Access to Health Services in Ontario for the Urban Indigenous Population

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Executive Summary

This report examines the challenges to accessing Ontario’s health services as experienced by the urban Indigenous community. The report draws upon a number of sources, primarily through the Friendship Centres across Ontario, members of the urban Indigenous community, and those working to support the Friendship Centre Movement as allies.

The collected input indicates that there are a number of challenges to accessing health services for the urban Indigenous community. There is a pattern of discrimination and stigmatisation that urban Indigenous people face when seeking out health services that prevents some and quickly discourages others from engaging in health services. This can lead to people putting off seeing health services until they are in a crisis state, leading to an over-reliance on emergency services instead of less costly prior measures. Health service provision is inadequate in a number of ways, including an insufficient number of health professionals available for diagnosis or treatment, a lack of local health service offerings - particularly in the north -- and an under-valuation of community-based urban Indigenous organisations, such as Friendship Centres, as key actors both on their own and in collaboration with mainstream services to work towards addressing Indigenous health needs and driving up health outcomes for the urban Indigenous population.

As a result, this report advocates for greater partnerships and collaboration with community-based, urban Indigenous organisations, including through increased funding for their unique services and supports. The report also advocates for strong changes to mainstream health services in order to improve their approaches and capacity for improving Indigenous health outcomes. This includes system-wide calls for cultural competency training so that health service providers can offer health services that are free of discrimination and stigmatisation. There is a strong need for the Ministry of Health and the Ministry of Transportation to work together to address the deficits of public transportation experienced in many places across Ontario and that greatly complicates access to health services. Additional system-wide approaches are needed to increase access to health professionals, reduce wait times, and increase access to diagnostics and test requirements that are required for additional supports and services.

By employing the recommendations in this report, access to health services will improve for the urban Indigenous community, making much-needed improvements on the health outcomes of the population. The Ontario Federation of Indigenous Friendship Centres and the Friendship Centres of Ontario look forward to supporting the implementation of these recommendations.
Introduction

This report is a submission of the Ontario Federation of Indigenous Friendship Centres (OFIFC) to the Ministry of Health and Long-Term Care (MOHLTC) highlighting the challenges and potential solutions to urban Indigenous people’s access to health-related services. The challenges are explored through the gaps, barriers, and needs associated with access to health services in diverse contexts. For the purposes of this report, diverse contexts are broadly defined as the relationship or lack thereof between urban Indigenous people and health care supports in different systems and environments in Ontario, such as in child welfare, correctional facilities, and schools. The wise practices and solutions for these challenges are wholistic, complex, and require fundamental recognition on the part of the provincial health care system and ministry on both the need to proceed with the urban Indigenous community as partners in setting, developing, implementing, and evaluating systemic changes, and on needing to shift goals from evaluating processes to evaluating health outcomes. This will ensure that changes drive actual health gains in the urban Indigenous community and result in meaningful improvements in access to services.

Urban Indigenous people face a myriad of issues that negatively impact their health. Some of these include the Indian Residential School legacy, a history of colonisation and colonial violence against Indigenous people, and over-representation of Indigenous children in child welfare agencies. Socio-economic factors also play a role in increasing the vulnerabilities and negative impacts on urban Indigenous people’s health and wellbeing. These factors as well as issues with the health system itself clash to interfere with urban Indigenous people’s access to health care services.

As the MOHLTC continues with its strategy to restructure health care, there are important considerations and requirements regarding urban Indigenous people that need to be recognized and implemented in the execution of the strategy. This report is intended to help fill those informational gaps and offer clear recommendations to ensure that the upcoming changes to health care include and equitably address the needs of the urban Indigenous population.

A large part of needed change will require continued recognition of Indigenous people as partners, as demonstrated by Premier Kathleen Wynne as she expressed, “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.” ¹ This means the continued involvement of urban Indigenous organizations in the planning, designing, implementing, monitoring, and evaluating of health initiatives to ensure that the needs of the urban Indigenous population and their right to equitable health care are respected.

About the Ontario Federation of Indigenous Friendship Centres

The Ontario Federation of Indigenous Friendship Centres (OFIFC) is a provincial Indigenous organisation representing the collective interests of twenty-eight member Friendship Centres located in towns and cities throughout Ontario. The vision of the Indigenous Friendship Centre Movement is to improve the quality of life for Indigenous people living in an urban environment by supporting self-determined activities which encourage equal access to, and participation in, Canadian society and which respects Indigenous cultural distinctiveness.

The OFIFC administers a number of wholistic, culture-based programs and initiatives which are delivered by local Friendship Centres in areas such as justice, children and youth, health, family support, long term care, healing and wellness, education, and employment and training. Recognized as hubs of the urban Indigenous community, Friendship Centres respond to the needs of tens of thousands of community members requiring culture-based and culturally-appropriate services every day. The Friendship Centres represent the most significant off-reserve Indigenous service infrastructure across Ontario and are dedicated to achieving greater participation of all urban Indigenous people in all facets of society, inclusive of First Nation – Status/Non-Status, Métis, Inuit and all other people who identify as Indigenous to Turtle Island.

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.

As locally-driven organizations, Friendship Centres engage their urban Indigenous communities through culture-based programs and services that shape their cultural components based on their local communities, ensuring cultural efforts are always from and for that community.
Urban Indigenous Health

The goals of the Ontario Friendship Centre movement include a commitment to honouring Indigenous customs and beliefs, ensuring a better quality of life through self-determined activities, and supporting the concerns of our communities. Indigenous worldviews place an emphasis on a wholistic way of life, one that values not only the links between community, family, and self, but also honours the interconnections within the natural world as well. Our relationship to our ancestors, the spirit world, Mother Earth, our families and our communities, form our Indigenous ways of being, seeing, knowing and doing.

With Indigenous worldviews serving as our foundation, the OFIFC incorporates three interrelated concepts in our approach to Indigenous health:

- **The Life Cycle**: It explains life through the passage of stages: infancy and childhood, youth, adulthood, and senior years. The stages of life are celebrated as each person brings forward different gifts and has a role in contributing to the prosperity of the community. The stages correspond to the four directions, four seasons, four gifts of kindness, honesty, caring and strength, and four elements of the environment: water, air, mineral and fire. The life cycle reflects the interrelationship and interdependency of individuals, families and communities and their responsibilities to each other. People have different and evolving needs throughout the life cycle which must be addressed through appropriate health policies and programs.

- **Wholistic health**: It incorporates the physical, mental, emotional and spiritual needs of the individual, family and community.

- **The Continuum of Care**: It incorporates health promotion, prevention, treatment and curative programs and services, and rehabilitation.

Indigenous people in Canada suffer from health problems at greater rates than the rest of the population. The reasons for this are complex and rooted in historical traumas, including the Indian Residential School experience, as well as systemic discrimination, and socio-economic factors negatively impacting health.

Indian Residential Schools (IRS) were the system whereby Indigenous children were forced to attend ‘schools’ and subjected to systematic racism, various types of abuse, hunger, and received a sub-standard education. The IRS experiences were

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3 Ibid.


instrumental in causing severe and lasting damage to Indigenous people across Canada, for which they are still recovering from today.\(^6\)

The most influential predictors of health relate to the social, economic, physical, political, and cultural environments in which we live, and they determine our ability to make choices that support a healthy and productive life.\(^7\) These factors are referred to as the social determinants of health. The social determinants of health do not operate in isolation of one another, and several determinants combine to affect the same individuals or population at the same time.\(^8\) Some commonly accepted examples include:

- Income and employment
- Physical environments
- Health behaviours
- Health care systems
- Environmental stewardship
- Education
- Education systems
- Housing
- Food security
- Community Infrastructure\(^9\)

The health of urban Indigenous people is most prominently influenced by the social determinants of health, which contribute to the underutilization of health care, including health promotion, prevention and management initiatives. Indigenous individuals and communities that live with the inequities of the social determinants of health experience a greater burden of negative health outcomes while also experiencing greater limitations in their access to resources that would improve the situation.

Understanding the challenges and solutions to Indigenous health requires foregrounding the above factors in the analysis of barriers and the process of determining recommendations.

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\(^8\) WHO.

Access to Services: Gaps, Barriers, and Needs

In reviewing the access to services gaps, barriers, and needs put forth by the OFIFC Friendship Centres, this report addresses access to health-related services in diverse contexts beyond what might be termed a more straightforward analysis of health care. In this report, contexts such as child welfare services and systems, correctional facilities, and schools are explored. The following are the gaps, barriers, and needs as identified from Friendship Centre staff and community members.

Physical Ailments Contexts

The challenges to accessing services for purely physical needs, such as for illness, chronic conditions, injuries, etc., breaks down into a few categories that, to some extent, are shared with mental health contexts.

Engaging with the Friendship Centres across Ontario, feedback from the urban Indigenous community highlighted that there were a few systemic barriers: racism and discrimination, transportation, system complexity, lack of service availability and diagnostics challenges, long wait times, language and literacy issues, cost and NIHB-related issues.

Racism and discrimination

Indigenous people’s experiences with the health care system are greatly influenced by their Indigenous identity. When using mainstream health services, Indigenous people are encountering racism, sexism and stereotyping, and find the western approach to health care to be alienating and intimidating. They are facing derision, condescension and dismissiveness by doctors, nurses, health and social workers for their illnesses. Because they are Indigenous, they are treated as being at fault for their health outcomes, their symptoms are ignored and they are treated poorly in comparison to non-Indigenous people. According to the 2015 First Peoples, Second Class Treatment report, racism against Indigenous people in the health care system is so pervasive that people strategize around anticipated racism before visiting the emergency department or, in some cases, avoid care altogether. This results in Indigenous people not seeking out needed care when symptoms arise, leading to later diagnosis and increased risk of complications.

Members of the urban Indigenous community often report facing a reception from mainstream health services that can sometimes be outright hostile or dismissive based on the person seeking health services being Indigenous. Clients of Friendship Centres have iterated a reluctance to access hospital services because of past racist comments or community incidents that had occurred. In one instance, a Friendship Centre referenced a hospital practice to label Indigenous patients as “aggressive”, “difficult client”, or “drug seeking individual” as soon as the patient is logged into the hospital system. The pervasiveness of this issue fosters a frequent practice amongst urban

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11 Ibid.
Indigenous people to defer seeking health services when there are no alternatives to mainstream services available, until their health state reaches a critical level. This puts excess strain on the more costly emergency room services as well as on the health and well-being of individual Indigenous community members.

The needs of the Métis population are not well understood or addressed in the health care system. Métis people lack access to programs available to both First Nations and Inuit populations, and the barriers they face are often distinct from those experienced by First Nations and Inuit populations.

**Transportation**

In order to access health services, Indigenous patients first have to make it to the closest health facility. In most cases, this means relying upon public modes of transportation. In many communities (particularly the North), there is a serious lack of adequate public transportation - or in some areas, there is no public transportation. This means an increased reliance on more costly methods of transportation, such as taxis, or, in some cases even requiring flights in order to reach an area where a health service is available. Fulfilling a referral for treatment, diagnostics, or assessments frequently means facing long commutes to neighbouring towns or cities, additional burdens to accessing health services that can jeopardize receiving health care for an already marginalized group of people. Increasingly, Friendship Centre staff report the limitation of program budgets in providing transportation for medical reasons as the health status of urban Indigenous people worsens. Ongoing medical treatment services, such as dialysis for patients with renal failure, require regular transportation multiple times each week. Furthermore, an aging urban Indigenous population with deteriorating health conditions has established the need for Friendship Centre health programs, such as the Life Long Program, to amend their hours, program schedules and budget planning to ensure access to lifesaving health treatments are available at all times. For the urban Indigenous population, transportation remains a major hurdle towards equitable access to health services.

**System complexity**

For many members of the urban Indigenous community, accessing mainstream health care services remains a daunting experience. For some, they are newly relocated to urban centres, adding an additional layer of unfamiliarity to accessing mainstream health services. Depending on the complexity of a person’s health care needs, there are varying levels of burden to connect to different health care services and moving through gate-keeping processes of referral requirements and related paperwork. All of these requirements can provide a daunting experience that can intimidate someone from beginning the process, or easily lose people through health service navigation. One of the most popular services that Friendship Centres provide (above and beyond their required duties) is to serve as a type of health system advocate, supporting urban

12 Health Council (2013).
13 Ibid.
Indigenous clients with paperwork, connecting them to the relevant health services, and generally making sure that Indigenous people get the appropriate health services for their needs.

*Lack of service availability and diagnostics challenges*

Health care accessibility is not equally represented across the province. For many areas, there is a shortage of doctors and specialists, as well as an absence of the wider variety of health services. The regionalization of health services to larger urban centres has put increased strain on existing resources, and often leads to a requirement for travel to receive relevant health care services (which, when travel cost compensation is needed, adds another level of system complexity via forms and other requirements that further delays and obfuscates the access of needed health care services). Diagnostics are often a necessary requirement before a critical referral can be produced to access significant follow-up and treatment. Without diagnostics, critical health needs can go unattended, even when health services are locally available, because the diagnostics were not.

*Long wait-times*

A combination of reduced number of doctors, specialists, and health services with increased health needs creates a very unhealthy health services access gap. In the case of Indigenous people, their health concerns are typically more prevalent in the community as opposed to their non-Indigenous counterparts. The increase in health issues places a greater emphasis on their need to access health services. The result is frequently severely exacerbated wait times in order to access the needed specialist, general practitioner, or general health support service, even after referrals have been achieved, because the availability of health services do not adequately reflect the need of the community.

*Language and literacy issues*

Across the province, the first language of urban Indigenous people may be English, French or an Indigenous one. Health terminology and medical-specific concepts are a challenge and without a certain level of English or French language ability, there is an added layer of complexity to the process of accessing and navigating mainstream health services. Frequently, a measure practiced by hospitals is to rely on Elders and other members of the Indigenous community to provide language support for these Indigenous patients - which is improperly remunerated (if remunerated at all). Friendship Centres connecting medical services to those who can provide language support report that even though these Indigenous community members are providing translation services, they are not reimbursed as would be someone providing French language services for the same role.

*Cost and NIHB-related issues*

Affordability of health services and related incurred costs are issues that affect all urban Indigenous people. Status First Nations and Inuit individuals are eligible for health service coverage through the national Non-Insured Health Benefits (NIHB) Program
which provides benefits for dental care, eye and vision care, medical supplies and equipment, drugs and pharmacy products, mental health counselling and transportation for medically necessary services. Due to constraints in applying and qualifying for NIHB services, many status and non-status urban Indigenous people, including First Nations, Inuit and Metis individuals, remain unable to access many health services which they cannot afford without insurance. Even where individuals are eligible for NIHB benefits, there are significant lapses in what is covered and the length of time for reimbursement, which negatively impact health outcomes.

Cost is an issue that is particularly affixed to transportation and challenges attached to non-insured health benefits. Shortages, demand and regionalization in health services can push patients to have to travel further afield to get the health care they require. This incurs additional costs such as a seat on a bus or plane, lodgings if one is required to stay overnight, and/or gas for additional travel on top of flights, etc. When transportation is covered by NIHB benefits, urban Indigenous people are subject to substantial delays in reimbursement and strict behavioural regulations which, if violated, can impact further travel requests and access to follow-up care. Delays for reimbursement can stretch as long as a year in some extreme cases and often contribute to further stigmatization of urban Indigenous people when health service providers are not reimbursed for services in a timely matter. For many urban Indigenous people, these delays to reimbursement can be a source of significant stress and may jeopardize their household budgets for other necessities. Changes to items covered by NIHB can also additionally strain the pockets of members of the urban Indigenous community. In some cases, Friendship Centres have heard of doctors and dentists refusing to accept patients whose services would be covered by NIHB, once again putting increased requirements on members of the urban Indigenous community to have to pursue access to health services further afield, and relying more on transportation than others.

**Mental Health and Addictions Contexts**

The challenges to accessing services for mental health and addictions (MHA) contexts parallels many of the categories that were highlighted for physical ailments.

Engaging with the Friendship Centres across Ontario, feedback from the urban Indigenous community highlighted that there were a few systemic barriers: racism and discrimination, transportation, system complexity, lack of service availability and diagnostics challenges, long wait times, language issues, cost and NIHB-related issues. Listening to the Friendship Centre communities highlighted several other concerns related to MHA issues; however, they are less connected to the access to services contexts that are the focus of this report. Readers are encouraged to read the OFIFC’s
two recent mental health and addictions reports for a wider view of the challenges and solutions for the urban Indigenous community on MHA.\textsuperscript{14,15}

\textit{Racism and discrimination}

Friendship Centre staff commonly report issues of discrimination on the part of mental health and addictions service providers, including doctors and nurses. This discrimination was also often combined with a lack of understanding of Indigenous people and the socioeconomic issues they face as a result of the legacy of Indian Residential Schools and a history of discriminatory practice on the part of Canada towards Indigenous people. These are relevant aspects of the increased MHA challenges experienced in some urban Indigenous communities, and require understanding and appropriate support strategies; increased discrimination and hostility towards those struggling with MHA issues only further entrenches the issues they struggle with while making them feel that the supports and services designed to help are not for them.

In many cases, exposure to hostile treatment and discrimination would keep Indigenous clients from returning or following-up with their MHA care needs or treatments. As with the case of physical ailments, this meant an increased likelihood for some Indigenous people to defer accessing health services until they had reached critical states, placing increased burden on emergency services with higher costs. At other times a lack of understanding of Indigenous issues could lead to increased child apprehensions by Children’s Aid Services, which has recently been found to be a serious issue in Canada by the Canadian Human Rights Tribunal.

For many urban Indigenous parents, the use of mental health supports including counselling, alcohol and drug treatment and harm reduction strategies are considered to be grounds for apprehension. In some cases, mental health services are located within proximity to child welfare services, discouraging parents from seeking aid to avoid profiling to child welfare services. The inability of mainstream services to effectively recognize and account for cultural differences has led to inaccurate labelling of minority parents such as Indigenous people as dysfunctional or unsuitable to parent.\textsuperscript{16}

The historical treatment of Indigenous people should not be underestimated when considering challenges to access to services. When minorities seek help from mainstream services, for many, they are attempting to overcome very legitimate concerns, and as such, “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.”\textsuperscript{17}


\textsuperscript{17} ibid.
Transportation
Transportation is as critical to accessing mental health and addictions services for physical ailments. Transportation is a critical need throughout the urban Indigenous community. Friendship Centres provide a wide range of cultural supports that help alleviate mental health issues such as stress or hypertension, while also cultivating individual- and community-based strengths. As such, transportation issues refers both to the difficulty of community accessing the Friendship Centres as well as mainstream health services. This occurs both as a local challenge and also when, all too frequently, fulfilling a referral for treatment, diagnostics, or assessments. Often times, urban Indigenous people seeking access to MHA services means facing long commutes to neighbouring towns or cities.

System complexity
In Ontario, access to mental health and addictions services and supports requires fulfilling substantive and interconnected processes. Access to psychologists and other mental health specialists requires seeing a doctor first and receiving the right referrals. In turn, these point a patient to additional segments of mental health services and supports that may in turn require further obstacles to clear and paperwork to complete to gain both access to these supports and services as well as financial coverage for receiving them. The complexity of processes for seeking and receiving access to mental health and addictions services can be daunting and off-putting, sufficient to discourage some Indigenous patients from seeking aid until they are in a crisis state.

Lack of service availability and diagnostics challenges
A lack of local diagnostics or assessments places a large burden on Friendship Centres to fulfill longer travel needs to ensure clients can access relevant mental health and addiction treatments. Additionally, much of MHA services are restricted only to those who have completed diagnostics tests from specialists, meaning that without these tests, those in need are barred from accessing many MHA health services.

When one’s mental health deteriorates enough or a crisis state arises, it is not uncommon for police services to become involved. Those struggling with mental health and addictions issues are at increased risk of having involvement with the justice system. When this occurs, there are options available, such as mental health diversions and court supports. However, accessing these avenues also requires assessments by specialists, leading many to the same system failures as accessing other MHA services.

Long wait-times
MHA-related diagnostics and assessments can require panels of professionals, such as confirming Fetal Alcohol Spectrum Disorder (a necessary step to access government supports and other aides). The prevalence of MHA issues is high in the general Canadian population, but for some urban Indigenous communities, for historical and ongoing issues of marginalization, discrimination, and systemic mistreatments, rates of MHA issues can be higher. Higher rates require increased access to both the diagnostics that are required to receive support, and they require increased availability
of support programs and treatments for MHA. Yet both suffer from notoriously long waittimes. It is clear from engaging with the Friendship Centres in Ontario that access to health services for MHA do not reflect the need of the urban Indigenous community to access supports and treatment.

Language and literacy issues
As with physical ailments and conditions, for those accessing MHA services for whom their first language is an Indigenous language, there is an extra layer of challenge to be overcome in accessing health services. Additionally, as, in many cases, therapeutic treatments can be talk-based therapies, there can be an extra emphasis on the need for relevant language ability. Friendship Centres have culture-based programming that provides support and that approach individuals, families, and communities from a strengths-based approach that help to address and prevent MHA issues, but they require increased support to fulfill these needs.

Cost and NIHB-related issues
As referenced above, status First Nations and Inuit are eligible for health service coverage through the national Non-Insured Health Benefits (NIHB) Program, which provides benefits for dental care, eye and vision care, medical supplies and equipment, drugs and pharmacy products, mental health counselling, and transportation for medically necessary services. Due to constraints in applying and qualifying for NIHB services, many status and non-status urban Indigenous people, including First Nations, Inuit and Metis individuals, remain unable to access many health services which they cannot afford without insurance. Even where individuals are eligible for NIHB benefits, there are significant lapses in what is covered and the length of time for reimbursement, which negatively impact health outcomes.

In terms of MHA-specific cases, Friendship Centre engagements reported back that there was a large preference to de-emphasize pills-based MHA treatments and instead have more talk-based therapies and culture-based MHA treatments and supports. In terms of mainstream services, psychotherapy is under heavy restrictions when offered outside of private medical plans. Psychotherapy is only covered financially when in hospitals, when someone has been committed, or in limited community access capacities. Wider availability at this time for those who cannot afford psychotherapist fees on their own is largely unavailable.

Child Welfare Related Contexts
The OFIFIC has been working on Indigenous child welfare issues in the urban Indigenous community for the last forty years. Child welfare policies resulted in the extensive removal of Indigenous children from their families and communities through the operation of Indian Residential Schools and the ensuing child welfare apprehensions dubbed the “60s scoop” era. These common historical experiences have led to the general social breakdown of contemporary Aboriginal families - resulting in higher rates of alcoholism and substance abuse; suicides; domestic violence; sexual, physical and emotional abuses. The resulting
intergenerational trauma and dysfunction widely experienced which has affected so many Indigenous peoples and their communities is almost always transferred to the next generation, invariably resulting in continuing high rates of child welfare involvement.

These issues continue to persist through the involvement of urban Indigenous families within the child welfare system. Today, there are three times more Indigenous children in the care of child welfare authorities than were placed in residential schools at its height of operation in the 1940s. The overrepresentation and treatment of urban Indigenous children and their families in the child welfare system have created barriers to accessing and improving health outcomes.

Mental health issues are the primary concern for apprehensions through CAS, which requires mental health assessments to be completed by a licensed psychiatrist. Due to extensive waitlists and underservicing in the mental health system, the process of completing the assessment along with other requirements of CAS can result in a waiting period of 1 to 2 years for families to regain custody of their children. Families who are faced with these systematic barriers become desperate to pay fees to skip assessment wait lists to quickly regain custody or become hopeless from the stress of the apprehension process.

Involvement with child welfare agencies with concurrent mental health and substance abuse disorders is further complicated for accessing treatment and stability needed to regain custody of children. Addictions to opiates that require access to methadone treatment can be stipulated from involvement with CAS or other child welfare agencies. Parents become targeted by child welfare agencies from their participation in methadone clinics, even when there are negative drug test results and denials of opiate addiction. At the community level, urban Indigenous families are discouraged from accessing any support or assistance while receiving methadone treatment from CAS to avoid unwarranted scrutiny or apprehension.

Access to family, child and youth mental health and counselling supports in Friendship Centre communities is limited and families are overwhelmed with lengthy referral processes and waitlists which create fear and anxiety. When health services are closely located or housed within child welfare agencies, urban Indigenous families are less likely to access these services. The stigma attached to urban Indigenous individuals with respect to mental health, addictions and chronic illness creates fear for repercussion or apprehension from child welfare agencies when seeking supports for these issues.

Correctional Facilities Related Contexts

It is almost nine times more likely that an Indigenous person will be incarcerated in the Canadian justice system than a non-Indigenous person. The drastic overrepresentation of Indigenous people in correctional facilities has a disproportionate effect on urban Indigenous communities and their health needs. While incarcerated, Indigenous people are subject to harsher treatment in many areas: Indigenous offenders serve a higher proportion of their sentence before first release; are disproportionately involved with security incidents, use of force incidents, segregation, and self-injury incidents; and are more likely to have their parole revoked and return to prison. The overrepresentation of urban Indigenous offenders in correctional facilities can be attributed to a confluence of factors, including the poor health of Indigenous people who are historically situated to be impacted by post-traumatic stress and intergenerational trauma.

Mental health is a serious concern for people involved with the justice system or incarcerated in correctional facilities. In Canada, it has been identified that more than 90% of Indigenous offenders have identified substance abuse to be a presenting problem. Friendship Centre staff working in proximity to correctional facilities across the province see that a majority of urban Indigenous offenders coming out of federal and provincial incarceration are in need of mental health and addictions supports during their transition back into the community. Instead of what they need, they find a dearth of needed mental health supports, and for what is available, usually long travel times are required to access it.

As a whole, the justice system employs difficult pathways for offenders who cite mental health issues in criminal offenses cases. Individuals who have been diagnosed with a mental health illness and are prescribed medication can access the therapeutic and mental health diversion programs; however undiagnosed individuals are posed with the challenge of getting diagnosed before qualifying for admission to court. Mental health diversion can take over a year to go before a judge and it cannot be used for cases with violent offenses.

Friendship Centres often offer the only culturally-based programming that can support urban Indigenous individuals who are involved with the justice system, are incarcerated within a correctional facility or returning to the community after being incarcerated; however program workers face difficulties gaining recognition for their expertise within the professional community. Friendship Centre staff consistently report that they lack

status within community service providers because they do not possess the specific academic, experiential or expertise background that is valued in Westernized ideas of mental health service provision. Due to this stigmatization, staff from Friendship Centres and other urban Indigenous community-based organizations are overlooked by judges, and probation and parole officers who are often likely to refer urban Indigenous offenders to mainstream services and programs for diversion and transition.

Typically, youth mental health diversion programs are often not culturally competent or based in Indigenous practices and beliefs. In cases where young offenders are mandated to participate in diversion programs through the Canadian Mental Health Association, urban Indigenous youth are less likely to comply, citing mistrust and preference towards an alternative Indigenous option. Friendship Centre staff report that urban Indigenous young offenders find success in culturally-based programming that places an emphasis on Indigenous worldviews, wholistic lifestyles and the value of relationship between community, family and self. When the justice system fails to offer culturally-relevant diversion opportunities to urban Indigenous youth, it further alienates young offenders and creates barriers to accessing mental health supports.

School Contexts

Urban Indigenous students are often challenged by health crises including pregnancy scares, threats of self-harm, and family health concerns. These stressors cause behavioural and performance concerns at school and during class time. Due to extensive waitlists for mainstream mental health supports, it is often arranged for urban Indigenous students to be pulled from classes to meet with mental health professionals or service providers during the school day, which causes disruption to their learning by leaving the student unfocussed or triggered when returning to class.

Feedback from Friendship Centres also highlighted that a severe limitation in access to mental health services in the case of urban Indigenous youth were a lack of services that were youth-specific. Mental health and addictions concerns need to be addressed differently for children and youth than it does for adults. The increase in general mental health and addictions services in an area does not necessarily translate to increased effective supports for younger generations.

Feedback from youth specifically on mental health and addictions indicated that greater awareness was needed for children and youth on services that were available - they indicated that for some of the resources that did exist, many who were in need of them were not aware of the services nor how to go about accessing them. They also indicated a need to add mental health services that addressed suicide prevention, youth bullying (including cyberbullying), substance addiction recognition and treatment, as well as more initiatives that were preventative in nature, which was usually equated with both youth- and family-based activities as well as cultural-revitalization activities.
Northern and Southern Ontario Comparison

The ability to access health services for urban Indigenous individuals varies based on geographical location within the province. Health service delivery in northern Ontario is much more limited when compared to southern regions. Urban Indigenous community members in Sioux Lookout, Red Lake, Fort Frances, Cochrane, Kapuskasing and other similar communities are typically sent to larger urban centres for specialized health services such as eye care, dental care or emergency services. Where specialized health services are available, waitlists are extended and are unable to respond to those in need of quick response in crisis.

Transportation and accommodations between these communities are often expensive or based on limited schedules. The cost of transportation can be reimbursed through Non-Insured Health Benefits (NIHB), but only for Status First Nations community members. The upfront costs and slow reimbursement period for the Northern Travel Grant through NIHB is a deterrent to accessing health care even when urban Indigenous individuals qualify. In the past, Friendship Centres have offered to cover upfront costs to alleviate the pressure of waiting for reimbursement; however, the demand for this service has become overwhelming for the Friendship Centres.

In communities where there are very limited medical services, urban Indigenous people are often medically evacuated to larger hospitals with more health care services. In northwestern Ontario, the proximity of many communities to the Manitoba border results in clients being sent to Winnipeg for some health services or medical operations in crisis. This practice leaves urban Indigenous individuals stranded in locations without the proper cultural or medical navigation support. Friendship Centre workers will advocate for urban Indigenous community members to be kept within the province or sent to hospitals with cultural supports, such as Thunder Bay Regional Health Centre or Meno Ya Win Health Centre in Sioux Lookout.

Local Health Access Networks (LHINs)

As a significant influence on the structure of health care in Ontario and having great oversight on access to health services, the LHINs require specific address in this report. The OFIFC has been historically opposed to the LHINs and their regionalized approaches to health care delivery since their establishment in 2006. The LHINs have failed in addressing the health service needs of the urban Indigenous population and continue to present systemic barriers to health care.

In their management of hospitals, long-term care, community services, and mental health and addictions services, the LHINs have demonstrated their inadequacy in serving Indigenous communities through the unchanged health status of Indigenous people in this province in the last decade. Indigenous people in Ontario continue to encounter numerous barriers to their access of health care resulting in their overall underutilization of health care services. Indigenous people are dealing with critical
issues of access to care, including traditional health and healing, systemic racism, mental health and addictions issues, and the lack of culturally appropriate services. The current structure of the LHINs and their delivery of health services are not flexible or adaptive to the distinctive needs of urban Indigenous people. Furthermore, the large majority of LHIN have been content to make token gestures to the Indigenous communities rather than engage in meaningful ways with the communities, frequently focusing on nearby reserves, and usually doing little more than creating unaccountable advisory function that have little, if any, influence or decision-making power inside the institution.

At the community level, Friendship Centre leadership and program workers have rated relationships with local LHINs as being extremely poor or non-existent. With few exceptions, Friendship Centres are not actively engaged in a working relationship with their local LHIN or Aboriginal Lead through regular contact, resulting in the needs and concerns of urban Indigenous community members not being heard or met. This lack of engagement for Friendship Centres’ efforts is reflected in LHIN in-action on health matters. Some Friendship Centres note limited service support or difficulty advocating for appropriate levels of health service funding.

The LHIN definitions of health care provision are inadequate for the urban Indigenous community as they do not recognize the efforts of the Friendship Centres towards Indigenous health outcomes or allow Friendship Centres to become Health Service Providers. LHINs expect Friendship Centres to conform to mainstream health models, leading to duplication of services and the undermining of cultural approaches to improving Indigenous health. The lack of an Indigenous health approach has led to distrust of health care services and providers, and community members continue to experience racism within the health care and LHIN systems and administration. Urban Indigenous community members ask Friendship Centre staff to accompany them to access LHIN health care services. Friendship Centres are not always able to because of a lack of resources or capacity. As a result of these issues, some Indigenous people will not access health services unless they are in crisis.

Furthermore, health services provided by the LHINs are not comprehensive and navigating them can be confusing, especially in communities where regionalization has disrupted health service delivery. Indigenous patient navigators are needed in and out hospital settings to support Indigenous health clients in the engagement of the health system so that they feel safe while appropriately using health services. Friendship Centres, while being left out by LHINs on health issues, are being over-engaged in other ways, such as the Life-Long Care programs covering the slack of inadequate support by Community Care Access Centres to Indigenous patients. Despite difficulty in addressing health concerns because of neglect by LHINs, Friendship Centres continue delivering health programs and services, and Indigenous people have seen a significant increase in their access to health care and important gains in their mental health and
Facilitating Access for Urban Indigenous People

Throughout the report the emphasis has been on what obstacles are present for the urban Indigenous community to access health services. Included below are recommendations to address these. Additionally, however, there remains a critical underpinning to the issue of access to health services that bears examination. While there is much that can be done to improve access to existing services, a key theme in what was heard from the urban Indigenous community was the need for greater support for non-mainstream services through community-based organizations such as Friendship Centres, as well as adding additional services that were culture-based that anchored service provision in culturally-competent and culture-based approaches to health and healing, including for both physical and mental health needs.

The direction to be taken away from this report must be in part that while access to services can be drastically improved through very specific and actionable approaches to better service the urban Indigenous community, access to services can also be improved through expanding the types of services available to access. To this end, the recommendations for this report will highlight not only improvements to existing services but what additional supports can be leveraged to more effectively improve health outcomes for the urban Indigenous community.

Leveraging Friendship Centres

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. Friendship Centre programming spans a wide range of types, from direct physical health supports like Life-Long Care, or their healing and wellness programs for mental health. Services and supports address both ongoing needs as well as being preventative, heading off both further physical complications and mental health issues.

Programs and supports are also 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. They also support the Indigenous community outside of Friendship Centres, such as providing advocacy roles with
mainstream health services or providing transportation for medical or court appointments.

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 engagements with the Friendship Centres, 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.

Recommendations

Through engagement with the urban Indigenous community and those working on the frontlines to provide needed supports and services, the OFIFC has compiled a list of recommendations that can be leveraged for immediate and dramatic impact to improve access to services for the urban Indigenous population of Ontario. The themes of these recommendations are several. Health service providers need to take approaches to service provision that increasingly recognize community-based urban Indigenous organisations as partners in designing, developing, implementing, and evaluating health and mental health initiatives. Health service providers need cultural competency training so that they can provide services free of discrimination and stigmatization. As well, systemic changes need to occur within mainstream systems to improve accessibility and availability.

- Increase partnership and collaboration between mainstream health services and community-based urban Indigenous organisations to ensure health initiatives, services, and supports are constructed in ways that recognize the needs of the urban Indigenous community;
  - This should include designated funding for organisations like Friendship Centres to support their increased engagement with health services in their communities;
- Require that health service staff receive cultural competency training;
- Increase local access to health and mental health specialists for the purposes of diagnostics and testing;
- Include coverage of psychotherapy from private practitioners (not limited to hospital and related contexts) as part of non-insured health benefits;
- Work collaboratively with the Ministry of Transportation to ensure equitable, safe, affordable access to transportation for medical purposes in urban communities;
- Provide community-based urban Indigenous organisations with increased transportation budget resources to provide urban Indigenous clients with needed supports to make health-related appointments;
- Create Indigenous patient-navigators for the urban Indigenous community that can support and advocate for Indigenous individuals and families in need of assistance with mainstream health services;
- Update the terms of NIHB to clearly include First Nation, Inuit, and Metis, status and non-Status as well as guarantee maximum time-limits to receive refund or coverage;
- Increase mental health and addictions-related service offerings that are child and youth specific;
- Increase funding to community-based urban Indigenous organisations to provide preventative, strength-based cultural programming to support urban Indigenous individuals, families, and communities; and
- Increase the number of culture-based mental health and addictions treatments available across the province for urban Indigenous people.

Conclusion

Health services can be greatly improved in order to better meet the needs of the urban Indigenous community. Actions towards this goal help achieve the principles of the Truth and Reconciliation Commission and recommendations, and they help to correct the destructive legacy the Ontario governance system has contributed to on the health and wellbeing of the urban Indigenous community. Urban Indigenous people have the right to equitable, culturally-competent health care from mainstream health services that are timely, effective, and free of discrimination and stigmatisation.

Improving access to health services is achieved in part through improving mainstream service approaches. However, the other critical component to improving health outcomes for urban Indigenous people is to recognize the unique contributions of community-based urban Indigenous organisations in supporting Indigenous people’s health and wellbeing. Such organisations are able to operate in ways that mainstream organisations cannot, such as offering supports in culture-based ways that address community needs while building strengths and achieving preventative impacts simultaneously. As community hubs and effective, proven advocates for the urban Indigenous community, Friendship Centres in particular warrant greater recognition through investments and partnerships in order to drive up urban Indigenous health outcomes.