding at the community level about mental health, addictions, and special needs. Effective outreach, education and prevention strategies are lacking.

Funding and Resources

Programs and services at the community level and the regional level are chronically underfunded, including schools.

Jurisdictional Issues and Government Policies Impede Access

There are several areas where federal policies impede access to provincial services. The most striking example that was identified in the engagement sessions relates to Non-Insured Health Benefits (NIHB). NIHB policy does not support travel or pay for rehabilitation services related to special needs, unless it is to a physician or NIHB approved clinician. Another NIHB issue that was identified is self-referral for mental health. Although the policy framework indicates that individuals can self-refer for mental health counselling, in reality funding for travel will be denied for self-referrals. Several engagement session participants from the Sioux Lookout Zone related that the only way a person living in a remote First Nation can access service outside of the community is to reach the point of crisis, that is, "to be a danger to one's self or others." When the individual has reached that point he or she will be medvaced out of the community, stabilized for seventy-two hours and returned to the community with no immediate support or follow up. When the person returns home, it will be six to eight weeks between counselling appointments.

Sometimes the individual will not return to the community and will live on the street in the urban centre where he/she was medevaced to. In reality, NIHB policy impedes access to appropriate services.

Indigenous And Northern Affairs Canada (INAC) registration policy has made it more difficult for some parents to register their children. Unregistered First Nation members cannot access health services, including mental health services. Non-registration is a growing problem.

Parents are afraid to disclose mental health or addictions issues to a counsellor in one sector because they are afraid that another jurisdiction, specifically the child welfare agency, will apprehend their children.

Building On The Things That Are Working

Participants in the engagement sessions, as well as survey respondents, indicated that very little is working. Many good programs and services would work much better with more training, better coordination, community case management, infrastructure and adequate resources, and more mental health and addiction workers at the community and regional level. Programs that are working (improvement for the client and community) are the Suboxone programs, traditional and cultural healing programs and land-based healing, and coordinated case management for suicide prevention and intervention in the communities that have these services. The Suboxone program needs an aftercare component to be successful.

Engagement session participants had many ideas for improving the system. Participants indicated that development of a team approach to service at the community level, as well as developing community level and regional level service hubs would improve the effectiveness of programs and services. Training is also critical. Participants also recommended that First Nation mental health workers and child welfare workers, along with other NAN First Nation service providers, be present at the table when provincial and federal government ministries are planning and making decisions about First Nation mental health and addictions services.

A system for data collection, management, and sharing is required to track actual numbers including type of referrals, number of suicide attempts and completions, and number and type of

mental health and addictions episodes. Data that reflects the actual situation on the ground in individual communities needs to be gathered and used to inform planning at all levels.

Service Equality

First Nations that are close to urban centres experience a different level of service compared to First Nations that are remote. For example, the Wabun Tribal Council communities located in the Timmins-Cochrane area are close to towns and centres where services can be accessed by road. The children in all but one of the five Wabun communities attend provincial schools. Provincial schools have more resources, including special education teachers and assistants. The children from these communities are more likely to have their special needs and mental health issues identified. They will experience more access to treatment and services than children from remote NAN First Nations or drive-in communities that are a long distance from an urban centre. However, the level of mental illness and addictions in drive-in communities is similar to remote First Nations. Community members residing in remote First Nations as well as drive-in communities struggle to navigate the complicated system of mental health and addictions services.

The Three Themes

Detailed information from the NAN mental health and addictions engagement sessions, the surveys and the document review, is presented in the following pages. The information is summarized in the final section of the report under the Three Themes: Taking Stock; Moving Forward; and Shared Outcomes

-Anita Asche Fraser, Facilitator, Report author.

Introduction & Community Context

Nishnawbe Aski Nation is a First Nation Provincial Territorial Organization (PTO) with forty-nine member First Nations. Thirty-four NAN First Nations are remote and accessible only by air or winter ice road. NAN First Nations are grouped into seven First Nation Councils and six independent First Nations. The people speak dialects of Cree, Ojibway, and Oji-cree. Most NAN First Nations are treaty partners with Ontario and Canada under Treaty No, 9. Seven NAN First Nations are beneficiaries of Treaty No 5, and one NAN First Nation is affiliated with the Robinson Superior Treaty. The NAN First Nation territories encompass almost two thirds of Ontario. The total population of the NAN First Nations, both on reserve and off reserve, is 45,000.

Each NAN First Nation is unique. Mental health and addiction programs and services vary from First Nation to First Nation. There are generally a core group of community workers coordinating various programs funded by Health Canada and/or Indigenous and Northern Affairs Canada (INAC).

All NAN First Nations are experiencing a health and wellness crisis resulting from the impacts of the residential school system, displacement from the land, the *Indian Act*, the erosion of culture, language and traditional lifestyle, and chronically underfunded, or non-existent services.

Communities are experiencing:

⇒ burgeoning mental health issues including depression, anxiety, trauma, post-traumatic stress (in children as well as youth and adults); increases in schizophrenia, bipolar disorder and other mental illnesses

⇒ high rates of suicide, including youth suicide (suicide of children as young as ten years old have occurred)

⇒ poor physical health and increasing incidence of disease and illness

⇒ escalating lateral violence

⇒ physical and sexual abuse

⇒ families in crisis

⇒ loss of parenting skills

⇒ family breakdown/family stress/family violence

⇒ inadequate infrastructure (sewer and water); lack of office and counselling space

⇒ overcrowded, substandard housing and acute housing shortages,

⇒ high cost of living and high food prices (e.g. box diapers $100 dollars, bag of milk $15)

⇒ Poor nutrition, high rates of diabetes and associated complications

⇒ loss of capacity to harvest and prepare traditional foods

⇒ disconnect between Elders and youth, Elders and adults (Elders are the knowledge carriers and traditionally have transferred the knowledge to the next generation)

⇒ continued erosion of culture and language

⇒ low literacy and numeracy rates

⇒ high drop out rates and high absenteeism at school

⇒ impacts of racism on mental health

⇒ children being taken into the care of child welfare agencies at alarming rates

⇒ poverty

⇒ high unemployment (in some communities as high as 80%)

⇒ high rates of drug and alcohol addiction

Pikangikum First Nation's Community Health Plan identifies that 97% of all their Tikinagan child welfare cases are alcohol related, and 90% of all probation in the community are related to alcohol use.

A 2014 study of 1206 consecutive births in the SLMHC catchment area found that the incidence of narcotic use in pregnancy has risen to 28.6%

According to the Canadian Psychiatric Association, suicide is the leading cause of death for Aboriginal persons under the age of 45. From 1986 to November 2014, there have been over 400 suicides in the First Nations in the Sioux Lookout area.

The Ministry of Health and Long Term Care is conducting Phase 2 of *Open Minds, Healthy Minds*, Ontario's comprehensive Mental Health and Addictions Strategy. "In order to inform provincial investments and program planning for Phase Two of Ontario's Mental Health and Addictions

Strategy, the Ministry is seeking advice from First Nation, Metis and urban Aboriginal organizations on the following key themes related to mental health and addictions and the delivery of programs and services to Aboriginal People"

1. Taking Stock
   - ⇒ What is working well
   - ⇒ What are the community needs?
   - ⇒ What are the program/service gaps?
2. Moving Forward
   - ⇒ Where and how can we build on existing initiatives?
   - ⇒ What culturally appropriate services are needed and where?
   - ⇒ What are the areas for enhanced cross-sector collaboration and how?
3. Shared Outcomes
   - ⇒ How do we increase awareness of programs and services among communities and individuals?
   - ⇒ How can we measure success together"

   -MOHLTC Funding Application for Engaging Aboriginal Partners

NAN has been funded by the MOHLTC to conduct the NAN Mental Health and Addictions Engagement Project. Two engagement sessions were held in fiscal year 2015-2016. A third session will be held in the fall of 2016 and will invite participants from all forty-nine NAN First Nations. A document review was conducted and a survey was developed to gather feedback from First Nation community service providers. The results of the three initiatives are contained in this report.

Mental Health and Addictions Engagement Session Findings

NAN held two Mental Health and Addictions Engagements Sessions. The NAN Health Advisory Committee, comprised of Tribal Council and independent First Nation Health Directors, participated in the first session in October 2015. Participants in the second session, held in March 2016, included two First Nation leaders, community health directors, front line workers, addiction treatment service director, concurrent disorders clinician, a mental health therapist, a Suboxone coordinator, and NAN Health Policy and Planning staff. During the sessions the participants provided input on the three key themes provided by the Ministry of Health and Long Term Care:

1. Taking Stock
2. Moving Forward
3. Shared Outcomes

NAN has forty-nine First Nations, spanning several districts and geographical areas. Every community is unique. The First Nations have varying levels of services in their communities. They also access services from outside the community in different ways, and through different agencies. While many of the issues are shared issues, there are differences between drive-in communities and remote communities. There are also differences between access to services for drive-in communities that are close to an urban centre, and drive-in communities that are several hours from a service centre. However, the problems with mental health and addictions that community members are experiencing are occurring in all NAN First Nations.

There is a lack of appropriate, accessible mental health services for all NAN First Nations.
There are also different levels of community capacity to address mental health and addictions, and needs differ from community to community. The following information is a compilation of the gaps/barriers/needs being experienced by NAN First Nations.

Gaps, Barriers, Needs

Infrastructure:

- ⇒ lack of infrastructure for counselling "people are meeting in cars" – and no confidentiality
- ⇒ lack of office space for workers
- ⇒ lack of accommodation for outside counsellors and mental health workers when they visit the community
- ⇒ lack of infrastructure to house a team of workers so they may work together
- ⇒ lack of adequate tools, (phones, computers etc.)
- ⇒ inadequate/substandard housing – people living in crowded conditions – contributing to and exacerbating mental health issues
- ⇒ lack of adequate/safe sewer and water facilities -35 of 49 communities do not have potable drinking water causing more stress on community members

Community Programs/Workers/Training

- ⇒ not enough community mental health workers
- ⇒ inconsistency of workers negatively affects trust
- ⇒ positions remain unfilled, sometimes for years
- ⇒ serious lack of training for mental health workers, high staff turn over with no re-training of new staff
- ⇒ lack of specialized training to address different mental health disorders
- ⇒ lack of trauma training – escalating rates of trauma and PTSD among children and youth as well as adults
- ⇒ confidentiality issues-related to being relatives and neighbours as well as lack of support/supervision and training for front line workers

"*No one wants to see the community worker in our community. We don't trust them to keep things in confidence and we know they don't have enough training to deal with complex and serious mental health problems or addictions.*"

-Participant, Mental Health and Addictions Engagement Sessions

⇒ NIHB makes assumptions that there are "appropriate" counselling services for every mental health issue in the community when it is rarely the case (denying travel outside of the community)

⇒ lack of secure data collection and sharing system – communities lack databases or access to databases

⇒ poor retention rate of workers due to burnout

⇒ Everything is being dumped on crisis workers. Crisis workers need a terms of reference. They are the ones being relied on and often they are related to the family in crisis.

⇒ If you are a crisis worker in a community your job is 24-7 with no counselling or debrief

⇒ front line community workers are underpaid

"There are some people doing excellent work, and don't necessarily have degrees or specialized accreditation. We should not just think that people with PHDs or master's degrees can do counselling, but everyone involved needs training to expand their skills."

-Participant, Mental Health and Addiction Engagement Session

Off Reserve Services

⇒ inadequate number of counsellors providing minimal amount of service e.g. 2-3 counsellors handling 75-100 people with serious mental health issues in an enormous geographical area. Counsellors may only be able to deliver **one counselling session every 6 to 8 weeks**. In some areas there is only one counsellor for 3-4 communities

⇒ burnout and employee retention issues

⇒ The inability to travel in to communities due to weather or community crisis, often means clients are being seen less than every six to eight weeks.

⇒ Some outside services only have the resources (human and financial) to travel into a community every 6 months, or once a year, especially for assessments of children and youth with special needs

⇒ Even when a treatment plan is made after a crisis intervention it is a minimum of six weeks between counselling appointments.

⇒ There are only 2 specialists for 33 communities in the Sioux Lookout Zone.

⇒ Mental health workers work nine to five Monday to Friday. After hours incidents fall to the community crisis worker, Nishnawbe Aski Police Service (NAPS) or OPP

Mental Health Services Outside of the Community:

⇒ The criteria for getting outside help is “**crisis.”** – i.e. going to harm self or someone else.

“If someone is suicidal or aggressive, they have to be right at the point of committing suicide or harming another person before they can access mental health services. At the crisis point they will be “form-oned,” (Form One –danger to self or others) medevaced out for treatment at a hospital, held seventy-two hours and then released. The person will either end up back in the community waiting eight weeks for a counselling appointment, or they will end up on the street in Sioux Lookout or Thunder Bay.” -Participant, Mental Health and Addiction Engagement Sessions

“When we tell the nursing station, or even the doctor, that is if we even get to talk to a doctor, we are advised to throw our relative with the addiction issue out of the house so that the person will come into crisis and then get medevaced out. It is very stressful on families and the whole community. The person is stabilized and sent back so the whole thing can start all over again…until someone dies.” -Participant, Mental Health and Addiction Engagement Sessions

⇒ Persons with mental health issues and addictions are often in conflict with the criminal justice system because NAPS and OPP are the first ones called due to the fact that person has not been assessed or treated for their mental health and addictions issues.

⇒ **There’s a 2 month waiting period for high-risk people to come out for treatment.**

⇒ James Bay Coastal Communities **–** only residential school survivors can come out for mental health treatment. This is a policy of the Weeneebayko Area Health Authority (WAHA). (Timmins does not have capacity to absorb the number of clients who need mental health and addiction treatment)

⇒ There are only two addiction workers for the whole of the James Bay Coast, as well as one First Episodes Worker.

⇒ In Moose Factory the counsellors at the hospital are the unofficial EAP for the hospital workers as well.

⇒ Keewaytinook Okimakanak Council is paying for services for First Nations clients, specifically for EMDR and PTSD.

Non-Insured Health Benefits

⇒ NIHB does not cover EMDR treatment for post-traumatic stress

⇒ Many mental health therapies are not covered by NIHB, e.g. art therapy.

⇒ Although NIHB says there are self-referrals for mental health issues, it doesn't happen. NIHB denies travel for self-referrals even when the person has had a plan developed by clinicians through an agency.

⇒ NIHB does not fund travel for special needs children and youth to be assessed or access services. A doctor must refer to another doctor (e.g. paediatrician, psychiatrist, psychologist) and families try to tack on services when they go out for medical appointments. Drive in communities can self refer to urban centers because they travel on their own or the First Nation has a medical van and they can get a ride. There are inequalities in access to service between drive-in and remote First Nations.

⇒ NIHB will only pay for services from certain level or designations – e.g. PhD, Masters etc. and these qualifications are a barrier to building mental health counselling capacity in First Nations and at the regional level.

⇒ Registration is an issue, partly due to INAC policy that fathers must also sign to register a child, and the time limits for registration. Unregistered children/youth/adults will not be approved for health benefits and cannot access health care services.

Coordination of Services and Programs

⇒ lack of coordination of services regionally

⇒ lack of coordination of community-based services and workers

⇒ lack of team approach to services at the community level

⇒ lack of communication between workers at the community level

⇒ lack of data sharing or central data base (no information shared between outside and community service workers/nurses/doctors) – occasionally children are receiving services

from more than one agency with different modes of care, sometimes conflicting modes of care

⇒ lack of coordination between federal ministries and provincial ministries example: NIHB policy does not support access to several provincially funded services.

⇒ lack of coordination between the Education Authority and the Health Authority at the community level

⇒ example of the planning difficulties related to jurisdictions – The Matawa Communities are associated with two health zones, Sioux Lookout and Thunder Bay, as well as three different health centres, and four different hospitals (Thunder Bay, Sioux Lookout, Geraldton and Hearst)

Data Collection and Database

⇒ There is no comprehensive data collection for First Nations. In order to plan or create programs, data needs to be gathered, and information sharing must happen between agencies, services, communities, and governments.

⇒ There is no central database where information can be stored and shared securely by all services.

⇒ Information sharing protocols and protection of data needs to be addressed.

⇒ 80% of deaths by suicide or alcohol and drugs are reported as "other". The cause of death is not recorded by the coroner if it is a suicide when the person is over eighteen. Only the family is given the cause of death. If the person is under eighteen there is an inquest.

⇒ Incidents are not reported.

"We are losing so many people. People are dying from many things, including mental health issues and addictions. Our community is traumatized. How can we work with governments and services to address these issues when no one has the whole picture?"

Participant, Mental Health and Addiction Engagement Sessions

"First Nations and service providers, as well as governments need to know how many completed suicides in each community and how many attempts. How many people died from drug overdoes? How can the government expect to improve services if no one has the information they need to plan? -Participant, Mental Health and Addiction Engagement Sessions

⇒ People should only have to tell their story once - data needs to be shared between service providers

⇒ Governments do not have the whole picture. Their forms don't collect enough data.

Child Welfare

⇒ Parents afraid their children will be taken away if they seek help for a mental illness for themselves or their children.

⇒ Children with special needs, mental health, and behavioural issues are being placed in care because there are no assessment or treatment services in the communities.

⇒ families and care givers for children and youth with special needs (including those who have not been assessed) are overwhelmed trying to cope with no services or respite.

⇒ Child welfare intervenes when there is crisis in the family that may have arisen out of mental health or addictions issues and children are removed from the community due to lack of services in the community to address the family's issues.

"We need prevention and treatment before apprehension." – Participant, Mental Health and Addictions Engagement Sessions

Nursing Station Response to Mental Health

⇒ Physical health is the priority, i.e. acute health or life-threatening issues. Mental health and special needs fall to the bottom of the list at the nursing station until it is a crisis.

⇒ There aren't enough physicians to spend enough time in the community to see people with special needs or mental health issues.

⇒ Once a person is in crisis, "a danger to themselves or others," they will be medevaced.

⇒ There is no coordination or collaboration with other community programs.

Special Needs

⇒ Children and youth with special needs develop compounding and concurrent mental health issues because special needs are not identified, assessed or addressed.

⇒ NIHB does not fund travel or service for special needs

⇒ lack of assessment

⇒ lack of services

⇒ lack of monitoring

⇒ speech and language needs are enormous in first nations but no services or access to service due to travel denials.

⇒ no support for families or parents

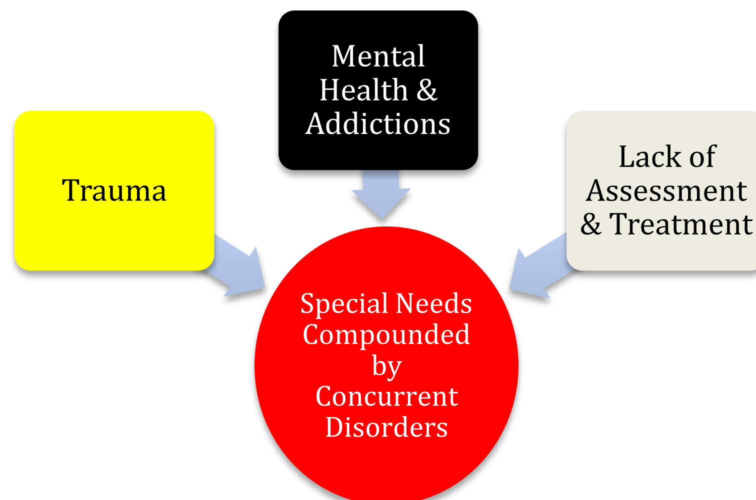
⇒ family burn out, family stress, family mental health issues due to lack of program and supports

⇒ lack of support in the schools, schools chronically underfunded. Funding is based on a formula that does not take into consideration he number of children with special needs.

⇒ large numbers of children not going to school due to lace of assessment/identification and support in the class room

⇒ Unaddressed special needs lead to mental health issues. Youth and adults are high risk for coming crisis, conflict with the criminal justice system, suicide, violence, victimization, stigma.

⇒ Trauma and family addiction issues compound special needs.



Special Needs and the Trauma and Mental Health Connection

Schools

⇒ Schools are not equipped to deal with all the special needs and mental health needs of the children and youth.

⇒ Children are staying home from school-large numbers of children do not go to school because there are not enough special needs support persons resulting in compounding

mental health issues, low literacy rates, isolation, low self esteem, depression, high risk to become victims of violence or abuse, suicide

⇒ in-consistent and high turn over of teaching assistants – year to year funding not decided until September – no multiyear funding

⇒ inequality of funding between First Nations schools and provincial schools

⇒ First Nation off-reserve high schools do not get funded for counsellors or crisis-AANDC only funds First Nations for these things and the schools are not First Nations.

⇒ First Nation schools are considered "private schools" which restricts their access to provincial programs and services.

Emerging Issues

⇒ When NODIN or another agency comes to a community in the in the Sioux Lookout Zone, it is taking 1-2 days to assess a school age child due to the complexity of the special needs and mental health issues.

⇒ There is an increase in the number of people with schizophrenia.

⇒ There is an increase in the number of people with bipolar disorder (also in children)

⇒ First Nations are also experiencing an increase in special needs including autism, and speech and language issues.

⇒ Children are committing suicide, some as young as ten years old.

⇒ There is an increase in the number of children, youth and adults with PTSD.

⇒ There is an increase in sexual addictions and pornography addiction. (the internet)

⇒ Communities are concerned about the potential long-term effects of Suboxone.

⇒ There are no maternal addictions programs or services in communities.

⇒ There is a need for detoxification programs at the community level as well as treatment and aftercare for addictions including Suboxone.

"No one wants to talk about sexual abuse but it needs to be addressed." –Participant Mental Health and Addictions Engagement Sessions.

⇒ nutrition – Communities need awareness around health diets and traditional foods. It is important to teach young people how to prepare traditional foods. Food prices are very high in remote communities.

Successful Programs

- ⇒ The WAHA IRS traditional healing program was extended by two years due to its success
- ⇒ Constance Lake FIRST NATIONS land based detox program
- ⇒ Suboxone programs – e.g. Slate Falls – 18 clients on Suboxone, worker reports a big improvement in the community
- ⇒ National Kids' Help Line (High numbers of youth accessing the national help line – however they need to connect the help line to services)
- ⇒ Telemedicine for follow up for counselling and psychiatric assessments
- ⇒ In Moose Factory a father started a day program for children with special needs and has been able to find some funding due to the success and popularity of the program
- ⇒ Nodin community wellness.
- ⇒ Webequie community case management for suicide prevention – coordinated case management for intervention, counselling and follow up. All community resources are used, even the church minister will do follow up.

Improving the System

- ⇒ more training and support needed for healing circles
- ⇒ more funding for traditional healing/cultural treatment, land based healing and aftercare programs (Moose Cree First Nation- within 2-3 months the traditional healing program expanded and was successful)
- ⇒ change NIHB policy as it currently will only pay for traditional healing for physical illness but not for a mental illness.
- ⇒ after care program for Suboxone clients
- ⇒ consistent prevention and intervention assessment
- ⇒ more use of video counselling and tele-psychiatry (does not work for crisis and requires safe place, but good for on-going counselling)

"When creating programs we need to look at the whole problem in the community, tools, infrastructure, office space, governance, accountability, capacity, training, and how it will work with other programs." - Participant Mental Health and Addictions Engagement Session

- ⇒ make an investment in more front line workers and community-based care

⇒ create services in the community for adults as well as youth and Elders

⇒ transitional services for children in care are lagging - improvements needed by ministry to respond to the applications before 18th birthday so clients can prepare.

"When we create a better system we need the front line workers in place first in order to deal with the increase in assessment and referrals that will come." –Participant NAN Special Needs Focus Groups

⇒ develop pathways so people understand the system and services they're dealing with, and need to educate people on those pathways

⇒ create regional service navigators to help clients and patients navigate the system

⇒ create service hubs at the community and regional level

⇒ develop programs for alternative training and paraprofessionals- Change NIHB policy as NIHB only pays for certain level of education or designations – i.e. - PhD, Masters and these qualifications are a barrier to building mental health capacity in First Nations and at the regional level

⇒ develop methods for cross sector collaboration at the community level with whatever services exist including: NNADAP, HBHC, FASD and nursing station as well as outside services.

⇒ Develop a shared central data base; protocols for sharing information; and training on confidentiality so workers can collaborate as a team and share information between community workers and outside service providers as needed; also to track data

⇒ system needs to be a "wraparound" service with good coordination until the person is well, and/or throughout their lifetime as may be required

⇒ system needs to be client/patient centred

⇒ develop community case managers

⇒ develop multidisciplinary team approach to community care

⇒ Nodin needs one trained counsellor per community (also trained in trauma)

⇒ more funding from government for addiction workers – James Bay Coast currently has one per 50 clients.

⇒ develop First Nation recovery and aftercare programs for alcohol, cocaine and other addictions

⇒ support First Nations to build healthy communities

⇒ build life and parenting skills into programs in the communities

⇒ create mechanisms for front line workers to be heard and give feedback to at levels of planning including the provincial and federal levels.

⇒ develop comprehensive community education and awareness for mental health, addictions and special needs, including clear pathways and information about services

⇒ provide mandatory cultural competency/safety training for all levels of service workers including community workers, regional service workers, doctors, service agencies etc.

⇒ The discussion on improving mental health and addictions systems and services for NAN First Nations should be based on principles.

⇒ **Resolve jurisdictional issues and improve cross-sector collaboration**

- Bring the provincial ministries involved with mental health together with First Nation representatives and front line workers regularly to address issues, gaps and barriers.
- Bring Health Canada/FNIB/NIHB to the table with Ontario to resolve the jurisdictional issues around travel/benefits/services/education
- Bring First Nation service providers, including child welfare agencies together with NAN, Tribal Councils, to collaborate and coordinate on issues.

⇒ **Infusion of new money to support solutions and recommendations**

* see diagrams on page Creating a System That Works, p 63,63,65 NAN First Nation Mental Health and Addictions Wheel., Client Centred Service Hubs Model, Consolidated Recommendations

NAN Mental Health and Addictions Survey Results

NAN distributed the Mental Health and Addictions Survey at related workshops and conferences. There were sixty-five survey respondents from twenty-four NAN First Nations, representing the seven NAN First Nation Councils, as well as two independent First Nations. Thirty-eight respondents were from road access communities and twenty respondents were from remote communities, while seven respondents did not indicate what communities they were from. The majority of respondents were front line mental health/social workers.

The Mental Health and Addiction Questionnaire asked six questions:

1. What mental health/addictions programs are you aware of in your community?
2. What is working well now?
3. What are the community needs?
4. What are the mental health/addictions programs and services gaps?
5. What other mental health programs are you aware of?
6. How can the community based mental health/addictions services be improved in your community?

The respondents tended to blend their answers together when answering the questions. The following are the survey results:

Question One - What mental health/addictions programs are you aware of in your community?

Most common answers, in order of how often they were identified by respondents:

1. Suboxone
2. None
3. NNADAP
4. FAS/FAE

Question Two - What is working well now?

Most common answers, in order of how often they were identified by respondents:

1. **Suboxone***
2. **traditional and cultural programs***/land-based healing/healing circles/drumming

   *These were by far the most repeated responses, in spite of the fact that some communities (North-eastern Ontario and James Bay Coast) are still without Suboxone programs, and some respondents had concerns about the long-term use of Suboxone.
3. “nothing” or “no active programs” or “positions for programs not filled”
4. outside of the community treatment programs when accessible
5. outside counsellors when they can visit the community regularly
6. crisis program
7. community men’s and women’s groups (specific to 2 communities)
8. community anti-bullying program (specific to 1 community)

Question Three and Six – combined answers. What are the community needs? How can community-based mental health addiction services be improved in your community?

There were many suggestions regarding community needs. By far the three most significant community needs / required service improvements identified by the respondents were:

⇒ **after-care for people being treated with Suboxone**

⇒ **more resources and support for land-based healing /traditional healing** /cultural teaching/ ceremonies/ bring traditional and cultural healers to the community

⇒ **more trained and qualified counsellors at the community level and regional level** /more one-on-one counselling /more visits to the community from qualified and trained counsellors /counsellors trained in trauma/ culturally competent, culturally safe and culturally appropriate services and training for counsellors /fill positions at community level/ more training for workers about addictions /workshops for workers about addictions

Followed by:

⇒ **youth services -** counsellors for youth /activities and recreation for youth /drug and alcohol awareness programs and education for youth /drug abuse and suicide intervention programs for youth

⇒ **community education / awareness / prevention programs for drugs and alcohol abuse**

⇒ **travel for mental health** services (remote communities, especially in the Sioux Lookout Zone have no access to services outside the community due to **NIHB travel denials**)

⇒ **infrastructure –** buildings / office space / place for confidential counselling / housing for community counsellors and counsellors in centres like Moosefactory. (lack of housing directly related to recruitment and retention of professionals) – youth meeting place

⇒ **reduce waiting lists** for counselling and services (Its taking too long to get help)

⇒ **trust & confidentiality at the community level** must be improved (education & awareness as well as training for staff and somewhere to hold counselling sessions

⇒ **standardized, mandatory and regular screening for special needs and mental health** at the school.

⇒ **daycare** to help parents dealing with addictions or attending programs

⇒ **community alcohol and drug abuse programs**

⇒ **Elders need counselling** and support services

⇒ **transitional programs** / halfway houses

⇒ **recreational opportunities and programs**/events/workshops/traditional events/sporting/hunting and fishing/ camping

⇒ **more volunteers**

⇒ **crisis training**

⇒ more use of **telehealth** when appropriate

*More **funding and resources** are required in order to address the needs identified by the survey respondents. This was identified repeatedly in the survey responses.

Question Five: What other mental health programs are you aware of?

⇒ no services identified - 45 respondents indicated they did not know of any services available, or left the questions blank

⇒ one-two services identified -16 respondents

⇒ three-five services identified - 4 respondents

Survey Results Summary

Awareness of mental health and addiction services at both the community level and regional level is very low among respondents. Some respondents consider there to be no services at the community level even though they are community workers. Positions do not necessarily translate into services.

Suboxone programs are working and are having a positive impact on lives and on the community in general. Aftercare for Suboxone is lacking, however not all communities have Suboxone programs and there is no opiate program on the James Bay Coast for the Muskegowuk First Nations.

Traditional and cultural programs are working, as well as land-based healing. Outside mental health programs where the workers can visit the community could be successful, but they do not visit enough and there is too much time between visits. Outside treatment programs are successful when community members can access them, but there is no aftercare programs in the community. Community crisis programs are working but the community crisis workers often burn out. Other individual programs developed and implemented by communities have been successful, like one community's anti-bullying initiative.

There is an immediate need to change NIHB policy and operational interpretation of policy regarding travel for mental health and special needs.

There is a critical need for trained, qualified, consistent mental health workers as well as the training and the infrastructure to support them, like office space and counselling rooms to ensure confidentiality for clients.

Communities need more comprehensive education about mental illness in order to raise awareness and reduce stigma. Communities need community-building activities like hunting, fishing, workshops, community events, recreational activities, cultural and traditional activities.

More focus and emphasis needs to be on youth, including youth mental health services, education about drugs and alcohol, recreational activities and youth programs.

There is need for transitional programs and aftercare, as well as programs for addictions other than opiates, like alcohol abuse and gambling.

Weeneebayko Survey Results

Weeneebayko Area Health Authority (WAHA) completed the NAN Mental Health/Addictions Survey as a team. The team included WAHA VP of Patient Care/Chief Nursing Executive; WAHA Chief Quality Officer; WAHA Director of Mental Health Program; WAHA Quality Coordinator. WAHA's Community Mental Health and Addictions program (CMH&A) staff provide mental health services in four remote First Nations along the James Bay Coast including Peawanuck, as well as Moosonee and Moose Factory.

*note - WAHA is not a First Nation community member or community worker, it is a Health Authority that provides services to 4 remote First Nations on the James Bay Coast as well as Moosonee and Moosefactory. Several of the programs and services listed below in question one are not community-based services.

Question One - What mental health/addictions programs are you aware of in your community?
WAHA referred to the Moosonee-Peawanuk Resource List.
* see the Appendix P. 69 for a list of programs and services.

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<td>2</td>
<td>What is working well now?</td>
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WAHA's CMH&A program uses both contemporary approaches and traditional approaches to health care
The Community Mental Health program conducts active referrals to the WAHA's Traditional Healing program
WAHA Telemedicine Program is actively used to address mental health and addictions concerns. Refer to the below statistics for further information:

Community Mental Health Program

In total, we had 2,682 individual patients served in 2014-2015 through the Community Mental Health program
These patients accounted for 6,333 visits
In total, we had 279 individual patients served for addictions in 2014-2015 through the Community Mental Health program
These patients accounted for 548 visits
Please note addiction counselling services were not provided for 5 months due to the recruitment of an addiction specialist

Specialty Services – Mental Health, Psychiatry and Addictions

In total, WAHA has 23 different specialists providing mental health, psychiatry and addictions services
In total, we had 859 individual patients served in 2014-2015 through the Specialty/Telemedicine Clinic program
On average, approximately 72 patients are seen per month

Traditional Healing Program

In total, 7955 client contacts were conducted in 2014-2015 through the WAHA Traditional Healing Program

Attawapiskat – 1,580 client contacts (19.9%)
Fort Albany – 1,255 client contacts (15.8%)
Kashechewan – 564 client contacts (7.1%)
Moose Factory – 1,778 client contacts (22.4%)
Moosonee – 1,498 client contacts (18.8%)
Peawanuck – 1,272 client contacts (16%)

Other – 8 client contacts (0.1%)

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<td>What are the community needs?</td>
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Responding to a Crisis in a connected and coordinated manner remains an area to be worked on. Service requests from NAN and HC are being received by WAHA's CMH&A program in response to a local area crisis. The requests are for Crisis workers to attend in the community. The CMH&A program provides mental health counselling and does not have trained crisis workers.

A crisis response team regionally would be beneficial as this currently does not exist in our region, WAHA's CMH&A program is being asked to fill this gap without the appropriate training
WAHA's CMH&A team members are "assigned" to a community crisis for a period of time
This additional demand on time takes time away from client work of which the program is designed for

Staff housing – recruitment and retention of staff is directly geared to housing availability. Housing is a recruitment and retention issue for applicants living inside and outside of the James Bay coast.

Housing directly impacts our ability to recruit qualified staff
Affordability of housing is also a key aspect based on availability
We also need to consider that some of our local mental health workers are in homes that are overcrowded and have several families in them (this doesn't allow the worker to decompress and step away from the community issues and also impacts confidentiality and privacy)

Staff supports – many of our locally based mental health workers in the communities require supports from external mental health staff to provide the local workers with relief (similar to a respite type service)

sometimes the situations that occur involve family members, external supports are required for purposes of impartiality, confidentiality and privacy
not being able to get any downtime because workers are always in the community is a continuous struggle and reflects in retention rates

Sustainable funding for a regional Central Intake and Referral Coordination program in mental health approach would be advantageous (this would support the one door approach to mental health care)

Supports a case management approach (allowing the workers to follow the individual more closely)

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4	What are the mental health /addictions program/services gaps?	• Lack of opiate withdraw programming available in the region
		  o Example - No resources to conduct a soboxone program
		    ▪ HR
		    ▪ Financial
		    ▪ Point of care infrastructure
		    ▪ External partners – pharmacy, First Nations
		
		• Physician specialized to work with addictions services would be advisable
		  o We currently have 12 FTE physicians but no one dedicated to addiction services
		
		  o With more robust funding of WAHA's CMH&A program, a proactive campaign can be focused on the prevention of substance and various mental health issues, rather than having a reactive approach
		
		• Lack of integrated service – funding is going to many different service providers within the region (WAHA, Public Health, Healing Lodges, etc.)
		  o Service providers who are funded through the Province, Feds and through third parties have different accountabilities, operational requirements, etc.
		  o Clients are referred to many different service providers depending on who is funded to offer these services
		    ▪ Different program ideologies also might confuse the client if different information is being provided by multiple service providers
		
		  o Again, a Central Intake and Referral Coordination program provides a structured approach to client referrals. Referrals are assessed using valid and reliable tools based on need and location. Local service providers would receive referrals with completed assessments. Presently the region is using a decentralized approach promoting a scattered environment.
		    ▪ Accountability & transparency - the current decentralized approach makes it difficult to complete statistical reporting.

5	What other mental health/addictions programs are you aware of outside of your community, and, are they accessible to you/your clients? Why, or why not?	*External Services*
		• Clients who are in need of services that are not offered within their community can be referred to any of the following organizations located within the NELHIN catchment
		  o Omushkegiskew House: Kapuskasing, Hearst and Smooth Rock Falls Counseling Service
		    ▪ P.O. Box 339
		    ▪ Crisis Line: (705) 336-2456 *Collect calls accepted*
		    ▪ Fax: (705) 336-1202
		
		  o Regional Aboriginal Mental Health Service - North Bay ON *ask for Regional Aboriginal Mental Health Service*
		    ▪ 50 College Drive, North Bay ON
		    ▪ Telephone: 705-474-8600

Mental Health and Addictions

Document Review

Documents that were reviewed:

NAN Multi-Agency Meeting and Counselling Roundtable, March 1, 2016 – minutes from meeting

Ontario Region First Nations Addictions Service Needs Assessment (2009)

Honouring our Strengths (AFN & Health Canada)

First Nations Mental Wellness Continuum Framework.

An Overview of Services and A Plan for Mental Health and Addiction Services for First Nations in the Sioux Lookout Area.

The Office of the Chief Coroner's Death Review of the Youth Suicides at the Pikangikum First Nation 2006-2008

Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy

Changing Directions Changing Lives: The Mental Health Strategy for Canada (2012)

NW LHIN, 2013 Mental Health and Addictions Demand Capacity Analysis

First Nations and Inuit Mental Health and Addictions Cluster Evaluation (2012)

Ontario's Policy Framework for Child and Youth Mental Health (2004)

Matawa First Nations: Back to our Roots: Chii Kee Way Meno Biimadeseyung

The Strategy to Overcome Prescription Drug Abuse/Misuse in Matawa Communities (2012)

NODIN – Suicide Paper

Nobody Wants to Die-They Want to Stop the Pain –Muskegowuk Inquiry Into Our Suicide Pandemic

Mental Health and Addictions Literature Review – Sioux Lookout Zone

Consolidated Recommendations

Workforce & Training

- ⇒ multidisciplinary teams (as opposed to one or two front-line workers for everything)
- ⇒ develop clinical supervision model
- ⇒ adequate numbers of workers (community-based and regional service providers) based on the **actual** community needs
- ⇒ increase the number of land-based and traditional healing workers and programs – acknowledgment of the critical importance of cultural/traditional healing methods – culturally appropriate strategies are FN developed
- ⇒ decrease turn over of staff through debriefing and support for front line workers
- ⇒ develop clear job descriptions to ensure workload is appropriately distributed
- ⇒ develop after hours workers or on-call system to reduce burn out of workers (e.g. crisis worker position can be 24/7)
- ⇒ on going training of an accredited workforce that is compensated in accordance with provincial equivalents including training in:
    - trauma
    - cultural competency/cultural safety
    - effective coordination and collaboration
    - education and prevention/outreach
    - confidentiality and trust building

Infrastructure

- ⇒ develop/build appropriate office space for workers, preferably together as a team
- ⇒ develop/build/ensure appropriate accommodation for regional workers when they visit
- ⇒ develop/build ensure safe place for clients to meet with workers that respects confidentiality
- ⇒ develop/build/ensure safe space for telemedicine counselling
- ⇒ develop on and off-reserve housing for mental health to address lack of housing capacity, and long wait-lists.

Continuum of Care

⇒ development of coordinated continuum of care for mental illness and addiction including prevention and treatment as well as aftercare

⇒ recognize communities as important resources an support them by developing capacity to address drug and alcohol use

⇒ funding for community based research and health planning in order to address the actual mental health situation in individual communities, and build capacity to address addictions and mental health

⇒ include long term care and Elder care, aging and mental health

Community Development, Ownership and Capacity Building

⇒ First Nation control of community services

⇒ hire, and train community development workers for each community

⇒ development of community wellness plans including:

- holistic plans that include mental health, addiction, special needs, physical health, education & school, and integrates all other community planning
- partnerships and linkages with regional services and all levels of government
- cluster resources to reduce or eliminate silos
- develop governance structures for multidisciplinary team/supervision/support/training/accountability

Education

⇒ The definition of a First Nations school doesn't exist in the *Education Act*. First Nations need building blocks put in place to keep things in place. A correct definition of FIRST NATIONS schools needs to be addressed.

⇒ First Nation Schools are currently considered "private schools" which restricts their access to resources.

Emerging Service Issues

⇒ address maternal addictions – lack of services – fear of using services due to fear of having children taken away -community support rather than placing people in care is required

⇒ Child welfare agencies have become the primary intervener and service provider for children's mental health. Also, children being apprehended and placed in care are more likely to receive service. Some parents have to give children up so they can access services for special needs. This causes stress, depression and anxiety for parents and families as well as the children.

⇒ SLZ clients must access community-based addiction workers. The can only access regional mental health services if they "also" have a mental health issue. It is not clear if this is a NIHB issue or Nodin policy.

⇒ NNADAP has become an "easy fix' for health Canada but workers are not trained for counselling and intervention for the "new" addictions e.g. opiates, methamphetamine

Supporting Families

⇒ early intervention

⇒ on-going support and education

⇒ on-going case management, including assisting families with services to help deal with the impacts of mental illness and/or addiction in the families

⇒ reduce waiting lists for identification and assessment of special needs and improve access to services (NIHB travel and benefit policies; local understanding of special needs and the connection to mental health; prioritization of special needs at the community level i.e. nurses, physicians, school, leadership)

⇒ develop a system of navigators to guide families and individuals through the service continuum of care

Working Together

⇒ collaborate with partners, reduce silos at community and regional level

⇒ regional and community services should meet together at least yearly

⇒ define rolls and responsibilities

⇒ provide education and information about services and programs in an integrated, coordinated on-going awareness and education

⇒ data collection and sharing – develop data sharing protocols and systems and create a collective, secure, password protected data base with multiple levels of information and access (PTOs, TCs, FIRST Nations, Service providers, Hospitals etc.)

⇒ all levels of government ministries (federal, provincial) involved in mental health and addictions including those involved with special needs and education should meet together with First Nations to determine needs and address resources in a more coordinated and collaborative way.

⇒ Government funded agencies that provide services to First Nations must meet with First Nations and government ministries together in order to collaborate and integrate services effectively.

⇒ coordinate mental health policy across jurisdictions and sectors – resolve policy and operational issues that create barriers to service e.g. NIHB travel policies and access to mental health services

Increase Existing Capacity

⇒ conduct research/scans on number and status of existing programs in each community

⇒ conduct research/scans on status of existing regional services and what is required to meet the actual needs of communities

⇒ case management model that includes supervision, support, training, coordination and team model for existing community services

⇒ address confidentiality and infrastructure for safe, private services

⇒ linkages - First Nation to First Nation and First Nation to regional level services through secure, data sharing – e.g. protocols and systems for protection of information when sharing; develop data base; have group meetings; do regular teleconferences, workshops, conferences.

Telemedicine

⇒ In Sioux Lookout Zone telehealth service is based out of Nodin,

o one-on-one counselling connects client and counsellor

- tele-psychiatry consultation with a psychiatrist
- tele-psychology

⇒ James Bay and Peawanuck is based out of Weeneebayko Area Health Authority

- tele-psychiatry consultation with a psychiatrist

⇒ study should be conducted to determine effectiveness

⇒ not suitable for crisis or crisis follow-up counselling

⇒ not suitable for assessment for special needs

⇒ need to ensure that all communities using the service have the infrastructure/space to accommodate telehealth in a safe and confidential environment

Funding

⇒ Evidence based data must be collected to support increased funding for First Nations mental health and addiction services in order to provide enhanced supports/training/capacity building/infrastructure/collaboration/and outside services as required

- funding models do not recognize true transportation and operational costs for First Nations
- funding models do not recognize the degree of trauma in communities
- Funding models do not recognize the lack of infrastructure and capacity

⇒ Funding is required to develop a centralize data base accessible to service providers/workers including funding for training; development of partnerships and service provider agreement/protocols for data sharing strategies; community agreements and buy-in

⇒ new funding required for more and expanded services, capacity building, training and support at the community and regional levels.

⇒ funding is required for expanded, comprehensive community education/outreach and awareness – including funding to the community and regional level services for communication structures as well as information delivery and materials development to increase awareness around mental health and mental health services, and to break down fear and stigma.

Document Review Special Highlights

Suicide and Trauma

"Hardly anyone cries at funerals for young people up North anymore…the people are numb"

–Participant, NAN Mental Health Engagement Session

The following information is an excerpt from the document, "Mental Health and Addictions in the Sioux Lookout Area - An Environmental Scan"

"In 2013 SLFNHA commissioned a study to examine reasons for suicide attempts and completed suicides in its catchment area. The study involved a review of 44 Nodin CFI files including 29 youth who were clients of Nodin CFI who had made multiple suicide attempts or gestures and 15 individuals of all ages who had completed suicide. Ten percent of the victims were under 15 years of age; a rate that is 45 times higher than the general population. Several common themes arose out of both samples:

1) *Traumatic Factors – familial*
   - ⇒ *The most common issues were: abandonment, parental separation and violence in the family.*
   - ⇒ *One third of the attempters had lost a close family member to suicide and two thirds of the completions had lost a family member(s) with one individual losing 5 family members to suicide.*
2) *Traumatic situations – non-familial*
   - ⇒ *Being the object of bullying.*
3) *Single incident trauma:*
   - ⇒ *Sexual assault: all women over 18 who had completed suicide were victims of a sexual assault within a year of their death, and 2 young girls who completed suicide were victims of sexual assault less than a year before death.*
   - ⇒ *4 attempters had other traumatic experiences as young children such as finding the body of a deceased relative.*

The following conclusions from this study were made:

- ⇒ *High-risk youth who make multiple gestures or attempts receive help – getting competent and caring assistance from NCFI.*
- ⇒ *Completed suicides did not receive adequate assistance:*
  - *Never referred out*
  - *Dropped out of counselling*
  - *Suicidal behaviour was not extreme enough to receive immediate service – put on wait list.*
  - *Language barrier.*
- ⇒ *Overriding theme was that there was trauma both ongoing and single event trauma. The most common ongoing trauma was abandonment as a child coupled with parental separation and being a witness to family violence. The most common traumas reported were sexual assault and loss of a close relative.*
- ⇒ *Special life situations – homosexuality, single motherhood.*
- ⇒ *Completed suicides may not have made previous attempts or gestures.*
- ⇒ *High-risk > teenage mothers, particularly if victims of trauma and abandonment.*
- ⇒ *Intellectually challenged young women – unique risk factors (risk of sexual assault).*

The Table below represents the number of suicides that the Nodin Crisis Response Program responded to. Incidences in which Nodin services were not accessed by the community are not captured in these numbers.

NODIN CRISIS RESPONSE PROGRAM						
Crisis		2010-11	2011-12	2012-13	2013-14	2014-15
Suicide	Completions	10	12	12	16	8
	Attempts	78	91	73	97	70
Homicides						8
Tragic Deaths						19
Crisis	Responses	119	193	193	281	129

Table Adapted from SLFNHA 2014-2015 Annual Report

Muskegowuk Council conducted an inquiry into the suicide pandemic its member communities are experiencing and produced a document called *“Nobody Wants To Die – They Want To Stop The Pain.”* There are 176 personal stories associated with the document. Sixteen key issues where identified:

⇒ *Indian Residential Schools*

⇒ *Sexual Abuse*

⇒ *Parenting Skills*

⇒ *Identity and Culture*

⇒ *Lateral Violence*

⇒ *Communication*

⇒ *Resources and Funding*

⇒ *Bullying*

⇒ *Mental Health*

⇒ *Gay or Two-Spirited Community*

⇒ *Family Violence*

⇒ *Housing*

⇒ *Education*

⇒ *Health*

⇒ *Unresolved Grief*

Recommendations were made to the leadership, the communities, and individuals under each key issue. The commissioners felt that, *“Since the issues came from Our Peoples Stories, The Commissioners felt that Our People – along with the community and its leadership – should be accountable for implementing each of the recommendations and possible solutions.”*

Several recommendations in the Health section of the Muskegowuk inquiry report parallel recommendations from the NAN Mental Health and Addictions engagement sessions:

⇒ *advocate for funding form more land-based activities*

⇒ *train and/or bring more traditional knowledge/healers*

⇒ *conduct workshops in communities on historical based trauma*

⇒ *reduce workload on front-line workers*

⇒ *hire more front line workers*

⇒ *increase awareness and education around drug use and side-effects of medicines*

⇒ *secure more funding for education supports to address falling attendance at school*

⇒ *secure funds for housing (government, industry etc.)*

⇒ *support individuals who want to build their own homes*

⇒ *develop community capacity in trades in order to build more homes*

⇒ *rebuild family relationships/workshops and training*

Prescription Drug Abuse

Matawa First Nations *Back to our Roots: Chii Kee Way Meno Biimadeseyung, The Strategy to Overcome Prescription Drug Abuse/Misuse in Matawa Communities (2012) echoes*
many of the themes that have emerged during the NAN Mental Health and Addictions Engagement sessions. The following are brief excerpts from the document:

Goals and Actions

Loon – Governance and Shared Responsibility

Fish – Educations, Health Promotion and Prevention and Harm Reduction

Wolf – Enforcement, reducing supply and lateral impacts

Bear – Client-centred services and community transition & re-integration.

Proposed Regional and Community Actions and Initiatives

1. *Adequate Staffing – proper monitoring and evaluation systems (funds for coordinators, MH staff and security)*
2. *Capital and Equipment Resources – local infrastructure (office space, counselling rooms, safe houses, detox centres, recovery and halfway houses, furnishings, office and program and equipment, etc.)*
3. *Travelling Team of Addictions Specialists*
4. *Support for Specialized community based centres*
5. *Research and Development of Client-centred Approach*

6. *Community Development Intervention Actions – address root causes, community responsibility and ownership, historical nature of issues, community trust building activities.*
7. *Anishinabe Land-Based Learning Program (learn from successful programs – Sandy Lake, Pikangikum, and KI)*
8. *Regional Patient Advocacy – for funding and support from governments, coordination and a whole-system response.*
9. *Ongoing Learning-Focus on PDA/M and Wellness – support for learning / sharing best practices and exchanging information, provide accredited training to front-line workers.*

Child & Youth Mental Health and the First Nations Education System

The following sections have been excerpted from the minutes of *NAN Multi-Agency Meeting and Counselling Roundtable, March 1-2 2016*

"There have been many suicide attempts. Four (students) in the hospital right now, and two being sent down south. Prior to these incidents, trying to get the students to a counsellor was very challenging. They had counsellors, but trying to make appointments wasn't possible (due to no appointments being available). There wasn't a clear plan in place for them, and then they attempted again. February 1st, there were 12 suicide attempts ranging in 11 years to 21 years old. We are dealing with an overload of these situations. NAN's been quick to respond, as well as Nodin. For us, we've been trying to get a school counsellor for two or three years, and we are always denied saying we're not eligible because our school is not on reserve, and other reasons. It's been very tough. We've been doing band-aid solutions. We're not trained to accommodate these needs for the kids. As a conduit to get them connected, we're good at that, but in these situations we don't have the resources. Students don't want to retell their stories(over and over to access resources). A student told us she doesn't want to talk about it (her issues) and then left school. Half an hour later she attempted suicide. Every day now the staff is in trigger mode when they see a student emotionally stressed. Hopefully we can get something in place for our students. Everybody is hurting for it. My phone rings past 8pm and I think the worst. There was a successful attempt in Neskantaga a few weeks ago. She was going to be one of our students at Matawa. We've gone to everybody we can think of to get a social worker, and we haven't been successful.

Hopefully discussions here can help clear the way for that. We do need the front line person there. It's too much, we're not trained in this area to fit the needs of the students."

-Principal of Matawa First Nations Education Learning Centre (Off-reserve alternative high school for students completing credits)

*First Nation schools are considered private schools, which creates restrictions on services that can be accessed.

Recommendation - The *Education Act* should be amended

⇒ *Even though INAC doesn't set teacher wages. The funding is so low; it's hard to keep teachers with lower wages. Friends are making 'x amount', and the longer they teach, the less they make compared to provincial counterparts.$ 50-$60 000 difference. If you can't pay them what they're worth, how do you keep them?*

⇒ *Teacherages/safe drinking water/ the cards are stacked against the communities.*

⇒ *Who goes to the north? Young teachers with no experience. In terms of program sustainability, it's hard to continue. If it's not people from the community, how long will that land based program run. If you want them to stay long term, they need to get paid, suitable accommodations, there's a lot more to it than what we are discussing.*
    - *Every community different in regards to resources. Community resource coordination tool kit. How to coordinate.*
    - *In the research done; for the most part schools have a 'guidance counsellor funding'. It's between 16 and 36, 000 dollars. If we do have these counsellors in place, they aren't as mental health, but to be under guidance. People think because we have a social counsellor, it is assumed that they have mental health background."*

Recommendation - Community resource coordination tool kit - How to coordinate.

"What we appreciate at DFC is that it has an Elder's program. It has a good effect on the students. That's the way we were taught; by our grandparents and parents. Taught to honour and respect. I act as an Elder one day at DFC and the students listen and respect you. I think it really works at

DFC. We had the freedom to explore. I think our students need that. The land is peaceful and we don't get distracted." –participant at roundtable

- ⇒ *Many provincial schools are recognizing the advantages of outdoor classrooms. The connection to the land is starting to be recognized. Identity and mental health are positively affected.*
- ⇒ *That's a focus on what we are looking at. The Elders have spoke about the importance of outdoor activities being a part of the regular school.*
- ⇒ *Land based learning, inquiry with land based learning, it's such a nice and gentle fit if it's woven from K to 12 curriculums.*
- ⇒ *That land and language and culture will be more prevalent.*
- ⇒ *The definition of a First Nations school doesn't exist in the education act. We need building blocks put in place; to keep things in place. A correct definition of First Nations schools needs to be addressed."*

Mental Health and Addictions Programs and Services

There are many programs and services that have been created in response to First Nation mental health needs. Some of the programs/positions/services are based in the community, while others are based at the regional level and delivered through hospitals, government funded agencies, private companies, and First Nation Health Authorities.
*See Appendix A for a preliminary draft list of services available to on-reserve First Nation members in the Sioux Lookout area.
*See Appendix page P. 69 for a draft list of services provided in the James Bay Coast region

Programs that are successful and running effectively at the community and regional level have been identified in previous sections of this report, (see Mental Health and Addictions Survey Results, and Mental Health and Addictions Engagement Sessions Findings P. 15). Engagement session participants identified very few programs and services that are working well. In addition, most community front line workers who responded to the Mental Health and Addictions Questionnaire indicated that few services were working at the community level. In fact most of the respondents were only aware of a few services in their community, and almost none outside of their community. Although there are several examples of high quality services and programs available, access is often an issue. Several factors contribute to the low success rate of good programs including long waiting lists; NIHB travel policy and operational level implementation of policies; lack of service coordination; lack of communication; lack of awareness of services at the community level; not enough workers or resources within the service agency to adequately service the needs of communities.

Specific reasons for services "not working"

Programs/Services/Workforce

⇒ lack of appropriate services for individual community needs including addiction services (assessment/detox/treatment/aftercare/family programs/life skills/parenting skills

- ⇒ not enough counsellors and front line workers at the community and regional level
- ⇒ capacity gap - unfilled positions at the community and regional levels; lack of qualified staff at the community level
- ⇒ critical lack of on-going training for community workers
- ⇒ lack of supervision and support for community workers
- ⇒ lack of infrastructure/space at the community to house programs and offices and accommodate outside service workers
- ⇒ community member familiarity with the community workers (stigma, confidentiality, trust)
- ⇒ large case loads for regional workers (8 weeks between counselling sessions)
- ⇒ lack of trauma and specialized training for all service providers and workers
- ⇒ lack of culturally appropriate services, lack of cultural competency and safety within services, programs

Communication and Coordination

- ⇒ lack of coordination/team approach to services and programs community (programs and regional services "silos")
- ⇒ lack of data sharing between workers and service providers including visiting physicians and community/regional mental health and addiction workers/lack of centralized database
- ⇒ lack of case management at the community level
- ⇒ lack of a comprehensive service review community by community to ascertain needs

Community Education/Awareness & Prevention

- ⇒ lack of community understanding of mental health and addictions issues
- ⇒ lack of knowledge about programs and services available
- ⇒ inability of clients/workers to navigate the out-side service delivery systems
- ⇒ mental health and addictions stigma
- ⇒ fear that children will be placed under the care of a child welfare agency if parents seek help for themselves or their children

Funding

- ⇒ year to year and late funding contributing to staff turn over, and lack of community planning
- ⇒ chronically underfunded education system – children fall through the cracks due to lack of school services for mental health and special needs including assessment - lack of funding for special needs by NIHB, and lack of funding for special needs in schools (AANDC)
- ⇒ chronically underfunded mental health and addictions programs/services regionally and at the community level
- ⇒ lack of funding for aftercare for Suboxone program

Trauma

- ⇒ communities in a constant state of crisis untreated community members suffering from high rates of PTSD and related illness, including children and youth.

Improve Services and Data Collection

- ⇒ conduct a comprehensive data collection initiative to develop a full list of services that can be accessed by First Nations on and off-reserve, including services in centres like Sioux Lookout, Moosefactory, Thunder Bay, Geraldton, Dryden, Kenora, Sudbury, Winnipeg, Timmins, Toronto etc.
- ⇒ conduct a comprehensive review of community services, **community by community**, in order to get accurate data on the status of services, including quality of service
- ⇒ develop a data base that can be accessible by stakeholders and First Nations including protocols and agreements for information sharing.

Addressing the Three Themes

Theme One - Taking Stock

What is working well now?

According to the existing work (document review) and the NAN Mental Health and Addiction Engagement Sessions, very little is working well. (see Survey results P. 26 and Mental Health and Addictions Engagement Sessions Findings P. 15) This does not mean that all the services that exist are poor services. In many cases it means the structure of programs and services (in silos), and the lack of coordination between programs and services has contributed to services “not working well.” Inadequate resources are allocated to off-reserve service providers resulting in not enough qualified mental health and addictions workers to service the First Nations. Agencies cannot afford to provide the necessary training for front line workers. The main reason services are not working is because there are not enough workers, travel dollars or training dollars.

Non-Insured Health Benefit (First Nation and Inuit Health Branch, Health Canada) policies interfere with First Nation members accessing services, especially if they live in remote First Nations. NIHB denial of travel for service is one of the main reasons that mental health issues escalate. NIHB does not approve travel for special needs children and youth to access service unless they are referred by a doctor to another doctor or specialist. This has led to hundreds, and perhaps thousands, of First Nation children and youth “falling through the cracks” and developing concurrent and compounding mental health issues and addictions, as well as outing them at high risk for addiction, depression, suicide, and conflict with criminal justice system.

On reserve programs are also chronically underfunded. Communities experience high levels of worker burnout and turnover. There are no dollars for training, support, supervision or basic infrastructure like offices or private counselling rooms where confidentiality can be ensured.

“When I go to some communities I have to do my counselling at the house I may be staying at. There are often trades people, and other services staying there too. I have had counselling sessions in cars. Infrastructure is a problem” -Participant Mental Health Engagement Sessions

*See previous section, Mental Health and Addictions Programs and Services, P. 48, for a detailed list of why services and programs are not working.

Potentially Successful Programs & Services

⇒ The WAHA IRS traditional healing program and was extended by two years due to its success

⇒ WAHA Mental Health and Addiction Services – (would function more successfully if it had more workers and clinicians. There is lack of housing for service staff.)

⇒ WAHA specialty services/telemedicine

⇒ Constance Lake First Nations land-based detox program

⇒ Suboxone programs (need aftercare programs to be successful)

⇒ National Kids’ Help Line (High numbers of youth accessing the national help line – however they need to connect the help line to services)

⇒ Telemedicine for follow up for counselling and psychiatric assessments (not crisis or special needs assessments)

⇒ Muskrat Dam family treatment program

⇒ In Moose Factory a father started a day program for children with special needs and has been able to find some funding due to the success and popularity of the program

⇒ Nodin community wellness program.

⇒ Nodin counselling (not currently successful in all communities due to lack of training of community front line workers not enough out-side workers to meet the community needs)

⇒ Crisis response – (community level, Nodin and NAN) – programs were working in the past and could be working better (crisis worker burn-out, crisis responder teams are causing an extra burden on the community with their needs e.g. food, bottled water-teams need to be more self-contained)

⇒ Webequie case management & coordinated suicide intervention and follow up program

What are the community needs?

The number of community needs is staggering. There has been a dramatic increase in the number of children suffering from serious mental illnesses, including post-traumatic stress disorder (PTSD). There has also been an increase in bi-polar disorder, schizophrenia, special needs, addictions, and lateral violence. There are not enough trained mental health workers in the communities to meet the community needs.

Community mental health workers are not trained in trauma counselling or treatment. Communities are overwhelmed by grief and trauma due to the high number of tragic deaths happening in their small, close-knit communities, including the on-going suicide epidemic. Families are under stress and living in crowded, substandard housing conditions. Community crisis workers are working "24/7" and are burning out. They have no support and no opportunity for debrief. Parents of children with identified and unidentified special needs are struggling to cope without respite or other special needs services, contributing to family stress and family breakdown. NAN First Nations' children are being taken into care at an alarming and escalating rate. Some parents have been forced to place their children or youth in care because of the lack of services and support.

Service agencies, like Nodin Child and Family Intervention Services, which provide mental health services to NAN First Nations in the Sioux Lookout area, are understaffed and underfunded to meet the needs of the communities they serve. The time between counselling sessions is typically 6-8 weeks, even for persons who were "Form One", (medevaced out the community to be stabilized, and then returned). Nodin provides mental health services to 33 First Nations, 29 of which are remote and accessible only by air or winter road. The service area spans a geographical area that is half the size of Ontario. The same issues exist along James Bay Coast with the Weeneebayko Health Authority where there is not enough staff to provide adequate addiction and mental health services to the First Nation communities they serve. The staff in both of these organizations are dedicated and qualified but there are not enough human resources to meet the communities' needs. NAN First Nations need more trained workers at the First Nation level and

at the regional services level who can provide satisfactory and sufficient services to meet the needs of each community. Communities need coordination of services at the community level. They need case management at the community level. Clients and workers need help navigating the outside system of services.

NAN drive-in communities are also experiencing an increase in mental health and addiction issues and have many of the same community issues. Drive-in communities that are close to urban centres have better access to mental health services. Communities members that are more than an hour drive from services have issues with access.

Communities need to be able to have special needs children and youth assessed. First Nation schools are federally funded and have limited resources for special needs support and assessment. Workers in the schools in most communities are not trained to support special needs children and youth, or children and youth with mental illness, especially trauma. Hundreds, if not thousands of NAN First Nations youth are falling through the cracks. When special needs go un-identified or are not addressed with treatment and support, mental health issues arise that complicate and compound the child's special needs. The children and youth can become adults who are at high risk for suicide, or to be victims or perpetrators of violence, and end up in conflict with the criminal justice system. Many children are not attending school due to the lack of identification of special needs and supports in the school. Communities need to be able access assessment and treatment services without being on waiting lists that last for years. In one case a child has (youth) has been waiting twelve years for an assessment. Parents with special needs children need respite and support. Exhaustion and burn out are contributing to stress, poor mental health and family breakdown.

"I look after my niece. She is twenty-five now. She has special needs but there was never an assessment. She is slow, didn't go to school much. She was also raped, and now she is getting aggressive and violent. She didn't want to report the rape when we explained to her she would have to talk about it. She is starting to physically harm us. We have no one who will stay with her anymore so we do not get a break. I am finding difficult to cope and I'm getting depressed. There are adults in our community who just stay in the house and never go anywhere. They have special

needs and no services or support." - Participant NAN Special Needs Focus Group, North Caribou Lake First Nation, February 2016.

Communities need education about mental health and addictions, as well as special needs. Prevention and intervention are critical components required to reduce the levels of crisis. There is a need for community outreach, reduction of stigma, and awareness about what services are available. Community workers need the assistance of a mental health navigator to help them assist clients. Clear pathways need to be developed and articulated.

There are jurisdiction issues impeding access to service. Non-Insured Health Benefit policies and localized interpretation of the policy framework contributes to community members not being able to access services outside of the community. No being able to access appropriate mental health services at the community level and at the regional level has left communities in a desperate situation, trying to cope with the mental health crisis they are faced with. Travel for mental health assessment and treatment is often denied by NIHB and always denied for special needs services if it is not the service of a physician or a practitioner with a designation approved by NIHB. This can lead to feelings of desperation and hopelessness because people in the communities are disempowered and begin to feel there is no help.

"The only way out of the community to get help when you live in a remote First Nation in the Sioux Lookout Zone is to be in crisis, meaning you are a danger to yourself or to others. There is basically no intervention, prevention, awareness, assessment or treatment going on at the community level." -Participant, Mental Health and Addictions Engagement Session

Communities need to be able to provide data on the actual mental health and addiction incidents in their communities in order to access appropriate funding for the "real," on the ground situation. The scope and degree of NAN First Nation needs are understated due to the lack of data. Communities need a way to collect, store and share data. An example of this is data concerning cause of death. Eighty-percent of suicides are listed as "other" by the coroner. Families are provided with information on how a family member died and they often do not choose to share that information. The only time a suicide or drug related death is reported as such, is when the deceased is a child or youth, under eighteen years old, because an inquest is initiated. Agencies

providing service to the community, as well as communities themselves, need to be able to collect and share data in order to do informed planning and be adequately funded. Workers, nurses, doctors, and outside service workers need to be able work as a team and share data and information from a central source.

First Nations need to be supported to build community wellness. The plans and activities for community wellness need to be community-based. All communities are different. Traditional and cultural healing activities have been successful in recovery and healing for First Nations members. Support for more community-based, land-based healing programs is needed.

Besides the community needs directly related to mental health services, communities have need of infrastructure. Housing, adequate sewer and water, infrastructure for recreation and, as previously mentioned, infrastructure that supports the coordination of services and service delivery. (database, offices for workers in proximity to each other to enhance coordination and communication, safe spaces for counselling, confidential telehealth and video conferencing spaces.)

*For details on community needs see Mental Health and Addictions Engagement Session Findings P. 15 and Mental Health and Addictions Document Review, Consolidated Recommendations. P. 36

Gaps and Barriers

Community needs are closely linked with gaps and barriers. Several gaps and barriers were identified in the above section about community needs. The following is a list of the main themes that emerged about gaps of barriers from the engagement sessions. A detailed list of gaps and barriers can be found in the Mental Health and Addictions Engagement Sessions Findings (P. 15) and also under Mental Health and Addiction Document Review, Consolidated Recommendations (P.36.)

Programs/Services/Workforce, Capacity

⇒ not enough mental health workers/services/programs at the community level and not enough mental health workers at the regional level (outside service provider level) to meet the needs of the communities – impacts access e.g. counselling sessions once every 6-8 weeks

⇒ lack of aftercare programs for Suboxone clients and for community members who have undergone treatment for other addictions

⇒ There are not enough trained or specialized persons to fill positions in the community and at the regional service level.

⇒ First Nation service workers with unmanageable caseloads are experiencing burnout at community level and regional level.

⇒ Confidentiality and trust issues make community members hesitant to access community-level programs

⇒ Fear of losing children to child and family services prevents people from seeking help and accessing service.

Training

⇒ There are critical training gaps for front line workers in all areas of mental health, especially trauma.

⇒ There are serious training gaps at the schools for teaching assistants and tutors.

⇒ There are training gaps related to cultural competency and cultural safety at all levels.

Support for Community and Family Wellness

⇒ There are not enough resources to support communities to develop community wellness plans and implement them.

⇒ There are not enough resources to support wellness plans for families, including life skills, parenting skills and training to support children with special needs.

⇒ There is no respite for parents with special needs children creating heavy stress loads on families. Families feel isolated.

⇒ not enough education about mental illness and addictions, especially for youth

⇒ lack of programs and recreation activities in most communities for youth and children

⇒ lack of mental health programs and services for Elders

Transition

⇒ lack of aftercare for Suboxone

⇒ lack of transitional and aftercare services for all addictions including alcohol and street drugs

⇒ lack of transitional and mental health support services for crisis patients returning home after "Form One" evacuation to hospital

⇒ There are children with special needs and mental health issues that are leaving the care of child and family services and being transitioned on their 18th birthday, even though agencies have notified the ministry in advance in order to prepare for transition ahead of time.

⇒ lack of half-way houses and transitional residences

⇒ lack of adult services in the community for special needs

⇒ Children with special needs who are not identified or treated will later become adults without benefits to support them because they were never assessed.

Infrastructure

⇒ inadequate infrastructure in communities for counselling and treatment space which impacts quality of service and confidentiality.

⇒ substandard and overcrowded housing contributing to family stress and mental health issues. Inadequate sewer and water systems (boil water advisories) contribute to community stress.

Traditional and Cultural Healing

⇒ Communities need more resources and support to develop and expand traditional/ cultural healing practices and activities, and to revitalize language and culture.

Government Policy and Jurisdictional Issues

⇒ NIHB travel policy and other policies impede access to service. The provincial and the federal government ministries involved with health, mental health and addictions, special needs, and education are not collaborating or communicating effectively in order to reduce silos, redundancy, lack of coordination and poor access to services.

⇒ INAC registration policies are making it harder for parents to register children. First Nation members who are not registered cannot access service.

"When we build programs and services we need to be cognizant of the whole picture. We need to consider whether there is capacity at the community level to staff and run the programs, whether there is space to house a program, and what training, supervision, and support for the worker is needed. How do positions and programs work together and fit together?"

-Participant Mental Health Engagement Sessions

Collaboration and Team Approach

⇒ lack of team or coordinated approach to case management and treatment at the community level (silos)

⇒ lack of appropriate structure and infrastructure at the community level to support a team approach

⇒ lack of communication and coordination between the community and outside services

⇒ lack of information/data sharing

Funding and Resourcing

⇒ There are large funding and resourcing gaps at the community service level and the regional service provider level to meet the "actual" community needs.

⇒ There is no comprehensive, standardized, system for information sharing or for data collection. (community-by-community, agency-by-agency) making it impossible to have a clear picture of what the actual funding and resourcing needs are.

⇒ First Nation services and programs are chronically underfunded to meet the needs of communities, including schools (lack of special needs and mental health identification, assessment, and classroom support)

Theme Two – Moving Forward

The majority of discussion around Theme Two will take place in the second phase of the NAN Mental Health Engagement Project. However, some preliminary answers to the questions in Theme Two emerged during the phase one engagement sessions.

Where and how can we build on existing initiatives?

⇒ bring all ministries and levels of government that should be involved in mental health to the table, including MCYS

⇒ expand and fund traditional /cultural healing at the community level

⇒ support and fund strategies and implementation to coordinate programs at the community level and develop coordination and collaboration with regional level service

⇒ fund and support communities to develop community-base aftercare programs (Suboxone and other addictions)

⇒ provide training dollars and networking/professional development opportunities for front line workers

⇒ include front line workers at the table when developing programs and service models

⇒ facilitate and support multi-agency First Nation service provider sessions to enhance collaboration including child and family service agencies.

⇒ support the development of regional and community-based mental health hubs with coordinated service and case management

⇒ support coordinated, appropriate rehabilitation service delivery for special needs in communities (e.g. speech and language)

⇒ acknowledge the lack of trained special education teachers and work with communities to find ways to improve services at the community level

⇒ ensure provincially funded mental health and special needs service providers are aware of their catchment areas and jurisdictions and adequately fund them to deliver service to First Nations, including special needs assessment and services

⇒ resolve infrastructure issues so that programs can run successfully at the community level with proper spaces to maintain confidentiality

What culturally appropriate services are needed and where?

⇒ Culturally appropriate services are needed at all levels and across all sectors involved with First Nation mental health and addictions.

⇒ cultural competency and cultural safety – All service workers going into First Nations need to be trained and educated in First Nation history including the impacts of colonialism/*Indian Ac*t/residential school legacy /racism. This should happen as part of school curriculum and at the level of professional training and post secondary education, as well as by the service agencies.

⇒ More traditional/cultural healing and land-based healing programs are needed at the community level and more access to services that integrate traditional healing methods. (NIHB currently funds travel for traditional healing for physical health issues, but not mental health)

⇒ support funding and training for community sharing circles, as well as intergenerational circles (e.g. Elders – Youth, Grandmothers-Granddaughters –knowledge exchange)

⇒ support land-based and traditional nutrition programs e.g. harvesting and preparing traditional foods.

What are the areas of enhanced cross-sector collaboration and how?

It would be beneficial for MOHLTC to work together with NAN First Nations and regional service providers, as well as with Health Canada (First Nations Inuit Health Branch and Non-Insured Health Benefits) and INAC when developing plans for services. Some federal policies conflict with access to provincial services resulting in inequality of access between First Nations peoples and the rest of Ontarians. For example, when the Ontario Ministry of Health stopped funding children and youth special needs (de-listed by OHIP) NIHB also stopped funding travel for special needs due a clause in the policy framework that requires NIHB to only provide a benefit for services that are covered by provincial health insurance. As a result, travel is denied for access to services for special needs. To develop a Mental Health and Addictions system that works for First Nations all parties need to be involved.

⇒ All provincial and federal ministries involved with health and mental health and addictions need to be at the table with First Nations and service providers in a multi-level/cross ministerial table.

⇒ Community and regional level front line workers need an opportunity to have their voices heard directly by NAN, Tribal Councils, service providers and by both levels of government (multi-ministerial meetings/multi-level).

⇒ There is a need for an event that brings community front line workers and First Nation service providers together to discuss issues, network, debrief, and have professional development opportunities at least once a year to enhance collaboration and cooperation within the system.

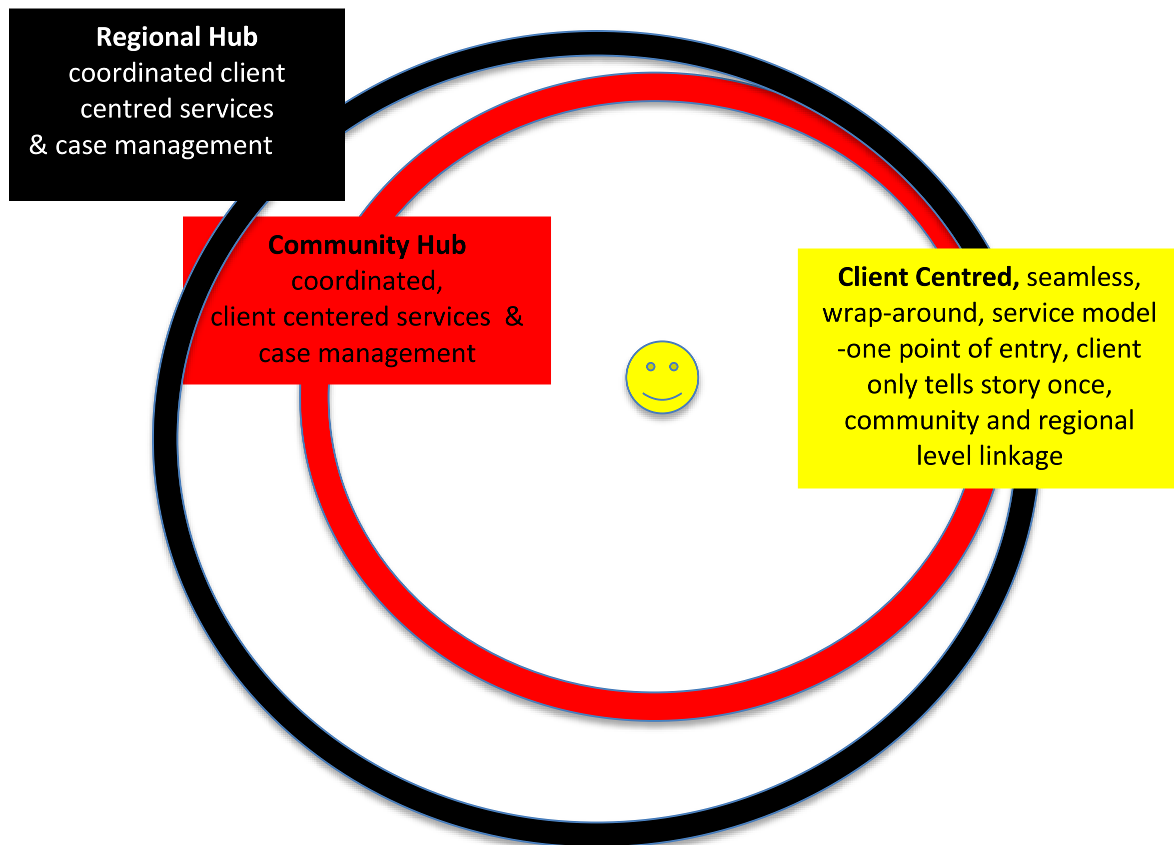
⇒ at the community level, initiative needs to be taken to develop a team approach to case management and to collaborate on services and treatment with physicians and nurses. - possible support from government for development of a "coordination

Theme Three – Shared Outcomes

⇒ Theme three will addressed in the second phase of the Mental Health and Addiction Engagement Project 2016-2017

Pulling It All Together

Client Centred Service Hubs Model



"We need to treat people. We have to remember that we are trying to help the person."
-Participant, Mental Health and Addictions Engagement Sessions

Creating a System That Works - NAN First Nation Mental Health & Addictions Services Wheel

- Client centered coordinated team approach with community level case management - includes:
- visiting physician, community nurse,
- special education teacher /support workers
- existing community programs (e.g. FAS/Healthy Babies NADAP/and other front line workers
- community social services including child welfare, crisis, Ontario Works
- provides community level intervention, assessment, treatment & aftercare
- community education, outreach
- data sharing including agreements, protocols
- appropriate infrastructure for confidentality & trust building) (counselling rooms/offices)
- emphasis on training and capacity building
- traditional and cultural healing practices and landbased treatment and aftercare
- linkages and collaboration with regional services

- **Client centred approach**
- culturally competent/safe/appropriate services
- coordinated multi-dicplinary servcies including private service agencies & service for special needs
- coordinated case management
- data and information sharing - shared data base between community and regional hubs/agreements/protocols
- on-going community linkages/ communication/collaboration/training/
- outreach education & prevention

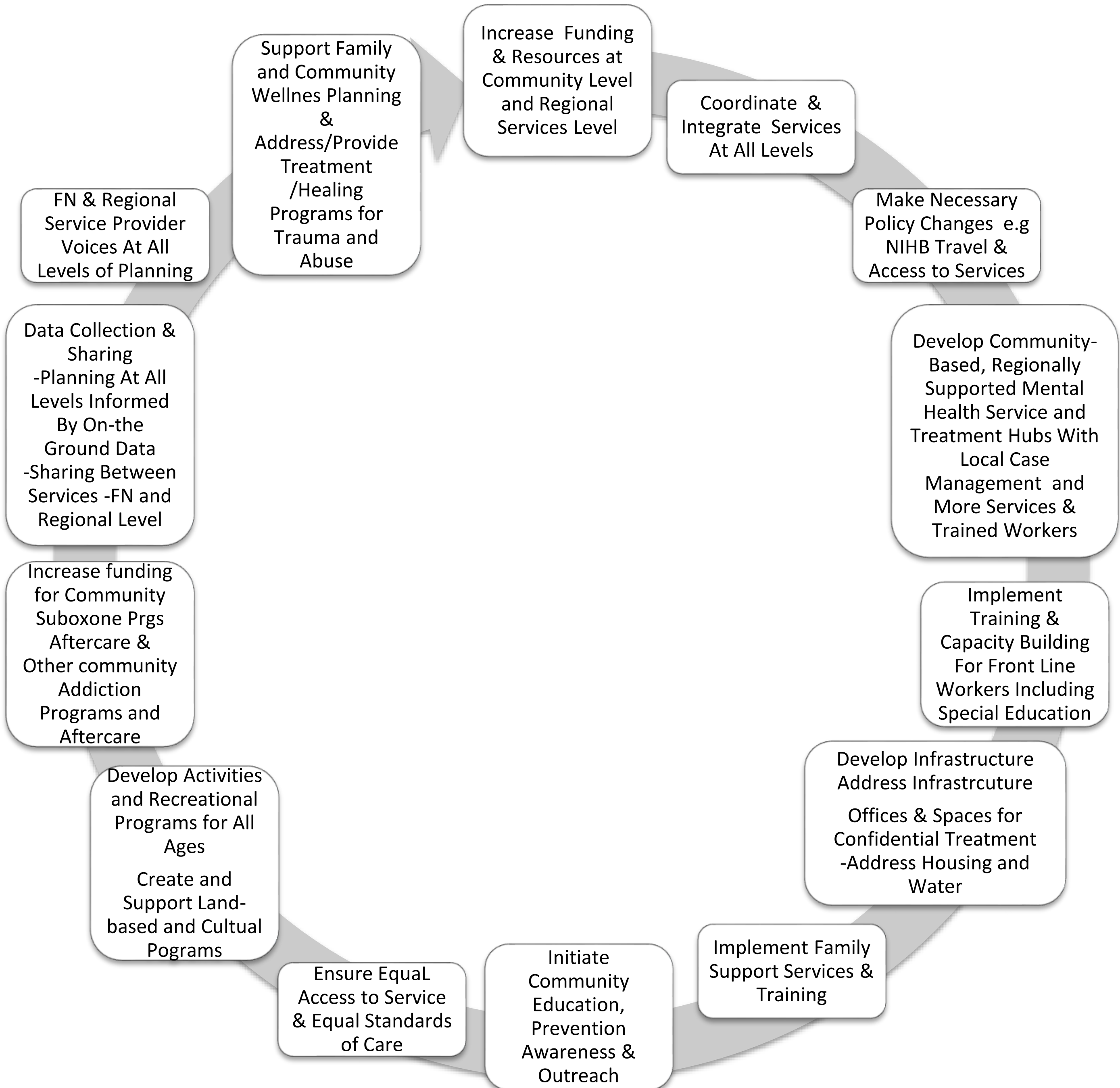
- community wellness planning that integrates all sectors:
- health & social services
- education
- infrastrucutre
- resource and economic development
- leadership
- governance and administration

- collaborative government and First Nation planning
- integrated planning and support for equal access to services, including travel to off-reserve services/treatment
- support for community planining processes and infrastructure development
- support for cross sector community-building and community wellness initiatives
- adequate resources/funding for programs & services at all levels

*Diagram developed from the input of the participants, NAN Mental Health & Addictions Engagement Sessions

"Treatment should be client centred. "   - Participant Mental Health And Addictions Sessions

Consolidated Recommendations



Appendix

MENTAL HEALTH AND ADDICTIONS SERVICES
AVAILABLE TO ON-RESERVE RESIDENTS IN SIOUX LOOKOUT AREA

SERVICES AVAILABLE IN SLFNHA COMMUNITIES										
FUNDING	**PROGRAM**	**ADMINISTRATION**	**SERVICES**	**PROMOTION / PREVENTION**	**EARLY IDENTIFICATION & Intervention**	**Crisis Response**	**Coordination**	**Treatment**	**Support & After Care**	**Worker Capacity Buiding & Support**
MOHLTC	Aboriginal Healing and Wellness Strategy			•	•	•	•	•	•	•
	Regional Response Program	SLFNHA								
	Reverand Tommy Beardy (Muskrat Dam)	Band	Alcohol and drug rehab for families, residential services, childcare for families, life skills, cultural programming, transition care, aftercare (for 1 year). Crisis support and training to other communities.	•				•		
	Mental Health Promotion/Awareness??									
?	Youth Workers	Band								
	Schools		School social counsellors							
	FASD Community Workers									
Health Canada / MCYS	Nodin CFI	SLFNHA	Tele-counseling/telepsychiatry/tele-psychology Sioux Lookout based workers (acute care / special services / intake / on-call / art therapy / psychology) Sioux Lookout based – travel to community (specialized counsellors / trauma team) Community Workers (Children's Addictions and Mental Health Workers – 15 communities / adult mental health counsellors – trauma team)		•				•	
	Cat Lake Youth Treatment Centre	Band						•		
Health Canada HSIF	Approaches to Community Wellbeing (Public Health Model)	SLFNHA		•						
	Firefly??						•			
Health Canada / MOHLTC	Regional Wellness Response / CWDT			•					•	•
Health Canada	NNADAP		Prevention, treatment and after care.	•						•
	NAYSPS	Band	Safe Talk / ASIST Training. (prevention and knowledge development)	•					•	
	Community PDA Detox / Aftercare			•	•			•	•	•
	Indian Residential School Survivors (6 staff)				•				•	
	Aboriginal Head Start	Band	Education, health promotion, culture and language, nutrition, social support, prental/family involvement.	•						
	Aboriginal FASD			•						
	Community Nursing Stations				•			•		
	CHRs									
	Building Healthy Communities		Suicide and crisis intervention training / coordination / assessment and counseling / referrals / after care	•					•	•
	Maternal Child Health			•	•					
	Bloodborn STI HIV/AIDS Prevention			•						
	Brighter Futures		Recreation workers / youth workers / coordination of services/ training / planning / information exchange							
								•		
	Home and Community Care								•	
	Health Planning & Quality Maintenance / Health Engagement – Capacity Building / Aboriginal Health Human Resource Initiative / Accreditation Services									•
	National Anti-drug strategy			•						
	Aboriginal Diabetes Initiative / Children's oral health intiative / communicable disease Emergency planning & response / Drinking water & waste water / environmental contaminents / Public health nursing services.			•						
				•				•		
	Dilico Anishinabek Family Care		Provides crisis support and training to FNs outside of their catchment area.							

SERVICES IN SIOUX LOOKOUT – ACCESSIBLE BY ON-RESERVE RESIDENTS										
FUNDING	**PROGRAM**	**ADMINISTRATION**	**SERVICES**	**PROMOTION / PREVENTION**	**EARLY IDENTIFICATION & Intervention**	**Crisis Response**	**Coordination**	**Treatment**	**Support & After Care**	**Worker Capacity Building & Support**
Public Health Agency of Canada	Aboriginal Head Start (Urban and Northern)	Friendship Centre	Education, health promotion, culture and language, nutrition, social support, prenatal/family involvement.							
LHIN	Firefly									
	Health Promotion and Education (hearing loss??)			•						•
LHIN	Mental Health and Addictions Program	SLMHC	Concurrent disorders, liaise with psychiatry, housing, justice system and social services. Counselling for abuse trauma, stress, family problems and anger. Crisis Intervention.				•	•	•	
	CCAC (off reserve)						•	•	•	
Public Health Agency of Canada	Sunset Women's Aboriginal Circle		Pre/postnatal information/support, resources, FASD information, literacy/language development, family and social support.					•		
	Ah-shawah-bin		Crisis intervention to victims of crime and tragic circumstances, referrals, advocacy, safety planning, court, police and hospital accompaniment.					•		
	Aboriginal Healing and Wellness Program	Nishnawbe-Gamic Friendship Centre	Support to community members through family violence support services, individual healing and wellness needs and accessing traditional services and supports. Available one-to-one or group setting.	•				•		
	Aboriginal Alcohol and Drug Worker Program	Nishnawbe-Gamic Friendship Centre	A cultural space for individuals: one-to-one consultation on treatment options/services, information and resources, support groups, holistic healing and cultural activities.	•				•		

SERVICES IN NORHTWESTERN ONTARIO – ACCESSIBLE BY ON-RESERVE RESIDENTS										
PROGRAM	**FUNDING**	**ADMINISTRATION**	**SERVICES**	**PROMOTION / PREVENTION**	**EARLY IDENTIFICATION & Intervention**	**Crisis Response**	**Coordination**	**Treatment**	**Support & After Care**	**Worker Capacity Building & Support**
Health Promotion and Education (hearing loss??)	MOHLTC			•						•
3 C's residential addiction (level 1)				•					•	•
Telemedicine / telepsychiatry								•		
CONNECT ???									•	
Residential supportive Treatment – level 2									•	
Mood disorders Association of Ontario									•	
Brain injury services of Northern Ontario			Homelessness Initiative – provides individuals with brain injury and mental illness and risk of						•	
Changes Recovery Home			Residential Treatment for addictions, including clients involved in justice system. Other support services to promote healthy lifestyle and referrals.					•	•	
Crossroads Centre			Residential addictions treatment, including pre-treatment prep and aftercare.					•		
Lake of the Woods District Hospital	MOHLTC		Inpatient services, crisis intervention, specific programs for Aboriginal individuals, individuals with justice system issues.					•		
Treatment Centres??	Health Canada							•		
Dilico								•		

Migisi (Kenora) Treatment Centre			Residential Drug and Alcohol Treatment					•		
Dryden – non-medical withdrawal								•		

Moosonee-Peawanuck Resource List.

⇒ WAHA Mental Health and Addictions Program
- Counsellors are available in each community
- Mental health and addiction services – workers for James Bay Coast
- Psychiatric Nurse Clinician in Moose Factory
- Psychiatry services are provided in person or via the Ontario Telemedicine

⇒ Payukotayno: Child and Family Intervention Unit
- Mental health and intervention services for those under
- 18 years
- Intake, assessment and case management
- Individual and family counselling Intensive care services and specialty clinics in psychiatry and psychology

⇒ Telehealth conferencing with Sick Children's Hospital
- Early Childhood Intervention program for ages 0 to 6

⇒ Sagashtawao Healing Lodge
- Family Healing Program (Three weeks)
- Individual Treatment Program (Six weeks)
- Assessment and treatment planning
- Individual and group sessions
- Nutrition program
- Recreation program
- Health services
- Community education and resources
- Aftercare planning and follow up
- Offers AA meetings every Friday at the Anglican Church

⇒ Timmins Native Friendship Centre
- Aboriginal court worker
- Homelessness Partnering Strategy project
- Life Long Care program

- Urban Aboriginal Healthy Living program
- Aboriginal family support for parents with children aged 0 to 7
- Prenatal support for mothers with infants aged 0 to 6 months old
- Akwe:go program, for ages 7 to 12
- Wasa-Nabin youth program for ages 13 to 18

⇒ Omushkegiskew House: Kapuskasing, Hearst and Smooth Rock Falls Counselling Service

- Provides safety, support and encouragement to abused
- women and their children or any woman in crisis
- Non-residential counselling services
- Crisis support program is offered with
- Follow-up support
- The shelter is staffed with experienced counsellors 24 hours a day

⇒ Porcupine Health Unit

- Chronic disease prevention
- Prenatal nutrition program
- Food safety
- Growing healthy families
- Health inspection
- Immunizations
- Infection prevention and control
- Injury prevention
- Nutrition Oral health
- Preschool speech and language program
- Sexual health
- Tobacco and substance misuse

⇒ Community Care Access Centre

⇒ Ministry of Community Safety and Correctional Services

- Provides probation and parole services across the Mushkegowuk region
- *Must be referred from the Justice sector