

# **“Good Mind”**

## **Ontario Federation of Indian Friendship Centres Mental Health Strategy 2006**

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## **INTRODUCTION**

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.

For the purposes of the OFIFC Mental Health Strategy (the Strategy) it is important to recognize that the focus on a 'good mind' is rooted in the understanding and believing that the mind drives all human visions (dreams), knowledge, feelings and behaviours. Thus, it's a critical aspect of well being and understood that a 'good mind' can only be achieved if the emotions are balanced with physical health, strong spiritual beliefs and custom. It is in the balancing of physical, mental, emotional and spiritual aspects of being that the mind is sound and 'good'. It allows individuals to live in peace with themselves, their families and to also possess a high or higher level of functioning within the community.

Aboriginal people across Canada, continue to experience high incidences of suicide, addictions, incarceration, family violence and other social problems. The Aboriginal Health Survey, the Ontario First Nations Regional Health Survey and the Royal Commission on Aboriginal People indicate that there are significantly higher rates of all mental illnesses, major depression and suicide, Fetal Alcohol Spectrum Disorder (FASD), prescription and illegal drug use, solvent abuse, alcoholism, gambling addiction and an increased exposure to all known high risk factors than other Canadians. All members of Aboriginal communities, including the children, youth, adults and seniors are affected.

The OFIFC Mental Health Strategy is in response to the increased demand for mental health services in urban Aboriginal communities and the fragmented, medically focused approach dominating mental health services today. The call for Aboriginal specific mental health services and additional community based mental health workers has been made throughout Ontario and was identified as a priority during the Aboriginal Health Blueprint process, as it was in the earlier Ontario Aboriginal Health Policy. Currently, there is no capacity within Friendship Centres to provide comprehensive, culturally appropriate mental health services or training. Clinically based mental health and addictions programmes and services are needed, in addition to traditional healing and culturally specific approaches.

The Strategy is a tool that will assist in directing policy, programming and training in the area of mental health and wellbeing. The Strategy is grounded in an Aboriginal worldview, utilizing a wholistic framework as its foundation.

## **BACKGROUND**

Assimilation policies and the genocide attempts on the Aboriginal population such as the 1960's scoop of Aboriginal children as well as the intergenerational impact of Residential School attendance from 1831 through the 1990's have resulted in widespread and chronic poor mental health in urban Aboriginal communities. Aboriginal people today suffer the long term effects of sexual abuse and violence as well as the underlying intergenerational effects of collective trauma. The Aboriginal Healing Foundation lists 32 intergenerational impacts that Aboriginal people suffer from on a day-to-day basis including all types of abuse, physical, mental, emotional and spiritual disorders, social dysfunction and toxic interrelations/communications. Intergenerational impacts occur when the trauma and grief of one generation is not healed or is ignored. (Aboriginal Healing Foundation Programme Handbook, 1999.)

Friendship Centre programme staff report that there are increasing numbers of clients who suffer from concurrent mental health disorders and/or multiple mental health problems. Little research is available examining this emerging trend. The Alberta Alcohol and Drug Commission survey for the general population indicates that between 35-50% of people seeking substance abuse treatment have psychiatric disorders. Front line workers in Ontario suspect similar findings would be made within the urban Aboriginal community and insist that more research is required to examine concurrent disorders in mental health and addictions.

### **Friendship Centre Response**

Programmes and services administered by the OFIFC and delivered by local Friendship Centres address the needs of those community members at all phases within the life cycle from pre-natal to elderly. Programmes and services are integrated as much as possible and target alcohol and drug abuse, FASD, children's growth and development, homelessness, family violence, health, disability and aging, economic development, youth development, employment and training, gambling addictions and justice.

Friendship Centre staff and volunteers currently do outreach, liaise with outside agencies, assess need and case manage with individuals and their families. Increasingly, all programmes encounter clients presenting with mental health concerns and concurrent disorders. Friendship Centre staff work to prevent, decrease risk, provide after care support and crisis intervention. There are inadequate resources and increasing demands for specific and concurrent mental health services within the communities. In the absence of proper mental health programming to refer Aboriginal people to, Aboriginal clients presenting

with mental health issues are challenged to achieve the maximum benefit from existing Friendship Centre programmes. Front line workers find themselves more involved in crisis management and therefore, less able to focus attention to the prevention aspects of programming.

For years after the funding was taken away from the L'il Beavers Programme the OFIFC has repeatedly identified children's mental health and wellbeing as a priority. The Government has finally committed funding for two new programmes. Akwe:go is a comprehensive programme for urban Aboriginal children between the ages of 7-12. The word Akwe:go means 'everybody' or 'all of us' in the Mohawk language. The programme provides the necessary social support, skills, and understanding to cultivate a child's inherent ability to make healthy life choices. Akwe:go targets children at risk and works to aid urban Aboriginal children facing complex challenges, including: physical and developmental disabilities; increased risk of exposure to violence, child protection, and youth justice systems; and, lowered educational achievements. It is also designed to offset an Aboriginal child's increased risk of exposure to poverty. Akwe:go is now available in twenty-seven Friendship Centres.

The Mental Health Demonstration Projects operate in three locations and is intended to demonstrate an Aboriginal specific family support practice that will mitigate risk to children and youth ages 7-15. The programme helps to decrease children and youth involvement in gang activity, drugs and alcohol abuse, and addresses mental health/addiction issues that result from high incidences of family violence. These programmes provide necessary interventions, community support networks, referrals and culturally appropriate services to high risk children, youth and their families. A comprehensive evaluation plan is being implemented to ensure programme continuity, best practices and sustained funding.

### **Issues Affecting Mental Health in Aboriginal Communities**

The relatively recent provincial mental health reform implemented by the Conservative government in Ontario in the 1990's, included the closure of hospitals. This meant that many Aboriginal people suffering with mental health disorders and addictions were released into the urban areas and not back to their communities of origin. According to the 2001 Statistics Canada Census data and the Aboriginal People's Survey (APS) seventy percent (70%) of the total Aboriginal population live off-reserve in Canada. Sixty-eight percent of the Aboriginal population (68.2%) is located in urban centres. In this environment, there is a significant need for mental health workers on the ground in urban centres whose expertise must be defined by Aboriginal community processes, and must include a support and referral network of traditional counselors, natural counselors (respected aunts, uncles, grandmothers and grandfathers within communities who are sought out by community members for guidance), and other community based mental health workers and therapists.

- There are serious gaps in addictions programmes and services as it relates to aftercare and follow-up. (OFIFC Consultation, 1995) Suicide prevention and intervention continues to be required throughout the province and not only in the north. Suicide attempts and completed suicides in Aboriginal communities have no geographic or age boundaries and must be addressed.
- Reports from the 2000/01 Canadian Community Health Survey (CCHS) show that higher rates of urban Aboriginal people had depressive episodes in the previous year. It also showed that depressive episodes are happening earlier in the Aboriginal population where youth become at risk of long-term depression. (Tjepkema, 2002.) Low socio-economic conditions in sections of the population cause stress and potentially can lead to addictions and depressed states of wellbeing.
- Aboriginal people in conflict with the law or required to appear before the courts experience a number of mental health issues even before they get to court or have contact with the judicial system, which are often not identified or dealt with. They may have episodes of depression, are survivors of sexual or physical abuse and have active addictions. There is also the growing understanding of a link between people affected by FASD and imprisonment. Ninety percent of people living with FASD have mental health issues such as depression, anxiety, self harm, anger, aggression, and substance abuse issues.
- Aboriginal people are disproportionately represented in the prison population. It is the nature of the penal system that convicted people are not assessed for mental health conditions which often creates an environment for addiction and violence. In one Ontario region, it is estimated by urban Aboriginal mental health managers that there are at least 500 prison inmates with serious mental health disorders who are not properly assessed and have improper medications to treat their illnesses. Untreated, people are self-medicating, over-medicating and getting introduced to the drug trade.
- Poverty also has long term psychological affects. The lower socio-economic condition of many Aboriginal people is not new. Census data from 1996 reported that almost one half of all the Aboriginal population lived on less than \$10,000 compared to about one quarter of all Canadians. (Stats Can Census, 1996.) Campaign 2000, Report Card on Child Poverty, 1998-99 indicated that 52% of all Aboriginal children are poor. It is also known that in 2000/01 the off-reserve Aboriginal population had lower levels of education attainment and household income and was less likely to have worked the entire year than the non-Aboriginal population. (Tjepkema, 2002.)

- Homelessness is also a major factor affecting mental health (The Toronto Report Card on Homelessness, 2001.) On the street there is the constant threat of violence, exploitation, drugs and illness. Aboriginal people are disproportionately represented in the homeless populations. In larger centres like Toronto and Ottawa the homeless population continues to grow with youth and family homelessness increasing. This past year, the OFIFC Homelessness Initiative assisted nearly 23,000 urban Aboriginal people who are either homeless or becoming homeless. People of all ages are included in the client demographics.
- Family violence affects individuals, families and the entire Aboriginal community. Statistics Canada reports that 25% of Aboriginal women and 13% of Aboriginal men reported experiencing violence from a current or previous partner over the past 5 years. (Domestic Violence in Canada, 2003) It is well known that domestic violence including wife battering and child sexual abuse is under-reported. Feelings of low self esteem, inability to trust and depression are common. Current research also indicates that child witnesses' experiences can be detrimental, affecting the physical, emotional and spiritual wellbeing of an individual.
- Aboriginal people addicted to gambling suffer negative impacts on their mental health and wellness. When a person is addicted to gambling, there's a tendency to lose household earnings, thereby drawing people into depression, suicidal thoughts, homelessness, and family violence. A recent study found that off-reserve Aboriginal gamblers were more likely to be at risk than non-Aboriginal gamblers, 18% versus 6%. (Statistics Canada, 2003)
- People with long term disability and chronic illnesses suffer additional mental health strain. The Aboriginal population off-reserve has chronic illness rates that are significantly higher than the general population, particularly in the area of cardiac health, arthritis, diabetes and long-term disability. (Tjepkema, 2002) It is also known that Aboriginal people with diabetes experience more health complications earlier on in life. (ICES, 2003).
- Only 54% of working age Aboriginal people are employed, compared to 71% of the non-Aboriginal population. Mental health issues with respect to employment and training often result in lateness, unexplained absenteeism, and a poor quality of work and ultimately the loss of a job. Losing your job can have devastating effects on the mental health of an individual including lack of motivation, self confidence and self-esteem.

- Friendship Centres have determined that a direct relationship exists between mental health and addictions. (OFIFC Consultation Report, 1995) The Aboriginal People's Survey 1991 reported that 73% of First Nations respondents said that alcohol was a problem in their communities and that 59% said drug abuse was a problem. The Aboriginal Healing Foundation recognizes the deep rooted cycles of drug and alcohol abuse as well as violence as complex intergenerational impacts of the residential school experience.

Despite this tremendous need for mental health services within urban Aboriginal communities, urban Aboriginal community health service providers are given token 'consultations'. This is unacceptable and must change. The provincial Mental Health sector is controlled by mental health hospitals and large health institutions like the Centre for Addictions and Mental Health in Toronto. They continue to operate from deep rooted paternalistic and racist patterns that do not recognize Aboriginal people's rights to self-determination in health and do not follow the Ontario Aboriginal Health Policy. The regulatory and policy environment of these institutions are also wrought with systemic racism and have an innate reluctance to change. These large hospitals have institutionalized processes which lack an Aboriginal framework. They also generally do not hire Aboriginal people recognized by Aboriginal communities as having appropriate mental health expertise.

The dominant clinical approaches applied to mental health also create significant barriers to case management and coordination between clinical and non-clinical programmes and services. There is a significant need for mental health workers on the ground in urban areas whose expertise must be defined by the Aboriginal community and must include a support and referral network of traditional counselors, natural counselors and other community based mental health workers. Reliable data on the extent and type of mental health disorders like bipolarity, psychosis and schizophrenia, for examples, does not exist.

Finally, mental health issues not only affect clients but front line workers as they encounter distressing issues on a daily basis. Incorporating self-care and appropriate debriefing methods for front line workers would assist in preventing burn-out amongst staff.

## **OFIFC VISION**

The current systems responding to Aboriginal mental health are fragmented and continue to split the physical, mental, emotional and spiritual aspects of self along with the treatment of children, youth, adults and seniors. The OFIFC vision entails the restoration of the people's 'good mind' by creating a system of response which is culture based, rooted in wholism and addresses mental health throughout the life stages and the healing continuum. Therefore, the OFIFC Vision is to:

*“Create a comprehensive Aboriginal specific Mental Health Strategy, based in wholism to address the contributing emotional, spiritual and physical as well as the cultural aspects of mental health throughout the life stages and the healing continuum.”*

## **Principles**

The OFIFC Mental Health Strategy is based on the following common principles.

1. Self Determination is fundamental and thus Aboriginal people must be involved in all aspects of mental health care delivery, including research, planning and development, implementation and evaluation. Aboriginal people must have full involvement at all levels of decision making.
2. It is the right of Aboriginal people to choose different models of mental health care based on the varying needs and priorities identified by different communities and based on the specifications of an individual client.
3. A Wholistic Framework addresses the physical, mental, emotional, spiritual, cultural, and social well-being of individuals and the whole community. Within a wholistic framework, both traditional Aboriginal healing methods and modern medical modalities are applied to contribute to the improved mental health of Aboriginal people.
4. Socio-economic issues have resulted in significant negative impacts on the mental health of Aboriginal people. Higher levels of poverty and unemployment, low educational status, inadequate or unaffordable housing, food insecurity and shared historical experiences resulting in some loss of cultural identity have had a negative impact on the mental health of Aboriginal people. Improving the social, economic and physical environments will contribute to improved Aboriginal mental health.

5. Mental health care services must be culturally appropriate and accessible to all Aboriginal people in Ontario, regardless of residency. There are numerous factors currently affecting access to mental health care including jurisdictional wrangling, systemic racism, the racist attitudes of medical professionals, distance, lack of transportation, financial resources, employment, and unresponsive mental health care programs. Barriers to accessibility are further exacerbated by the refusal or reluctance to accommodate, recognize or include traditional and alternative therapies.
6. Mental health services must be provided in a culturally secure environment and manner. Services must be reflective of Aboriginal cultural rights, views, values and expectations. This includes putting a stop to 'culture based' services run by non-Aboriginal medical personnel and honouring self-determination of Aboriginal people to address mental health.
7. A coordinated and collaborative inter-sectoral approach is required. Service delivery needs to be better coordinated within the mental health care system between primary and secondary services.
8. Guaranteed funding and political willingness and commitment are central to a mental health strategy for Aboriginal people.

## **CURRENT ABORIGINAL MENTAL HEALTH PROGRAMMING**

There are a wide range of programs and services offered in Ontario to the urban Aboriginal population. They are mainly uncoordinated as a result of jurisdictional wrangling, fragmented programme funding allocations, programme funding competition and the marginalization of urban Aboriginal mental health challenges and communities within the mental health system. The results are that many Aboriginal people are receiving inadequate and/or inappropriate care.

Treatment Centres, Friendship Centres and other referral agents have been working together within the mental health and addictions field. However, there remains a lot of work to do in case management, coordination, education and training. Relationships between federal, provincial and regional stakeholders must be built, coordinated and maintained to ensure that urban Aboriginal community members requiring mental health services do not fall through the cracks. Finally, an accountability process should be implemented to identify ways in which mental health programs and services controlled by non-native interests, like that of the Centre for Addictions and Mental Health can be held accountable to urban Aboriginal communities and their respective health managers.

The First Nations and Inuit Health Branch of Health Canada funds the National Native Alcohol and Drug Abuse Programme (NNADAP) and the Non-insured Health Benefits (NIHB) short-term, crisis intervention mental health counseling. This programme and benefit are intended for First Nation citizens only. Access and eligibility for First Nation people living off-reserve is inconsistent and unreliable.

The Ontario Ministry of Health Funded Programs and Services includes crisis intervention, mental health counseling, case management, addictions treatment, court diversion with some e-learning and concurrent disorder capability. They also fund nine addiction treatment programmes, the majority of which are in northern parts of the province. The two Aboriginal based Community Health Centres in Toronto and Timmins also provide mental health services. There were a number of new mental health projects announced in March 2006 to support Aboriginal health facilities and other agencies in addressing mental health in the Aboriginal community across the province.

The Aboriginal Healing and Wellness Strategy funds programmes such as Health Access Centres, Healing Lodges, Crisis Intervention workers and Community Wellness workers which have some mental health capacity.

The OFIFC has begun work in mental health through research and demonstration projects. These projects include:

1. The preparation of the *Mental Health and Addiction OFIFC Consultation Report, 1995*.
2. Preparation of the *OFIFC Community Mental Health Best Practices Project: Research on Effective Intervention with Urban Aboriginal Youth, 2001*.
3. Demonstration Projects: The third phase of AHWS identified mental health as a priority and as a result the OFIFC Children's Mental Health Programme is housed in three member Friendship Centres. The focus is to mitigate high risk behavior amongst youth ages 7-15.

Along with the demonstration project the OFIFC administers an Aboriginal Alcohol and Drug Worker Programme in 10 Friendship Centres and the Community Wellness Worker Programme in 27 Friendship Centres. Finally yet importantly, after ten years of lobbying all Friendship Centres now operate Akwe:go a children's programme targeting at risk Aboriginal children ages 7-12.

## **OVERALL STRATEGIC APPROACHES**

The OFIFC Mental Health Strategy has been developed in collaboration with all of the programmes at the OFIFC using the Healing and Wellness Continuum as a model which incorporates the life cycle. The overall strategic approaches include the following:

1. Strengthen OFIFC commitment to the Urban Aboriginal population throughout the province by incorporating mental health programming within Friendship Centres.
2. Implement mental health programmes and services to include prevention, care and treatment, education, research and coordination.
3. Approach mental well-being as part of the healing continuum which includes the physical, mental, emotional and spiritual elements applied to all the life cycle stages.
4. Ensure that Aboriginal mental health services are available which network and support Aboriginal community agencies.
5. Ensure that Aboriginal mental health services are accountable to and endorsed by the community.
6. Establish an Aboriginal-designed system of referrals.
7. Increase the number of trained and available Aboriginal traditional healers/therapists.
8. Provide ongoing training and professional development in the area of mental health for Friendship Centre staff.

## **STRATEGIC DIRECTIONS**

The OFIFC will employ a strategic directional approach to mental health similar to other priority health issues. The strategic directions are in line with Ontario's Aboriginal Health Policy and other important policy documents driving health programs and services directly affecting Aboriginal people in Ontario. The OFIFC would also participate in the identification, development and delivery of other Aboriginal community specialized mental health services, such as regional based services for sexual health, for example.

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

The Ontario Health Policy and subsequent health strategies and initiatives like the Aboriginal Healing and Wellness Strategy, Ontario Diabetes Strategy, Cancer Care Ontario recognizes Aboriginal self-determination in health. The Mental Health sector in Ontario however, has completely ignored Aboriginal rights, has not kept abreast of Aboriginal health trends, is not aware of Aboriginal people's community health vision and has not included Aboriginal people in its decision making processes. It is not surprising then that this exclusion of Aboriginal health service providers has resulted in a complete lack of care to significant sectors of the Aboriginal population and seriously inadequate care to the Aboriginal population as a whole.

The OFIFC respects and supports Aboriginal community health vision(s) and Aboriginal determination in health.

### **Goal**

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

### **Gaps and Barriers**

1. Appropriate access for Aboriginal community health service providers to "Aboriginal" programmes at the Centre for Addictions and Mental Health and large Regional Hospitals is non-existent.
2. It is unclear at present how the Local Integrated Health Network (LIHN) system will adequately and appropriately engage Aboriginal health service providers, how the LHIN system will effectively meet the needs of Aboriginal health consumers and ultimately improve the health status of Ontario's Aboriginal population.
3. Urban Aboriginal community access to the planning of Health Canada's National Native Alcohol and Drug Abuse Programme (NNADAP) and Non-Insured Health Benefits (NIHB) crisis intervention Mental Health counseling is non-existent.
4. There is reportedly no access to Ontario's Assertive Community Treatment (ACT) teams for Aboriginal people or within Aboriginal communities.
5. Disregard for Aboriginal health planning processes, service providers and culturally appropriate planning methods.
6. There is limited funding to properly support urban Aboriginal health planners.

## **Approaches**

### **Involvement in the Ontario Aboriginal Mental Health Strategy Development**

An Ontario Aboriginal-specific Mental Health Strategy can potentially respect Aboriginal people's right to self-determination in health and strengthen relationships between stakeholders to ensure the mental health needs of Aboriginal people are effectively addressed and funded.

### **Government Relations and Representation**

Aboriginal people must be the visionaries and governors over their health, health planning and delivery structures. In addition representation of urban Aboriginal communities within all provincial and federal mental health planning environments, institutions and agencies is required. On and off-reserve stakeholder representation issues also require discussion and resolution.

### **Strategic Direction #2 Mental Health Status**

Where opportunities exist, the OFIFC will involve itself with culture based and culturally appropriate health promotion, prevention, service delivery and treatment of mental health disorders and addictions within the Aboriginal community.

### **Goal**

To improve the mental health status of Aboriginal people and bring mental health disorders and addictions to manageable levels through direct involvement in the design, development and delivery of Aboriginal specific mental health programmes and services.

### **Gaps and Barriers**

1. There are not enough community based mental health workers on the front lines including Aboriginal psychiatrists, psychologists, therapists, multidisciplinary teams, addictions counselors and community mental health workers.
2. There is an underutilization and no formal recognition of traditional healers, medicine people, traditional counselors and natural counselors as valuable mental health professionals.
3. Aboriginal people are generally not accessing current mainstream first line, intensive or specialized care that is available, and are often left without treatment, which leads to preventable early complications, self medication, addictions, injury and death.

4. Aboriginal Healing Lodges and Treatment Centres are not given proper recognition as the effective mental health institutions that they are and continue to be under funded, prohibiting their necessary expansion and professional development of their staff
5. Additional Aboriginal Healing Lodges and Treatment Centres are required in Ontario.
6. Suicide prevention services outreach and crisis intervention within urban centres need to be increased.
7. People with concurrent disorders and addictions remain inadequately serviced and their needs go unaddressed.
8. There is a general lack of collaboration and cooperation between health professionals working with Aboriginal people suffering with mental disorders and addictions.
9. Culturally appropriate supportive housing is practically non-existent.

## **Approaches**

### **Integration and Strategic Partnering**

The OFIFC will continue to apply integration standards within the organization to enhance quality of care to ensure people at risk receive some level of service. Strategic partnerships will be developed to facilitate cooperation and collaboration amongst health professionals and design, develop and deliver Aboriginal specific mental health programmes and services. The organization will also promote the utilization of Aboriginal healing lodges and treatment centres as effective mental health and wellness alternatives.

### **Strategic Direction #3**

#### **Access to Programmes and Services**

There are access issues within the current mental health system at every level including, legislative, administrative and programme barriers like limited funding and maximum client numbers. A comprehensive analysis is required to fully appreciate current mental health programme and service access issues.

#### **Goal**

To ensure improved equitable access to quality, culture based and culturally appropriate mental health programmes and services.

#### **Gaps and Barriers**

1. In populations where Aboriginal people are over-represented and at highest risks - in prisons, among the homeless and foster care - mental health assessments and treatments, including the availability and monitoring of required medications is not offered.

2. There are serious gaps and lack of coordination in addiction services available to the urban Aboriginal population.
3. There is serious potential for avoidance by the Ministry of Health and Long Term Care and the Ministry of Children and Youth Services in meeting the mental health care needs of youth 16-18 years of age. Mental health programming offered by both Ministries currently overlaps creating the potential for either Ministry to avoid responsibility. Conversely, they may allocate mental health resources elsewhere in the hopes that the other Ministry will fill the gap in services and/or funding.
4. Inadequate access to advocates to assist Aboriginal people in navigating the mental health system.
5. Systemic racism and stereotyping.
6. Inadequate medical transportation.
7. Inadequate and inappropriate mental health facilities.
8. Lack of recognition, acceptance and support for traditional healing methods.
9. Language, communications and cultural barriers are widespread.

## **Approaches**

### **Client Advocacy**

The provision and promotion of advocacy through training, education and resource development needs to be implemented where applicable. Health care providers require education about the challenges to access the mental health system and must be included in discussions to plan and create change. A direct patient advocacy service is needed. Also, front line workers require professional development in the area of effective systemic advocacy on behalf of clients.

### **Cross-Cultural Education**

Quality cross-cultural curricula need to be designed, developed and delivered by Aboriginal people to health care professionals, institutions and other significant mental health care stakeholders.

### **Mental Health Care Professional Human Resource Development**

Ongoing involvement in national, provincial and regional health human resource development planning is required to ensure Aboriginal people address the acute shortages of Aboriginal nurses, doctors, psychiatrists, psychologists, therapists, multidisciplinary teams, addictions counselors and community mental health workers. Involvement is also required to ensure recognition, inclusion, quality development and integration of traditional healers, medicine people, natural counselors and other traditional community based workers.

Combined, these approaches will foster and create much needed systemic change.

## **CONCLUSION**

The OFIFC Mental Health Strategy is the policy formalization of nearly 30 years of commitment to improve and restore the 'good minds' of the people. The OFIFC will continue to create programmes, services, resources, information and build capacity to address the multitude of challenges facing urban Aboriginal people in the management of mental health and the complex issues that arise as a result.

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A detailed list of Sources Consulted is available from the OFIFC. A number of elders, traditional people, and OFIFC staff were consulted over the years and were instrumental in defining the OFIFC Mental Health Strategy.

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