Words before all others

We come together to offer our sacred prayers of acknowledgement to the Creator.

We recognize the sacred responsibilities that are entrusted us in serving our community.
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Aboriginal Mental Health Approach

Introduction

As the only original population of this land, Aboriginal people have a unique relationship to Canada. They have endured government policies that ultimately denied and devalued their culture, identity, and key practices and relationships that had previously ensured good mental health. The impact has been a legacy of reclaiming and redefining mental health and re-establishing positive mental well-being in individuals, families, and communities.

The current systems that are in place to respond to Aboriginal mental health issues are fragmented and often inconsistent with Aboriginal approaches to building and sustaining good mental health and responding to mental distress. While there are many mental health programs and services offered to the urban Aboriginal population in Ontario, these supports are largely uncoordinated. As a result, many Aboriginal people are recipients of inadequate and/or inappropriate care despite the fact that, due to adverse socioeconomic factors, Aboriginal people often have the highest incidence of mental distress, including suicide and depression.

The Ontario Federation of Indian Friendship Centres

The Ontario Federation of Indian Friendship Centres (OFIFC) is a provincial Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres across Ontario. The vision of the OFIFC is "to improve the quality of life for Aboriginal people living in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian society and which respects Aboriginal cultural distinctiveness."

To make this vision a reality, the OFIFC administers various programs that are delivered in Friendship Centres throughout the province to address urban Aboriginal needs in the areas of health, justice, mental health and addictions, education, employment and training, economic and social development, children and youth initiatives, housing and homelessness, violence and abuse, and cultural awareness and identity.
Since its inception, the OFIFC has been a strong advocate for addressing mental health issues in Aboriginal communities. Long before the official recognition of the effects of intergenerational trauma on individuals and communities, the OFIFC understood that poor mental health can be a direct consequence of colonization, the residential school system, and a variety of other lived experiences, and that those lasting scars must be healed before optimal well-being can be achieved.

“Good mental health includes the physical, mental, emotional and spiritual aspects of well-being; it is understood that good mental health cannot exist in the absence of the other three aspects, and that wholistic health is interconnected with the life cycle and a continuum of care.” (Submission to the Mental Health Commission of Canada: Recommendations for the Improvement of Mental Health in the Urban Aboriginal Community 2010)

The OFIFC and member Friendship Centres incorporate a cultural and wholistic approach to programs, service design, development, delivery, and evaluation of mental health programs.

**A vision for Aboriginal Mental Health**

In 2006, the OFIFC produced “A Good Mind: Aboriginal Mental Health Strategy” which articulated a clear vision and strategy to achieve positive Aboriginal mental health. Both the vision and strategies remain strong for today and the future. The OFIFC’s Vision is to:

“Create a comprehensive Aboriginal-specific Mental Health Strategy, based in wholism to address the contributing emotional, spiritual and physical as well as the cultural aspects of mental health throughout the life stages and the healing continuum.” (“Good Mind”: Ontario Federation of Indian Friendship Centres Mental Health Strategy 2006)

The restoration of the people’s ‘good mind’ requires the creation of a system of response that is culture-driven, rooted in wholism, and addresses mental health throughout the life stages and across the healing continuum.
1. The Starting Point

A. Aboriginal People in Canada and Ontario

Aboriginal people are a growing, dynamic population. The Aboriginal population in Canada makes up approximately 3.8 percent of the total population.1

- Between 1996 and 2006 the Aboriginal population grew by forty five percent (a rate six times that of non-Aboriginal peoples).
- The Aboriginal population residing off-reserve in Ontario has grown to make up 78 percent of all Aboriginal people in the province.2
- Aboriginal youth are recognized as the fastest growing population in Ontario - more than 50 percent of the Aboriginal population is under the age of 27.3

In Ontario

Ontario has the largest provincial Aboriginal population, a population that comprises 21 percent of Canada’s total Aboriginal people.11

- 80.4 percent of all Aboriginal people in Ontario live off-reserve;
- Of the percentage of Aboriginal people who live off-reserve, 62.1 percent of individuals live in urban areas;
- 48 percent of Aboriginal people are under the age of twenty-four; and
- It has been forecasted that in 2017, Ontario will continue to have the highest absolute number of Aboriginal people.

As a result of this migration to urban settings from First Nation reserves, many individuals lose their Federal Aboriginal status protection.

B. A Unique Relationship with Canada

Aboriginal people are the original inhabitants of this land. Despite significant attempts to devalue and ignore the relationship between the nation and its Aboriginal population, there are numerous examples of legislation that highlight and reinforce the absolute necessity of addressing Aboriginal concerns in a way that is respectful of, and driven by, this unique population.

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Section 35
Section 35 of the Constitution (1982) affirms the Aboriginal and treaty rights of Aboriginal people, which includes the right to practice culture freely and without discrimination and to have access to culturally-appropriate services and supports.

Self Determination
The concept of self-determination is critical for Aboriginal people and has a profound impact on mental wellness. The Royal Commission on Aboriginal Peoples, the World Health Organization (WHO) and the United Nations in the Declaration on the Rights of Indigenous People support Aboriginal self-determination as a positive social determinant of health.

The Aboriginal Health Policy for Ontario also recognises that Aboriginal people have the right to develop and determine policies, programs and services, allocation of resources, and the selection of representatives on planning bodies in relation to their own health concerns.

C. Defining Aboriginal Mental Health

Language is a powerful tool that can convey the subtleties of meaning and importance; for instance, mental illness, mental distress, and mental wellness are all phrases heard frequently in the Aboriginal community, and these terms reveal where future investments must be focused.

Definitions of Aboriginal health have often recognized the different worldviews that inform the understanding of the language used to describe health and disease.

Aboriginal explanations of mental health and illness differ from Western definitions which are exemplified through the disciplines of psychology, social work and psychiatry, and which tend to focus on pathology, dysfunction or coping behaviours that are rooted in the individual person. Aboriginal mental health is relational; strength and security are derived from family and community.

Aboriginal traditions, laws and customs are the practical application of the philosophy and values of the group. The value of wholeness speaks to the totality of creation — the group as opposed to the individual. (Little Bear, L. (2000). Jagged Worldviews Colliding. In M. Battiste (Ed.), Reclaiming Indigenous Voice and Vision (pp. 77-85). Vancouver, BC: UBC Press.

The frequency with which terms like “mental illness” or “mental distress”, phrases that place emphasis on pathology and dysfunction, are used points to the influence
that Western biomedical worldviews have had on Aboriginal identity. To produce optimal mental well-being in Aboriginal individuals and communities, the focus must be returned to the relational and collective strength that has traditionally defined Aboriginal mental health.

D. The loss of Aboriginal cultural identity

A person’s cultural identity is based on specific ideas, values, and behaviours that shape the way that person perceives and understands their place in the world. That “personal model of reality” will have an impact on who you understand yourself to be, how you perceive your relationship with others, what agency you bring to your life, and what responsibilities you consider yourself to have.

What sets Aboriginal people apart from mainstream populations is that Aboriginal culture and its articulation as the act of every day good living is the basis of building and maintaining relationships with the land (which encompasses all beings and constructs of the land) that allow individuals to exercise respect, reciprocity, responsibility, personal agency, and self-actualization and that it is the forum through which Aboriginal peoples represent and bring forth their strengths that allow for resiliency. Aboriginal culture contains within it intrinsic truths that have withstood centuries of assault and that form the strengths upon which Aboriginal peoples construct connections to one another, the land, their ancestors, and their self. Including culture in the work that the OHRC does for, by, and with Aboriginal peoples is vital as it connects individuals and communities to one another; the land; our ancestors; and indigenous ways of being, seeing, knowing, and doing. Most importantly, culture is vital because it is healing, and its absence has clearly been demonstrated as destructive for Aboriginal peoples (i.e.: through the effects of historic colonization practices in Canada). (Ontario Federation of Indian Friendship Centres, ‘Feedback to the Ontario Human Right’s Commission’s Minds that Matter.’ 2012)

How can a person be in a state of good mental health when they have lost or have been denied their identity? Is identity not critical to good mental health? The policy of “removing the Indian from the child” could not have been more explicit; the history of colonization of Aboriginal people was carried out with the intention of destroying identity, culture, and self-determination.

The restoration of identity has been a key strategy for Aboriginal people in Canada. Through the restoration of culture, healing processes, and the reestablishment of the legal status of First Nation, Inuit and Métis people, Aboriginal identity continues to be defined.
“Identities do not exist before they are constructed... and are shaped in part by recognition, absence of recognition or misrecognition by others. Cultural identity has three elements: self-identification, community identification and external identification.” (Simard, 2009, p. 50)

Some significant legal shifts have occurred in recent years:
- In January 2013 the Federal Court ruled that 200,000 Métis and 400,000 non-status Indians in Canada are indeed "Indians" under the Constitution Act, and fall under federal jurisdiction. "The recognition of Métis and non-status Indian as Indians under section 91(24) should accord a further level of respect and reconciliation by removing the constitutional uncertainty surrounding these groups," Federal Court Judge Michael Phelan writes.
- On September 19, 2003, the Supreme Court of Canada delivered its landmark decision in R. v. Powley which recognized and affirmed the existence of Métis as a distinct Aboriginal people with existing rights protected by s. 35 of the Constitution Act, 1982

Aboriginal identities are rooted in culture and tell us who we are while providing us with guideposts for dealing with life issues as they arise. Without identity, people are unable to formulate a balanced response to difficult situations. They react, mimic what they have seen in others, or move away from that which they do not have the skill to face.

The impact on mental health of a lost or negatively defined identity has had significant consequences for Aboriginal people in Canada.
2. A Cultural Framework

A. Two Worldviews

An Aboriginal approach to mental health begins with the understanding that there are many worldviews with differing perceptions of mental wellness, mental health, mental distress and mental illness. Each of these viewpoints entail different approaches to the restoration and maintenance of mental wellness.

Mental health, within an Indigenous knowledge framework, is viewed as well-being rather than illness. The focus is on collective forms of prevention and intervention. The western or biomedical model poses a one-dimensional or limited view of mental health.

An Indigenous worldview is based on traditional culture and knowledge and ways of knowing.

*Indigenous knowledge is a complete knowledge system with its own concepts of epistemology, philosophy, and scientific and logical validity...which can only be understood by means of pedagogy traditionally employed by these people themselves.* (Dr. Daes, “Report on the Protection of Heritage of Indigenous People. P.41” in Battiste, Marie & Henderson-Youngblood, James. 2000. Protecting Indigenous Knowledge and Heritage: a Global Challenge. Purich’s Aboriginal Issues Series, Saskatoon, Saskatchewan: Purich Publishing.)

The western worldview presents knowledge as something that can be acquired and accumulated, whereas “…within the Indigenous world the act of coming to know something involves a personal transformation.”

Ideally, a mental health system that supports Aboriginal people would recognize the validity and unique benefits of the Indigenous worldview.

B. The Indigenous Worldview and Mental Health

“The Elders often speak of having a ‘good mind’. Having a good mind is to possess intelligence, good reasoning skills, a positive outlook, superior discernment, being observant with a strong ability to recall, have clarity and coming from a place of inner peace. The idea of the Good Mind/Message comes from the Haudenosaunee Great Law of Peace, given by the Peacemaker who also gave the concepts of Power and of Peace. The Great Law teaches the

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4 Peat, 2002 p.6
concepts of love, peace, equity, coexistence, cooperation, power, respect, reciprocity and generosity. Therefore, if Good Mind exists within the community it means that peace can also exist.” (Ontario Federation of Indian Friendship Centres, ‘Good Mind: Mental Health Strategy’, 2006)

The focus on a ‘good mind’ is rooted in the understanding and belief that the mind drives all human vision (dreams), knowledge, feelings, and behaviors. Thus, the mind is a critical aspect of well being, and it must be understood that a ‘good mind’ can only be achieved if the emotions are balanced with physical health and strong spiritual beliefs and customs. The concept of a ‘good mind’ is not solely a teaching tool, but rather a four-directions based, integrative way of living.

C. The teachings that inform the Vision

Life cycle teachings

An Aboriginal worldview perceives and defines the traditional and sacred responsibilities of Aboriginal men and women through the Life Cycle teachings, basing their role on where they are on the Cycle and the gifts that they possess at that time that can help them fulfill certain roles. Each person in the community relies on one another other to fulfill their roles in order to bring balance to the sacred circle. Balance comes when children are preparing to be future inheritors, grandmothers are teaching the children, women are protecting traditional knowledge, and men are protecting their families and ceremonies. Aboriginal men and women work together to ensure that their roles are accomplished, allowing children and grandmothers to accomplish theirs as a result. Teachings often say that Two-Spirited people can take on the roles of both men and women, making them very powerful, allowing them to act as teachers, medicine givers, or mediators. (Feedback to the Ontario Human Rights Commission’s Minds that Matter: Report on the consultation on human rights, mental health, and addictions. 2012.)

The Aboriginal Life Cycle Teachings were shared in 1993 with the Aboriginal Healing and Wellness Strategy by Sylvia Maracle. The teachings were later documented in For Generations to Come: the Time is Now – A Strategy for Aboriginal Family Healing, Final Report. The Aboriginal Life Cycle is based on Haudenosaunee teachings and identifies the different stages of life and the specific contributions that they entail.

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The Healing Continuum

The Healing Continuum represents the stages that an individual moves through as they recover from trauma and approach optimal well-being. Healing is the journey and wellness is the goal, but it is important to claim and define wellness throughout the journey and not only at its completion. All programs that address Aboriginal mental health must have a healing component that corresponds to one aspect of a wholistic system.

Promotion: We begin to talk about what we can do.
Prevention: Address the question of how to avoid the crisis or the situation. By asking these questions, we can develop programs that are proactive in avoiding the negative situation.
Crisis Intervention: Government often focuses on crisis intervention because it needs to respond to urgent issues.
Curative: When we look at a situation and see that it continues to repeat itself, then we need to look at the systemic and individual change that is needed.
Rehabilitative: When we address issues, there is a recognition that change has to occur on many levels.

Promotion of Stability: There cannot be a constant state of change on any issue. Leadership at times needs to recognize the progress and allow time for the change to be absorbed and lived. In some cases, the changes we seek in our communities are profound and require that each individual community member have the opportunity to learn, change, and then experience that change in their lives.

Training: Aboriginal organizations are often offering not only a different way of looking at an issue but also different ways to address the issue. Training is required for workers and for leaders to understand the issue and respond to it in a culturally-driven way.

Supportive Resources: This response can take the form of funding for any of the type of programs above, but it is also intended to represent a shift in power where there is sharing of resources through significant changes in legislation and policy.

D. The principles that inform the Vision

The OFIFC Mental Health Strategy in 2006 developed a set of principles that would form the basis of a provincial Aboriginal Mental Health Strategy:

1. **Self Determination.** Aboriginal people will be involved and included in all levels of decision-making, in all aspects of mental health care delivery, including research, planning and development, implementation and evaluation.

2. It is the **right of Aboriginal people** to choose **different models of mental health care** based on the varying needs and priorities identified by different communities and based on the specifications of an individual client.

3. A **Wholistic Framework** addresses the physical, mental, emotional, spiritual, cultural, and social well-being of individuals and the whole community. Within a wholistic framework, both traditional Aboriginal healing methods and modern medical modalities are applied to contribute to the improved mental health of Aboriginal people.

4. **Socio-economic issues** have resulted in significant negative impacts on the mental health of Aboriginal people. Higher levels of poverty and unemployment, low educational status, inadequate or unaffordable housing,
food insecurity and shared historical experiences resulting in some loss of cultural identity have had a negative impact on the mental health of Aboriginal people. Improving the social, economic, and physical environments will contribute to improved Aboriginal mental health.

5. Mental health services must be **culturally appropriate and accessible** to all Aboriginal people in Ontario, regardless of residency. There are numerous factors currently affecting access to mental health care, including jurisdictional wrangling, systemic racism, the racist attitudes of medical professionals, distance, lack of transportation, financial resources, employment, and unresponsive mental health care programs. Barriers to accessibility are further exacerbated by the refusal or reluctance to accommodate, recognize, or include traditional and alternative therapies.

6. Mental health services must be provided in a **culturally secure environment and manner**. Services must be reflective of Aboriginal cultural rights, views, values, and expectations. This includes putting a stop to ‘culture based’ services run by non-Aboriginal medical personnel and honouring the self-determination of Aboriginal people to address mental health.

7. A **coordinated and collaborative inter-sectoral approach** is required. Service delivery needs to be better coordinated within the mental health care system between primary and secondary services.

8. **Guaranteed funding and political willingness** and commitment are central to a mental health strategy for Aboriginal people.

**E. Key Concepts of Aboriginal Mental Health**

There have been a number of approaches developed by First Nations, Inuit, Métis, and pan-Aboriginal organizations to support and sustain the mental wellbeing of Aboriginal people.

*Indigenous concepts of well-being extend beyond the absence of disease to an understanding of individuals living in harmony with others, their community, and the spirit worlds.* (National Collaborating Centre for Aboriginal Health, (2010)

Many Aboriginal approaches have been based on the teachings and original understandings in an Indigenous worldview and have reflected a number of consistent elements:
**Wholistic approach:** Mental health responses must promote practices that involve all aspects of a person’s well-being (physical, mental, emotional, and spiritual) in both prevention and treatment.

For Aboriginal people, the healing continuum is about ‘wellness’ not ‘illness’. Besides sharing healing traditions, Aboriginal communities are bound by a concept of wellness, where the body, mind, heart, and soul are interconnected. In a supportive, community-driven society, Aboriginal mental health services and programs encompass the needs of the individual, family and community in a cultural, wholistic approach. (OFIFC Submission on Draft Regulation Entry-to-Practice Competency Profile for Registered Psychotherapists and Registered Mental Health Therapists, 2011)

The Royal Commission on Aboriginal People, among others, described ways to restore balance through education, raising self-esteem, reclaiming identity, leaving abusive relationships, learning traditions, customs and spiritual teachings, and letting go of accumulated pain. The healing is wholistic and inclusive of improving one’s physical, mental, emotional, and spiritual state. The improvement of economic, political, and social standing are interconnected with individual wholistic aspirations of healing.

**Culturally-driven:**

“Manifestations of one’s culture (for example, traditions, ceremonies and language) are often important sources of pride and self-esteem, serving to support individuals in their struggles against adversity.”

Elements of cultural practice which have been identified as important factors in mental wellness include the following:\footnote{Dell et al 2011, Stout and Kipling 2003, Van Uchelen et al 1997, Tousignant and Sioui, 2009.}
• Traditional healing practices (e.g. traditional medicines, sweatlodges, healing circles);
• Wholistic vision of health, such as the teachings embedded in the Medicine Wheel;
• Learning from, obtaining guidance from, and spending time in the presence of Elders;
• Having a sense of being part of a First Nation / Métis / Inuit / Aboriginal community;
• Speaking an Aboriginal language: Language is a basic conveyor of culture, and people are in general most readily connected to their emotions and intimate thoughts in their first language. Suicide rates drop to zero in those communities in which at least half the band members reported a conversational knowledge of their own language;
• Participation in ceremonies and cultural activities;
• Aboriginal child-rearing philosophy and respect for the child;
• Spirituality;
• Storytelling;
• Aboriginal values: respect, autonomy, pride, contribution (helping/giving to others), forgiveness, coming through hardship, resistance;
• Living in a good way (e.g. courtesy, honesty, self-esteem); and
• Connection to the land, and respect for nature and the animal world.

**Resiliency Based**: Resiliency is a concept that resonates powerfully for Aboriginal communities. Despite the deliberate attempts to dismantle First Nation, Inuit and Métis culture, families, and communities, Aboriginal people have demonstrated incredible resiliency. The concept of resiliency is present throughout Indigenous culture and represents the ability to overcome deprivation and adverse conditions in life.

Resilient individuals have strengths, attitudes, and skills that enable them to manage their lives and cope with adversity. All societies generally agree upon certain basic factors that are necessary for health and strength⁸:

- Forming good relationships;
- Not harming others or oneself;
- Contributing in positive ways to family, work, community and friends; and
- Doing those things that encourage mental and physical health for oneself and others.

Resiliency is enhanced when key protective factors are in place. Protective factors that help a child or individual to overcome deprivation and deal with adverse life conditions include: caring and supportive relationships, positive high expectations,

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opportunities for meaningful participation in the family and the community, a strong sense of identity, healthy and supportive families and communities, strong coping skills, knowledge of culture and language, and a positive view of the future.9

Interviews with Aboriginal people living in Vancouver’s Downtown Eastside identified factors that were perceived to be vital to strength. The themes that emerged are strongly related to Aboriginal values and traditions, including10:

- Having a sense of community;
- Identity—knowing who you are as an Aboriginal person;
- Traditions as a source of strength;
- Contribution—helping/giving to others;
- Spirituality;
- Living in a good way (e.g. courtesy, honesty, self-esteem); and
- Coming through hardship.

**Relational (Interconnected):** In all Indigenous cultures there is consistent recognition that we are interconnected and must rely on and care for each other in order to survive and succeed in life. This idea is sometimes referred to as the ‘natural protective network principle’.

> “Aboriginal mental health is relational, strength and security are derived from family and community. Aboriginal traditions, laws and customs are the practical application of the philosophy and values of the community. The value of wholeness speaks to all of Creation – the community group as opposed to the individual. As such, community driven Aboriginal services and programmes must encompass the needs of the individual, family and community in a cultural, wholistic approach in order to promote good mental health for urban Aboriginal people." (Ontario Federation of Indian Friendship Centres. Submission to the Mental Health Commission of Canada: Recommendations for the Improvement of Mental Health in the Urban Aboriginal Community, 2010. p.16)

The interconnectedness of the individual, their (extended) family, the community, and the natural and spiritual environment acts as a protective factor; people are aware that they are never alone and that there are always resources to support them.

> “The natural protective factors are the systemic structure which has existed within the Anishinaabe teachings for a millennium. It...acknowledges the protective factors, the system needed to be in place, and the roles and the responsibilities of the people within the circles.” (George Simard, 2008)

9 Chansonneuve, 2010
10 Van Uchelen et al 1997
Harmony Circles provide a visual representation of the wholistic and interconnected way that Aboriginal mental health services should be designed. Each circle strives to be in balance with every other circle. This concept is called the Harmony Circles because the balance between each circle creates overall harmony. If one circle is not in balance and is not providing basic needs, then the surrounding circles are negatively affected. The circle nestled inside a circle shows how each part of the community is connected, from the individual to the largest socially organized structure.

“There is consensus that individualism approaches are not highly relevant or effective in Aboriginal communities. In particular, given the existence of large extended family networks within First Nations communities and the frequent occurrence of complex multi-generational family issues, most experts agree that large-scale wholistic or ecological interventions are needed. It is not expected that individually focused models of treatment, such as behavioural therapy, will bring about sustainable change in environments with complex, interdependent relationships.”

Community Driven Healing: Community-driven healing initiatives that identify and promote traditional sources of strength are described as being most successful in addressing Aboriginal issues around the world. Initiatives that nurture wellness and strengths — such as autonomy of will and spirit, sharing, spirituality, respect, honour, compassion, and cultural pride — are described as most likely to facilitate healing.

“Most recent community-based mental health and wellness programs for Aboriginal children and youth are founded on local control and cultural sensitivity, are committed to building on the existing and traditional strengths of the community and use traditional healing practices. This points to an important shift in the approach to health and wellness in Aboriginal communities over the last decade or two. However, program developers still need to determine if the shift is having an impact on outcomes at either the individual or the community level. It cannot be assumed that making system-level changes will immediately translate into benefits for the individual or the community. “ (Bill Mussell, Karen Cardiff, Jennifer White The Mental Health and Well-Being of Aboriginal Children and Youth: Guidance for New Approaches and Services. A Research Report Prepared for the British Columbia Ministry of Children and Family Development, 2004)

Trauma Informed Practice: Brain trauma and post-traumatic stress disorder (PTSD) provide new information about what happens to a person’s sense of well-being when trauma occurs. The Aboriginal community in Canada, with the explicit articulation of the experience of intergenerational trauma as a result of residential schools, has exposed the need for mental health practices that are trauma informed.

The intergenerational impact of colonization and residential schools is strongly supported by research. “For First Nations youth who had at least one parent that attended residential school, 26.3 percent have thought about suicide, compared to only 18.0 percent of those youth whose parents did not attend residential schools.”

Healing: Just as the effects of intergenerational trauma ripple through a family and a community, so too can healing from this accumulated trauma be contagious, especially when a variety of different approaches happen simultaneously around the individual and within their family and community. Some of the specific interventions that support healing include:

- Breaking the silence: talking about history in a more accurate way, including both the traumas and the resilience, wisdom and survival of First Nations, Inuit and Métis people;
- Cultural revival: cherishing and practicing cultural traditions;

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11 First Nations Centre NAHO, 2005
12 Solanto, 2008
Preserving language: “language is medicine”;
Healing from addictions;
Community control and self-government over education, health care and other areas;
Reconnection to the land, including pursuing land claims;
Honouring the role of women and including more women in leadership positions; and
Restoring pride and hope by exposing youth to role models and possibilities.

**Traditional Medicine:** The *World Health Organization* defines traditional medicine as, “the sum total of knowledge, skills and practices based on the theories, beliefs, and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve, or treat physical and mental illnesses”. In this context, Aboriginal traditional healers, elders, medicine men or woman, and midwives are the pedagogy of traditional knowledge and health practices that have been passed down from generation to generation for thousands of years.\(^\text{13}\)

The Urban Aboriginal Communities Thrive (U-ACT) initiative of the OFIFC, completed in March 2013, used a community-driven research model to identify the urban Aboriginal mental health service needs and gaps of five communities throughout Ontario. The results of this initiative illustrated the overwhelming importance of the key concepts of Aboriginal mental health discussed in this section. The most widespread recommendations from the five communities (Barrie-Midland, North Bay, Ottawa, Sault Ste. Marie, and Timmins) included:

- Increased cultural competency of service providers;
- A focus on developing culturally-appropriate and accessible services for youth;
- Increased focus on cultural competency in all existing programs and services; and,
- The implementation of an Aboriginal-specific wholistic mental health framework.\(^\text{14}\)

This research was provided to the Ministry of Health and Long Term Care in a report format in May 2013.

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\(^\text{13}\) OFIFC Submission on Draft Regulation Entry-to-Practice Competency Profile for Registered Psychotherapists and Registered Mental Health Therapists, 2011.

3. Issues and Needs

A. Colonization

One cannot talk about strategies to promote the mental health and well-being of Aboriginal people without engaging in a discussion about the serious impact of both colonization and the residential school experience on Aboriginal people, families, and communities. Most Indigenous people cite colonization as the single greatest contributor to cultural, geographic, economic, and political dispossession. Colonization is also the root of many of the symptoms of mental distress.\(^{15}\)

*The chaotic conditions that exist within many First Nations communities are commonly traced back to colonization and the residential school experience, which are both known to have actively and intentionally suppressed Aboriginal knowledge and cultural values. In particular, residential schooling interfered with the Aboriginal family structure and its cultural foundation. The experience has been both highly disruptive and responsible for creating a generation of individuals who, having been removed from their families, often no longer understood what it meant to be part of their family of origin, let alone how to create a healthy family of their own.*

*The problems associated with colonization in First Nations communities have been well documented. These include disintegration of the social fabric of Aboriginal communities; destruction of self-respect and self-esteem; disruption of family life resulting in problems related to alcohol, drug and solvent use, as well as physical, sexual and emotional abuse; and suicide.*  

Residential schools for Aboriginal children were first established in the 1800s, and generations of Métis, Inuit, and First Nations children have been taken from their families. The last residential school closed in 1996.\(^{16}\) Aboriginal people have suffered many losses from the residential school experience, including historical memory, innocence, language, meaning, connection, identity, and life.\(^{17}\)

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\(^{15}\) National Collaborating Centre for Aboriginal Health, 2010.
\(^{16}\) Health Canada, 2013.
\(^{17}\) Assembly of First Nations, 1994.
Canadian policy makers now acknowledge the historical context and continuing impact of colonization on Aboriginal people, and numerous government reports have echoed a commitment to supporting initiatives that promote the health and well-being of Aboriginal people. The apology by the Prime Minister of Canada in June of 2008 was explicit in recognizing that colonization, and specifically the residential school system, was a strategy designed to eliminate the Indian identity with the policy objective of “removing the Indian from the child”.

With the creation of the Truth and Reconciliation Commission, the link between colonization, government policies, and the mental health of Aboriginal people is increasingly understood.

*About ninety eight percent of Residential School survivors suffer from a mental health issue and the leading cause of death for Aboriginal people up to forty four years of age is suicide (with the Aboriginal suicide rate being up to fifty times [Sioux Lookout, Ontario] that of non-Aboriginal populations).* (Mood Disorders Society of Canada, 2009)

The current mental health situation of Aboriginal people in Canada has its roots in the past. A long history of extensive and profoundly negative impacts of colonization on Aboriginal people has contributed to generations of trauma, the effects of which are still being felt today, and which are directly reflected in the lower health status of Aboriginal Canadians across many mental and physical health indicators.\(^{18}\)

**B. Aboriginal Social Determinants of Health**

A social determinants-based approach to mental health care complements the Indigenous understanding of health and well-being. For Aboriginal people, addressing any issue means addressing the social determinants of health, including: history, housing, nutrition, education, culture, languages, family violence, poverty, employment, racism, and stereotypes. Aboriginal families are impacted by a number of these determinants that intersect and influence one another. Most importantly, history provides a vital context for understanding the poor health and social outcomes for many Aboriginal people.\(^ {19} \)

Aboriginal people are consistently overrepresented among the disadvantaged in a wide range of social and economic measurements. Evaluation of any social determinant of health at any point in the life cycle will reveal that Aboriginal people rank the lowest and are often the most vulnerable people in our country to incidences of mental distress. For every social determinant of health, there is a direct link to mental health.

\(^{19}\) OFIFC, 2009.
In 2009, the Ministry of Health and Long-Term Care released a report discussing the role that exclusion and gender play as social determinants of mental health. Research found that social exclusion due to material deprivation, decreased participation in social activities, and exclusion from decision-making and civic participation negatively impact mental health, hitting marginalized groups, such as Aboriginal people, especially hard.

**Poverty**

Aboriginal people in Canada are more than twice as likely to live in poverty as compared to non-Aboriginal people, and upwards of 50 percent of Aboriginal children and youth live below the poverty line. Research completed by the OFIFC has shown that more than 47 percent of urban Aboriginal children in Ontario live in poverty. The living conditions, or quality of life, of Aboriginal people ranks at 63 on the Human Development Index created by the United Nations, according to a study performed by Aboriginal and Northern Affairs (2004). This is comparable to the quality of life experienced by disadvantaged individuals residing in Third World countries.

Poverty has long-term psychological effects. Aboriginal people earn significantly less, on average, than their non-Aboriginal counterparts and, according to the World

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Health Organization (WHO), poverty increases the risk of having a mental health disorder. Detrimental socio-economic conditions cause stress and can potentially lead to addictions and depressed states of well-being.  

**Children and Poverty**

In June of 2013, the Canadian Centre for Policy Alternatives and Save the Children Canada discovered that half of status First Nations children in Canada live in poverty. This is consistent with the research that has been done by the OFIFC and other organizations in the last ten years. In 2000, the OFIFC released its report *Urban Aboriginal Child Poverty: A Status Report on Aboriginal Children and their Families in Ontario*. The report revealed the increasing difficulties urban Aboriginal families across Ontario were experiencing in securing the most basic necessities of survival such as obtaining enough money for food, clothing, housing, transportation, basic health care, and recreation.

As a result, the OFIFC commissioned a follow-up report entitled *Child Hunger & Food Insecurity Among Urban Aboriginal Families* (2003). The study concluded that 79 percent of respondents indicated that they worried about running out of food, 35 percent of their children had gone hungry, 11 percent reported that their children had missed school because there was no food, and 7 percent reported that they had been involved with CAS because of food shortage. The study findings clearly demonstrated that, for many urban Aboriginal families, the reality of food shortage is an immense issue that has contributed to negative outcomes.

**Housing and Homelessness**


A stable and adequate home is a vital aspect of good mental health as it can significantly reduce stress and depression. However, existing data show that Aboriginal people are overrepresented in the homeless population throughout the country, accounting for more than 90 percent (Thomson, Manitoba) of some homeless populations.  

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24 Belanger, Y.D., Head, G.W., & Awosoga, O., (2012), Assessing Urban Aboriginal Housing and Homelessness in Canada, Final report prepared for the National Association of Friendship Centres and
people make up only 0.4 percent of the population, while the 2006 Toronto Needs Assessment Survey found that 26 percent of Toronto’s homeless population were Aboriginal.

The 24 percent of off-reserve Aboriginal children that are living in over-crowded homes, often without heat and water, are likely to experience higher than average incidences of mental distress as adults, and this risk increases if they should ever become homeless. Mental health issues in homeless youth in Canada occur at a rate 2.5-5 times higher than the national average for youth. A snapshot survey conducted by the National Learning Community on Homeless Youth on February 29, 2012, found that, out of 751 homeless youth, 54 percent had mental health issues and 66 percent of these individuals had experienced barriers to secure housing as a result of their mental health. A lack of a permanent address makes it more difficult for homeless individuals to access and stay connected to mental health services, and conversely, mental health issues can make it difficult for individuals to access shelters and other supports.

**Violence**

Aboriginal children and youth are exposed to higher rates of family violence and victimization than other groups. The Department of Justice issued A Review of Research on Criminal Victimization and First Nations, Métis, and Inuit Peoples 1990 to 2001 (2006) which highlighted the effects, later in life, of abuse on Aboriginal children and youth. The review indicated that exposure to abuse as a child or youth can normalize violence and increase the risk that the affected individual will repeat the cycle of abuse, as victim or victimizer, in his/her own intimate relationships. According to the Canadian Centre for Justice Statistics, “Children [and youth] who are exposed to [violence] in the home [are] more likely to exhibit physical aggression, indirect aggression, emotional disorders, hyperactivity, and to commit delinquent acts against property.” In addition, experiences of violence lead to an increased risk of Aboriginal children and youth engaging in self-destructive behaviour, such as alcohol and substance abuse, self harm, and high risk sexual behaviour, as a means of coping.

Violence and victimization have profound negative effects on the development of a healthy sense of self. Violent and abusive environments are dangerous and stressful, leaving the children who grow up in them plagued by feelings of fear, helplessness,

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26 National Learning Community on Homeless Youth. “Mental Health for All?,” February 2012.
27 Bill C-4 An Act to Amend the Youth Criminal Justice Act Submission to the Justice and Human Rights Committee. June 2010.
and anxiety. It is reported that youth who experience or witness prolonged abuse often leave home at an early age, and that many of these youth become homeless and are further exposed to serious health risks by engaging in prostitution, substance abuse, unprotected sexual activity, and criminal activity as a means of survival.  

**Violence Against Aboriginal Women**

The OFIFC’s *Strategic Framework to End Violence against Aboriginal Women* states that Aboriginal women are eight times more likely to suffer from physical, emotional, mental, and spiritual violence and abuse than non-Aboriginal women and are five times more likely to die from it. Additionally, almost fifty per cent of Aboriginal women receive serious or life-threatening injuries due to violence.

“A shocking 1996 Canadian government statistic reveals that Indigenous women between the ages 25 and 44, with status under the Indian Act, were five times more likely than other women to die as a result of violence.” [Amnesty International, *Stolen Sisters, Discrimination and Violence Against Indigenous Women in Canada*, 2005]

The work done by the Native Women’s Association of Canada, through the Sisters in Spirit initiative, has documented the disappearance or murder of more than five hundred Aboriginal women. These numbers are conservatively low, however, and would be expected to be much higher if not for the lack of reporting and follow-through that tends to occur in cases involving Aboriginal women.

**Criminal Justice**

Aboriginal people are involved with the justice system at rates nine times the national average, they are subjected to considerably higher rates of racial profiling, and they receive less humane treatment as compared to non-Aboriginal people.  

While Aboriginal people make up less than 5 percent of Canada’s population, they account for almost 20 percent of its Federal inmates, among whom the rates of mental illness, upon intake, have risen by 70 percent in Federal prisons since 1997.  

The most recent report released in March of 2013 by the Correctional Investigator of Canada indicated that the Aboriginal inmate population has jumped by 43 percent in the last five years. The investigator found that Aboriginal offenders are more likely to serve more than one sentence and are disproportionately prone to self-injury.

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“Aboriginal people in conflict with the law or required to appear before the courts experience a number of mental health issues even before they get to court or have contact with the judicial system, which are often not identified or dealt with. They may have episodes of depression, are survivors of sexual or physical abuse and have active addictions.

It is the nature of the penal system that convicted people are not assessed for mental health conditions which often creates an environment for addiction and violence. In one Ontario region, it is estimated by urban Aboriginal mental health managers that there are at least 500 prison inmates with serious mental health disorders who are not properly assessed and have improper medications to treat their illnesses. Untreated, people are self-medicating, over-medicating and getting introduced to the drug trade.” (“Good Mind”: Ontario Federation of Indian Friendship Centres Mental Health Strategy 2006)

The Correctional Service of Canada (CSC) Annual Plans and Priorities Report 2003-04 and 2005-06 identified that an extremely high percentage of Aboriginal inmates report early drug and/or alcohol use (80 percent), physical and sexual abuse (45 percent), parental absence or neglect (41 percent), and poverty (35 percent) in their family backgrounds. Further, 28 percent of Aboriginal inmates had been raised as a ward of the state and 15 percent had attended residential school.31

Aboriginal Youth and Criminal Justice

Much like their adult counterparts, Aboriginal youth are over-represented within the criminal justice system at all stages of the process. In Ontario, Aboriginal boys aged 12 to 17 comprise 2.9 percent of the young male population but account for nearly 15 percent of males in correctional services.32 The Ontario Aboriginal Justice Strategy Development Paper included an Aboriginal youth profile to expand on these alarming statistics, and found that many Aboriginal young offenders are given sentences that average 30 days longer than those given to non-Aboriginal youth. These longer sentences are based on the perceived higher criminogenic needs of Aboriginal offenders rather than the severity of their charges. Criminogenic needs are related to recidivism, and include employment, education, substance abuse, martial/family relations, associates/social interaction, community functioning, and emotional orientation.

In 2004, the Department of Justice released A One-Day Snapshot of Aboriginal Youth in Custody Across Canada and found that Aboriginal youth were approximately eight

31 Ontario Federation of Indian Friendship Centres Briefing Note: Aboriginal Inmate Health in Federal Correctional Facilities
times more likely to be in custody than non-Aboriginal youth. The *Snapshot* suggested that this disproportion was likely due to the high rates of poverty, substance abuse and victimization that is prevalent among Aboriginal communities. The research also indicated the possibility of discrimination within the youth criminal justice system.\(^\text{33}\) This discrimination may be at least partially responsible for the suicidal thoughts experienced by 11 percent of Aboriginal youth in custody and the attempted suicide and self-harm experienced by a further 11 percent of incarcerated Aboriginal youth.\(^\text{34}\)

**Aboriginal Women and Criminal Justice**

In 2006, the UN Human Rights Committee expressed concern about the treatment of female inmates in Canada, especially Aboriginal women and women with disabilities, and in 2009, Canada’s own Federal Correctional Investigator declared mental health issues to be the most pressing issue for the CSC.\(^\text{35, 36}\) According to the 2010-11 report of the Correctional Investigator of Canada, the average number of women in federal custody per day is just over 500, with conservative estimates indicating that 50 percent require further mental health assessments. Over the past decade, the number of Aboriginal women in federal institutions has risen by 86.4 percent and Aboriginal women presently account for approximately 34 percent of incarcerated women, or a total of 174 individuals, half of whom are likely to need mental health assessment.\(^\text{37}\)

**Child Welfare**

Aboriginal children and youth are overrepresented within the child welfare system, a fact that can be attributed to the legacy of the residential schools. Although they make up only about five per cent of the child and youth population of Canada, the *Canadian Incidence Study of Reported Child Abuse and Neglect* found that Aboriginal children and youth account for more than 15 percent of child welfare cases and 25 percent of children in care. Currently, there are 27,000 Aboriginal children in governmental custody – three times the number that were in custody at the height of the residential school system and more than any other time in Canada’s history,

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\(^{33}\) Ontario Federation of Indian Friendship Centres (OFIFC) Briefing Note: Youth Justice and Mental Health in Ontario.

\(^{34}\) Ontario Federation of Indian Friendship Centres Briefing Note: Aboriginal Inmate Health in Federal Correctional Facilities.

\(^{35}\) Bingham, Elizabeth. Sutton, Rebecca. (May 2012). “Cruel, Inhuman and Degrading?: Canada’s Treatment of Federally-Sentenced Women with Mental Health Issues.” International Human Rights Program, University of Toronto Faculty of Law.


including the 60s Scoop era.

Many reasons exist for this over-representation, including higher rates of poverty and unemployment in urban Aboriginal communities and the generational effects of the 60s Scoop.\textsuperscript{38} Urban Aboriginal children and youth are most often apprehended because parents are mistakenly perceived as inappropriate after having disclosed a mental health and/or addictions issue. The roots of those mental health issues often lie in generational trauma caused by the 60s Scoop and the residential school system. In addition, research indicates that a strong correlation exists between a young person having been involved in the child welfare system and future justice system involvement – 84 percent of adult offenders reported spending time in foster care, 61 percent in group homes, and 24 percent having been adopted.\textsuperscript{39} Overall, the high numbers of Aboriginal children and youth in the child welfare system points to, and contributes to, a cycle of poor mental health, substance abuse, and justice involvement that can be traced back to the scars of colonization.

**Self-Determination**

The idea of Aboriginal self-determination has been widely recognized as a positive social determinant of health. The Royal Commission on Aboriginal Peoples stated that “services designed and controlled by Aboriginal people can do much to heal the wounds visible in [Aboriginal] statistics [with regard to] social dysfunction, family breakdown, suicide and attempted suicide among youth, substance abuse [and] trouble with the law.” For example, a 1998 study found that youth suicides are dramatically lower in those First Nations communities that exhibit “cultural continuity”, a concept that encompasses various aspects of community-driven control over key systems and services in the community and involves taking “active steps to preserve and rehabilitate their own cultures”.\textsuperscript{40} More than half of those First Nations communities studied (111 of 196) had no known suicides during the targeted 5-year period. The remaining communities suffered rates of youth suicide some 500 to 800 times the national average. It was concluded that the presence of the following in a community substantially reduced the number of suicides:

- a) Taking steps to secure Aboriginal title to traditional lands;
- b) Self-government or community control over educational services;
- d) Self-government of police and fire protection services;
- e) Self-government of health delivery services;
- f) Establishing, within the community, officially recognized cultural facilities to help preserve and enrich the cultural environment.

\textsuperscript{38} OFIFC Feedback to the Ontario Human Rights Commission’s *Minds that Matter: Report on the consultation on human rights, mental health, and addictions*.


\textsuperscript{40} Chandler and Lalonde, 1998.
C. The status of Aboriginal Mental Health

“[The] overall mental health of Aboriginal people continues to be at serious risk...”
(The Standing Senate Committee on Social Affairs, Science and Technology, “Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada”)

Aboriginal people across Canada continue to experience high incidences of suicide, addictions, incarceration, family violence, and other social issues. The Aboriginal Health Survey, the Ontario First Nations Regional Health Survey, and the Royal Commission on Aboriginal People indicate that Aboriginal people experience significantly higher rates of all mental illnesses, major depression and suicide, Fetal Alcohol Spectrum Disorder (FASD), prescription and illegal drug use, solvent abuse, alcoholism, gambling addiction, and greater exposure to all known high risk factors than any other group in Canada. All members of Aboriginal communities, including children, youth, adults, and seniors, are affected. For instance, in 2000-2001, approximately 13.2 percent of the Aboriginal population living off-reserve had experienced a major depressive episode in the past year, a rate 1.8 times higher than the non-Aboriginal population at the time. The earlier onset of these depressive episodes in the Aboriginal population leaves children and youth at risk for long-term depression and mood disorders.41

Minds that Matter states that there are groups of people with mental health and addictions issues that, because of intersecting Human Rights Commission (HRC) grounds, experience increased racism and discrimination which makes it harder to find a job, housing, or access to services than those who do not experience the interconnection of more than one HRC ground. What it lacks, however, is a discussion about the fact that urban Aboriginal people are affected by intersecting HRC grounds (gender, gender identity, sexual orientation, age, race, language, culture, religion, and spirituality) at a rate surpassing that of non-Aboriginal populations. (Feedback to the Ontario Human Rights Commission’s Minds that Matter: Report on the consultation on human rights, mental health, and addictions.)

The currently observed poor mental health status of the Aboriginal community is directly related to the ongoing disadvantages that Aboriginal people experience with respect to the social determinants of health. As iterated above, Aboriginal people are more likely than non-Aboriginal people to experience multiple and intersecting discriminatory barriers in the realms of housing, nutrition, education, culture,

language, family violence, poverty, employment, and child welfare. These interconnected issues combine to create an environment where optimal mental health is difficult, if not impossible, to build or sustain.

**Aboriginal Children and Youth**

The Urban Aboriginal Task Force (UATF), released in 2007, highlighted the need to investigate and understand the many interrelated challenges that urban Aboriginal children and youth face in Ontario due to the observation that the prevalence of addictions, mental health issues, and suicide likely point to a variety of unmet mental health needs. The limited research and data available in the area of children’s mental health suggest that 15 to 21 percent of Canadian children and youth are affected by mental health issues, with significantly higher rates for Aboriginal children and youth. In Ontario, more than 500,000 children and youth are estimated to live with at least one diagnosable mental health disorder, with the prevalence of Fetal Alcohol Spectrum Disorder (FASD) estimated to be as high as 20 percent among Aboriginal children. These statistics are incredibly significant given that, according to the Statistics Canada 2006 Census, 48 percent of Aboriginal people in Canada are under the age of 24.

**Concurrent Issues**

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

**Intergenerational Trauma**

Intergenerational trauma has been classified as Type 3 trauma, which is distinct from Type 1 (a single occurrence) and Type 2 (repeated or extended trauma experienced by a single individual such as war, torture, history of sexual abuse, etc.). The

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42 Ministry of Health Promotion and Sport, *Aboriginal Problem Gambling Needs Assessment and Environmental Scan* (Toronto, ON: MHPS), 12.
44 “Good Mind”: Ontario Federation of Indian Friendship Centres Mental Health Strategy 2006
45 Solanto, 2008
residential school system, while the most visible, is certainly not the only cause of intergenerational, or Type 3, trauma affecting the Aboriginal community in Ontario.

Type 3 trauma was initially inflicted generations ago with the arrival of Europeans to the area that is now Canada. The newly arrived settlers introduced diseases for which the Indigenous people had no immunity, resulting in sweeping epidemics that decimated entire populations. With the death of many hunters, farmers, and food-gatherers, the remaining Indigenous population faced season after season of intense starvation. Colonization began against a population that had already been significantly weakened. Generations of Indigenous people were then undermined through the banning of culture and the relocation of communities to unfamiliar lands; this constituted a profoundly destructive act for a society whose very identity was rooted in the land. When alcohol was introduced, many found that it could numb the pain caused by this assault on identity and could induce a transitory illusion of wholeness. The introduction of residential schools and the resulting stolen generations represent just one of many destructive layers of Type 3 trauma.

The ripple effect of trauma upon trauma had an enormous impact as loss and grief accumulated over generations. Each successive assault happened so soon after the previous one that communities had no opportunity to recover, and the residue of unresolved trauma was handed down to the next generation.

In Canada, the accumulated pain is now beginning to emerge. There has been an eruption of trauma symptoms in Aboriginal youth accompanied by behaviour that is so intensely self-harming and harming to others that it is as if the youth had themselves experienced those generations of trauma.

"Intergenerational or multi-generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. What we learn to see as "normal" when we are children, we pass on to our own children. Children who learn that ... [sic] sexual abuse is "normal", and who have never dealt with the feelings that come from this, may inflict physical and sexual abuse on their own children. The unhealthy ways of behaving that people use to protect themselves can be passed on to children, without them even knowing they are doing so. This is the legacy of physical and sexual abuse in residential schools."(Chansonnette D (2005) p.51)

What happens when an entire generation of children has been exposed to intergenerational trauma? The historical trauma of Aboriginal people has resulted in a number of well-documented health and social consequences that directly impact on the well-being of the family. Save the Children Canada found that trauma that
removes children and youth from their communities, families, and/or culture increases their chances of entering the sex trade, because their vulnerability, due to the loss of protection, safety, and sustenance, forces them into a situation where the sex trade industry seems to be the only option for survival. This loss of protection is often coupled with low self-esteem, which further increases the chances of involvement with the sex trade.46

Addictions

Substance abuse in the Aboriginal community can be directly linked to the legacy of the residential school system; the separation from family and community caused many Aboriginal people to abuse drugs and alcohol as a coping mechanism to avoid confronting the sexual, physical, mental, spiritual, and emotional pain of their experiences.

One in five Aboriginal youth use solvents, with one in three of those being younger than 15 and more than half starting to use before the age of 11. The cause of death from alcohol in Aboriginal populations is 43.7 per 100,000 individuals (versus 23.6 for non-Aboriginal populations) and is seven per 100,000 individuals (versus 2.6) from illegal drugs.47

Suicide

The leading cause of death for Aboriginal people 44 years of age and younger is suicide. The overall Aboriginal suicide rate is up to fifty times (Sioux Lookout, Ontario) higher than that of non-Aboriginal populations and the suicide rate for Aboriginal youth aged 15 to 24 is five to six times greater than that of non-Aboriginal youth. Suicide is clearly linked to mental health issues like depression as well as trauma, including childhood sexual or physical abuse, rates of which are estimated to be significantly higher among Aboriginal populations.48,49 While youth suicide rates are not evenly distributed across communities, the generalized youth statistics are sobering. Aboriginal girls are 7.5 times more likely to commit suicide than non-Aboriginal girls, and Aboriginal boys are 5 times more likely to commit suicide than non-Aboriginal boys. Overall, Aboriginal males have the highest rates of suicide of

49 First Nations, Métis and Inuit Children and Youth: Time to Act, National Council of Welfare Reports, 2007
any group in Canada.\textsuperscript{50}

\textsuperscript{50} Submission to the Mental Health Commission of Canada: Recommendations for the Improvement of Mental Health in the Urban Aboriginal Community 2010
4. The Response to Aboriginal Mental Health Needs

Each and every facet of an Aboriginal person’s life is interconnected, meaning that any efforts to address mental health issues in Aboriginal communities must be wholistic in nature and must address the factors that lie upstream, namely the history of colonization, the resulting intergenerational trauma, and disadvantages in terms of the social determinants of health.

The jurisdictional responsibility for mental health falls under the purview of the provincial government, whereas the responsibility for Aboriginal people, under the Indian Act and the British North America Act, falls to the federal government. Depending on the specific issue at hand, the duty to respond to the social determinants that impact Aboriginal people’s mental well-being is jurisdictionally varied.

“Typically the responsibility for health care, including mental health care, for urban Aboriginal people falls within the jurisdiction of the provincial government. However, according to Out of the Shadows at Last, the "Parliament of Canada and the federal government have long-term responsibilities for the state of well-being of all citizens of Canada, including all Aboriginal peoples." Therefore, the federal government also has a responsibility for the urban Aboriginal community. (Out of the Shadows at last, p 25) The report also emphasizes that “an unprecedented level of both federal leadership and intergovernmental collaboration is necessary to address the epidemic mental health problems, including suicide and addictions, in Aboriginal communities.” (OFIFC Submission to the Mental Health Commission of Canada: Recommendations for the Improvement of Mental Health in the Urban Aboriginal Community 2010)

A. The Ontario Government

The Ontario government oversees a wide range of programs and services that are intended to address Aboriginal mental health, including those programs that are run through the Aboriginal Healing and Wellness Strategy, Akwe:go and Wasanabin, and children and youth mental health workers, among others. These programs are often limited and are strategically placed throughout Ontario. The limited availability of culturally-driven services, combined with the understandable reluctance of Aboriginal people to attend inappropriate mainstream programs, has resulted in significant service gaps for Aboriginal individuals with mental health needs. While it is true that
conversations about improving the mental health system in Ontario have been conducted in earnest over the last seven years, the urban Aboriginal community has thus far been largely overlooked during the discussion and development of strategies to move forward.

**Discussions**

In July 2009, the Ministry of Health and Long Term Care (MOHLTC) released a discussion paper titled, *Every Door is the Right Door: Towards a Ten-Year Mental Health and Addictions Strategy* that identified the strong correlation between mental health issues and addictions while highlighting the gaps in existing services.

In July and October of the following year, the OFIFC participated in two *Aboriginal Mental Health* discussions with delegates from the MOHLTC, the Ontario Native Women’s Association (ONWA), the Métis Nation of Ontario (MNO), and Noojimawin Health Authority in the interest of communicating several key Aboriginal mental health priorities in advance of the creation of a *10-Year Mental Health and Addictions Strategy*. These priorities included the development of an Aboriginal-specific mental health and addictions strategy (or an urban Aboriginal component to the *10-Year Mental Health and Addictions Strategy*) which would align with the *Aboriginal Health Policy for Ontario* and incorporate the *Strategic Framework to End Violence Against Aboriginal Women*, the initiation of a specific provincial response to Fetal Alcohol Spectrum Disorder, as well as the creation and/or expansion of urban Aboriginal mental health and addictions services.

In December 2010, the Health Minister’s Advisory Group on Mental Health and Addictions released *Respect, Recovery, and Resilience: Recommendations for Ontario’s Mental Health and Addictions Strategy*. The troubling lack of Aboriginal Representation in the Advisory Group, combined with a disregard towards the consultation processes of Aboriginal communities, led to a document that failed to recognize the urgent need for culture-driven, Aboriginal-specific approaches to mental health and addictions.

These reports, along with input from Ontarians, led to the creation of the *Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy*. The Strategy has five goals:

1. Improve mental health and well-being for all Ontarians;
2. Stop stigma and discrimination;
3. Create healthy, resilient, inclusive communities;
4. Identify mental health and addiction problems early and intervene; and
5. Provide timely, high quality, integrated, person-directed health and other human services.
Frameworks

The vision of the *Open Minds, Healthy Minds* strategy is to support Ontarians throughout the life stages with integrated, easily and quickly accessible, and individual-centered mental health and addictions (MHA) services that will allow for all people to enjoy good mental health and well-being and for those with MHA issues to fully participate in their own recovery and community. These aspects of the Strategy align with the vision of *Good Mind*, which is to improve the mental health and well-being of all urban Aboriginal people throughout the Life Cycle, using an integrated continuum of care approach to MHA service delivery that allows for easily and equitably accessible, individual-centered services.

The first three years of the strategy have been dedicated to addressing child and youth mental health (CYMH), with $257-million in funding allotted. Specific Aboriginal child and youth mental health positions have been created that are dispersed throughout a variety of community organizations.

In November 2006, the MCYS released *A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health*. The Framework has four over-arching goals:

1. A child and youth mental health sector that is coordinated, collaborative and integrated at all levels, creating a culture of shared responsibility;
2. Children/youth and their family/caregivers have access to a flexible continuum of timely and appropriate services and supports within their own cultural, environmental and community context;
3. Optimal mental health and well-being of children and youth is promoted through an enhanced understanding of, and ability to respond to, child and youth mental health needs through the provision of effective services and supports; and
4. A child and youth mental health sector that is accountable and well-managed.

Aboriginal specific needs are not addressed in the Framework despite it acknowledging, “15-21 percent of children and youth [in Canada] are affected by mental health disorders that cause some significant symptoms or impairment – with significantly higher rates for Aboriginal children and youth.” The report also revealed that only one in six children and youth with a mental illness received some form of specialty mental health service and that these rates may be even lower for Aboriginal children and youth.

The report recognized that “the cultural and linguistic needs of Aboriginal and Francophone children, youth and their families/caregivers need to be considered when addressing mental health issues and developing and delivering programs, services and supports” and the framework “calls for government and community
partners to work together to promote the optimal mental health of all children and youth, and to identify and support children and youth with, or at risk of developing, a mental health problem or illness."51

Despite the issues and needs clearly identified in the report, the approach to this initiative has so far been problematic for the urban Aboriginal community. For example, the OFIFC and other provincial Aboriginal organizations were not properly consulted when funding was distributed earlier this year for the hiring of Aboriginal Mental Health and Addictions Workers. As a result, only four Friendship Centres received Aboriginal Mental Health and Addictions Workers. If the provincial government is truly committed to the optimal mental health and well-being of children and youth, a greater effort must be made to meaningfully engage with the OFIFC on a provincial level so that Friendship Centres are not overlooked as community hubs that are ideally positioned to maximize the results of increased funding.

Out of the Frameworks and Discussions

Consistent challenges that have been experienced when working with the provincial government in developing frameworks and policies include:

- A lack of consultation with the Aboriginal community. The province did not consult with the Aboriginal communities in Ontario during the development of the Strategy or during the creation of Every Door is the Right Door. The failure to consult “has created some significant and fundamental weaknesses in the documents [including a] lack of reference to Aboriginal people at all in the Every Door is the Right Door discussion paper.”

- When consulting with the Aboriginal community, the government has previously confused consultation and engagement with the on-reserve population with Aboriginal consultation (which includes urban Aboriginal people, First Nations, Métis, Inuit and non-status Indians that have no formal affiliation to a First Nation community.)

- A failure to acknowledge that the Aboriginal population is essentially the proverbial “canary in the mines” when it comes to mental health. All mental health indicators suggest that an Aboriginal specific process to explore and address the issues would be most effective.

- A tendency to ask the Aboriginal community to respond to documents and draft policy frameworks that were not written with an Aboriginal worldview in mind, thus limiting the usefulness of the document and the chance of uptake by the Aboriginal community.

- The lack of a coordinated effort within the government to address a number of socio-economic situations simultaneously in order to ultimately benefit mental health.

Overall, there has been a profound lack of continuous investment in the creation and implementation of Aboriginal specific approaches to addressing mental health. Without these specific strategies and frameworks, the well-being of Aboriginal communities will continue to decline and the provincial government will not be able to meet the foremost goal of its Strategy, namely the bettering of the mental health and well-being of all Ontarians.

Moving Forward With the Provincial Government

The Province’s strategy, *Open Minds, Healthy Minds*, is focused specifically on children and youth until 2014. In preparation for the next, adult-focused, stages of implementation, it is essential that provincial urban Aboriginal organizations are supported in the development of tools to ensure that the goals of the Strategy are achieved for urban Aboriginal communities. The table below illustrates the high level of consistency between the goals of the provincial Strategy and those of *Good Mind*, the OFIFC’s 2006 urban Aboriginal mental health strategy. These desired outcomes simply cannot be achieved for the urban Aboriginal community without the use of the culturally-specific framework described in this report.

<table>
<thead>
<tr>
<th><strong>Open Minds, Healthy Minds Goals</strong></th>
<th><strong>Desired Measurable Outcomes</strong></th>
<th><strong>OFIFC Good Mind goals and other policy advice</strong></th>
</tr>
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<tbody>
<tr>
<td>Improve the mental health and well-being of all Ontarians</td>
<td>More Ontarians will know the risk factors for mental illness and/or addiction and the steps they can take to reduce their risk and improve their mental health and well-being.</td>
<td>Strategic Direction Two of <em>Good Mind</em> has the goal of improving the “mental health status of Aboriginal people and bring mental health disorders and addictions to manageable levels through direct involvement in the design, development and delivery of Aboriginal specific mental health programs and services.”</td>
</tr>
<tr>
<td></td>
<td>• A higher proportion of children entering Senior Kindergarten will score high on the Early Development Instrument (EDI)</td>
<td>As outlined during the <em>Aboriginal Mental Health Discussions</em> in 2010 with the MOHLTC, the development of an Aboriginal-specific mental health and addictions strategy (or an urban</td>
</tr>
</tbody>
</table>
| Stop stigma and discrimination | Ontarians have a better understanding of mental illness and addiction.  
• People with mental health and addiction problems seek help earlier  
• People with mental health and addiction problems report less stigma and discrimination in public services  
• People with mental health and addiction problems report less stigma and discrimination in the workplace  
• People with mental health and addiction problems and their families report that they feel more at home and supported in their communities | Strategic Direction Three of Good Mind has the specific goal of “improved equitable access to quality, culture based and culturally appropriate mental health programs and services” through addressing racism and discrimination as a barrier for urban Aboriginal peoples to access MHA services. |
|---|---|---|
| Create healthy, resilient, and inclusive communities | • More people who are homeless or “under-housed” have stable, safe, supportive housing  
• More seniors have housing options that meet their mental health needs  
• Fewer people with a mental illness and/or | Overall vision of Good Mind.  
The 4 Urban Aboriginal Family Treatment Centers proposed by the OFIFC in 2010 will produce strong and resilient families and |
| | | |
| Earlier identification and intervention | Ontarians know the early signs and symptoms of mental illness and addiction and who to call for help.  
• Human services professionals know the early signs and symptoms of mental illness and addiction and make appropriate referrals  
• Increase the number of mental health and addiction agencies working with primary care providers  
• Ontarians receive a mental health and | This is consistent with key recommendations that the OFIFC has provided to the provincial government for a number of initiatives, including the suicide prevention and intervention services that were suggested during the Aboriginal Mental Health Discussions in 2010. The OFIFC goes further in asking that early |
| | | communities through wholistic, collective healing. |
| Timely, quality, integrated, and individual-centred services | addictions check as part of routine primary care  
- Primary care providers provide more mental health and addiction services  
- Reduced prevalence of opiate addiction  
- People with mental health and/or addiction issues receive appropriate services earlier in the course of their illness  
- Fewer people with a mental illness or addiction present at emergency departments  
- Fewer youth with mental health and/or addiction issues end up in the criminal justice system  
- More youth graduate from high school  
- Fewer youth drop out of college or university  
- Rates of attempted and completed youth suicides decrease  
- More seniors with dementia receive supportive care | identification be linked to measuring for social determinants of health and the mental health consequences of intergenerational trauma. |
| Shorter wait times for hospital-based services, fewer repeat visits to hospitals, more appropriate linkages to and referrals from the justice system, better mental health outcomes and quality of life, and decreased burden on the health care system by MHA services  
- People with lived experience and their families report better access to peer and family support  
- People with lived experience and their families report more positive experiences in their contacts with service providers  
- More people with lived | This goal aligns with Strategic Direction One of Good Mind, which strives to establish planning processes to ensure people receive integrated and individual centered services.  
During the Aboriginal Mental Health Discussions in 2010, the OFIFC suggested that the creation and/or expansion of urban Aboriginal mental health and addictions services should
experience/complex needs have a collaborative and individualized health and wellness plan used by all providers

- More mental health and addiction services can provide integrated care for people with a mental illness and an addiction (concurrent disorders)

- Shorter wait times for community-based and hospital-based mental health and addiction services

- Rates of unplanned hospital readmissions drop

- Reduced number of clients with emergency department visits (stratified by first versus repeat visits) and total number of admissions to hospital

- Fewer people with a mental illness or addiction are in long stay or alternate level of care beds in hospital

- Improved collaboration between hospital and community MHA services, housing, and social services.

- Reduce persons denied service without an assessment because of restrictive eligibility criteria

- Increased collaboration between community MHA agencies and primary care

- Increased access to MHA service through primary care teams which provide culturally competent care and peer support across the life span

- Better collaboration between police/courts and hospital/community MHA providers

- Reduced police contact with persons with MHA

be considered a priority, including the development of specialized urban Aboriginal services to support individuals who have experienced violence.
• Reduced number of youth, adults and seniors with MHA entering the justice system

B. The Federal Government

A High Profile Conversation

In 2008, the federal government apologized to the Aboriginal people of Canada for the government policy of residential schools and the resulting intergenerational trauma. Between 2006 and 2008, the federal government established The Truth and Reconciliation Commission, the Indian Residential Schools Resolution Health Support Program, and the Settlement Agreement, which included the Common Experience Payments for residential school survivors.

At the same time, the federal government closed the Aboriginal Healing Foundation, which had been created to respond to a specific recommendation of the Royal Commission for Aboriginal People and provided the only community development model for healing programs, and ended the National Organization for Aboriginal Health, which had tracked health statistics, including the relationship of health and mental health to various social determinants. The government also cut back funding to the National Aboriginal Organizations, all of whom had been working to address important mental health issues, and ended the funding to the Sisters in Spirit initiative of the Native Women’s Association of Canada, which had provided a clear and compelling story of the connection between intergenerational trauma, violence against women, and mental health. In their first month of office in 2006, the federal government cancelled the Kelowna Accord, which had committed $5-billion to addressing health, including mental health, and poverty in Aboriginal people in Canada.

The remaining programs currently administered through the federal government have experienced significant changes in policy direction and investments. Some examples include:

• The First Nations and Inuit Health Branch of Health Canada funds the National Native Alcohol and Drug Abuse Program (NNADAP) and the Non-Insured Health Benefits (NIHB) short-term, crisis intervention mental health counseling. This program and benefit are intended solely for First Nation citizens. Access and eligibility for First Nation people living off-reserve is challenging, inconsistent, and unreliable.
The Community Action Program for Children (CAPC) provides locations where families can connect with their local community and obtain information, referrals, and access to public health and social services. Programming may include family resource centres, parenting classes and drop-in child groups, home visiting, and more specialized programs, such as support for mothers dealing with substance abuse.

The mandate of the off-reserve Aboriginal component of the Canada Prenatal Nutrition Program (CPNP) in Ontario is to improve the health of Aboriginal mothers and their babies from before birth up to six months of age, and their families, by offering community based, wholistic, and culturally relevant programming. CPNP projects may provide food supplements, support, education, referral to other services, and counselling to “at-risk” pregnant women. Support counselling may address lifestyle issues that can affect the baby, such as smoking, alcohol use, and family violence.

The future of CAPC/CPNP programming is plagued with a high level of uncertainty.

The long-term commitment by the federal government towards good mental health for Aboriginal people takes a strongly individualistic approach. The government’s reliance on individual payments and individual counselling are inconsistent with the community healing, community development, and community based investments that have been called for by Aboriginal people since the Royal Commission on Aboriginal Peoples in 1996.

C. The OFIFC

The OFIFC supports Friendship Centres in offering a wide range of programs and services that are designed to address the needs of urban Aboriginal community members at all phases within the life cycle, from prenatal to elderly. Programs and services are integrated as closely as possible and target alcohol and drug abuse, FASD, children’s growth and development, homelessness, family violence, health, disability and aging, economic development, youth development, employment and training, gambling addictions, and justice. Friendship Centre staff and volunteers currently perform outreach, liaise with outside agencies, assess levels of need, and act as case managers for individuals and their families. Increasingly, all programs report having encountered clients who present with diagnosed and undiagnosed mental health concerns and concurrent disorders. Friendship Centre staff work hard to prevent, decrease risk, and provide after care support and crisis intervention.

Urban Aboriginal communities are faced with a steadily increasing demand for culturally specific and concurrent mental health services, combined with inadequate
resources to address the issue. In the absence of appropriate mental health programming to which referrals can be made, Aboriginal clients presenting with mental health issues are forced to seek help outside of the Aboriginal community, often to the detriment of their healing process. Front line workers find themselves more involved in crisis management and therefore less available to focus attention on the prevention aspects of programming. The OFIFC has previously requested funding for 4 Aboriginal Family Treatment Centres and 100 mental health and addictions workers to address this significant service gap but has not yet received the necessary response.

In addition to the administration of programs and services, the OFIFC has been consistent in responding to the frameworks, policies, programs, and initiatives that have been developed by the provincial government with the intent to respond to the mental health needs of Ontarians. However, the level of Aboriginal engagement that has been demonstrated by the provincial government has been inconsistent, ineffective, and poorly planned. An effective response to address Aboriginal mental health concerns must include these four key elements:

1. Grounded in an Aboriginal framework that reflects:
   - Culture
   - Historical trauma
   - Intersectional human rights framework
   - Legal and jurisdictional framework
   - Social determinants
2. Integrated policy and program approach
3. Work in partnership with the Aboriginal community
   - Invest in urban Aboriginal organizations
4. Build capacity of the mental health system and the organizations addressing mental health.

The following quotes are recommendations taken from different submissions that the OFIFC has offered to the provincial and federal governments in the last ten years.

1. Aboriginal Framework
   a. Cultural Framework
      - “Increased mental health and well-being of urban Aboriginal people, with holistic, self-determined, and culturally-specific MHA services across the Life Cycle that are as close to home as possible.”
   b. Historical Trauma
      - “Recognize the historical trauma that Aboriginal people have faced because of the Indian Act and the explicit link between this and current
urban Aboriginal realities and incidences of mental health and addictions issues.”

- “Recognize the isolation, racism, and loss of culture and language that is associated with being an urban Aboriginal person.”

c. Intersectional Human Rights Framework

- “Address the interconnection of social and political inclusion and gender with human rights for urban Aboriginal people.”
- “Recommend that the basic human right to adequate housing is advocated for and upheld in Ontario by all governments and service providers, especially for urban Aboriginal children, youth, and adults.”
- “Recognize the additional discrimination, racial profiling, and negative stereotypes that an urban Aboriginal faces, particularly because they are Aboriginal.”
- “Support the development of an Urban Aboriginal Mental Health Strategy in Ontario which would include a focus on human rights in regard to mental health.”

d. Legal and Jurisdictional Framework

- “Discussion about the province’s responsibility (because of Federal transfer payments to do so) to equally address the needs of all Aboriginal peoples, regardless of status or residency.”
- “Inclusion of self-determination in the (sic) guiding principles to ensure that this right was upheld in the development, implementation, delivery, and evaluation of all urban Aboriginal services, programs, and research that come out of the strategy.”

e. Social Determinants Perspective

- “Increased focus on the social determinants of health, integration, early identification and intervention, cultural appropriateness, and individual and community capacity building to ensure that the MHA needs of urban Aboriginal people are adequately represented across the Life Cycle.”

2. Integrated Policy and Program Approach

- “The Provincial government link social assistance with the actual cost of housing, review and improve its affordable housing and anti-poverty strategies to adequately address the needs of urban Aboriginal people with mental health and addictions issues, and increase social assistance rates to bring annual household incomes above the poverty line.”
- “The Federal government implement a national housing and anti-poverty strategy, including a focus on urban Aboriginal people and the role that Friendship Centres play in service provision.”
• “The Ontario government re-focus Child and Family Services funds from urban Aboriginal apprehension to improving mental health and addictions outcomes to allow urban Aboriginal children and youth to stay in their homes and communities, where they have the best chances at remaining healthy, in school, successful, and safe.”
• “Advocate for the rights of urban Aboriginal women to retain custody of their children while in a residential treatment facility, by recognizing the cultural role of family in taking over guardianship during this time.”
• “Recognize the increased involvement of apprehended urban Aboriginal children and youth in the sex trade industry due to loss of community, family, culture, and self-esteem.”
• “Increased representation of urban Aboriginal people as front line workers and decreased representation in homeless populations, the MHA system, the justice system, foster care, and social programming.”

3. Work in Partnership with the Aboriginal Community
• “Advocate for the Federal government’s support of the OFIFC’s Strategic Framework to End Violence Against Aboriginal Women, paralleling the support of the Provincial government and the recommendations by Amnesty International in 2004 to increase support, services, and programming for Aboriginal women in Canada.”
• “Work with the OFIFC to develop Aboriginal-specific human rights documents and provide the associated education and awareness through Friendship Centres.”
• “Opportunity for increased funding, political support of urban Aboriginal MHA initiatives, availability of urban Aboriginal-specific MHA programming (including but not limited to mental health and addictions workers, addiction treatment facilities, urban-based treatment lodges, regional family treatment centres, and access to the services of elders and traditional people), improved relationships and integration between urban Aboriginal and mainstream service providers, and urban Aboriginal-specific MHA policy development.”

Investment in Urban Aboriginal Organizations
• “Increased emphasis on the strengths of urban Aboriginal people in addressing their own community’s MHA needs.”
• “Recommend that the Federal and Provincial governments increase funding to Friendship Centres to allow increased program delivery to ensure that the mental health needs of urban Aboriginal people are met, without them having to seek inappropriate services from mainstream organizations.”

4. Build Capacity in the Mental Health System and in organizations dealing with
mental health

- “Recognition of the need for increased representation of urban Aboriginal people as front line MHA workers and in the development, implementation, and evaluation of all MHA policies, programs, and research that affect them and their communities.”
- “Highlight the need for mainstream organizations to be respectful of urban Aboriginal people and to work collaboratively with Friendship Centres to make sure that they receive appropriate mental health and addictions care and supports.”
- “Increase education to mainstream mental health and addictions organizations to ensure that there is an understanding of the necessity to accommodate the cultural, language, and spiritual rights of urban Aboriginal people that use their services.”
- “Recognition of the need for increased Aboriginal-specific MHA research, with a particular focus on urban Aboriginal populations which are rarely included.”
- “Work with the criminal justice system in Ontario to ensure that Gladue Principles, as per the 1999 Supreme Court of Canada’s decision in R. v Gladue that led to the implementation of s. 718.2 (e) in the Criminal Code of Canada, are respected and used in each case involving an urban Aboriginal person.”
- “Recommend mandatory, ongoing training on Gladue Principles for those persons working in all aspects of the justice system.”
- “Advocate for mandatory cultural training (administered through the OFIFC) for those providing mental health services to Aboriginal people and in charge of creating Aboriginal-specific policy and legislation.”
- “Recommend that basic standards and expected practices of mental health care and service provision for Aboriginal people are developed, implemented, and adhered to in Ontario.”

D. Aboriginal organizations and Non-Aboriginal organizations working on Mental Health

There are a variety of players that are involved in the current focus on mental health, including government, provincial organizations, and service providers. As we move toward an integrated model that addresses the social determinants of health, we will encounter the need for even more players to have the opportunity to sit at the table and provide input into this vitally important issue. Already, for governments and mental health leaders in Canada, the jurisdictional foundation of mental health service has acted as a significant roadblock to responding to the mental health needs of Aboriginal people. Relationships between federal, provincial, and regional
stakeholders must be built, coordinated, and maintained to ensure that urban Aboriginal communities receive the appropriate, timely, and accessible mental health supports that are so desperately needed.
5. The Future

A. Outcomes to strive towards

In the last ten years, the OFIFC has responded to at least ten separate initiatives around mental health produced by either the federal or provincial government. In some cases, Aboriginal people were not even recognized as a unique population that required a specific conversation and level of engagement. The OFIFC has consistently reflected a number of key recommendations. The two overriding messages communicated to the government have been:

a. Recognize the unique relationship of Aboriginal people based on history and need; and
b. Engage the Aboriginal community in solutions and in the development and implementation of mental health frameworks, policies, programs, and delivery models.

The desired outcomes in relation to good mental health for all Aboriginal people in Ontario can absolutely run parallel to and build upon the Provincial work, but it must be understood that there are crucial needs that extend well beyond “Open Minds, Healthy Minds.” The specific outcomes necessary for positive Aboriginal mental health will require thoughtful deliberation within the Aboriginal community to ensure that these outcomes are meaningful and can be integrated into the broader work being completed by the province. Two outcomes that are fundamental to the success of Aboriginal people are focused on intergenerational trauma, namely:

- An understanding throughout the mental health system of the impact of intergenerational trauma; and
- Continued and ongoing acknowledgement and treatment of intergenerational trauma until there are no symptoms of intergenerational trauma in any Aboriginal person, family, or community.

The province must begin a conversation with the Aboriginal community and those that work within the Aboriginal community to address mental health, and any work must begin with an Aboriginal framework to address the mental health and wellness of Aboriginal people. Similar to the process involved in creating “Open Minds, Healthy Minds”, this work would require thoughtful deliberation and the time to consider options. The Aboriginal mental health model that will emerge will be built upon meaningful and sustainable relationships that are capable of withstanding the
implementation challenges inevitably imposed by limited resources and difficult strategic choices.

**B. Aboriginal Mental Health Model**

A successful Aboriginal mental health model must be built on a cultural foundation, including:

a) The Life Cycle teachings that recognize that each stage of life requires unique supports to ensure full realization of responsibility and relationships to the self, family, and community; and
b) The Healing Continuum which offers clear direction on the different elements of an integrated system that is vital to the support of Aboriginal mental health.

The eight stages on the healing continuum are integrated and interconnected. The first five areas of the wheel are strongly focused on ensuring that wholistic and culturally appropriate services and programs are available to all Aboriginal people. The last three parts of the wheel examine the systems and processes that must be in place to bind this circle together as it continuously changes and evolves.

**Promotion and Prevention**

Alongside diagnosis, the promotion and prevention of mental health issues is integral to identification and intervention of mental distress and mental illness. Given that social determinants are proven to have a significant impact on mental health, it is vital, from a preventative viewpoint, that these determinants are addressed promptly, appropriately, and most of all, effectively. The use of mainstream programs that, for example, teach individuals how and where to buy healthy food while overlooking the barriers of prohibitive cost and distance, are not only ineffective, but also highly detrimental to the wellbeing of Aboriginal communities. If embedded systemic racism is not addressed, it is not possible to meaningfully prevent mental distress or support the mental health needs of Aboriginal people. There are a number of Aboriginal models of care that place equal emphasis on the community context, including the associated social determinants of health and cultural integrity, as on clinical diagnosis and response. These models need to be integrated into all promotion and prevention efforts directed towards Aboriginal people in order to ensure culturally relevancy.

**Crisis Intervention, Curative and Rehabilitative**

Once a person has experienced mental distress they will likely be exposed to a plethora of different responses. An Aboriginal integrative system response would:
• Recognize the opportunity to re-establish or build resiliency in the person and re-establish their connection to others;

• **Recognize the concurrent relationship of different diagnoses of mental illness and addictions**, in that issues often occur together and have many common connections, and for this reason, Aboriginal approaches for addressing mental health issues are often closely linked to wholistic mental wellness strategies;

• **Provide a continuum of care** with the understanding that effectively addressing mental health issues requires a collaborative and inter-connected range of services from prevention and resiliency-building, through assessment/diagnosis, various types of treatment, and case management, to aftercare;

• **Ensure culture permeates** design and delivery of services, both in treatment and in health promotion and prevention efforts that are delivered in a culturally safe way; and

• **Provide trauma informed services.**

**Promotion of Stability**

• **Leadership**: The transformation we are looking for is in each individual, family, and community. A community development model must be applied to ensure stability for all as an ongoing response to mental distress. There are many types of leaders in an Aboriginal community: formal leaders, traditional leaders (the Elders), and our emerging leaders (the youth). The service providers (often called helpers) are not always identified as “leaders” but, in the mainstream systems, are often the only people invited to provide input into the creation of frameworks and programs that will impact the entire community. All forms of leadership must be engaged in order to ensure sustainability of the change and to identify issues, gaps, barriers, and strategies for change.

• **Collaborative models of working together**: Strong relationships support stability. Protocols and tables that bring Aboriginal and non-Aboriginal agencies in mental health services together and allow partnerships to be built are a critical aspect in addressing mental health.
• **Wholistic models of planning and care:** Given Aboriginal approaches to mental wellness, it is important that the comprehensive, collaborative plan incorporate several key qualities:
  - Includes a range of both prevention and treatment programs;
  - Adopts a community-based approach that takes into account all aspects of the life cycle;
  - Addresses the social determinants of health;
  - Places importance on the integration of culture and culturally-based teachings and practices into community life and mental health services;
  - Recognizes the key role of family, including extended family, and the importance of “mainstream” services.

• **Organizational and community capacity building:** We envision that each person and family is in a circle of care where they are each held differently depending on their needs and own capacity for healing at the time. Each person, organization, and system that the individual and family comes into contact with needs to establish a relationship of cultural safety.

  “At the heart of the OFIFC’s Aboriginal Cultural Competency Training (ACCT) is the strengthening of professional relationships between urban Aboriginal and non-Aboriginal organizations and clients—a relationship built on the concept of Trust, Friendship, and Mutual Respect. Throughout the training, participants have the opportunity to build a shared understanding of contemporary priorities, the concept of allied relationships, Aboriginal wholistic healing, and the importance of infusing on-going Aboriginal cultural competencies throughout organizational practices through meaningful engagement with Aboriginal community.”
  OFIFC Aboriginal Cultural Competency Training Information Sheet, 2013

**Training**

Every person engaged in responding to the mental health needs of Aboriginal people must receive a level of training that reflects each of the key elements of the Aboriginal Mental Health Framework and respectfully challenges the person to address any biases or prejudices that could interfere with their ability to work with Aboriginal people.

**Supportive Resources**

• **Funding:** A continuous and sustained investment in key programs, services, and processes will be essential to support any model that is developed.

• **Research:** Aboriginal-driven research that illustrates and complements the Indigenous worldview will be critical in supporting and building an Aboriginal
mental health model. Further necessary research includes the impact of culture as a protective factor, cultural continuity at a community vs. individual level, and how the depth and frequency of involvement in cultural activities affects their efficacy as protective factors. The way that Indigenous research is carried out is equally important to the subject matter. Indigenous research builds capacity in individuals and communities to reclaim culture and identity, to tell their story, to be advocates for their own needs, and to create products that will work for them.

- **Address systemic barriers:** Strategies to address urban Aboriginal mental health must deal with systemic racism and discrimination, poverty, housing, food security, violence, and the other social determinants of health.

- **System wide (cross jurisdictional) collaboration and planning:** Models of health care and educational competencies must take into account the Aboriginal traditional concepts of health, and must preserve and strengthen Aboriginal health systems as a strategy to increase access to, and coverage of, equitable health care. The establishment of clear mechanisms of cooperation between health care stakeholders, educational institutions, policy makers, and government departments and Aboriginal communities and traditional healers is imperative in order to ensure responses to regulations affecting culture and traditional knowledge remain in the socio-cultural context of Aboriginal communities.

  Full and effective participation of Aboriginal communities in consultation and decision-making related to all matters of Aboriginal health is vital. Health care policies, programs, and services for Aboriginal people must be planned, designed, and developed by Aboriginal people and must be available in all necessary locations as identified by Aboriginal communities.

**C. A time to move forward**

The Ontario Federation of Indian Friendship Centres is uniquely positioned to initiate and support the development of a strong response to the mental health needs of urban Aboriginal people. In addition to facilitating more than 50 specific service sites throughout Ontario that address the needs of urban Aboriginal people, the OFIFC has acted as a leader in continuing the conversation around urban Aboriginal mental health. The OFIFC has consistently provided the provincial and federal governments, as well as mental health stakeholders, with recommendations in response to their varied initiatives throughout the past ten years. These recommendations have included an Aboriginal-specific mental health and addictions strategy, creation and/or expansion of urban Aboriginal mental health and addictions services (including Urban Aboriginal Family Treatment Centers), and specialized services to address suicide.
prevention/intervention and experiences of violence, among others. With our understanding of systemic issues and the nature of intergenerational trauma, we know that the battle for optimal well-being of all urban Aboriginal people will be long-term and likely fought uphill. However, the time has come to invest in Ontario’s future by beginning a new journey, one that stems from and moves with the Aboriginal community. It is time to turn to Aboriginal people, the true experts on Aboriginal mental health, to construct a meaningful response to the mental health issues that are currently being faced by Ontario’s urban Aboriginal community.
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