Mental Health and Addictions Strategy (MHAS) Phase II Engagement:

Final Report on Key Themes 2 & 3
Moving Forward & Shared Outcomes

December 2016
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About the OFIFC

The OFIFC is an urban Indigenous organization representing the collective interests of twenty-eight member Friendship Centres located in towns and cities throughout Ontario. Friendship Centres are not-for-profit corporations that are mandated to serve the needs of all Indigenous people, regardless of status. Friendship Centres are the primary service delivery agents for Indigenous people in urban areas.

The OFIFC assists the Friendship Centres through program delivery and community development support as well as advocacy. Through supporting self-determined activities that encourage equal access to and participation in Canadian society and which respect Indigenous cultural distinctiveness, the OFIFC works to improve the quality of life for Indigenous people living in an urban environment.

Among the OFIFC policy priorities, it has consistently advocated for increased access to culturally-appropriate mental health and addictions services, decreased stigma associated with mental health and addictions, and improved health and well-being for all urban Indigenous people in Ontario. Mental health and addictions issues can be derived from both the symptoms and causes of poor attainment of social determinants of health. Because of the influence of these broad factors, it is critical that health and mental health work be wholistic and integrative in nature. This perspective informs the OFIFC’s policy work on health and mental health and addictions.

Indigenous people have unique needs when navigating a Westernized mental health and addictions system. Therefore, high-quality mainstream services that are culturally competent and delivered free of discrimination and mental health and addictions stigmas is critical to meeting the health needs of the urban Indigenous community. Alongside mainstream service engagement, Friendship Centres deliver several programs that directly address mental health and addictions issues, including the Children’s Mental Health Project, the Aboriginal Community Mental Health Program, and the Aboriginal Alcohol and Drug Program. The wholistic and comprehensive array of programs and services offered by Friendship Centres both directly and indirectly promote positive mental health by addressing needs in the areas of health, food security, justice involvement, education, employment and training, housing and homelessness, violence and abuse, and cultural awareness and identity. It is this comprehensive, wholistic approach that has led Friendship Centres to make lasting, positive impacts on the mental health and wellbeing of their urban Indigenous communities.

Introduction

This report is the second provided by the OFIFC for informing the process of ongoing design and implementation of the Ministry of Health and Long-Term Care’s Open Minds, Healthy Minds Mental Health and Addictions Strategy. Currently in the strategy’s second phase, the Ministry scope has expanded to focus on adults, transitional aged youth, addictions, transitions, funding reform, and performance measurement across the system. Earlier this year, the three urban Indigenous partners working on the strategy (the MNO, the OFIFC, and ONWA) completed engagements with their
communities on mental health and addictions issues to inform each organization’s respective report.

For the entirety of this engagement process, there are three key themes: 1. Taking Stock; 2. Moving Forward; and 3. Shared Outcomes. The OFIFC’s earlier report focused primarily on the first theme. This report emphasizes two and three. The report details the critical gaps and issues, and priorities and recommendations from the urban Indigenous community on what they are facing for mental health and addictions. While for this engagement the OFIFC went to five sites, and there are many more, the findings have been consistent with feedback coming in from Friendship Centres in Ontario from other areas of the province as well. In addition, from the themes and recommendations from all three urban Indigenous partners, commonalities were identified. This led to the production of joint recommendations, which represent priorities and actions recognized by the different constituents across the organizations. The joint recommendations are also included in this report.

Background
Mental health issues are initiated and exacerbated by many factors outside of directly ‘mental health’ issues, such as poverty, discrimination, homelessness, food insecurity, and many other stressors and influential factors. Triggers for mental health and addictions issues can be found in a broader context of poor health and wellbeing. Considering that Indigenous people in Canada suffer from health problems at greater rates than the rest of the population,¹ ² this has significant bearing on Indigenous mental health and addictions issues. In a survey of Indigenous people living off-reserve, Métis, and Inuit, Statistics Canada reported disconcerting rates for health concerns:

- In 2007-2010, First Nations people living off reserve, Métis, and Inuit reported poorer health compared with non-Aboriginal people [ . . .]
- All three Aboriginal groups were more likely to experience household food insecurity than the non-Aboriginal population. The rates were 27% of Inuit, 22% of First Nations people and 15% of Métis compared with 7% of non-Aboriginal people³

A review of the statistics available by Kirmayer, Brass, and Valaskakis produced a troubling snapshot of some of the health hurdles faced by Indigenous people in Canada:

³ Ibid
• Compared to the general population, life expectancy for both sexes was seven years shorter for the First Nations and at least ten years shorter for the Inuit.
• Aboriginal persons had much higher rates of tuberculosis, diabetes, heart disease, and hypertension.
• Aboriginal persons had 6.5 times the national rate of death by injuries and poisonings.
• High rates of family violence and sexual abuse were self-reported.
• Rates of problem drinking and solvent use were significantly higher in some Aboriginal communities.
• Age-standardized rates of youth suicide were three to six times higher than the general population.4

The reasons Indigenous people experience these disparities at such heightened rates compared to the general Canadian population are becoming increasingly acknowledged in society. There have been a few notable public statements, announcements, and information releases that help build an understanding for the above statistics. In 2008, Prime Minister Stephen Harper issued a formal apology on behalf of the federal government for its role in Indian Residential Schools, a destructive colonialization process that oversaw considerable harm to Indigenous people, as individuals, families, and communities. In 2016, Premier Kathleen Wynne also issued a formal apology for the role of the province in this destructive process as well, acknowledging the deep and damaging impacts that permeated within Indigenous communities and continued to today. The Truth and Reconciliation Commission issued its findings and recommendations in June, 2015 after an extensive exploration into the history and impacts of the Indian Residential School System (which lasted from the late 1800s to 1996). In January of this year, Cindy Blackstock won a court case at the Canadian Human Rights Tribunal in a case against discrimination of Indigenous children by the child welfare system.

Essentially, Indigenous people in Canada have undergone extreme and long-term political and cultural discrimination, as deliberate acts to culturally erase distinct people in part by disconnecting them from their strong and healthy traditions, practices, skills, and capacities.

Culture and Mental Health
Health and wellbeing, and particularly mental health, has always been partly a cultural construct. Traditionally, Western medicine has approached diagnostics and treatment with a bias against difference to what was accepted by dominant society. More recently, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has undergone repeated attempts to make it more cognizant to the importance of considering clients’

culture and ethnic background. The Mental Health Commission of Canada, a national body tasked with promoting improved mental health services in Canada as well as greater connectivity between provinces, advocates for a mental health system that is both culturally safe and culturally competent, and that can also respond to issues unique to Indigenous people. This new perspective is based on a growing amount of research exploring the role of culture in how people both experience and express mental health, as well as issues and improvements for treatment related to culture.

One of the first obstacles to care is a diagnostic one. In a review of research, the practice of psychiatric epidemiology was found to fail in applicability when it came to cultural variations from mainstream. This was because to some degree, how people experience stress and how they demonstrate it varies depending on different cultures. Depending on the history and background of a people, they could be experiencing mental health strain from trauma related to their unique histories and experiences with racism, such as in the case of Canada’s Indigenous people. There is a risk in seeking support from the mainstream system when one is a member of a marginalized community. Mainstream practices often run counter to cultural practices. In some cases, this different perspective can lead to inaccurate labels of dysfunction or unsuitability in a person, calling into question such things as their ability to parent. Historical distrust can have significant influence in how and whether Indigenous people access the mental health system, as, “Practitioners need to be sensitive to the fact that many immigrants, persons of colour, and Aboriginal North Americans have had less than positive experiences with ‘the authorities’ and with Western-oriented psychiatric services.”

The role of culture in mental health has also been shown to correlate with increased results for mental health services. A growing body of evidence from Canada, the US, Europe, and explorations into Indigenous groups’ experiences in Australia and New Zealand have established not only the relevance of culture-based mental health care, but also its increased efficiency. A meta-analytic review was conducted in 2006, reviewing some 76 studies that explored the effectiveness of mental health treatments that were culturally adapted to clients. Drawing from studies that explored culture’s role and influence with therapy across a range of different backgrounds, including Indigenous people, the researchers noted a correlation between targeted, culturally-specific intervention and improved efficacy, finding in their analysis that this correlation

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8 Hwang, Myers, Abe-Kim, and Ting. *A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model*. (Clinical Psychology Review 28, 2008), 211-227.


10 Ibid, 117.
was linked to up to four times the effectiveness of an intervention that was 'multicultural' or generic models that were not adjusted for participant culture.\textsuperscript{11} This means that for an Indigenous context, a generic mainstream intervention (not based in a specific Indigenous culture), or even a general 'multicultural' therapeutic intervention, would do drastically less well versus an Indigenous-people-specific therapeutic intervention. Therapeutic interventions rooted in the culture of the people they are intended for would consequently do significantly better for the target people. The researchers noted that, "optimal benefit is apparently derived when the treatment is tailored to a specific cultural context."\textsuperscript{12}

A 2013 systematic review looking specifically at culturally-relevant suicide prevention interventions for Indigenous people showed a similar correlation between cultural relevance and increased impact. A systematic review of 17 electronic databases and 13 websites was undertaken for a range of years stretching from 1981 to 2012. Their review was international, covering Indigenous people from Canada, the USA, Australia, and New Zealand. While varying methodologies made analysis somewhat challenging, overall, Indigenous youth who received culturally-relevant suicide prevention intervention were less likely to commit suicide and demonstrated less hopelessness.\textsuperscript{13}

Overall, the absence of considerations of the importance of culture in treating mental health can lead to many issues in Indigenous contexts, from a failure to build relationships with Indigenous people so that they feel safe to access needed services, to treatments that undermine or act incongruently to the cultural context of Indigenous clients. Furthermore, culturally-specific treatment has been linked with enhanced success, including over that of mainstream, non-Indigenous services to Indigenous people.

Also critical to remember, when an effort or process is ‘tailored’ to a specific cultural context, there is an obligation to avoid certain approaches that are sometimes practiced in mainstream services: examples to be avoided are ‘pan’ Indianism, and efforts that ‘square the circle’ or attempt to decorate mainstream approaches with symbolic cultural features. Non-culture-based treatments do not adequately recognize or address mental health issues in Indigenous clients, and culture-based efforts that practice ‘pan’ culturalism or a general multicultural approach blunt mental health interventions, pointing to the need to have therapies, treatments, and mental health supports that are rooted in local Indigenous cultures and carried out by relevant actors in those local areas, or communities. Contracting out, or attempting to make a ‘cultural’ approach that is multicultural instead of culture-specific, for example, Anishnaabe, or Mohawk-specific, leeches efforts of their effectiveness while simultaneously disrespecting local

\textsuperscript{12} Ibid, 541
Indigenous communities. Efforts that usurp or pass over communities’ cultural distinctiveness and local mental health stakeholders can contribute to the harming of trust and relationships between Indigenous people and mental health services, and undermine the service providers’ own efforts to improve mental health in Indigenous communities. Whereas with mental health supports, by, from, and for Indigenous communities, research demonstrates that these methods have the greatest positive influence on urban Indigenous people’s mental health.

This has been a brief review of the literature available, but evidence is readily found for the importance of incorporating culturally-relevant and culturally-competent mental health care and services for Indigenous people, and the importance of recognizing and supporting culture-based treatments as effective ways to promote mental health and wellbeing for Indigenous people.

What was also clear from the research was that determining what to do to be culturally cognizant in mental health service provision was still elusive to mainstream efforts. Commitment from the top does not always filter down to understanding amongst service providers – and a lack of understanding undermines efforts on the ground to pursue commitments of cultural inclusion. The OFIFC has always recognized the importance of culture in mental health and addictions supports and services, as well as the advantages of mental health programs rooted in community culture, including local traditional supports. Through engagement with the urban Indigenous community, it has frequently been heard that the importance of culture has not been reflected in Ontario’s mainstream services. It has also been heard that Friendship Centres and their mental health programming have seen significant positive changes in clients through local, culture-based services and supports.

The Role of Friendship Centres in Addressing Mental Health and Addictions

Friendship Centres have been a part of the provincial landscape for over fifty years. During this time, they have provided a wide range of wholistic, culture-based programs and services across the life cycle. Friendship Centres are locally-driven and practice meaningful engagement with their local Indigenous community through involving parents and children in culture-based programs and services that are Indigenous designed, developed, delivered, and evaluated. The Friendship Centre model of integrated service delivery is both flexible and responsive to the needs of the community while also building capacity for self-determination at individual and community levels. This unique model has proven effective in narrowing the socio-economic gap between Indigenous and non-Indigenous people. Between 1985 and 2007, investment in Indigenous community infrastructure and programming has been demonstrated to have created a growing and vibrant urban Indigenous middle class.14

In addition to service delivery, Friendship Centres are the cultural and social gathering place for urban Indigenous and non-Indigenous communities in Ontario. As sites of

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cultural reclamation, Friendship Centres play critical roles in facilitating opportunities for cultural practice in urban environments. This is achieved in part by providing access to Elders and other traditional people, as well as hosting traditional events and activities.

The Friendship Centre community hub model has achieved many successes for urban Indigenous people, including providing critical, culture-based supports and services to address the mental health and addictions challenges of the communities.

This community hub model has also facilitated the development of meaningful partnerships and relationships both within the Indigenous community and without. Friendship Centres frequently engage in localized and regionalized system and community planning initiatives to ensure that the needs and priorities of the urban Indigenous community are included. In addition to this, Friendship Centres engage with mainstream agencies and non-profits through innovative partnership agreements to co-locate health and social services in Friendship Centres. These arrangements promote efficient use of community resources by increasing access in a cost-effective matter. Friendship centres establish partnerships, advocate for the needs of their communities, and provide their own culture-based supports and services as a truly comprehensive, thorough, and effective way to improve the quality of life for urban Indigenous people.

In terms of the Friendship Centres’ own initiatives, for mental health and addictions, much of this work has been done through the following Friendship Centre programs:

**Health Programs**

**Addictions and Mental Health Programs**

The Addictions and Mental Health Programs are (1) the Aboriginal Alcohol and Drug Worker Program (AADWP), and (2) the Aboriginal Community Mental Health Program (ACMHP). Currently, there are 16 addictions and mental health workers in Friendship Centres across Ontario, with 11 AADWP sites and five ACMHP sites. These workers, through these programs, offer cultural spaces for people faced with mental health and addictions challenges. The focus of the programs is to support people to find the help they need to move towards a healthier lifestyle. The methods for the programs vary, and include one-on-one consultations on treatment options, treatment centres, and non-Indigenous health services, as well as accompanying people to the doctor and helping to understand doctor instructions and notes regarding prescriptions. In terms of cultural services, through these programs, people can experience support groups, wholistic medicine wheel teachings that cover the whole person (physical, mental, emotional, and spiritual), and include involvement in culture-based activities, such as drumming circles and ceremonies. When it comes to cultural supports and wholistic approaches, people of all ages are eligible to access these programs.

The AADWP workers across the sites implement culture-based programming that is rooted in the communities: traditional cultural practices will vary depending on the identity and needs of the First Nation, Métis, and Inuit community members for each
area. Cultural practices can range from traditional arts to ceremonies and lessons from Elders. Group support programming is done through targeted efforts to AADWP clients, and more integrated approaches across Friendship Centre programs. These cultural programs address addictions and promotes recovery and sobriety maintenance. For the 2015-2016 year, some of the extraordinary successes of the AADWP workers and their wholistic support of their clients and their communities are reflected in the table below:

**Group Service**

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Counseling</td>
<td>447</td>
</tr>
<tr>
<td>Support Groups</td>
<td>171</td>
</tr>
<tr>
<td>Talking/Sharing Circles</td>
<td>71</td>
</tr>
<tr>
<td>Cultural Events</td>
<td>2396</td>
</tr>
<tr>
<td>Social Events</td>
<td>3085</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7170</strong></td>
</tr>
</tbody>
</table>

Client numbers over the past three years:

![AADWP: Client Numbers](chart)

**Healing and Wellness Programs**

The ACMHP workers are similar in that their efforts to support clients and the community are rooted in local contexts. The program allows for the flexibility that ACMHP workers in Anishnaabe communities can emphasize medicine wheel teachings, while workers in areas with a large Haudenosaunee presence can use corn husk doll workshops, and when Métis require services, workers can do healing blanket teachings. In short, the Friendship Centre ACMHP workers are able to work through culture-specific practices to help reach and uplift clients and the community to support their resiliency and recovery. All variants embrace teachings of balance, respect, healthy relationships, and support those desiring to live a healthier life with sound mental health. Some of their successes and hard work are highlighted in the table below for the 2015-2016 year:
### Group Service

<table>
<thead>
<tr>
<th>Service</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Counseling</td>
<td>584</td>
</tr>
<tr>
<td>Support Groups</td>
<td>50</td>
</tr>
<tr>
<td>Social Events</td>
<td>2129</td>
</tr>
<tr>
<td>Cultural Events</td>
<td>1040</td>
</tr>
<tr>
<td>Talking/Sharing Circles</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3862</strong></td>
</tr>
</tbody>
</table>

Client numbers over the past three years (Other stayed the same at 1):

![ACMHP: Client Numbers](image)

The Healing and Wellness program is delivered through coordinators located across 27 Friendship Centres and one delivery site. The Healing and Wellness Coordinators provide support in a variety of capacities, including, support services for those facing family violence, individual healing and wellness needs of clients, and providing access to traditional supports and services. Coordinators work through a variety of approaches, from one-on-one settings to group activities. As with other programs at the Friendship Centres, the Healing and Wellness program also works in integration with other programs of the Friendship Centre to help ensure all of a client’s needs are being met – physical, emotional, mental, and spiritual.

Client numbers for the Aboriginal Healing and Wellness Program (Other and Undisclosed were below 5 for each year):
Kizhaay Anishinaabe Niin

These Anishnaabe words mean, “I Am a Kind Man”. The program works with men and boys to stop and prevent violence against Indigenous women. Kizhaay Anishinaabe Niin (KAN) uses one-on-one counselling and group work with traditional teachings to promote healthier understandings from men on the value of women, and teaches and encourages healthy behaviours for the respectful treatment of women.

The programs delivered in Ontario Friendship Centres support and engage the urban Indigenous community through wholistic methods that target peoples’ physical, emotional, mental, and spiritual well-being. The program workers use a wide variety of approaches to maximize support for clients and the urban Indigenous community. The cultural approaches are based on local contexts and community needs, ensuring that they are always relevant for the cultural, healing needs of the different urban Indigenous communities across Ontario.
Health Outreach Program

This program exists in areas absent of Aboriginal Health Access Centres. Workers for this program support clients to have their health needs met, and work to provide support in a way that addresses the physical, mental, emotional, and spiritual aspects of a person. Clients are connected to both traditional and mainstream health services, and workers integrate their program with other Friendship Centre programs to help ensure the best health coverage for clients.

Client numbers for the Health Outreach program:

Kanawayhitowin

An initiative rather than a program, the English translation for this Cree word is, “Taking Care of Each Others’ Spirit”. This initiative is an adaptation of the Neighbours, Friends and Family campaign in Ontario, modified to incorporate cultural and traditional approaches to healing and wellness. The initiative focus is to educate communities on the prevention of violence against women, using training, resources, and other methods to help promote awareness and action to recognize and protect women in need.

The OFIFC’s Mental Health and Addictions Strategy

The above programs are facilitated and supported through the OFIFC’s strategy, which helps to protect and advance the rights and priorities of urban Indigenous communities to pursue the health care that is most relevant and effective to each urban Indigenous community. The OFIFC’s strategy allows for flexibility and local priority setting and leverages local culture to drive the mental health successes of the local Indigenous population.

The OFIFC and the Friendship Centres approach mental health and addictions with a lens that strongly differs from mainstream approaches. It is important to understand the principles and approaches to mental health and addictions to better appreciate the
OFIFC’s wholistic framework. It is on these principles and strategies that the Friendship Centres and the OFIFC are able to build mental health and addictions initiatives that appropriately address the health needs and goals of the urban Indigenous community.

The OFIFC Mental Health Strategy is based on these common principles.

1. Self determination: this refers to the right to be involved and included at every level of the decision-making process for all aspects of mental health and addictions care;
2. Indigenous right to different models of health care: this refers to the right of Indigenous people (from communities to individuals) to select mental health care models that are relevant to their needs and priorities;
3. A wholistic framework: this refers to the need to address the multiple aspects of Indigenous people, from the physical, mental, emotional, spiritual, cultural, and social well-being, to addressing individuals, families, and communities as collective parts of a complete framework;
4. Socio-economic issues: this refers to the importance of considering the negative impacts that socio-economic issues have had on Indigenous people, and as such, attention and effort need to be directed on improving conditions of poverty, lower educational status, inadequate and unaffordable housing, and other areas that directly relate upon improving Indigenous people’s health;
5. Culturally appropriate and accessible mental health services: Indigenous people have a right to care that respects their needs and is available to them in the ways, forms, and locations where they need it;
6. Culturally-secure environment and manner of mental health service provision: Indigenous people need mental health care that reflects their Indigenous cultural rights, views, values, and expectations. This includes eliminating and stopping the provision of culture-based services provided by non-Indigenous medical personnel. Culture-based differs from culturally-appropriate as the former refers to teachings and the latter to respectful practice.
7. A coordinated and collaborative inter-sectoral approach to mental health care: Coordination and collaboration between primary and secondary mental health services prioritizes the needs of those accessing the mental health system over that of the borders and restrictive mandates of service providers. This approach builds a service and support system that better attends to the needs of clients and better ensures that those in need receive the treatment and supports they need when they need it.
8. Guaranteed funding and political will: A system fraught with funding gaps and drastically varying funding commitments faces tremendous hurdles in the form of high staff turnover, service provision gaps or lapses, and community distrust in the integrity of those services and the governance that oversees these damaging practices. Firm funding practices can only be established when the political will is there to make and keep needed funding commitments.
Overall Strategic Approaches

1. Strengthen OFIFC commitment to address in an integrated approach the Urban Indigenous needs 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 of the life cycle stages.

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

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

6. Establish an Indigenous-designed system of referrals.

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

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

The principles and strategies of the OFIFC and member Friendship Centres were built on decades of work in urban Indigenous issues and cultivated through grassroots engagements with urban Indigenous people. These principles and strategies inform the OFIFC’s work and the Friendship Centre programs to prioritize the particular needs of urban Indigenous people. The pillars of what are needed for healthy urban Indigenous communities are outlined in the principles and strategies, reflecting a plan of action and structure of support that is far better suited to meeting the needs of urban Indigenous people and improving their socio-economic standards than a mainstream general approach could achieve.

Reframing Power Relations: An Approach to Mental Health and Addictions Treatment that Works for Everyone

Recent announcements and position statements of the Premier of Ontario are highlighting a changing relationship between the province and Indigenous people. When making a statement in provincial parliament on May 30th of this year, the Premier made a commitment on behalf of the government of Ontario to be partners with Indigenous people.¹⁵ This commitment was in part based on a recognition that a legacy of dictating change for Indigenous people does not work to make positive change or to build positive relationships, and actions which have been made on Indigenous people rather than with them have caused tremendous harm to Indigenous people in Canada.

Currently, Indigenous health and related socio-economic factors describe a disadvantaged population, one for whom general public systems have not met their needs.

Health

- From 2007-2010, Indigenous people off-reserve indicated poorer health in comparison to non-Indigenous Canadians
- Indigenous adults had significantly higher rates of obesity than non-Indigenous people (First Nations: 26%, Métis: 22%, Inuit: 26%; non-Indigenous people: 16%)
- Indigenous people were more likely to go through food insecurity (First Nations: 22%; Métis: 15%; Inuit: 22%; non-Indigenous people: 7%)\(^\text{16}\)

Socio-economic

- In 2011, Indigenous people were less likely to be employed (Indigenous people: 62.5%; non-Indigenous: 75.8%)\(^\text{17}\)
- In Ontario, the unemployment rate of Indigenous people aged 25-54 was 9.1 percent compared to 6.3 percent for non-Indigenous Ontarians\(^\text{18}\)
- From the OFIFC’s *Child Hunger & Food Insecurity Among Urban Aboriginal Families* report (2003), 79% of Indigenous respondents identified that they were concerned they would run out of food, 35% of respondents identified that their children had gone hungry, 11% identified that their children had missed school from lack of food, and 7% stated they had experienced CAS involvement because of food shortage\(^\text{19}\)

When reshaping systems to also work for urban Indigenous people, there is a critical need to modify approaches to both recognize and address the unique challenges, historical influences, and community priorities of urban Indigenous people when planning, designing, implementing, monitoring, and evaluating initiatives. Mainstream services need to make spaces for Indigenous needs and priorities, as well as respecting Indigenous processes and knowledge. As well, services by and for Indigenous people require financial support and partnership with mainstream services. A wholistic approach has proven to work with Friendship Centres in Ontario, with high receptivity by Friendship Centre clients, and successful program goals being achieved repeatedly with

culture-based or culturally-relevant services and supports by the Friendship Centre staff and program workers.

Why the Friendship Centre Model Works
Friendship Centres achieve their mandate to improve the quality of life of urban Indigenous people through a variety of approaches that are woven together, addressing a broad range of social determinants of health. Each initiative is localized to the particular characteristics, needs, and goals of the different urban Indigenous communities across Ontario. That being said, there are core attributes or practices that were identified through the engagement sessions.

From the Urban Indigenous Communities: What is working well
From the five Friendship Centres and their partners in supporting the urban Indigenous community for mental health, there were four key themes that rose out of the input that exemplified what was working well. (1) Culturally-relevant services and supports, (2) wrap-around services, (3) a community hub approach, and (4) socio-economic engagement.

These are key features of OFIFC member Friendship Centres as a whole and are very much not restricted to the Friendship Centres participating in this engagement, nor are they different from what has been reported by Friendship Centres over the past many years. The reason these approaches are reflective of Friendship Centre practice is because in the Friendship Centre movement’s experience, these approaches are what are needed by the urban Indigenous community. They are what work.

Culturally-relevant Services and Supports
Culturally-relevant services and supports differ from the culturally-competent. Culturally-competent is a descriptor intended for the provision of services by non-Indigenous providers. Culturally-relevant services are those services and supports delivered in cultural ways, and thus typically delivered through Indigenous service and support providers.

The Friendship Centres themselves run cultural programs that directly and indirectly address participants’ mental health and addictions issues, as well as accessing cultural resources from other actors in the Indigenous community for mental health. The cultural model is reported by providers to make a critical difference in reaching and supporting urban Indigenous people to reach their health goals.

The engagement sessions highlighted these initiatives, such as Kizhaay Anishinaabe Niin (“I Am A Kind Man”), which is a program to engage Indigenous men and youth to help them understand what constitutes violence against Indigenous women and help support them in joining together and ending the violence. The engagement also highlighted initiatives like Aganaweiditouin (a women’s healing circle), traditional healers, healing gardens, culture-based addictions treatments, and many other cultural mental health and addictions programs.
Some of the initiatives are direct culture-based treatment programs; some are support programs meant to round out support for these treatments or cover gaps in mainstream treatments and supports that lack cultural components.

Wrap-around Services
Urban Indigenous people face many challenges in accessing services and supports in a variety of areas, not just mental health. As an approach to address these multiple challenges, Friendship Centres have modelled themselves to provide wrap-around services. This refers to the multiple services provided through the Friendship Centre as it covers things from mental health to health, to housing, labour and employment, provision of food stability resources, and so on. People know that by accessing the Friendship Centre, they can address many needs at once. This is a particularly potent approach when transportation issues in the urban Indigenous community are also very obstructive. By centralizing these services, Friendship Centres go a long way towards maximizing supports for the urban Indigenous community, and ensuring those who need help the most are getting it.

Community Hub Approach (collaboration and partnership)
As locally-driven organizations, Friendship Centres engage their urban Indigenous communities through culture-based programs and services that base their cultural components on their local communities, ensuring cultural efforts are always from and for that community. Programs and supports are collaborative, with a breadth of services that cover many aspects of the needs and priorities of the community. As a part of this approach, the Friendship Centres are heavily engaged in partnerships with other community organizations, resources, and services, including mainstream providers. Friendship Centres offer their spaces for support workers and employment counsellors to come in, for school teachers to meet with parents, and pursue additional opportunities to bring in supports and services for Indigenous people. Through this outreach, they build influence in the community to improve considerations in mainstream services to understand and pursue the needs of Indigenous people, and they counsel a greater appreciation for cultural differences and understanding for the unique challenges and obstacles that Indigenous people face, improving the cultural competency of service delivery. From the engagements, it was heard many times that other service providers would seek out the support or aid of Friendship Centres to help that external service in meeting the needs of an Indigenous client. Friendship Centres have established themselves over many years as a hub of support, direction, and friendship for the wider community, an approach that simultaneously helps the Friendship Centre fulfill its direct role in helping the urban Indigenous community while also helping the wider, non-Indigenous community to revise its own practices and approaches to Indigenous people for the better.

Socio-economic Engagement
Mental health and addictions issues have strong ties to external factors such as housing needs, food insecurity, and unemployment. It is incredibly difficult to successfully
address the mental health and addiction needs of someone who is homeless. Likewise, when someone is struggling to feed their family, or in a constant state of hunger, all of these push upon one’s mental health. Friendship Centres recognize the interconnectedness of these socio-economic issues to the urban Indigenous community’s health and wellbeing. Part of the goal of the wrap-around services and community hub approach is to make those connections with housing resources, food resources, and employment opportunities, and to make sure those who need these are receiving those referrals and connections.

The collective approach of these factors, the culturally-relevant services and supports, the wrap-around services, the community hub approach, and the socio-economic engagement are part of a wholistic effort to support the urban Indigenous community to build strength and resilience and improve their mental health and wellbeing. In part, it is the collection of these approaches and initiatives that makes Friendship Centres such a critical partner to mainstream mental health services and supports. The Friendship Centre movement is built around a recognition of community needs as well as a grassroots connection that ensures that Friendship Centres and their supports evolve and adapt along with the urban Indigenous community to provide the community what’s needed and to work with mainstream services and the government to recognize and incorporate these needs within their own initiatives.

**Mental Health and Addictions Engagements**

**What are the Community Needs**

As in the previous report, in the areas where things are going well, this does not mean that these initiatives have the support they need to meet the needs of the urban Indigenous community. In terms of the above ‘working well’ areas, they all would benefit from increased supports.

The needs of the communities are extensive. In brief, here are some of the more dominant needs as highlighted through the engagement sessions by community participants (as opposed to youth):

- Additional culturally-relevant services and supports
- Transportation
- Programming that goes beyond individuals to address families
- Patient navigation and advocacy
- More treatment centres (locally available)
- After-hours services for mental health and addictions (for adults and children)
- Services and supports for youth aged 16-18 (the two-year service gap)
- Mental health treatment that emphasizes talk therapy over pills
- Additional emergency services (for adults and children)
- Increased methadone clinic accountability
- Increased aftercare supports for addictions treatment
• Wait-times reduced
• Streamlined service access to remove barriers to enrollment
• Funding streamlined and contracts extending to 3 or more years
• Anti-stigmatism and anti-discrimination training for health providers towards those struggling with mental health or addictions issues
• Anti-racism training for those in the health system
• Culturally-competent mainstream mental health and addictions services

The youth who participated in engagement sessions were asked what they saw as the challenges to their communities. Their responses reflected certain themes as well. They provided more responses than are included below: these are intended as major answers appearing across communities.

• Substance issues and addictions
• Racism
• Bullying (including cyber bullying)
• A lack of addictions or mental health services for youth
• Depression
• Youth homelessness

Moving Forward
We asked community participants what they wanted to move forward for their community mental health and addiction needs, and we asked youth participants what sorts of solutions and positive things they wanted in their communities. The solutions and ideas that came forward were quite thorough in coverage of the communities.

From the community

• Culturally-appropriate mental health services
• Culturally competent mainstream health services
• Additional Indigenous mental health workers
• Official health care system navigators
• Increased wholistic care approaches to be available
• Care that is locally available
• Longer addictions treatment programs
• More information that is senior accessible on mental health care options and services
• Increased access to traditional healers
• Translated health documents for Indigenous languages
• An Indigenous language translator on-call for health service needs
• Additional funding that has consolidated reporting needs, with multi-year contracts, and localized access restrictions (so that one urban community does not receive most of the funding, depriving other nearby, fewer-resources communities from winning funding)
• Increased funding for socio-economic initiatives that impact on mental health and addictions issues
• Increased availability of talk-based therapy over prescriptions
• Mental health and addictions supports and services aimed specifically at urban Indigenous youth

From the youth
• Activities, sports, and other options for healthy youth engagement
• Cultural activities for youth
• Improved anti-bullying policies and initiatives in schools
• Improved awareness of mental health and addictions services and supports for urban Indigenous youth
• Youth drop-in centres
• Youth emergency safe spaces (available 24/7 to be available when youth need it)

Both community and youth contained many more answers, but beyond these, they were individualized to specific communities.

Measurements
When engaged on the issue of evaluating mental health and addictions, communities provided answers that may provide some invigorating challenge to mainstream health systems. No community addressed this area in the same way, but their answers share characteristics.

In general, the communities provided answers that increased the importance and influence of the communities themselves in evaluating whether health services were meeting goals. In part this was shown through the communities identifying that community members, those accessing mental health and addictions services, should be among the evaluators, if not the main evaluators, of these services. It was also reflected in the shift from current health evaluators to what the communities wanted to track to determine health and wellness success, such as participants becoming peer supporters and role models, measuring whether children and youth are moving off of psychiatric drugs, using approaches that increase peoples’ self-esteem, using person-centred approaches, and measuring participant impressions of services.

Participants’ answers reflected a more wholistic view of mental health care that addressed the whole person: body, mind, emotion, and spirit. They also gave some preliminary ideas of ways of accessing these, including the following:

• Participant perception-of-care surveys
• Measuring how participant-driven mental health and addictions care is
• Use community-based standardized assessment for health care providers (relevant to each community’s challenges and priorities)
• Program flexibility to meet the needs of individuals
• Quarterly reports
• Surveys
• Community well-being evaluations
• Using a Child and Adolescent Needs and Strengths (CANS) assessment for progress tracking
• Extending existing programming based on user input
• Progress reports
• Journaling – to inform professionals
• Increased personal follow-up
• Evaluating funding consistency
• Tracking and stabilizing standards of health and matching Indigenous to non-Indigenous standards

Community priorities
One of the goals of this series of engagements was to identify community input for five key themes provided by the Ministry of Health and Long-Term Care. These themes were (1) adults, (2) transition-aged youth, (3) addictions, (4) funding reform, and (5) performance measurement. While those are relevant themes, communities were not necessarily concerned with providing answers that neatly fit within them. As part of the engagement process, each community received a feedback report on their contributions both for their own use (and in reflection of the OFIFC USAI research framework), and to confirm the accuracy of the OFIFC’s analysis of the communities’ answers. For the purposes of this report to the ministry, the community priorities have been collected under the above five key themes. Many priorities touch on two or more themes, and as such, the reader is encouraged to be flexible in considering how to implement these priorities, (for instance, many priorities are meant to be applied across the age continuum). Priority themes are an aid to interpretation, not a restriction. Nevertheless, the five themes from the ministry provide a useful framework for organizing and approaching the priorities.

From the community

ADULTS

• More health specialists, including doctors – especially pediatricians – psychiatrists, and mental health workers for adults and youth to meet the needs of the community
• More cultural programs of treatment, locally accessible:
  • Cultural programs have been observed by providers to have increased impact on Indigenous people, as well as to be more requested by them for their own treatment;
  • Transportation adds significant challenges in terms of costs, accessibility, and wait times; by having these services locally accessible, it greatly reduces the obstacles for people in need to benefit from these services.
• More Indigenous Mental Health and Addictions workers in frontline services and care:
• Having representation in organizations goes a long way towards making those services more approachable to the urban Indigenous community as well as to increase the culturally-relevant service provision that is important to the successful treatment of Indigenous people.

• Having local treatment options for mental health and addictions, including cultural treatment programs, and support for traditional healers and Elders to participate in ongoing and new healing and wellness programs

TRANSITION-AGED YOUTH

• Supportive housing for a variety of needs – transition houses for those leaving correctional facilities; housing for homeless; and safe places for youth;
  • Housing is intimately tied to a person’s mental health, and having housing bears a strong correlation to avoiding more at-risk living scenarios that may increase or lead to mental health or addictions issues

• School-related initiatives to target and support children and youth as an ongoing preventative and supportive measure
  • Such as, implementation in schools of essential skills, such as budgeting, home economics, cooking, trades, environmental and outdoor land-based teaching
    • These skills teach self-sufficiency and self-care as well as decreasing the risk of poverty, which is strongly linked to mental health issues

• Youth mentorship, leadership camps, and related initiatives to build self-confidence and resiliency

ADDITIONS

• Increases in programs and initiatives to address mental health and addictions needs, including for children and youth as well as adults, as well as increasing collaboration with those working in the criminal justice system to meet the needs of many urban Indigenous peoples entangled in the justice system while suffering from mental health and addictions issues or facing prosecution for mental health and addictions related actions

• More mental health and addictions programs, including an alcohol and drug worker program for Indigenous people, and a children’s mental health program

• A coordinated mental health and addictions services calendar that facilitates identifying available, relevant agencies and programs for mental health and addictions issues

FUNDING REFORM

• There is a strong need for the role of a designated Indigenous navigator for the local health care and related support services systems who would help coordinate services and collaboration:
  • Such a role would need committed funding and have their official role recognized amongst health services and supports to help with coordination.
• More funding for human resources so that there are more people to fulfill health services and supports:
  • Providing the opportunity for more services or collaboration without also increasing the human resources needed to fulfill these roles puts undue strain on people already stressed to provide significant frontline services and supports;
  • Providing more hands over which to spread the work is key to maintaining quality of service, ensuring clients receive equitable services, and ensuring that the frontline service providers are also receiving the equitable treatment needed to prevent burnout in the fulfillment of their duties
• An Indigenous language translator on-call that can provide health-specific translations;
  • Particularly up north, more Indigenous people speak their traditional language as their primary language – this can be a challenge when attempting to fulfill their health needs
• Localized funding that is reserved for smaller communities, including a simplified proposal process for funding, and longer-termed funding to reduce reporting needs;
  • Competitive processes can favour larger communities over smaller ones, and in situations where travel in-between is very difficult, this can seriously exacerbate health care deficits in less populated areas that have quite legitimate health needs;
  • Service provision for health can be extremely taxing; adding highly technical proposal requirements for funding as well as frequent reporting needs puts undue strain on the process of providing services and supports
• Reliable, accessible, and affordable public transit
• Having family supports for those caring for someone struggling with mental health and addictions issues
• Increased family-based service provision

PERFORMANCE MEASUREMENT

• Addressing and removing the delays in diagnoses and treatment because of wait times and de-rostering requirements:
  • Wait times and de-rostering issues represent serious blockages towards receiving appropriate health care;
  • Without a diagnoses, people cannot be redirected to relevant support options, including mental health diversion and court support, or special considerations in the school system;
  • De-rostering and rostering requirements do not work well with a highly mobile urban Indigenous population. For many Indigenous people in remote communities, health care is provided rotationally rather than with a full-time staff and health centre. When health clients roster in a remote community and then relocate to an urban centre, they face significant challenges attempting to connect with and de-roster from their previous healthcare providers. In these contexts, de-rostering becomes a serious obstacle and can compromise the receiving of timely and equitable health care.
• This obstacle interferes in several ways, such as a block to employment or obtaining food, which in turn exacerbate mental health and addictions issues, but it also has immediate impacts on mental health and addictions treatment by making it challenging to get to health services in the first place
• More education for service providers, including medical providers, and community members on Indigenous peoples, the legacy of Indian Residential Schools, the history of colonialization impacts, and mental health and addictions to decrease stigma and racism in the community
• The inclusion of cultural practices, ceremonies, and supports throughout programming to help provide wholistic healing and wellbeing
• Addressing and removing the delays in diagnoses and treatment because of wait times:
  • Wait times represent serious blockages towards receiving appropriate health care;
  • Without a diagnoses, people cannot be redirected to relevant support options, including mental health diversion and court support, or special considerations in the school system;
• More education for service providers, including medical providers, and community members on Indigenous peoples, the legacy of Indian Residential Schools, the history of colonialization impacts, and mental health and addictions to decrease stigma and racism in the community

From the youth

ADULTS
• More activities would help establish a healthier community
  • These activities ranged from youth-oriented (such as learning to hunt, trap, or fish, or receive wisdom from Elders) to community-oriented, such as the calls for community clean-ups, community dinners, and family nights
  • All the activities recommended would foster supportive groups and positive attitudes as well as feelings of accomplishment
• More supports for mental health and addictions in the form of counselling and healthy alternative activities and lifestyles

TRANSITION-AGED YOUTH
• Crisis centres and shelters for the community as well as housing, but also housing and crisis services specifically for youth
  • Issues of homelessness or at-home situations which put youth at risk could lead to such practices as couch surfing, putting a strain on their mental health as well as potentially exposing them to more at-risk behaviours
• More supports for youth to help with depression, self-harm, and anxiety, as well as better ways of informing youth through schools as to the options available
• Greater flexibility in program mandates or offering services to address the youth age gap of 16-18 to keep youth from falling through the cracks of service provision
• More social workers to meet the mental health and addictions needs of youth
• Increasing youth engagement and providing safe spaces would help with prevention and promotion of healthier lifestyles
• There needs to be programming and collaborative efforts by agencies to foster and build positive outlooks and pride from youth, and to complement these efforts with increased access to mental health and addictions services for those who need it
• Housing and safety issues need action, including both housing for the community as well as housing and safe places specifically for youth
• More school engagement for promoting healthy life skills and safe spaces free from bullying
• Community work to improve health and well-being in a few capacities, from bullying, unhealthy activities, and environmental actions to foster a healthier community overall

ADMISSIONS
• The community needs a local health clinic to provide accessible mental health and addictions treatment
• For mental health and addictions treatments that do exist, there needs to be improved dissemination of information about these options, particularly in school environments
• More supports for initiatives that have a strong impact on mental health and addictions, such as an employment centre, having youth centres and activities, and educational support

FUNDING REFORM
• More mental health and addictions treatment options in the community for youth and adults
  • These treatments should feature a strong non-pharmaceutical component, such as talk-therapy
  • Services should be accessed and provided in a stigma- and discrimination-free environment
• Alternative approaches to mental health and addictions treatment need support, including the use of traditional healing ceremonies, and counselling supports for families of those struggling with mental health and addictions issues
• The community needs more shared resources for healthy community lifestyles, such as recreational facilities and family-based programming, youth centres, accessible gyms for those with transportation and financial issues, and other safe spaces for socializing in safe environments

PERFORMANCE MEASUREMENT
• De-stigmatization training on mental health and addictions as well as Indigenous cultural competency training for health providers to remove stigmatization and stereotyping people may feel when seeking out assistance
Local Health Integration Networks (LHINs)

Local Health Integration Networks, or LHINs, are responsible for the management and service planning of hospitals, long-term care, community services, and mental health and addictions services. As such, much of what is in the purview of the LHINs has strong bearings on urban Indigenous health.

LHINs are around nine years old, legislated into existence as of 2007. Their role is the planning, coordinating, monitoring, and funding of health services in their areas. The province is divided up into 14 LHIN regions:

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

To date, in terms of urban Indigenous health, LHINs have failed to make changes. Urban Indigenous health outcomes remain seriously behind their non-Indigenous counterparts. Their relationships with Friendship Centres are largely non-existent, and Friendship Centre successes in improving the health and mental health of their communities can be said to be largely in spite of LHIN actions (or lack thereof), not because of them.

In an effort to improve access to health care and improve health service provision, the Ministry of Health and Long-Term Care (MOHLTC) is currently planning to expand the reach and responsibilities of the LHINs. Under the MOHLTC’s proposed changes, “LHINs would assume responsibility for planning, managing and improving the performance of all health services within a region, while still maintaining clinician and patient choice.”

Due to the practices of the LHINs and their failure so far to appropriately engage urban Indigenous people, the extension of their services as a response to urban Indigenous health needs would only exacerbate the LHINs’ failures to positively impact urban Indigenous health, and would likely increase the challenges of Friendship Centres to support their communities. LHINs are also fundamentally unable to provide culture-based treatments and supports, which are central to the successes in improving Indigenous health that the Friendship Centres have had.

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20 For more information on each LHIN and to see a visual map of their respective regions, refer to the LHIN website: [www.lhins.on.ca](http://www.lhins.on.ca)

To avert the increased problems enhanced LHIN influence would have on Friendship Centres, the OFIFC recommends that the MOHLTC provide direct funding of Friendship Centre programs and services, administered through the OFIFC.

**Indigenous Family-Treatment Centre Framework**

Before reviewing the recommendations from the communities, it is important to explore another critical framework that is particularly relevant for mental health and addictions treatment for Indigenous people. As previously noted in this report, the mainstream research findings, the findings of the OFIFC’s own work and experiences, and those of the Friendship Centres, mental health and addictions treatment works best when it embodies the following characteristics:

- It includes the Life Cycle of individuals: this means it addresses people in multiple stages of life, from young to senior;
- It takes a Wholistic approach to health: it incorporates the physical, mental, emotional and spiritual needs of the individual, family and community;
- It takes a Continuum of Care approach: this incorporates health promotion, prevention, treatment and curative programs and services, and rehabilitation;
- The approach is culture-based and culture-specific;
- It uses a co-located, coordinated, and collaborative approach of multiple supports in one place;
- The approach is self-deterministic;
- It includes socio-economic considerations, needs, and priorities; and
- It is accountable to and endorsed by the community

In short, the treatment should be in line with the OFIFC principles and overall strategic approaches for mental health and addictions treatment. A concept that succinctly represents these and follows the practices that mainstream research identifies as maximizing the impact of MHA interventions is a family-treatment centre framework.

As defined by the OFIFC, this model would be a centre designed to serve all members of the family (children, youth, women and men) simultaneously in order to provide a wholistic and integrated healing approach to the family. Approaches to family healing would be flexible in order to accommodate different family realities (i.e. single mothers, or grandparents in parental roles). Youth who choose to leave a dysfunctional family environment would also be able to access the Centre.

To represent much of the community-aspects of the approach, a family-treatment centre would be linked with community agencies that provide screening, addiction services and aftercare support as well as services to address housing, legal issues, education, vocation, and other needs. For example, women’s programmes could be linked with childcare programs, social services and family violence services.

A family-treatment centre would reflect and continue the practices that have proven to be successful for the urban Indigenous community. While the OFIFC would eventually
like to see four located throughout Ontario (North Western, North Eastern, Central, and Southern Ontario), a staged process following a pilot would allow for a flexible, streamlined development of these approaches across Ontario to ensure the success of the family-treatment centres.

Family-treatment centres located in urban locations would reflect that Ontario’s urban Indigenous population is more than three times the size of its on-reserve population, and this approach would reflect the mental health and addictions treatment needs within communities with approaches that work and are locally informed. By working with the entire family, this reduces concerns about child care, housing, and other intersecting socio-economic and familial concerns. A culture-based approach drawing on the Elders and traditional teachers of surrounding communities would ensure a culture-informed practice. Programming that is across the continuum helps prevent issues from passing from one generation to the next, and ensures longer-term support through aftercare that helps keep families healthy. The approach to work with the whole family helps foster and cultivate strong families that are not just resilient but supportive, preventative, and skills-equipped to better engage with life challenges.

Currently, family-treatment approaches are almost non-existent in Ontario. There are only a few, and those that are Indigenous specific, only two: the Reverend Tommy Beardy Memorial Wee Che He Wayo Gamik family-treatment centre near Sioux Lookout, and the Native Horizons Treatment Centre in Hagersville. Indigenous family-treatment centres are a needed community resource in Ontario. To guide this process, the OFIFC has developed a more detailed framework than can be fully detailed here, and welcomes collaboration and support on this framework to see these centres established and assisting the urban Indigenous community.

Joint Recommendations

In partnership with the Métis Nation of Ontario and the Ontario Native Women’s Association, a set of core joint recommendations was also developed. Each organization addresses the urban Indigenous communities in their own approach and their own service delivery sites. However, there are many shared points of interest and action between the constituents of all three organizations. For this reason, it was determined that a set of joint recommendations that had value across all three organizations and their satellites would be beneficial to determine essential actions.

The criteria to determine a joint recommendation was that it had to be strongly represented in the data across the engagement sessions of all three organizations. This means that anything included in the joint recommendations was reflected in the input each organization gathered from their community engagements, and the drafting of the recommendation was done to reflect some flexibility for each organization to enact the recommendation. It also means that there are several recommendations that would be organization-specific. Those are not included in the joint recommendations, but their absence from the joint recommendations should not be mistaken for less importance.
Both joint and individual recommendations deserve attention and thorough consideration.

The prevailing message heard across engagements was that the current health system was insufficient to meet the mental health needs of the urban Indigenous population. The current system is fundamentally lacking in its support of Indigenous-specific methods of mental health and addictions treatment and support. The system is not accessible, as it fails to make a positive impact on the mental health outcomes of the urban Indigenous population, and it has no real mechanisms to hold it accountable to the urban Indigenous community. These factors magnify the failings of each to create a health care system that needs to make specific, equitable investments in the provision of Indigenous culture-based treatments and supports as well as serious modifications to mainstream operations to address the mental health issues that are a legacy of Canada’s colonial, patriarchal past and present policies and practices enacted on Indigenous people.

The themes for changes across engagements were that participants wanted treatments to be rooted in strength-based, wholistic, culture-based, harm-reduction approaches that empower individuals, families, and communities to continue to safe-guard their health, adopt more and more healthy lifestyle practices, and build resiliency. Urban Indigenous people wanted treatments that were culture-based, where they could seek recovery that healed them in-part through empowering them with the recovery of their own cultures and practices. In all aspects, be it at urban Indigenous community hubs or through mainstream health services, mental health and addictions treatments and supports need to be dramatically more accessible, including more transportation availability. Mental health treatments also require greatly reduced or removed wait-times, greater access to specialists, and more options for mental health therapy that is talk-based or psychotherapeutic as opposed to heavily pills-based, and that are covered by insurance. Additional Indigenous MHA workers are needed to provide treatment, and more services, mainstream and Indigenous-specific, are needed to address community needs. With that in mind, it is important to address the unique cultural differences of different Indigenous groups, in particular Métis culture, which is often missing in FNMI culture-based care. Indigenous women have unique needs, challenges, and priorities, which are critical to keep in mind when considering and implementing the recommendations below: cultural approaches must also be gendered, as discrimination and other obstacles are often gendered or magnified along gendered lines. Finally, specific attention and space needs to be embedded in mental health support processes to also consider the needs of the lesbian, gay, bisexual, transgender, transsexual, gender non-conforming, queer, questioning, intersex, asexual spectrum, and Two-Spirited or LGBTT2QQIA members of the urban Indigenous community. Unfortunately, judgement, outright hostility and phobia, and a lack of understanding towards some members of society remain pervasive. Stressors, discrimination, and other challenges coping with intolerance along participants’ identity beyond that of race and culture can instigate or exacerbate poor mental health or addictions issues. Supportive mental
health processes and systems need to also reflect and be welcoming of these members of the community.

Overall, participants urged for a more wholistic approach to treating mental health and addictions. This includes modifying approaches to address concurrent conditions, and recognizing critical, related issues, such as culturally relevant, safe, affordable housing, and safe, affordable, and accessible transportation, as intimately tied to people’s mental health, access to services and the effective treatment of mental health and addictions issues. Finally, as one of the cornerstones to the provision of mental health care in Ontario, the Local Health Integration Networks (LHINs) require binding direction on carrying out ethical urban Indigenous engagement and oversight on related mental health and addictions initiatives. There are seven key recommendations, as well as their accompanying action items to enact those recommendations.

LHIN-specific recommendations to drive equitable and accountable reform for mental health and addictions treatment for urban Indigenous people:

- Create mechanisms in LHIN regulations to include local urban Indigenous communities and community organisations through bodies or structures in a co-leadership role with LHIN leadership in determining, designing, measuring, and evaluating urban Indigenous-related LHIN services and initiatives.
- Require LHINs to reach out to local urban Indigenous communities in goal-setting and the monitoring and evaluation of mental health and addictions services, with the Indigenous community the arbiter of the extent of their participation and the nature of the body-structure formed to elicit their direction for the LHINs.
- LHINs are to have annual reviews of urban Indigenous community health outcomes for their regions and present findings publicly to the urban Indigenous communities of their region.
- Set within the regulations accountability measures for partnership, wellness, and outcome indicators, as well as the determination of consequences (including financial) that may result from failing to achieve set outcomes.

System-wide recommendations, applicable at local, regional, and provincial levels:

1. Increase access to culturally-relevant care.
2. Enhance the delivery of care through recognizing and supporting culture-based provision of care and adopting culturally-appropriate approaches to care.
3. Increase resources and support for urban Indigenous organizations to more effectively engage and collaborate with the mainstream health system and agencies.
4. Develop education and training on culturally-appropriate care, as well as investments in increasing resources and capacities for delivering culture-based care are needed.
5. Include cultural education and training as priorities to meet the needs of the urban Indigenous population.
6. Require systems changes to improve the health system’s ability to address and support the health needs of urban Indigenous people.
7. Continue partnership and collaboration with urban Indigenous partners are required to continue moving health care forward.

The input from participants from the different engagements and constituency groups emphasized clear and needed structural changes to and investment in the provision of mental health and addictions treatment. Among these changes are having more services available, in both mainstream and community-based urban Indigenous-specific health service provision sites; to be provided by Indigenous people whenever possible, with sufficient staff increases for community-based urban Indigenous-specific sites to prevent community health providers from burning out.

Approaches that empower individuals, families, and communities are needed to support systemic change and continue the improvement of peoples’ health and prevent mental health and addictions issues. This is in line with the MNO, the OFIFC, and ONWA’s advocacy for mental health and addictions service provision that is structured to consider and address Indigenous people throughout the life cycle in community-driven, responsive, and accountable ways.

While the joint recommendations are included here, the OFIFC, the MNO, and ONWA released a joint report that focuses only on the joint results. This report features an extended list of action items for each recommendation. For further details on the action items, refer to the joint report.22

OFIFC Recommendations
The following recommendations are based upon the needs of the Friendship Centre communities to meet the mental health and addictions needs of the urban Indigenous community. Similar to the joint recommendations, the OFIFC recommendations range from prescriptive statements made in community engagements to those translated from community needs to speak to actors and stakeholders on mental health and addictions and related areas. The following recommendations will lead to effective and needed changes to mental health and addictions treatment, services, and supports.

ADULTS

- Development of an urban residential treatment program delivered in locations across the province
- Expansion of Indigenous mental health and addictions health programming by urban community-based Indigenous service providers
- Creation and support of off-reserve Family Treatment Centres across the province

• Provide options for safe, accessible, and affordable public transportation options to access health care as well as employment as a related impact factor on mental health and wellbeing
• Increase funding and supports for Friendship Centres to continue to establish and develop partnerships in the community to improve services and supports for urban Indigenous people
• Simplify de-rostering requirements to remove this block to accessing health care among the mobile urban Indigenous community
• Increase the availability of mental health transition supports for Indigenous people transitioning from correctional facilities to urban communities, with services being locally available
• Support the collection and promotion of community health services among health service providers, mainstream and Indigenous

TRANSITION-AGED YOUTH

• Increase resiliency and self-empowerment programming for urban Indigenous youth to address depression, self-harm, anxiety, bullying and cyber-bullying, and substance abuse, including community programs and in-school supports
• Increase awareness for urban Indigenous youth of the mental health and addictions supports and services that currently exist for them in communities, including in the community and in-school outreach
• Increase the availability of mental health and addictions programs for youth and children
• Support the development of cultural resource programming for life promotion programming targeting ages 18-24 and aimed at providing a range of resources and supports for the achievement and maintenance of good mental health.

ADDICTIONS

• Increase preventative programming on mental health and addictions that is culturally-relevant to different urban Indigenous communities
• Create Indigenous family-treatment centres (FTC) for mental health and addictions issues using the OFIFC FTC framework, with first a pilot and eventually four centres located across Ontario

FUNDING REFORM

• Create translated resources and make a translator call-in service to support urban Indigenous people who speak their traditional language to support their comprehension of the services they are receiving and make more informed decisions (this service is particularly needed for more Northern urban Indigenous communities)
• Increase funding for culture-based activities that foster resilience, knowledge, and relationships for individuals, youth, families, and communities
• Fund the expansion and creation of more culture-based mental health and addictions treatment programs that are locally accessible
• Expand the availability of talk therapy services that are insured
• Increase the availability of safe, affordable, accessible housing for youth, adults, families, and for transitional supports, as crisis centres, and safe spaces for youth
• Increase engagement with and support of Friendship Centres as a community hub for wrap-around service delivery for urban Indigenous people
• Increase supports for food security for urban Indigenous people, including for Friendship Centres as a community hub

PERFORMANCE MEASUREMENT

• Instigate mandatory cultural competency training for mainstream health service providers
• Instigate mandatory anti-stigmatization and anti-discrimination training for health service providers on those suffering from mental health and addictions challenges
• Increase the availability of mental health and addictions supports and services that address the whole family
• Involve local urban Indigenous communities in goal-setting and the monitoring and evaluation of mental health and addictions services, allowing that goals and engagements may differ between different urban Indigenous communities
• Increase the importance of socio-economic factors and community well-being in evaluating healthcare objectives for the urban Indigenous community

Conclusion

In a post-Truth and Reconciliation Commission context, the importance of partnership and collaboration between Indigenous and non-Indigenous people is becoming increasingly recognized by government. On Monday, May 30th, 2016, the Premier of Ontario, Kathleen Wynne, announced in her speech that the relationship between Indigenous and non-Indigenous people would be recognized from the position of the government as one of equals and partners: “I rise today to express a personal commitment as Premier – and the commitment of the government of Ontario – to being full partners with Indigenous Peoples on our journey towards reconciliation and healing.” This statement was supported and reinforced by announcements of further funding of $250 million dollars over the next three years, “on programs and actions

focused on reconciliation, which will be developed and evaluated in close partnership with our Indigenous partners."\textsuperscript{24}

As the OFIFC and its Friendship Centres continues to work in collaboration with other actors to improve the quality of life for urban Indigenous people, our own role is supported by the Premier’s declaration. While this enhanced position is in part a reflection of the province’s revised approach to engagement, part of the definition of what it means to be partners, and what collaboration should look like, and the evaluation of the success of shared initiatives, rests with Indigenous partners.

Evaluating success is both about sharing the role of evaluation, and it is about making space for the criteria valuable to all stakeholders. The mental health and addictions engagement sessions carried out by the OFIFC informs what these mean in a mental health and addictions reform context. Through these engagements, those working in the urban Indigenous communities in Ontario have shared their needs and gaps, their recommendations and priorities. They have offered details on how they want to improve their ability to collaborate, and they have shared some of the criteria valuable to them to meet their community goals for good mental health and wellbeing. The OFIFC looks forward to further discussions on mental health and addictions with relevant stakeholders, and the organization looks forward to continued movement on these issues with fellow actors as partners.