Report

Ottawa Urban Indigenous Health Strategy

Summary of Focus Groups

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Summary of Focus Groups

A. Introduction

Many First Nations, Inuit and Métis people in Ottawa face significant health challenges. Through conversations over a period of time among leaders of Indigenous services and Ottawa health organizations, notably between Allison Fisher of Wabano Centre for Aboriginal Health and Dr. Vera Etches of Ottawa Public Health, the idea for an urban Indigenous Health Strategy for Ottawa arose. Several Indigenous health service organizations and Ottawa-based hospitals and health agencies are interested in seeing what more can be done through a joint strategy that unites people from across organizations to make a difference for Indigenous health at the system level.

The work by the Champlain LHIN and the LHIN's Indigenous Health Circle Forum was recognized as having a mandate at a larger scale. There remains a need for a city-wide approach to health services for First Nations, Inuit and Métis within the Ottawa area.

Over the last year there have been informal discussions between Ottawa Public Health and the Indigenous community, including the Ottawa Aboriginal Coalition, Akausivik Inuit Family Health Team, Tungasuvvingat Inuit (TI), and Wabano Centre for Aboriginal Health. Based on the interest expressed in these conversations, formal interviews and focus groups were initiated, starting with the Ottawa Aboriginal Coalition Elders Council and Ottawa Public Health.

Focus groups and interviews were organized with 12 First Nations, Inuit and Métis organizations and mainstream health service organizations (see Appendix A for a list of agencies). Also a community gathering, Elder's Council and youth gathering were held. A presentation was made to focus group participants, highlighting a number of key points that had arisen from previous work in the community, and further input was solicited on a series of key questions (see Appendix B for a list of the focus group questions). This report provides a summary of the information gathered through these focus groups and interviews.

A Word on Terminology

In general, the feedback from the focus groups was that "First Nations, Inuit and Métis" are the preferred terms. It was also suggested to give the proper name to each nation: Métis, Algonquin, Anishnawbek, Inuit, etc. wherever possible. **"**Indigenous" is increasingly used and was suggested as a simpler term. "Indigenous" and "Aboriginal" are Pan-Aboriginal terms and Inuit tend to feel they are not reflected in these.

B. A New Approach: Elements of an Indigenous Model of Care

Previous work and consultations have raised a number of recurring points about what an Indigenous model of health care would look like, and these have been summarized below. These elements, which were based on earlier conversations with the OAC Elders Council and with leaders of the Indigenous community, were presented at the focus groups. There was strong support from all participating agencies and focus groups for all eight points in the Indigenous approach to health.

Elements of Indigenous Model of Care

- A focus on prevention and promotion (requires a realignment in the system).
- The community member is the lead in how they address their health concerns and we strengthen their will to stay healthy and in balance in their life. They "own" their care plan.
- We practice informed choice instead of making decisions for others.
- We recognize that community members are dealing with multiple issues at the same time and so we would use a wholistic model that simultaneously considers the four directions of health: mental, emotional, physical and spiritual.
- There are multiple people supporting the community member.
- There are collaborative relationships between health institutions and community services as the community member is supported in their life journey (health services, community services, managing of conditions, exercise, diet, mental health factors)
- A recognition that people maintain their own health when they have a strong sense of healthy identity and a sense of belonging to the community so that they can access services and programs they need. If a person experiences shame they are not motivated to access any services.
- A recognition that historical colonization policies and institutional cultures have built in practices that reinforce shame relationships.

C. Identifying First Nations, Inuit and Métis Clients

Overall, the hospital and health care system does not provide a consistent way for Indigenous people to self-identify. The LHIN does not collect data, but has access to data across the system, and there is almost none that is Indigenous-specific. Hospitals sometimes collect information about Indigenous identity but it is used for statistical or financial purposes, not to design culturally-based programs or care for that person. At CHEO, for example, this involves tracking patients from Nunavut by health card number for financial purposes under the agreement with the Government of Nunavut. Also, First Nations patients are tracked through their Band number (if applicable), and that is also for financial purposes. Indigenous identity is a question in Health Links,but a fairly new question.

Ottawa Public Health staff noted that community services in Mental Health and Addictions submit client profiles which include nationality/ethnic heritage and there is provision for selecting Indigenous. Some chronic disease programs track this information, but it is uneven.

Among those organizations who participated in the focus groups, Indigenous organizations, Inner City Health, Royal Ottawa Mental Health Centre and the Sandy Hill CHC ask specifically about First Nation, Inuit and Métis identity and track this information in their data systems. Wabano staff mentioned that the Nightingale database, which is used by all CHCs, has been customized to add First Nations, Inuit and Métis.

The Royal Ottawa Mental Health Centre does ask specific questions about Indigenous identity. They noted that they have three different intake systems (intake into the hospital, out-patient services and outreach services), so that people may potentially be triple counted. Despite that, the number of First Nation people that self-identify is quite low and not proportionate to the population. This is in contrast to the Inuit population.

> *"Asking demographic questions is uncomfortable for health care agencies, because there is institutionalized racism. If we don't ask, we can't track the over-representation or identify who is missing. If we don't measure what we are doing, we are making decisions based on anecdotes not evidence."*
> (OPH focus group)

The Ottawa General Hospital does ask self-identification information, often related to funding arrangements. When they do ask both raised a number of concerns about being able to get accurate information. There is a great deal of sensitivity in asking the question in a way that shows respect.

Throughout the data collection, Indigenous participants often identified that they were reluctant to self-identify at mainstream health services because they had experienced racism in the past, and presume that self-identification will lead to poor treatment. They are suspicious about why the institution wants to know their Indigenous status, because of the history of discrimination and assimilation aimed at Indigenous people.

Service providers do not always explain why the question is being asked - to provide culturally safe services. Since clients are not informed, they often do not choose to provide the

information. There were also concerns about whether the provider has the capability to deliver culturally safe services so what would be the point of identifying as an Indigenous person. Finding the best way to ask can be complex. The Toronto Central LHIN project "We ask because we care" was intended to find a safe way for Indigenous clients to self-identify, and reportedly took three years to implement. Their process revealed that a history of racism and isolation was a major aspect in why Indigenous clients did not self-identify, and having culturally aware health care staff is key to success. CHEO noted that they have undertaken several initiatives to improve services to the Indigenous community, and have not been able to find an effective and culturally safe way to inquire of patients about their Indigenous identity.

D. Strengths and Successes

The focus groups identified a number of local strengths and successes that have supported the advancement of Indigenous health in Ottawa. Some of these are provided below as illustrations.

Creating Community

Wabano and the Métis Nation of Ontario highlighted the critical importance of creating community as part of creating conditions for healthy living. For example, social and cultural events hosted by MNO provide an environment of human connection, and the sense of being part of a larger community that accepts you for who you are, all of which contributes significantly to overall well-being. These events have a stronger cultural component to them, and this grounds people in a positive identity as Métis. Other Indigenous organizations also organize community events for the same reasons and with the same holistic health benefits for participants. It was suggested that this element of connection and sense of community needs to be integrated into future health strategies.

Never Say "No"

Inner City Health have a practice that no one is barred from the service. Those who are using alcohol or drugs, or who may be acting out, are not prevented from accessing services or being on the premises. The staff recognize that people may be living with damage that severely affects their ability to function, and will work with a person from whatever starting point they are at. Over time, people gain coping skills, as they learn, and they start to become well. It is a slow process, as Inner City Health deals with people who are often in crisis, however it is possible to provide effective support that enables small successes and progress with patience.

Online Training

CHEO referred to online training on cultural competency available through the LHIN, (available at http://www.sanyas.ca/training/ontario) and that staff find highly effective. It was stated in the focus group that "staff here love it and are looking forward to the next module, which is on mental health." Online learning, in which relatively brief modules can be accessed by staff individually and at times that are convenient to them, are increasing preferred by health care staff, especially younger cohorts.

Language Training

CHEO has worked with the Ottawa Inuit Children's Centre to have Inuit language training provided to staff who work with the Inuit community. An Inuk parent noted that they were very surprised and pleased to be greeted in Inuktiitut when visiting CHEO for the first time.

Culturally Appropriate Tools

Each year, Wabano puts on a Culture as Treatment Symposium that offers mainstream service providers not only the knowledge but specific cultural tools to build capacity on individual service and health providers.

MNO is looking at developing health assessment tools that are culturally-based. These could potentially be adapted and integrated throughout the health care service system in Ottawa and/or serve as a model for the development of culturally appropriate templates specific to Métis people.

System Navigation

A nurse navigator role has been established at Cancer Care, and this is a very patient-directed approach working exclusively with Indigenous patients and families, which is a new concept for staff and sometimes a challenge for them. CHEO is working with TI to establish a navigator role as well. Several Indigenous agencies, such as Wabano and Ottawa Inuit Children's Centre, provide a system navigation function for their clients dealing with the health care system.

Develop Deep Partnerships

CHEO has previously developed an excellent relationship with Akwesasne. This was a formal partnership, in which the hospital became members of the Akwesasne health team. As representatives indicated, "We tried to figure out a model of care provision that works for the community and for health providers. It was an enormous amount of work to bridge the considerable differences between the hospital and the Mohawk community – cultural differences, ways of work, models of health and health care, and so on." CHEO representatives commented that it required a great deal of work to develop the relationship but that it was valuable and worthwhile.

Frontline Trust-Building

Ottawa Public Health representatives working in Family Health and Sexual Health talked about the process of gradually building trust with frontline staff in Indigenous organizations. This is a process that takes time, and is largely responsive in that the OPH staff respect the importance of Indigenous agencies making the decision about whether and when to involve OPH. Being available as a resource person and working with parents and families in a practical, supportive and respectful way helps to gradually build confidence that the relationship can be useful to the Indigenous providers. Trust is built between individuals and continuity in the OPH representative is helpful.

Going into community and into Indigenous services

The Royal Ottawa Mental Health Centre has developed a number of services that are delivered in partnership with Indigenous service providers or service providers that work closely with Indigenous community members. For example, a psychiatrist provides services at Akausivik on a consistent basis and the ROH outreach team works closely with Indigenous community members in the shelters.

Go "the Extra Mile"

Indigenous service providers often indicated that one key difference between their work and that of other agencies is that, even if the person who comes to them does not fit within their program criteria, they will work with the person to find them the service that they need. This means being open and welcoming to everyone and taking time to sit and talk with them, as some people will not always explain what they need in the first few minutes of interaction. They are distrustful of services and need to feel that they are being listened to and that the staff cares about them as a person. For those who do not fit within program parameters, staff will try to find a way to serve them and/or will find a service that can help them. This generally does not mean telling the person to contact a specific agency, but rather making the call and talking with the other service provider to make a connection, helping the client understand the process to access the other service and sometimes even helping them with forms.

E. Barriers

Lack of Cultural Safety

If a community member goes into a hospital, lab services, or some other part of the health care system, the workers, for the most part, do not look like them and may not be able to relate to them. People need to see images and words from their own culture; and overt and welcoming symbols to let them know that Métis, Inuit and First Nations are welcome. Frequently, community members described walking into a health institution and thinking: "You have no idea who I am."

There is a lack of knowledge of the history of First Nations, Inuit and Métis peoples, the damage done to Indigenous cultures, communities and families, and the continuing impacts today. There is also a lack of knowledge of the strengths and traditions of Indigenous cultures.

Community members say they are not taken seriously in mainstream services. They are seen as a number, not a person, and are often seen only briefly. Often, the services are very clinical and unfriendly, and not welcoming. People say they are taken more seriously by mainstream service providers when they are accompanied by outreach workers (e.g. from Wabano).

> *"Service providers talk like you are not there."*
> (TI focus group)

Both Indigenous and non-Indigenous providers noted that non-Indigenous health providers may not understand how to effectively listen to and work with Indigenous clients. Some clients may not speak out to advocate for themselves, are frustrated and come across as aggressive, or may not disagree overtly with the doctor but know they cannot follow the regime the doctor recommends (because of cost, or other reasons). Clients have had experiences that affect the relationship with health care providers, and providers do not know.

There is a stigma in the medical system and many people are not comfortable coming into institutions. They are sometimes re-victimized by the intake process and pressured to share information or tell their story yet again for reasons they do not understand. To disclose one's medical story to a person where there is a low level or no trust can result in feelings of shame or embarrassment.

In some settings, such as large institutions and shelters, the building and the rules are like a residential school, which triggers some clients.

Language is sometimes an issue. Some Inuit prefer their own language, and English is also a second language for some health care providers, so they are trying to communicate across a wide divide.

Sometimes clients want culturally based services (e.g. from Indigenous organizations) and sometimes not. They need to have the choice of going to Indigenous services or non-Indigenous ones, and to receive culturally safe care wherever they go. The health system also has to be culturally aware that First Nation, Inuit and Métis may be asking for different services and organizations when asking for culturally appropriate services.

Cultural services are now starting to be offered in a few local hospitals. For example, the Cancer Care Facility at The Ottawa Hospital provides a space for the whole family to be involved in ceremony, a vented room for smudging, etc.

For all these reasons, cultural safety and cultural competency are critical to improving the health of First Nations, Inuit and Métis clients. Training and other forms of staff development are essential. Non-Indigenous institutions and agencies who received training from Indigenous organizations (e.g. Wabano's symposiums on "Culture as Treatment") are very appreciative of them, and stress the need for more training.

Turnover among doctors, nurses and other caregivers undermines the development of trusting relationships and culturally safe services. There is a learning curve on cultural competence and it requires a commitment to lifelong learning.

Systemic Discrimination

The relationship between Indigenous people and the health care system is long and complex. Systemic discrimination is embedded in some parts of the health care system, and has been there so long that people in the system may not see it. If a person "looks" Indigenous, they may be treated differently. Clients still report hearing overtly racist comments. The Elders expressed their concerns that this is, sadly, an experience they hear from community members and that they have personally experienced.

As a result, going into a hospital or other formal health care setting can be a stressful and triggering experience for Indigenous people. Because of past experiences, community members may assume that they will experience racism in mainstream services. They may feel there is no point going to health services and their health conditions may worsen.

Physicians and pharmacies do not understand the Non-Insured Health Benefits Program (NIHB). "No, we can't give you Tylenol at no cost" is a typical comment. Some Indigenous community members described this as incompetence or racism, and felt that the provider should have been disciplined for failing to provide the service.

Some barriers are not specific to the Indigenous community, e.g. everyone tends to not plan end-of-life care. However, for Indigenous people, this is compounded by systemic discrimination.

> *"Our institutions are still very white-looking."* (Inner City Health focus group)

Provider-Centred Structure of Health System

In the presentation to focus groups, it was identified that the health care system is currently organized around the needs of providers, rather than being client-centred. The construction of existing services does not support easy access by community members. This observation was strongly endorsed in several of the focus groups. Specifically the hours of operation, where services are provided, the way services are provided, the perception of what constitutes safety and whose safety needs are being met was all identified as being specific to the needs of the health care providers.

Lack of Collaboration

Mainstream health services do not consistently refer Indigenous people to Indigenous organizations. Similarly, there is not consistent collaboration on discharge. For example, even if Wabano specifically asks to be a part of the discharge plan in order to provide follow-up, clients are often just sent home and Wabano is not informed.

> *"Where is the table to sit down together and identify barriers and address them?"* (CHEO focus group)

There is a lack of shared planning among Indigenous and non-Indigenous organizations in the health sector, and we continue to work in silos. This lack of shared planning is also true within the Indigenous community, in part, because of the competition for limited funds to support the Indigenous community. There is an embedded bias that First Nation, Inuit and Métis community members can access generic services and when they do not then there is a duplication of services.

Transportation

Lack of transportation is a major barrier to accessing health services. Many people do not have access to a vehicle, and public transit is expensive or inaccessible. Many people are new to the

city and have trouble getting around. Clients described how they had to walk hours to attend a health appointment.

Akausivik and Wabano each have one location, so clients may not go because they live elsewhere in the city. The difficulties in transportation emphasize the need for Indigenous services throughout the city, to take health services to the clients rather than forcing community members to come to the services.

Cultural, social and educational events and activities are available, but the poor transportation makes it a challenge for people to attend.

ODSP/OW do not approve bus tickets back to a person's home community for cultural activities because they are not considered "treatment".

Rigidity of Health Care System

Health providers in the mainstream system are constrained by defined roles, and strict procedures that sometimes exclude people unnecessarily. The Indigenous approach is to provide a wholistic service. Whatever the person needs is responded to including bringing services to them, or collecting different services in one place, or adapting programs to meet an individual's needs.

> *"Mainstream services do not focus on the client and help them, they only do what is in their specific mandate"*
> (Odawa focus group)

Providers set rules that become barriers, e.g. services are only available at certain hours, or if the person misses appointments they are charged a fee (which acts as a disincentive to set the appointment in the first place). The lack of flexibility and the lack of recognition of the impact on people's lives is a challenge. (This barrier is also related to the lack of trauma-informed service.)

Health cards are very difficult to get replaced, and the system is very rigid about requiring them. Why can't services keep people's information on file?

Services are Not Trauma-Informed or Reflective of the Complexity of Needs

The depth of the trauma experienced by some Indigenous community members, whether through the intergenerational legacy of residential schools or the lasting social, economic and cultural impacts of colonialism including the violence and racism in their daily lives, is not fully acknowledged or understood by mainstream services. Nor, are the resiliency and Indigenous based strategies for healing and recovery understood.

> *"The depth of the trauma experienced by Aboriginal clients is not fully understood by mainstream services."*
> (Inner City Health focus group)

The person who is triggered and acts out can be labeled as being a difficult or uncooperative client. A person can be triggered by elements that are an integral part of the mainstream service model, e.g. having to ask to use a washroom, just as they did in residential school. If the client acts out and service providers do not understand then people can be described as difficult or uncooperative.

Because of a siloed approach to delivery of services, service providers can often only address one issue at a time, yet many Indigenous community members have multiple issues. Community members do not receive the level of assessment that their needs require and there is not a full consideration of the complexity of their case. Community members are sometimes viewed as being non-compliant because they have complex needs. A person may not make an appointment because they need help to remember the appointment and transportation to get there.

Service provision needs to become more trauma-informed. Doctors need to know how to work with at-risk clients and people with complex needs. Community members with complex needs require a significant level of assistance and an array of services; some programs are designed to recognize and respond to this, but many are not.

Difficult to Access Services When Using Substances

Community members who have addictions often experience judgment from service providers and frequently are barred from services because of their addictions. This is a barrier sometimes in Indigenous services as well, as community members are not allowed to access cultural services if they are using. One agency gave the example of a community member who was not permitted to access an Elder because the person in question frequently uses alcohol. Community members in this situation experience shame. The question was posed as to whether a harm-reduction approach could be used instead.

Lack of Certain Services or Awareness of Services

The participating agencies also identified a number of gaps in health services for the Indigenous community, where the services do not exist or need to be significantly enhanced:

- Case management for Indigenous clients
- Access to Elders within health services and as part of the spectrum of wholistic care. Elders need to be recognized as professionals and experts in the health system.
- Access to a family physician, especially for those new to the city or who move back and forth from their home community to Ottawa. This is also important because it is much more difficult to get a referral to specialized care without a family physician.
- Funding arrangement do not always allow providers to match client needs with the services available. For example, the LHIN funds individual counselling, yet some participants felt it would be helpful to offer a wider range of choices, such as a healing circle led by an Elder.
- It is very difficult to find appropriate psychiatric services and quickly, because when clients need services they need them right away.
- Culturally specific residential addictions treatment programs are limited and none are available locally. There is only one withdrawal management center, which does not always have sufficient capacity, nor is it culturally based.
- NIHB disallows some services, e.g. a second crown on a tooth (instead the tooth is pulled). Also, OW does not cover hearing aids, so some people do without.

- There are only two homeless shelters that accept women who use substances and one has men as well, where the woman's abuser may also be staying. These are the most vulnerable women and our service delivery model exposes them to more violence.
- More beds are needed in shelters for women leaving a domestic violence situation (the shelters are often full and cannot guarantee a woman a bed).
- Lack of childcare prevents some people from going to health services.
- Culturally-based residential setting for youth with mental health issues.
- Services for homebound community members.
- Services for clients in jail.

Métis Nation of Ontario (MNO) pointed out that their cultural gatherings (and presumably those of all Indigenous agencies) could be used to connect community members with health services and health promotion programs they may not be aware of.

Complexity of the System

The health care system has a daunting array of services, with multiple locations, eligibility criteria, and access processes. Even the experience of entering a hospital can be overwhelming and it is often difficult to find one's way. One medical appointment can generate numerous other appointments, with labs, specialists, etc.

Some progress is being made in setting up advocacy and navigation supports for the Indigenous community to access the right services when they need them, such as the nurse navigator at Cancer Care. CHEO is working with TI to establish a navigator role as well.

Barriers to Using Indigenous Services

Akausivik and Wabano each only have one location, so community members must find their way to these services, even if they live elsewhere in the city, or go without culturally based health services.

Staff resources are stretched very thin in the Indigenous agencies, and they are consequently not able to offer services at a level to meet the demand.

Some Indigenous clients are reluctant to access Indigenous services for various reasons. Sometimes this is because they have a perception that these services are somehow of lower quality than mainstream services, or that confidentiality will be breached. Also, people in the Indigenous community know each other. If someone has a bad relationship with a particular family and the worker at the agency is from that family, they may not want to go to the service. Clients dealing with addictions may be barred from Indigenous agencies.

People on the Québec side of the river want to access Indigenous specific services in Ottawa because there are none in their city. They see this side of the river as part of their territory, and yet the provincial boundaries prevent them from using culturally-based health services.

Finally, not all Indigenous people access Indigenous services.

Financial Barriers

First Nations, Inuit and Métis people face significant financial barriers in accessing health care: parking costs, bus fare, something to eat while waiting at the hospital, etc. Clients have no funds for all these extra costs, which may not be major but are still a barrier. Poverty compounds health access issues. Cost may also be a factor in being able to eat healthy food, or being able to implement a course of action their doctor recommends.

Other Barriers

Some policies have unintended impacts. For example, a practice of taking services to people in their homes is excellent in many ways, but if it replaces a program that brought people together to access the same service in a community location, then it deprives them of important social interaction.

There is concern that Indigenous women going into hospital to give birth are flagged by the Children's Aid Society, simply because of their Indigenous status. Almost all of the CAS concerns are about poverty not about abuse. There have been cases where community members believe women had miscarriages because of the stress of CAS being involved before the birth of the child.

There are administrative complexities dealing with multiple jurisdictions (for example, Akwesasne manages relationships with five jurisdictions in the US and Canada), and the bureaucratic constraints of the Indian Act (Band numbers, etc.). The record-keeping, the tracking of costing and so on make this an onerous area.

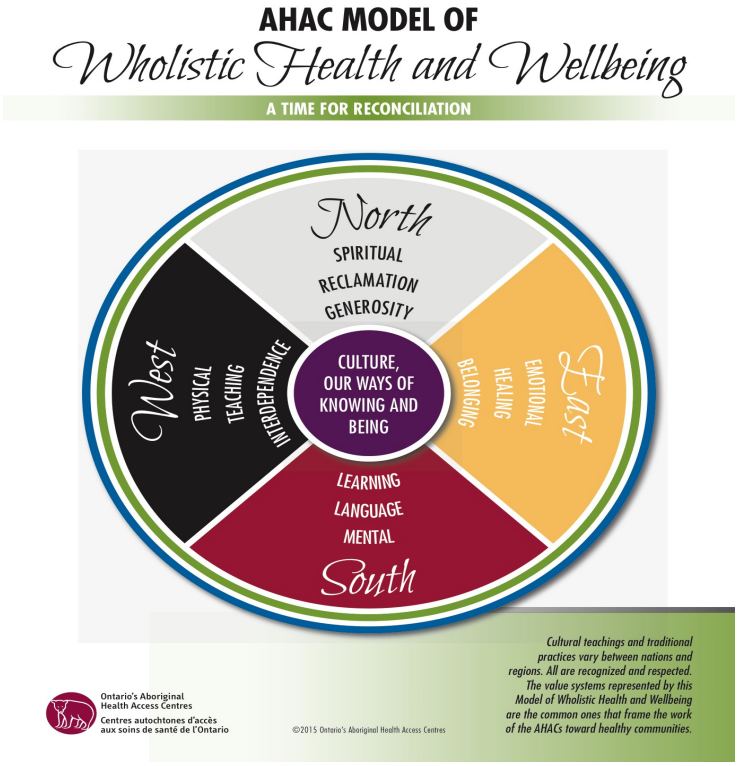
Street-involved people are very independent, and like to take care of themselves. They have major health needs but tend to minimize them, so they do not go for services or they delay going until the condition is severe and the health implications are much more serious. Sometimes people will also do without services they need because they prefer not to deal with the health system, e.g. they need glasses but have none.

F. Models and Strategies

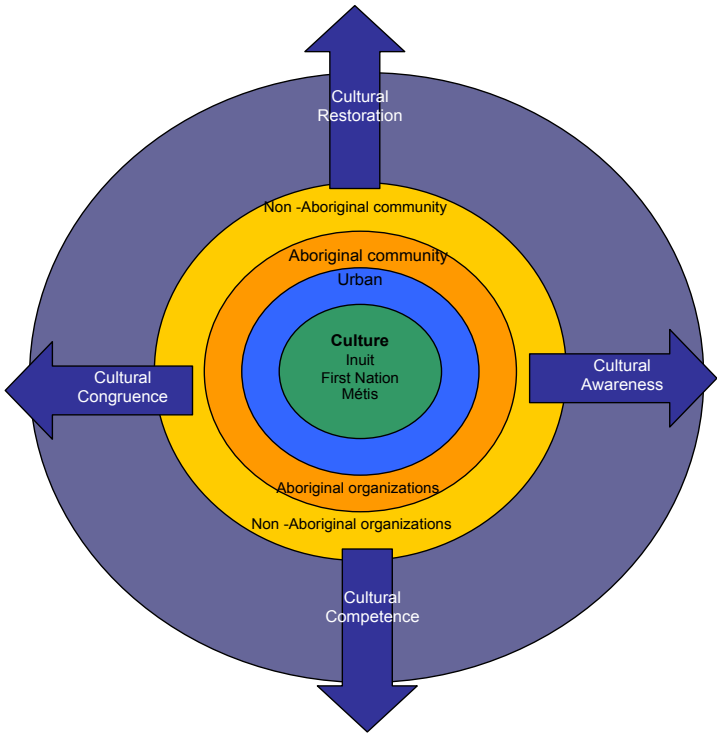
Indigenous Models of Health and Health System Collaboration

Two models have already been developed by Indigenous agencies for use in the health sector. One was developed by Aboriginal Health Access Centres in Ontario and is used by Wabano. The other was developed by the Ottawa Aboriginal Coalition through a project exploring collaboration between Indigenous and non-Indigenous agencies in the mental health field and is applicable to health systems generally.

More information on the two models is provided in Appendices C and D.



The Ottawa Aboriginal Coalition model



Feedback on the Models

There was strong support from all participating agencies and focus groups for the AHAC model and the OAC Collaboration Model, and both were seen as helpful. Some considered the two to be complementary. One concern was that the AHAC model may be perceived as First Nations-focused, as it is based on the Medicine Wheel, and so might be less meaningful to Métis and Inuit as a result. The OAC model was seen as particularly useful in looking at relationships, community-wide changes and health systems overall. The OAC model has been adapted by Mary Simon for use in the Inuit community of Kuujjuaq.

Participants in the focus groups pointed out that the Indigenous approach to health and the models for improving health systems have the potential to benefit everyone, both Indigenous and non-Indigenous, and that the mainstream system has a strong interest in learning from the Indigenous community about improved health approaches.

In particular, participants highlighted the following:

"The Health Links description of health is almost exactly the same, which is why we often say we have a lot to learn from Indigenous models."
(Champlain LHIN focus group)

- Strong support to move from an illness-based to a wellness-based approach.
- Essential to address wider social determinants of health. For example, youth need jobs and education in culturally safe teaching environment.
- Agree that we need to go well beyond the construction of health as Primary or Tertiary care.

"Hope is key to good health."
(Inner City Health focus group)

Health interventions are happening throughout the community – in schools, community centres, recreation centres, and so on – not just in health care settings. We need to ask if all of these are culturally safe.

- Having a client-centred approach means going to the client: providing services in their home, or at locations in the community that are easy to access, familiar to them and trusted. We need to bring education and services to the community rather than asking them to come to the institution.
- Focusing on "community members" rather than "clients" is consistent with a community-based approach that recognizes the range of social and cultural supports that are key to good health.

Changing the focus from "clients" to "community members" is great.
(MNO focus group)

- Create community, a sense of connection among community members, so people feel they are part of a larger identity and people. A sense of belonging and being in community is essential to maintaining good health and helping people heal.

"It is absolutely essential to have culturally safe, competent, kind, non-judgmental care."
(Wabano focus group)

- Focus on culture as an integral part of the healing process and as essential to maintaining good health. Have more cultural programming in the health system. For example, have Elders come to healthy child development programs and talk about traditional ways of child rearing. Ottawa has a good array of Indigenous cultural activities, and we need to support clients to participate more, if they choose, e.g. through providing transportation.

- Health promotion and outreach to the community is important. Community members need to know about services available, and how they can live in a healthy way. Some agencies pointed out that they work with people in crisis, so prevention is the endpoint, after they have worked with the clients for a long time and they are stable enough to manage their own well-being in a more preventive way.
- Collaboration among services is key. All service providers need to be on the same page, and work with each other, for many reasons: so clients don't have to repeat their story, to provide more seamless care, to reduce duplication, and so on.

> *"For many people, their history is hidden because it was very dangerous to be Métis, e.g. your land was taken from you. As a result, the knowledge of Métis identity was not necessarily passed to succeeding generations, and so for some, now is a time of rediscovery of their heritage."*
> (MNO focus group)

Specific Comments on Services

- There is a need for more trauma-informed counseling.
- There are questions of inaccessibility to health services for community members who are using alcohol or drugs; people are not being helped by being barred and shamed.
- Ottawa needs culturally safe detox services, a culturally safe methadone provider, and a culturally safe treatment centre in the region.
- There needs to be more support at CAS Ottawa for Indigenous families. There is a liaison worker, but the position is stretched too thin.
- Are we meetings needs of the aging Indigenous population? We need to provide long-term care, outreach for aging at home, cancer care, etc. all in a culturally safe manner.
- More outreach programs are needed for youth.

There were a number of comments specifically related to the OAC Collaboration Model, particularly on cultural competence and on cultural congruence. These two aspects were identified by many as where the most work is needed.

Cultural Competence

(*Note: Both "cultural safety" and "cultural competence" were used by focus group participants, and they seemed to use them to mean almost the same thing, although "competent" applies to people and services while "safe" seems to refer mostly to programs and services. The Alliance may want to reach an understanding of whether they use both terms, how they define them, and how this is related to the expectations for mainstream services.*

It is important to strengthen and expand culturally-based services by First Nations, Inuit and Métis agencies and also offer more of these cultural services within hospitals and other mainstream health institutions and agencies, such as ceremony and traditional teachings.

At the same time, Indigenous people have the right and the option to access services throughout the community. Staff everywhere in the health system need to have the skills, understanding and tools to provide culturally safe care to Indigenous clients, wherever they access services.

Being culturally competent means service providers would be able to respond respectfully and effectively to an Indigenous person in a manner that recognizes, affirms and values the person, their family, community and Indigenous background. Cultural values need to be respected and embodied in everyday ways of work. The services need to respect people when they come in, build relationships and build trust. Culturally competent service involves changes in staff practice, in policies and procedures, and in the way services are delivered.

Most of the comments from the focus groups referred to cultural competency training for staff. There was a concern that there is often resistance to cultural competency training ("Why are we doing this?") and it needs to be mandatory.

Who needs to receive this training? Essentially, everyone in the health system needs these skills and understanding, and the following groups were specifically mentioned: frontline staff, emergency department staff, nurses, physicians and senior management. One hospital manager also pointed out that turnover can be high, for example, among the nursing staff, and that it might make sense to have a two-tier training approach. All nurses would receive basic cultural competency training, and a small core would receive more intensive training and would be designated to work with Indigenous patients who self-identify. Overall, it would be helpful to identify what depth of training is needed for which groups of health care staff: all need a basic understanding and some might be designated for more extensive competency levels.

In discussing methods of training, several points came up:

- Some element of cultural competency need to be highlighted in the orientation for new staff, so that the expectation is established from the beginning,
- Online training is highly effective because people are very busy and can easily access the training whenever they have time (e.g. in the evenings, on breaks, etc.). The online modules offered through the LHIN were received very positively in several health organizations who participated in the focus groups.
- One-off training is not sufficient. Cultural competency is an ongoing learning process, and the issues are complex. Regular training needs to be ensured to refresh and to continue to deepen the learning.
- It is important that the respective First Nations, Inuit and Métis people define what cultural competency is and who is qualified to provide the training (there are a number of fake "experts" on cultural competency training).

Several people commented that we need to move towards integration of cultural competency in the professional education of all health care providers. Work with universities and colleges in Ottawa (schools of medicine, social work, etc.) could lead to introducing cultural competency training. Providing placements for students in Indigenous organizations can also contribute to their cultural competency education.

The discussions in the focus groups did not specifically explore possible content of the training, however several comments did arise. In particular, participants in the focus groups emphasized the importance of understanding the history of colonialism that has led to this point, as well as certain foundational information about cultural practices. It was also raised that the content on the distinct First Nations, Inuit and Métis cultures needs to be authentic and accurate.

We need to constantly identify best practices in providing culturally competent or culturally safe care, and be able to show that it works and what it looks like.

Inner City Health
We tried for six months to hire an Inuit outreach worker, working in collaboration with TI, and had no success. Committing to full time employment was hard for some people. We also found people did self-sabotage tactics (did not come to the interview, even though we provided lots of supports and accommodations). So, after not being able to hire anyone, we asked our clients why no one wanted the job. Their response was that people should not be getting rich by helping others, because helping others was just being a good Inuk. A full-time worker was not a culturally appropriate solution to the problem. So we had more conversations and our clients created a new approach- they themselves are ambassadors to those who are struggling. They are paid in chits for country food and once they have collectively accumulated enough chits, they hold a feast for community members.

Cultural Congruence

Cultural congruence is understood to refer to change at the system level, including the implementation of measures such as case management, joint protocols, culturally based assessment tools, and a single plan of care. Comments at the focus groups touched on some aspects of cultural congruence.

The commitment to Indigenous health needs to be integrated into strategic planning of health institutions and also planning at the system level to ensure it is addressed throughout the service system. The intent is to get to the point where a client can walk in anywhere and be treated in a culturally safe manner, and directed to culturally appropriate services.

Indigenous organizations sometimes elect to establish a memorandum of understanding (MOU) with a mainstream institution early on in the relationship, as the basis for buy-in. This agreement at the leadership levels formalizes senior commitment early on in the process, which then trickles downs to programs and services.

Development of cultural safe and wholistic assessment tools for use across the system are one aspect of cultural congruence, and MNO noted that they are looking at developing such tools.

What Needs to Change in the Existing Health System?

Previous work on health needs of Indigenous people in Ottawa has highlighted several aspects of the current health system that need to change in order to move towards the Indigenous model of health care and system collaboration, as noted in the box below. These were presented in the focus groups, and participants in all focus groups concurred that these changes are needed.

What Needs to Change in the Existing Health System?

- Cultural safety training and practices in all health institutions.
- Build on the successes of health promotion and community based services to understand how to build relationships with community members that are wholistic in nature. (e.g. walk in counselling clinical services)
- HR policies that ensure that Indigenous people are hired in all parts of the health care system.
- Different service delivery models to be client-centred, culturally safe, etc.
- Realignment to a wholistic model of care.

Many of these points have been covered above in the discussion of the models, however the question of human resource policies has not yet been referred to, and the focus groups noted a number of specific comments about the need for change in health human resources:

- In order to ensure the hiring of more Indigenous staff, there is interest in establishing a ratio of Indigenous people in health services and instituting an affirmative action program to achieve that ratio.
- Finding and retaining Indigenous staff is the challenge. Hiring Indigenous liaison workers is good, but if there is no safe environment around them, then they cannot accomplish much. One Indigenous person in a mainstream organization is not sufficient, we need to change the whole organization.
- Change is needed in all aspects of HR: recruitment, training, supportive policies, coaching, supervision, etc. in order to hire, retain and support Indigenous employees in the health care system.
- It is important to not treat Indigenous staff as if they are a representative of all Indigenous people, or expect them to go to every meeting to provide an Indigenous perspective.
- We also need more Indigenous people on boards and in management positions, not just in frontline positions.
- Encourage Indigenous people to enter health occupations.

G. Health Priorities

Overall, there was strong support for the top two priorities emerging from previous discussions in the community:

- Access to culturally safe services
- Mental health and addictions

However, these were only two priorities out of the entire wholistic approach, and it is important to not lose sight of the whole picture. As participants pointed out in the focus groups, it is hard to select

"In a way, it is difficult to priorize certain services – Indigenous children need access to the full range of services all children need." (CHEO focus group)

only some issues as priorities because the needs are complex, extensive and inter-connected. It is important for Indigenous people to have access to the full range of services in the health care system and a broad range of community services, not just certain priority areas.

It was frequently mentioned that, regardless of the specific priorities chosen, a social determinants of health framework is fundamental and must be considered regardless of the presenting issue or priority issue. As one Elder noted, "everything is connected. My housing affects my health. How I am treated when I go out into the community affects my health. What I eat and whether I have enough income to eat correctly will affect my health. It is not just one thing."

The two main priorities are discussed first, and then following that are some additional priorities that were highlighted in the focus groups.

Access to Culturally Safe Services

> *"This means integrating culture throughout, automatically, in everything, not just smudging once in a while."*
> (Inner City Health focus group)

Expanding Indigenous-specific health services is important. At the same time, many Indigenous people will continue to access mainstream services and so it is important that these services be culturally safe. This means automatically integrating culture throughout all health services in everyday practice, and "not just smudging once in a while". Everyone in every hospital, clinic and agency should be aware of and sensitive to Indigenous cultural issues.

No one sees themselves as prejudiced, yet racism is there in the health care system. Prejudices have been there so long, people do not see them. The media seem to only provide the bad news about Indigenous people, which reinforces negative stereotypes. We need to systematically counteract this negativity and educate and inform health providers at all levels.

There is a complexity to providing culturally safe services. There are different approaches to culturally based services among Inuit, First Nations raised in their home community, those raised in urban settings, etc. In addition to the distinctions among First Nations, Inuit and Métis, we need to respect distinctions among nations (Algonquin, Anishnabek, etc.). Also, there are different levels of practicing one's own culture: some people have very limited knowledge of their own culture, some have a strong Christian background, some live their culture every day, and so on. Somehow we need to find ways to respect all of this complexity – Indigenous people cannot be lumped together.

Part of cultural safety is taking the time to listen respectfully to clients, and to remember that every individual is unique. Workers need to take time to learn, and to know the questions to ask.

Cultural safety also includes access to traditional teachings and medicines within health care services, including having Elders, ceremony and important cultural practices that comfort the client and support them in the healing process.

Indigenous organizations find that they have to constantly re-explain to mainstream service providers certain basic information about their clients. The example was given of an agency who brings an Inuk child to a therapist: it takes at least three sessions for the therapist to begin to grasp who the Inuit are, their cultural context and the depth of historical trauma, at which point a new therapist may well become involved. Health care professional often have a great deal of misinformation or no information at all about Indigenous people.

Indigenous agencies have been educating mainstream services for a long time, and it still seems like so much more is needed. The Truth and Reconciliation Commission *Calls for Action* place responsibility on mainstream agencies to learn, to make changes and to not always look to Indigenous organizations to shoulder the responsibility for change.

"Culture is a way of life, not just the Grandfather Teachings or the Medicine Wheel, it's how we treat each person every day. It's a way of being."
(Odawa focus group)

Funding models need to reflect the imperative of cultural safety. Perhaps it is time to make cultural safety a requirement of funding. In the same way, funding streams need to recognize the distinct needs of First Nations, Inuit and Métis and provide support for health services that recognize these distinctions.

(Note: There are also additional comments on cultural competency training of health care staff in the section of this report on "Models and Strategies".)

Mental Health and Addictions

Mental health and addictions issues were identified as one of the top health concerns for Indigenous people, and especially for youth and children.

It was acknowledged that many mental health issues are tied to historical trauma. It was also acknowledged during the focus groups that the mainstream system has not been effective in meeting the mental health needs of Indigenous children and adults.

"Housing is absolutely key to addressing this issue [mental health]".
(Champlain LHIN focus

The most frequently mentioned need specific to mental health and addictions was the absence of a culturally safe addictions treatment centre in the Ottawa area. (The work of Mamisarvik was acknowledged in this respect.) When a person is ready to go into treatment, the services need to be available immediately and it would be preferable for the program to be in the local area. Some participants spoke of a treatment program being developed through Minwaashin Lodge that will have a wholistic family centred approach. Clients want Indigenous specific programs for addictions treatment.

Participants reminded us that spiritual well-being, and creating a sense of community and belonging are both important elements of mental wellness, and need to be considered in the design of a health system response to the mental health needs of First Nations, Inuit and Métis.

Other identified gaps in mental health and addictions services and programs highlighted the need to:

- Provide mental health case managers to advocate for clients and attend appointments with clients to increase the quality of care and to follow up with clients and service providers.
- Improve access to social and cultural events for people with mental health issues (e.g. through providing medical transportation)
- Offer a more diverse range of mental health supports (psychiatry, psychotherapy, Elders, healing circles, etc.)
- Advocate for funding to establish local Inuit mental health workers
- Expand access to intensive case management services – Some people have chaotic lives, and need lots of support to live healthy lives. For example, working with the person on housing issues, addictions, mental health and related concerns.

Other Priorities

Housing

- Safe, affordable housing is extremely important to the health and wellness of people.
- If people are housed in scattered sites, they feel very isolated. They need community for social and cultural well-being. Some return to homeless shelters for the social connection even though they have access to regular housing.
- We need to have culturally based care provided in the housing, where people live. Inuit in particular often seek to live in community and it is important have a cultural element in the housing provided. People want to live together, in extended families and kinship and friendship networks, so it makes sense to provide the housing that accommodates that.
- People need to have a choice in housing (i.e. not grouping all the "similar" families together).
- Lack of adequate housing impacts other factors about health, e.g. people living in a shelter are probably not getting the nutrition they need.

Healthy child development

- This was identified as a priority based on unmet needs that providers were aware of, as well as the very young Indigenous population in Ottawa.
- Culturally-specific programs are needed for early childhood development
- How do we connect with high-risk children who are not even accessing services?
- This area is also linked to mental health in that Indigenous children are more prone to mental health difficulties.
- (Healthy child development was raised as a priority in five focus groups.)

Infectious diseases

- Indigenous people are over-represented in cases of tuberculosis, and sexually transmitted and blood-borne infections. Why is this? We need more research but also frontline doctors and nurses need education to recognize cases that might be TB.
- (Infectious disease was raised as a priority in three focus groups.)

Health outcomes

- How do we know if services and programs are reaching First Nations, Inuit and Métis community members and if they are effective?
- Health outcomes are currently much worse for Indigenous people than other sectors of the population. For example, First Nations people contract cancer on average 10 years younger than non-Indigenous people. "You're too young to have cancer", is a frequent comment from physicians because they are not aware of the Indigenous statistics and consequently do not readily accept the signs of the disease in younger patients. Indigenous people also have low rates of early screening and higher rates of late stage diagnosis (i.e. what could have been treated it if they had come earlier).
- (Health outcomes were raised as a priority in two focus groups.)

Communications and Health Promotion

- Much more emphasis is needed on health promotion and prevention programs, delivered in a culturally competent way. The most effective programs take a wholistic approach and use a cultural base.
- Families are not necessarily aware of existing services and more needs to be done to communicate information to them services available.
- (Prevention and/or communication about services were raised as a priority in five focus groups.)

Food insecurity

- People need better access to healthy food (e.g. through transportation to stores where they can buy nutritious food or through delivery of a good food box to their home). Many people do not have ready access to transit or have health conditions which make it hard to travel or carry groceries, and they end up going to the corner store, which is closer and easier, and buying unhealthy foods. Cost is also a factor in obtaining healthy food and obtaining traditional or country food.
- (Food insecurity was raised as a priority in three focus groups.)

Chronic disease

- This was a priority identified by the Indigenous Health Circle Forum of the Champlain LHIN. Diabetes was particularly mentioned by focus groups members.
- (Chronic disease was raised as a priority in five focus groups.)

Collaboration

- Collaboration is key – health care providers need to support, honour and collaborate with community agencies on the ground and with each other. Indigneous people often are dealing with complex health conditions and multiple issues, and overall we have not found a way to work together to effectively support people in this situation. The current system erects barriers to addressing the needs of Indigenous people in a wholistic way. For example, the Health Ministry cannot fund housing or food, yet these are essential to health and sometimes their absence is a more critical factor in illness than anything else. The intent for a whole-of-government approach has been announced, now we have to find a way to deliver.
- (Collaboration was raised as a priority in three focus groups.)

Finally, there were a number of areas that were raised only once during the various focus groups:

- Respite care
- Medical transportation
- Home support (foot care, cleaners, community support services, food preparation, etc.)
- Make dental care and dental screening more available to Métis people
- Better access to naturopaths and homeopaths
- Undiagnosed cirrhosis of the liver
- Pain management
- Palliative care
- Seniors, including an increasing concern about dementia

H. Collaborative Relationships

Community members have complex lives and many are dealing with multiple health challenges. To serve them in a wholistic way requires that there be multiple services supporting them in their life journey. Given that, it is essential that the different services collaborate well with each other.

There is a clear understanding among the organizations who participated in the focus groups of the importance of collaboration, and all of them reported numerous relationships. The most frequently mentioned collaborations were with Wabano Centre for Aboriginal Health, Minwaashin Lodge and community health centres (CHCs). The word cloud below gives an indication of all the partners mentioned in focus groups, and how often each of them were cited.

Some of the non-Indigenous organizations commented on the distinctions between Inuit and First Nations, in terms of culture, ways they access services, and service delivery models that work for them.

"Cultural safety is not the same conversation with Inuit and First Nations. There are different approaches, and one program may not fit all needs. There may need to be the same commitment to relationship-building, but the interactions at the clinical level are distinct."
(CHEO focus group)

What is Involved in Collaboration?

All of the organizations commented that they have a number of positive and effective relationships with other service providers in the city, both Indigenous and non-Indigenous. They discussed some of the steps and approaches involved in effective collaboration, including the following:

- It helps to lay the ground work by holding meetings between the leadership of the health institutions and the leadership of Indigenous organizations.
- Trust-building and relationship-building takes time and an investment from both sides. An example was given of a highly effective collaboration in the past that was the result of a significant investment on both sides, by the Indigenous body and by the health institution. There can be turnover in organizations which slows down this process. Also, Indigenous organizations typically have fewer people and resources than large institutions, making this investment more onerous.
- Staff in Indigenous organizations trust individuals in the larger health institutions, but not the institutions. We need to build more relationships at all levels, including at the senior leadership, so that the elements of collaboration can permeate throughout the collaborating organizations.
- Collaboration needs to go beyond communication. We need to find a way to provide wrap-around services for Indigenous people.
- In some cases, certain programs in non-Indigenous organizations take a more responsive stance. They build relationships with Indigenous organizations and then wait to be invited, recognizing that what they have to offer may not be of immediate interest to the Indigenous agencies in the community.
- Successful collaborations often involved expertise in cultural competence flowing from the Indigenous organization to the health institution, and sometimes involved clinical expertise or guidance flowing from the non-Indigenous health institution to the Indigenous group. One example was given of CHEO providing specialized services on-site at Akausivik Family Health Team, because community members trust Akausivik and feel comfortable accessing services there.

Challenges

"We find with many service providers, there is an openness to collaborate around meeting Indigenous needs, but not the awareness, training, or understanding."
(Champlain LHIN focus group)

Focus group participants commented on some of the challenges in building collaborative relationships. The main concern raised was that mainstream organizations have a great deal of learning to do about Indigenous history, the impacts of colonialism, and becoming culturally competent. This process of learning is essential for creating partnerships, and both Indigenous and non-Indigenous organizations raised this as a key point

for moving forward. It was observed that Indigenous organizations have had to bear the burden of educating non-Indigenous organizations and that these organizations need to take more responsibility in seeking to learn.

It was also pointed out that some funding is based on the number of clients, which can lead to competition where agencies are reluctant to "share" clients. We need to find a way to put the needs of clients first.

A few of the comments raised specific concerns about specific services. There was also a comment that at least one mainstream agency (the Ottawa Police Service) had improved how their Mental Health Crisis Unit has shifted their demeanour and now approach situations in a very calm and helpful manner.

I. Moving Forward

Involvement in Developing and Implementing the Strategy

Participating organizations expressed an interest in continuing to be involved in the initiative, and the way in which that might happen varied somewhat according to the group.

Wabano, TI and Akausivik Inuit Family Health Team have all expressed an interest in being involved and playing a leadership role in the alliance.

CHEO, the Royal Ottawa Mental Health Centre and the Ottawa Hospital are also interested in being at the table. They already have some collaborative initiatives underway (e.g. working with TI to have an Inuit navigator for the hospital services), and expressed a desire to listen and learn more about the needs of the Indigenous community and how to appropriately meet them. Inner City Health strongly supports the initiative, and after consulting with their Indigenous partners, signed on as it was seen as being helpful to have Inner City Health at the table. Sandy Hill CHC is very supportive of the initiative and will wait to see what structure emerges for the alliance so they can see how they can best play a role. Cancer Care will be involved through the senior leadership of the Ottawa Hospital, and in addition, the Cancer Care Program itself would appreciate being invited to the community gathering and other similar forums as the Strategy is rolled out. The program also offered to shared the cancer care plan they are developing.

Ottawa Public Health (OPH) is committed to the creation of an Alliance. Administrative support will be available to schedule/host initial meetings, co-develop and distribute agendas, minutes, terms of reference, an action plan and other supporting documents as necessary.

As a provincial entity offering services locally in Ottawa, MNO is in a unique position, and the leadership will need to consider the most appropriate role going forward. To assist in this, MNO requested additional information about what would be involved in participating on the Alliance body.

Champlain LHIN is connected to Indigenous health planning through the Indigenous Health Circle Forum, many of whose members are also involved in the Alliance. Some connection beyond that makes sense, although the exact role of the LHIN in relation to the OIHS requires further consideration.

Odawa Native Friendship Centre questioned the need for the Alliance. As there are a small number of Indigenous agencies involved, Odawa suggested that it might be simpler for OPH to meet with each agency individually. It was also indicated that if the Indigenous Health Strategy does not include concrete outcomes, Odawa would be less interested in participating. In addition, Odawa suggested that rather than two co-chairs from organizations that have a direct interest in the issues, it would be better to have an independent chair, someone who has expertise in Indigenous health.

Suggestions for Upcoming Steps

"What is needed is somewhat clear, but the 'how' is very hard." (OPH focus group)

During the focus groups, a number of aspects were suggested for consideration in the next stages of the process, including:

a) Involving the community

- Engage youth, Elders and community members, including LGBTQ community members. The planned community forum will be a good opportunity to involve the community, and it may be helpful to have specific elements for youth and for Elders either at that forum or as separate gatherings.
- Hold a gathering or conference to facilitate dialogue among grass roots workers to feed into the Strategy.

b) Align with other initiatives

- Ensure that there is a clear alignment between the Strategy and the priorities and plans of the Indigenous Health Circle Forum of the Champlain LHIN.
- Take into consideration the Patients First provincial legislation.
- Consider City of Ottawa related strategies.
- The funders need to be engaged, to ensure that funding does not set up barriers that prevent the community from implementing an Indigenous health strategy.

c) Elements of the Strategy

- Who is the keeper of the strategy? Who signs on to it?
- Set out a solid plan of how, with whom and when services can be delivered in a culturally appropriate way.
- Set measurable indicators for each year to see if we are making progress, e.g. existence of protocols, etc.
- Who monitors cultural competency? Who sets the standard of what cultural competency is? Do we expect all staff in the sector to reach cultural competency, or just some? (and if so, which ones?)
- Ensure the strategy is monitored, and functioning at an appropriate level.
- Put in place mechanisms for ensuring Strategy is actually implemented, and that agencies are accountable for implementing it.

- Reporting, indicators, and our understanding of what is success need to be aligned to wholistic care approaches.
- The planning process needs to be Indigenous led and based, so that services and systems are a co-creation with the community.
- The key point is that, although there will be adjustments as we test different approaches and learn how to do better, the Strategy has to lead to improvement in the lives of Indigenous people.
- Maintain an up-to-date snapshot of Indigenous people in Ottawa to inform the ongoing strategy.

d) Possible research

- It might be useful to develop a collaborative health status initiative from an epidemiological perspective. What are the true data? For example, OPH could change internal processes to start capturing the data for Indigenous populations and then put a strengths-based, health equity lens on it. Tell the story of the data and the community can tell us the solution.
- Involve academics who can provide support to the Strategy, by undertaking research or advising on research initiatives.

It was suggested that this needs to be an ongoing Alliance, with a Strategy that evolves over time as key indicators are achieved.

We need to always have an up-to-date snapshot of Indigenous people in Ottawa and which nation they identify with, e.g. Vancouver now has more Inuit than Ottawa (need to update our demographic information).

Appendix A: Agencies Participating in Focus Groups

Ottawa Aboriginal Coalition

Cancer Care Program, Ottawa Hospital

Champlain LHIN

Children's Hospital of Eastern Ontario

Inner City Health

Métis Nation of Ontario

Odawa Native Friendship Centre

Ottawa Public Health

Sandy Hill Community Health Centre, Intensive Case Management Team

The Ottawa Hospital

The Royal Ottawa Mental Health Centre

Tungasuvvingat Inuit

Wabano Centre for Aboriginal Health

(Note: A focus group with the Akausivik Inuit Family Health Team has been requested but not yet scheduled; Akausivik was involved in early discussions about an Ottawa Indigenous Health Strategy and expressed interest in playing a leadership role.)

Community Focus Groups

Elder's Gathering
December 2015 Community Gathering
June 2016 Youth Focus Group with Ottawa Aboriginal Coalition

Appendix B: Focus Group Questions

This initiative will involve Indigenous agencies, Ottawa Public Health, local hospitals and other community-based health service organizations in the development of a coordinated strategy to respond to the identified priority health needs of First Nations, Inuit and Métis (FNIM) peoples in Ottawa.

The concept was presented to the community at the Ottawa Aboriginal Coalition (OAC) Forum in December 2015, where a health and wellness theme highlighted a strong value for social connectedness and inclusion.

Initial meetings between Ottawa Public Health and Indigenous partners have reinforced that the strategy must be very practical and only focus on 2-3 concrete objectives.

Previous consultations in the Indigenous community have consistently identified the following priorities:

- Access to culturally safe services;
- Mental health & addictions;
- Communication (e.g. awareness of services and appropriate engagement strategies);
- Healthy Child Development;
- Infectious diseases; and
- Health outcomes (e.g. how do we know if services and programs are reaching FNIM community members and if they are effective?)

With a **client-centred approach** in mind, the overarching question for this consultation is: *What is the ability of the local health sector to respond to the identified priority health need(s) of First Nations, Inuit and Métis community members?*

Discussion Questions

<u>FNIM-targeted services</u>

1. Does your organization serve a particular part of the Indigenous community (e.g. First Nation, Inuit or Métis)?
    a) If so, what percentage of your services or resources focus on this group?
    b) Do you ask questions to track identity?

<u>Health needs</u>

2. What are the most frequent requests for health services or resources that your organization receives from FNIM community members?
    a) Which of these services are easy to provide? Why?
    b) Which are more challenging to provide and/or not provided at all?
    c) What barriers exist that may prevent clients from accessing your services? What alternative solutions are offered to ensure that clients receive appropriate services?

Collaboration

3. Who do you currently collaborate with to ensure that FNIM clients are aware of and receive appropriate services? Who would you like to collaborate with in the future?

Moving forward

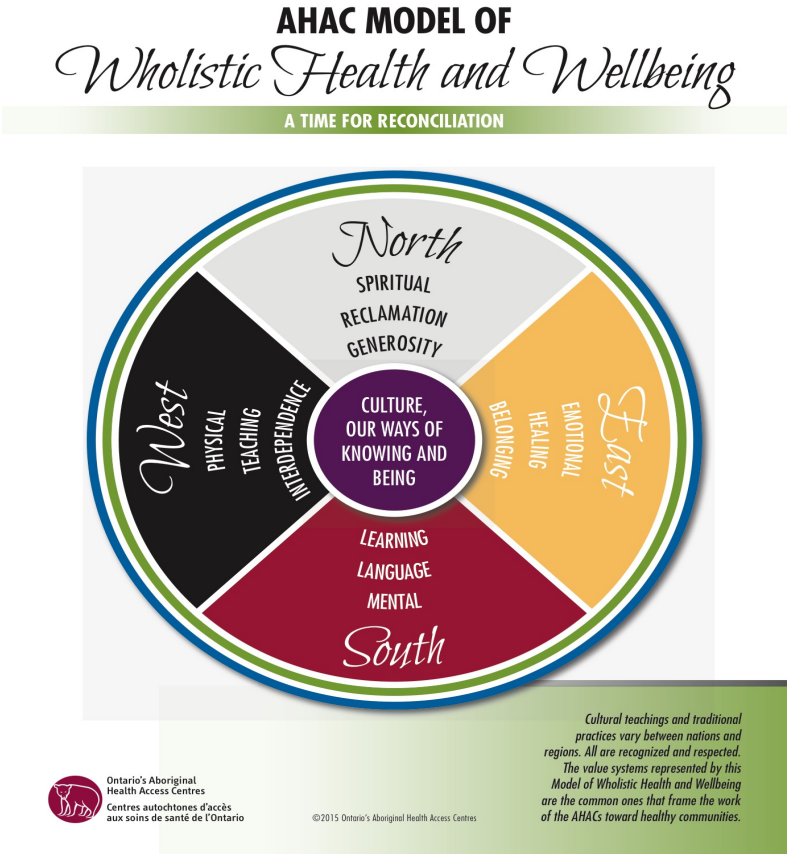
4. Based on the list above from previous consultations, which one or two priority health needs would you see as the focus of an Indigenous Health Strategy for Ottawa?

5. Would you be interested in working with the Urban Aboriginal community in the development and implementation of an Indigenous Health Strategy that would improve access to services for the Aboriginal community?

6. How do you see your organization contributing to an Indigenous Health Strategy for Ottawa?

Appendix C: AHAC Model – Wabano Centre for Aboriginal Health

The model is used in different forms by Aboriginal Health Access Centres (AHACs) across Ontario. The description following is based on a video prepared by Wabano Centre for Aboriginal Health to explain Wabano's model of care to their own staff and to community partners. The video can be accessed at:
https://www.youtube.com/watch?v=Kksaq5Ohm_g



Circle: The model is based on the circle, and the circle is a foundational concept that carries importance in many Indigenous cultures around the world, including in Canada. In the circle, everyone belongs, no one is more important or less important than anyone else, each person is distinct and unique, everyone can see everyone else, and there is always room for one more.

Culture: At the centre is culture because it is the heart of every aspect of Wabano's work, and the foundation of every program, service, activity and initiative. Culture informs every aspect of the work and every stage, from planning to doing to reflecting.

Belonging (East): The Medicine Wheel has four aspects, reflecting the Four Directions, but these are interconnected and not separate from one another. Going around the Medicine Wheel starts in the East, the place of belonging. In providing programs and services, it is essential that people feel they belong, that they are welcome as soon as they enter a space. It is about how

people feel when they come into an agency or institution, when they interact with staff. People may have experienced trauma, or be ill or injured, or be new to the city. Whatever their situation, it is important that they feel safe and respected from their first contact.

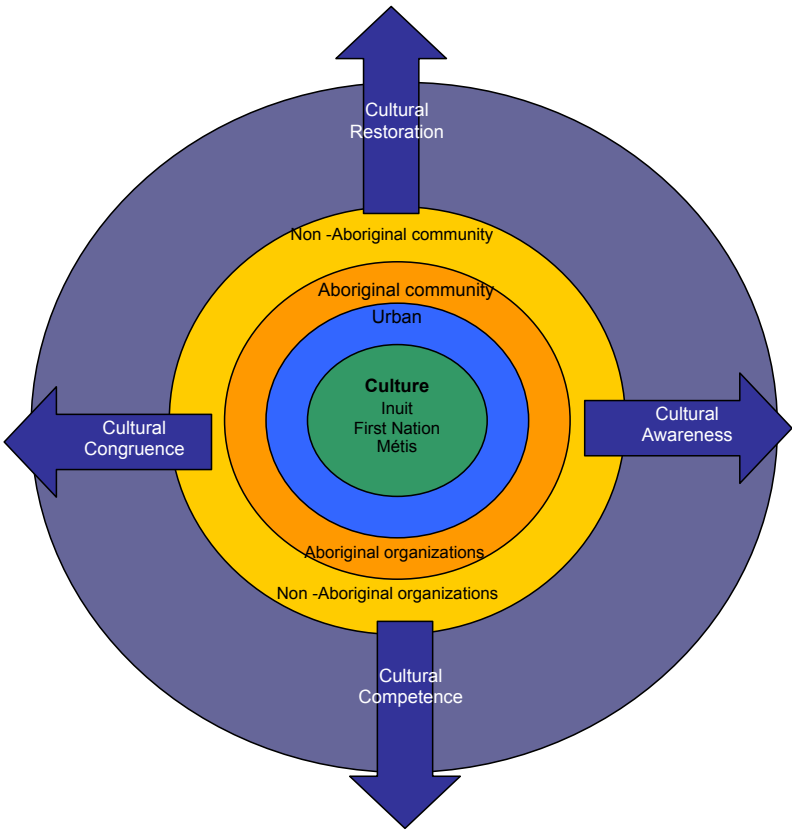
Mastery (South): This aspect of the Medicine Wheel is about learning, increased knowledge and changes in behaviour. It is about one's own mastery of skills and understanding, and also about sharing with others the knowledge and actions to help them live better lives, so that they become masters of their own lives.

Interdependence (West): This is about our place in the community, our relationships with other agencies and services, our responsibility to serve the greater good all inform the model of care. Part of this is instilling pride in the people who access our services to share what they have learned with their families and others in their lives. This aspect of the Medicine Wheel reminds us that we are stronger together.

Generosity (North): Long-term planning in Indigenous terms means thinking about the impact of our actions on the next seven generations. Considering this long-term responsibility leads almost inevitably to generosity, to giving something lasting to the future generations, and this shapes the way services are designed and delivered.

Appendix D: OAC Collaboration Model

Based on previous experiences of collaboration and recognizing the limited resources in the Aboriginal community the Ottawa Aboriginal Coalition decided in 2012 that it would develop its own collaboration model that it could bring to the table as the starting point of the discussion. The OAC wanted to avoid failed approaches where Aboriginal representatives at tables have been outnumbered, out voiced and out voted on every decision. The OAC held three meetings prior to developing the Collaboration model in order to focus the discussions and assess the current context.



The Collaboration Model Explained

The Collaboration model is designed as a wheel to represent the process that Aboriginal and non-Aboriginal service providers will have to go through together. The middle four circles represent what all service providers need to know in order to effectively serve Aboriginal people.

Culture (the middle circle)

Culture is at the centre of all the work done. Each Aboriginal person has unique cultural traditions and teachings including how healing is most effectively done in that culture.

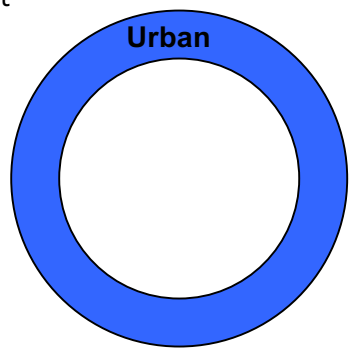
Ottawa service providers are working with a **diverse Aboriginal community** made up of First Nation, Inuit and Métis people.

There are approximately 35,000 Aboriginal people in Ottawa. The largest groups of First Nation people in Ottawa are Algonquin, Cree, Ojibway and Mohawk. Most Inuit in Ottawa are from Nunavut, however Ottawa is also a health and education location for Inuit from Nunavik. The Métis population in Ottawa are primarily from Ontario settlements as far as Sudbury and as close as Bancroft.

An urban context

The second circle recognizes that Aboriginal people in Ottawa are living in an urban environment and there are a number of implications that service providers need to consider:

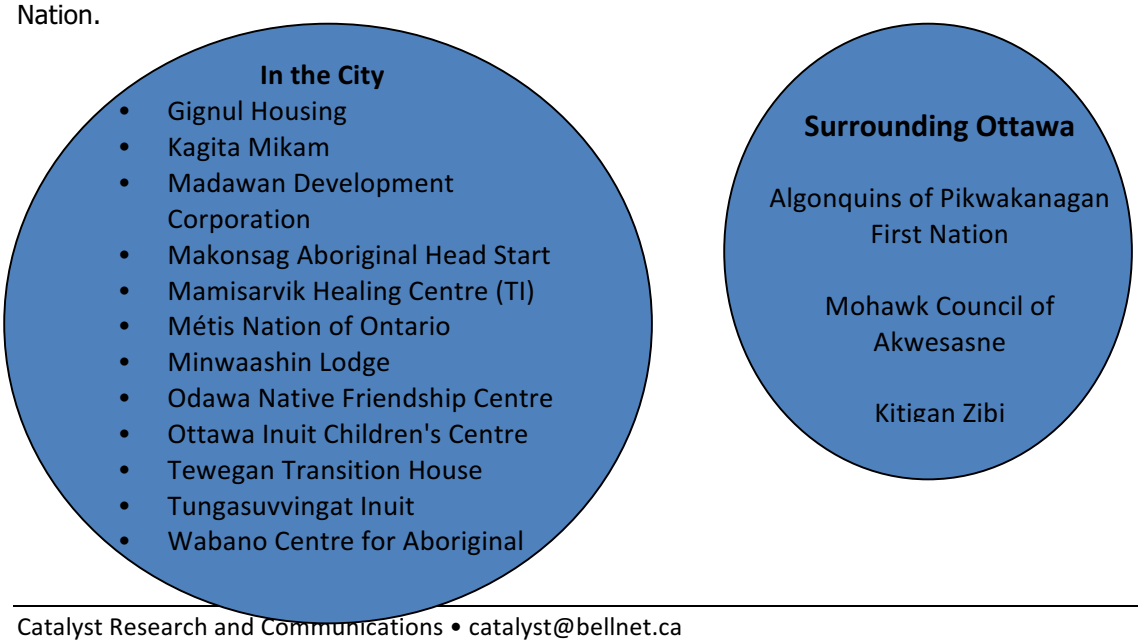
- Many Aboriginal people in Ottawa are here for employment and education and are living away from their home community. They may not have the same supports that they would have in their home community.
- They may have significant ties to the community and be affected by what is happening in their home community. We have seen youth suicide clusters jump between communities because of close connections.
- Aboriginal people raised in the city may not have been exposed to their culture and have a hunger to know about who they are and develop a stronger sense of identity.



Aboriginal organizations

There are eleven Aboriginal service organizations in Ottawa with only two funded to provide direct clinical mental health services, Wabano Aboriginal Health Centre and Tungasuvvingat Inuit. All Aboriginal organizations provide a wide range of protective programs including culturally based programs that promote a positive mental health. Some programs offers counseling and mental health supports for specific constituencies, like Minwaashin that offers supports to women and children who have experienced violence.

Ottawa is surrounded by and closely connected to three Aboriginal communities: Algonquins of Pikwakanagan First Nation, Mohawk Council of Akwesasne and Kitigan Zibi Algonquin First Nation.



Service providers in Ottawa need to understand the dynamics of the Ottawa Aboriginal community. Just in the last six months, the local community has been going through some dynamic changes:

- Wabano Centre for Aboriginal Health is the process of completing its world-class building and staff were relocating into the new space.
- The Odawa Native Friendship Centre has sold its building and different programs including the Alternative High School are in the process of relocating.
- The Makonsag Aboriginal Head Start program had applied to the National Capital Commission to relocate to Victoria Island and in the interim is in the process of relocating.
- AANDC confirmed at the end of January, 2013 that OAC had received approximately $250,000 of Community Investment Funds for community-based projects that had to be completed by March 31st, 2013.
- The Ottawa Inuit Children's Centre purchased a building that will be used to support programming, potentially including Inuit youth programming.

As the national capital, Ottawa welcomes the Aboriginal people from across Canada. The four months of the research was a busy time for us as the Aboriginal community welcomed the Idle No More movement to our community and provided support to Chief Teresa Spence as she held her hunger strike on Victoria Island.

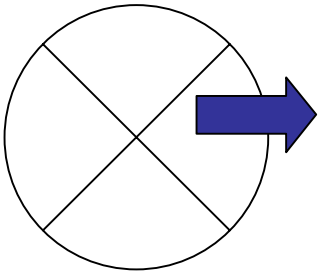
Non-Aboriginal organizations

There are numerous non-Aboriginal organizations that provide mental health services to Aboriginal people in the Ottawa community. The research on Aboriginal Youth and Mental Health needs identified 72 organizations - each providing a range of services. Often it is extremely challenging for the limited number of Aboriginal organizations to maintain information about all of the different programs in the non-Aboriginal organizations that could support clients without a coordinated communication approach.

The Four Directions

Collaboration is a process. The medicine wheel describes the process of collaboration through the strengthening of a relationship between non-Aboriginal and Aboriginal service providers with the focus on providing the best possible service to the client.

East – Cultural Awareness



The medicine wheel starts in the east where awareness is established that there are two worldviews that co-exist: an indigenous worldview and a mainstream worldview. Knowledge of both is required in order to move forward in the relationship and ideally every mental health service provider that works with Aboriginal people will have an awareness of:

a) The impact of colonization and, more specifically, the residential school legacy;
b) How colonization and intergenerational trauma impact the social determinants of health
c) What are protective factors for Aboriginal mental health;
d) Culturally based tools and interventions; and
e) Trauma informed practice.

The Aboriginal community over the last ten years has provided many educational opportunities to the Ottawa service provider community to increase cultural awareness, including

- The annual Wabano Centre for Aboriginal Health *"Culture as Treatment"* symposium for professionals;
- The Mental Health conference by Minwaashin Lodge in March 2013;
- The training provided to the school boards on the legacy of residential schools and the purchase of the Legacy of Hope kits for the schools;
- Specific training provided by different Aboriginal organizations to specific non-Aboriginal service providers including the Ottawa Children's Aid Society; and
- Ongoing education and awareness training through committee work.

To ensure sustained cultural awareness there needs to be:

- Recognition that indigenous knowledge, including awareness of mental distress and healing methods are credible and valid as other professional knowledge;
- Continuous investment in cultural awareness training and development in every organization that is working with Aboriginal people;
- An organizational training plan that reflects the nature of the workplace (e.g. the degree of turnover in staff; the orientation practice of the organization);
- Compensation for Aboriginal organizations that are providing continuous cultural awareness training; and
- Curriculum development and delivery of specific courses in colleges and universities for mental health professionals.

An Aboriginal understanding of mental health The OAC collaboration model

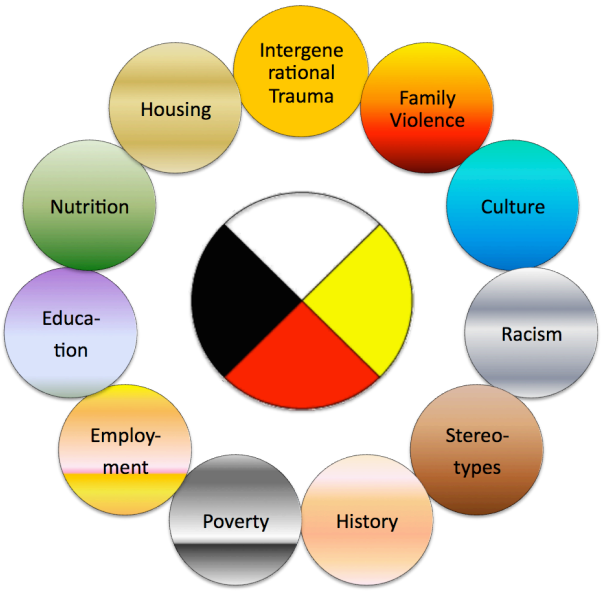
> The Elders often speak of having a 'good mind'. Having a good mind is to possess intelligence, good reasoning skills, a positive outlook, superior discernment, being observant with a strong ability to recall, have clarity and coming from a place of inner peace. The idea of the Good Mind/Message comes from the Haudenosaunee Great Law of Peace, given by the Peacemaker who also gave the concepts of Power and of Peace. The Great Law teaches the concepts of love, peace, equity, coexistence, cooperation, power, respect, reciprocity and generosity. Therefore, if Good Mind exists within community it means that peace can also exist.
>
> **(A Good Mind, OFIFC, 2006)**

Building on the description of a "good mind" described in the OFIFC's document "A Good Mind", and the different approaches used in Ottawa to support and sustain mental wellbeing for First Nations, Inuit and Métis people, there are six consistent elements in addressing mental health:

1) Culturally based: Culture permeates design and delivery of services, both in treatment and in health promotion and prevention.

2) Holistic: Mental health strategies and services must address all aspects of a person's well being (emotional/physical/spiritual/ mental) in both prevention and treatment. The life cycle wheel is just one model that can support planning of what services are needed to support both individuals and the community.

3) Social determinants of health: The recognition that current and historical factors impact well-being, including poverty, housing, food security, intergenerational trauma, dislocation from the land, and cultural disruption and suppression.

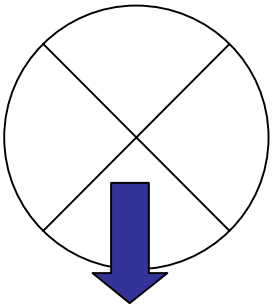


4) A continuum of care: various versions of the continuum of care have been developed, for example, the ***Honouring Our Strengths*** framework uses the following six elements:
    - Community development as prevention;
    - Early identification; brief intervention and aftercare;
    - Secondary risk reduction targeted at people with high risk of harm due to substance abuse, to provide support (physical injuries, car accidents, crime, suicide and other harms);
    - Active treatment;
    - Specialized treatment for complex cases;
    - Care facilitation (which includes cultural support and social determinants of health).

5) recognition of interconnectedness of the individual, their (extended) family, the community, and the land and natural environment;

6) distinction-based: First Nations, Métis and Inuit all have distinctive cultural approaches and diversity within each group, and a mental health model for Aboriginal people in the Champlain LHIN needs to be meaningful to all three distinct groups.

South – Cultural Competence



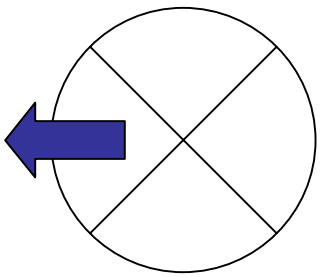
When we move to the south we move to the area of emotions and the development of relationships. Culturally competent service providers would be able to respond respectfully and effectively to an Aboriginal person in a manner that recognizes, affirms and values the person, their family, community and indigenous background. Cultural competency is the commitment to incorporate cultural knowledge into practice.

A cultural competent person has the ability to assess what is most appropriate for the client with respect to service delivery. It relies on three key elements:

- *Culturally competent services and programs in Aboriginal organizations*: Culturally based mental health programming and services needs to be delivered by Aboriginal organizations.
- *Referrals* to Aboriginal organizations when Aboriginal people want to receive culturally based services. The referral system needs to be simple and accessible to the greatest number of workers in non-Aboriginal service organizations so they know whom to call.
- *Joint programming* between Aboriginal and non-Aboriginal organizations is an effective way to bridge the lack of cultural knowledge and capacity in organizations. Examples of successful joint programming in Ottawa includes the CAS Circle of Care program which provides Aboriginal families working with CAS an Aboriginal process through an Aboriginal organization.

System reform is required to support culturally competent practice. Service organizations that are client focused and doing appropriate referrals to Aboriginal organizations need to be able to reflect those referrals into their client numbers and not be penalized.

West – Cultural Congruence

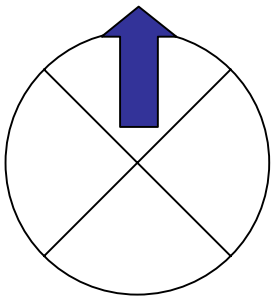


In the west we are in the physical realm and our actions and tools need to reflect our knowledge and relationships. We recognize that there are different worldviews that need to co-exist in order to provide services and we have the relationships to develop congruent tools and systems. Cultural congruence ensures that all mental health organizations will be able to accurately assess the needs of an Aboriginal person and provide an appropriate set of interventions. Key elements of cultural congruence are:

- *Case Management (Service coordination*) would be based in an Aboriginal organization if it were an Aboriginal person being served.
- *Assessment tools* will be culturally based and developed by Aboriginal people to ensure that a holistic model is applied in doing assessments. Asking Aboriginal service providers to adapt or provide input into non-Aboriginal assessment tools would not be done.
- *A Single Plan of Care* would support the system changes and ensure that case management for Aboriginal people is done in Aboriginal organizations.

- *Protocols* would be developed that would support a seamless process between organizations in order to support effective case management.

North – Cultural Restoration



Cultural restoration builds on the knowledge and relationships acquired over time. It recognizes that trust is critical to effective planning. Planning and funding tables would have the capacity to consider the specific needs of the Ottawa Aboriginal population and ensure that strategic investments are made to support a vulnerable population. Planning tables would also have an understanding of the power dynamics between Aboriginal and non-Aboriginal people.

Specific elements that would exist would include:

- *Planning tables* would have an informed approach to serving the Aboriginal community and sufficient representation of Aboriginal people.
- *Aboriginal specific policy on mental health*
- *Specific funding* for Aboriginal mental health services.
- *Establishment of a provincial Aboriginal collaboration body* that can support the development of curriculum for mental health professionals; develop culturally based assessment tools and describe specific culturally based interventions.

Glossary

Cultural awareness

Culture is a process through which ordinary activities and conditions take on an emotional tone and a moral meaning. These processes include the embodiment of meaning in psychological and social interactions. Culture is a dynamic lived process that includes beliefs, practices, and values. It is not homogenous or static but is constantly evolving. It is inseparable from historical, economic, political, gender, religious, psychological, and biological conditions.

Cultural awareness is the acknowledgement that cultural differences exist, and involves being willing to recognize and accept cultural differences within a population being served.

(Hart-Wasekeesikaw, Fjola (2009) *Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education: An integrated review of the literature*. Aboriginal Nurses Association of Canada)

Cultural sensitivity

Cultural sensitivity is the recognition of the importance of respecting difference. It means taking the cultural background and experiences of First Nation, Inuit and Métis clients into consideration when providing services. Cultural sensitivity is expressed through behaviours that are considered polite and respectful by the other culture. It includes acknowledging the diversity within and between First Nations, Inuit and Métis, and knowing that no two people, even from the same cultural group, experience the world in exactly the same manner.

Cultural sensitivity does not generally involve challenging historical or systemic inequities, and although different cultures are respected, they are considered "other" and the dominant culture remains the point of reference.

(Hart-Wasekeesikaw, Fjola (2009) *Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education: An integrated review of the literature*. Aboriginal Nurses Association of Canada.
Métis Centre of the National Aboriginal Health Organization (2013). *Towards Cultural Safety for Métis: An introduction for health care providers.*
Giger, J., Davidhizar, R. Purnell, L., Harden, J., Phillips, J., & Strickland, O. (2007). American Academy of Nursing Expert Panel Report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. Journal of Transcultural Nursing, 18 (2), 95-102.)

Cultural competence

Cultural competency refers to adapting the knowledge, skills, and practices of health care providers to meet the needs of clients from different cultural backgrounds. It involves not letting one's personal beliefs have an undue influence on the way in which services are provided to those with a worldview different from one's own. Cultural competence includes having general cultural and cultural-specific information so the health care provider knows what questions to ask.

(Hart-Wasekeesikaw, Fjola (2009) *Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education: An integrated review of the literature*. Aboriginal Nurses Association of Canada.

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According to the OAC Collaboration Model, A cultural competent person has the ability to assess what is most appropriate for the client with respect to service delivery. It relies on three key elements:

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(Ottawa Aboriginal Coalition (2013). Collaboration in Practice: The Ottawa Community Responding to the Mental Health Needs of Aboriginal People in Ottawa. Ontario Federation of Indigenous Friendship Centres)

Cultural safety

The concept of cultural safety was first introduced in New Zealand in response to ongoing concern over the effects of colonialism and the perpetuation of inequities from neo-colonial processes that disregarded the beliefs of the Maori and privileged those of the dominant European culture.

Cultural safety moves beyond cultural awareness, cultural sensitivity and cultural competence.

Cultural safety practice:

- Acknowledges that we are all bearers of culture;
- Exposes the social, political, and historical contexts of health care, including racism, institutional discrimination, and colonization,
- Understands the power imbalances inherent in health service delivery, including those based on the social, political and historical contexts,
- Seeks to redress these inequities and challenge unequal power relationships, including through education,
- Enables practitioners to consider difficult concepts such as racism, discrimination, and prejudice;
- Understands that cultural safety is determined by those to whom services are provided;

(Hart-Wasekeesikaw, Fjola (2009) *Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education: An integrated review of the literature*. Aboriginal Nurses Association of Canada.
Métis Centre of the National Aboriginal Health Organization (2013). *Towards Cultural Safety for Métis: An introduction for health care providers*.)

Cultural congruence

The OAC Collaboration Model places cultural congruence in the west of the Medicine Wheel, and describes it in the following way.

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Trauma-informed services

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.
(The Trauma Informed Care Project, Orchard Place, Des Moines, USA.
http://www.traumainformedcareproject.org/)

Trauma-informed practice is: providing services in a manner that is welcoming and appropriate to the special needs of those affected by trauma.
(Harris & Fallot, 2001 as cited in Trauma-Informed: The Trauma Toolkit (2013), Klinic Community Health Centre, Winnipeg)

Triggering

People can develop PTSD when, out of necessity, they react to and survive traumatic events by emotionally blocking them during and after the trauma. This allows the experience to dominate how they organize their lives, and often causes them to perceive subsequent stressful life events in light of their prior trauma. Focusing on the past in this way gradually robs their lives of meaning and pleasure.

PTSD can be placed on a continuum from minimal traumatic impact to moderate effects, and to high or complex PTSD that includes additional symptoms associated with severe long-term

childhood trauma, e.g., sexual and physical abuse, residential school experience. In general, the more prolonged the trauma and the more interpersonal in nature, the more severe the impact will be. Traumatic events can be understood to be on a continuum from a single event (e.g car accident), to prolonger family violence, to colonization/historical trauma (e.g. the Holocaust or residential schools), to war.

Words, objects, or situations that are reminders of the event can trigger re-experiencing symptoms. Re-experiencing symptoms include:

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating,
- Bad dreams,
- Frightening thoughts

Klinic Community Health Centre (2013). *Trauma-Informed: The Trauma Toolkit*
National Institute of Mental Health, "Post-Traumatic Stress Disorder".
https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml