

Mi'kmaq • Nova Scotia • Canada

TRIPARTITE FORUM

**HEALTH WORKING COMMITTEE**

# Exploring Health Priorities in First Nation Communities in Nova Scotia



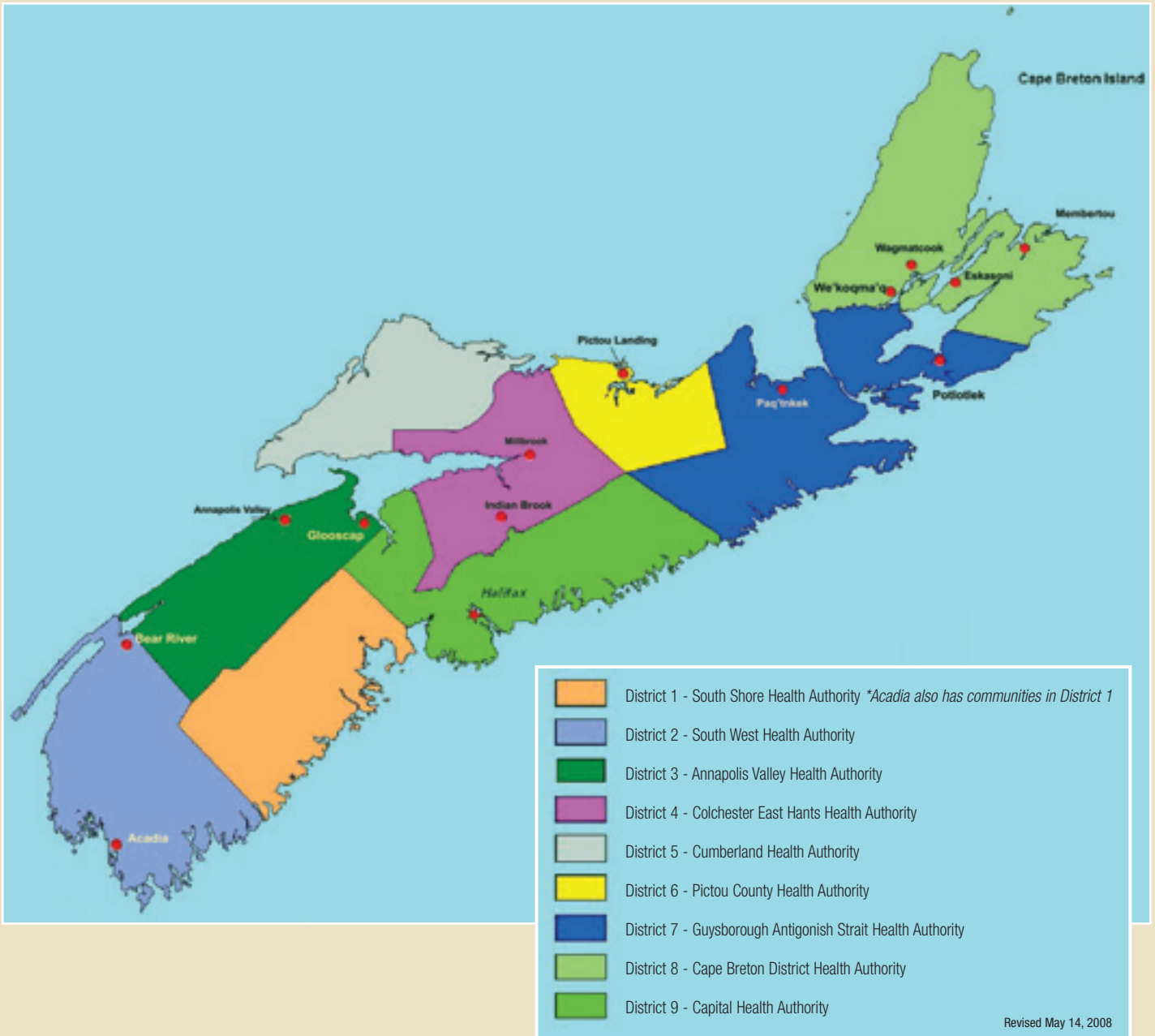
SUBMITTED BY:

**HORIZONS**  
COMMUNITY DEVELOPMENT ASSOCIATES INC.

OCTOBER 2008



## Nova Scotia Health Districts (2006) and First Nation Communities



### Disclaimer

The content contained in the current report reflects the views of First Nation communities, First Nation youth, and health system partners who provided input into the current project, and not necessarily the views of the Tripartite Forum or its Health Working Committee.

This report is not intended to serve as a comprehensive account of the progress made towards addressing the recommendations outlined in the "Providing Health Care, Achieving Health" report, nor is it intended to cover all the work being done to address First Nation health issues since 2005. Rather, it is meant to highlight the knowledge and experiences shared by participants. It is offered as a planning tool for communities and health system partners who are working to address the health needs of First Nation communities in Nova Scotia.





## Acknowledgements

### **Message from the Co-Chairs of the Tripartite Forum Health Working Committee**

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In 2005, the **Tripartite Forum's Health Working Committee** directed a community engagement process to inform the Nova Scotia submission to the National Aboriginal Blueprint. The resulting report, *Providing Health Care, Achieving Health*, was submitted as input into the National Aboriginal Health Blueprint and distributed as a tool for advancing the health of Aboriginal people in Nova Scotia.

This report builds upon the 2005 work to identify the current health priorities, needs, and challenges of Mi'kmaq people in Nova Scotia. While it does not constitute a formal reporting of progress made since the recommendations in the 2005 report, it does give us a sense of the local successes and opportunities for addressing the 2005 recommendations, as well as current health priorities for Nova Scotia Mi'kmaq communities.

The key health priorities for each of the three groups of project participants – First Nation community members, First Nation youth, and health system partners – are outlined in separate sections of the following report (detailed results are attached as appendices), with the overall project trends described in the discussion and conclusions section. We encourage First Nation communities and partners to broadly share the results of this project and use the information contained in the report as a tool for planning for First Nation health in Nova Scotia.

We would like to extend a sincere thank you to all the First Nation community members, Elders, youth, Health Directors, and partners who contributed their time and knowledge to this project – without you we would not have been able to provide the rich, insightful information contained in this report.

Special thanks go out to the project Sub-committee members for their support and guidance throughout this project, in particular Janet Pothier (Health Advisor, The Confederation of Mainland Mi'kmaq) for her role in working with the Health Directors and acting as a liaison between the project and our partners at The Confederation of Mainland Mi'kmaq and the Union of Nova Scotia Indians.

We would also like to acknowledge the funders for this project – The Mi'kmaq-Nova Scotia-Canada Tripartite Forum, Health Canada (First Nations and Inuit Health), and the Nova Scotia Department of Health.

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#### **Darlene Paul**

Mi'kmaq Co-Chair

#### **Paula English**

Provincial Co-Chair

#### **Wade Were**

Federal Co-Chair





## Acknowledgements

### Message from the Project Consultants

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Sincere thanks to the Tripartite Forum Health Committee and its Co-Chairs for strategic guidance throughout the course of this work: Darlene Paul (Mi'kmaq Co-Chair); Paula English (Provincial Co-Chair); and Wade Were (Federal Co-Chair). We appreciate your review and feedback on the design and implementation of the process, and especially the openness and flexibility required to ensure that the work was conducted in a manner that placed First Nation communities at its centre.

The Tripartite Forum Health Committee project Sub-committee members played a key role in guiding this process from beginning to end. You provided good advice and direction and also helped problem-solve as challenges arose. We appreciate your commitment to learning and your respect for First Nation communities. Sincere thanks to the project Sub-committee: Bernice Martin (former Senior Policy Analyst, Aboriginal Health, Nova Scotia Department of Health); Janet Pothier (Health Advisor, The Confederation of Mainland Mi'kmaq); Kirstin Nucklaus (current Senior Policy Analyst, Aboriginal Health, Nova Scotia Department of Health); Maria Kuttner (Director, Primary Health Care, Nova Scotia Department of Health); Nicole Priddle (Policy Advisor, First Nations and Inuit Health, Health Canada); and Sally Schafer Gibbs (Acting Senior Policy Analyst, Policy and Intergovernmental Relations, Health Canada).

Special thanks to Sub-committee member Nicole Priddle, who acted as the point person for the project, for your thorough and thoughtful feedback and support, and especially for your willingness to learn with us throughout the process.

Special thanks also to Sub-committee member Janet Pothier for acting as liaison between The Confederacy of Mainland Mi'kmaq Health Directors and *Horizons*, and for asking good critical questions all along to help keep the process on track for communities. Our thanks also go to Health Committee Co-Chair Darlene Paul, who acted as a liaison between *Horizons* and the Union of Nova Scotia Indians Health Directors.

The Health Directors (and/or their counterparts) played a pivotal role in this process, and it couldn't have happened without you. Thank you to all Health Directors for your willingness to arrange and promote the sessions in your communities, and for giving us advice about whether/how to best proceed in your community. We respect and appreciate the generosity of your time and community expertise very much.

We extend our respect and sincere appreciation to the Elders who blessed the sessions with prayers and your wisdom.

Finally, and most importantly, our deepest thanks and appreciation goes to everyone who participated in the process. Thank you for sharing your time and knowledge by coming to the community sessions and by responding to the web surveys. We appreciate the gift of your hope, your belief in your communities, and your bravery – thank you for sharing your stories with us and trusting us to take them forward. We do so with great respect.

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**Cari Patterson, Jean Robinson-Dexter, and Melissa Neil**





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## Report Summary

### Background & Context

The Mi'kmaq-Nova Scotia-Canada Tripartite Forum (the Tripartite Forum) was formed in 1997 as a partnership between the Nova Scotia Mi'kmaq, the Province of Nova Scotia, and the Government of Canada. Its purpose is to strengthen relationships and resolve issues of mutual concern affecting the 13 Mi'kmaq communities in the province.

In 2005, a sub-group of the Health Working Committee (HWC) led a community engagement process to inform the Nova Scotia submission to the National Aboriginal Blueprint. Over an eight-week period, six meetings were held throughout the province to collect input about Mi'kmaq health concerns. The resulting report, *Providing Health Care, Achieving Health*, was submitted by the Tripartite Forum as input into the National Aboriginal Health Blueprint.

It should be noted that the process used in the *Providing Health Care, Achieving Health* project was limited and was not widely supported by some First Nation partners. Challenges with the 2005 process included:

- Five community-based meetings and one provincial meeting were held, and all input was combined. All 13 First Nation communities were invited to participate in one of the sessions; however, since each community did not have its own session, individual community-based recommendations did not emerge from the process;
- Fifty-eight recommendations for addressing First Nation health issues emerged from the 2005 process – none of which were prioritized for easy use by health system planners and First Nation communities; and
- The language used for the 2005 recommendations was not particularly easy to interpret and use at the community level.

The HWC acknowledges these challenges, and designed the current project to enhance the process used in 2005. The purposes of the current project were to:

- Hold community discussions on First Nation health issues with all communities and health partners;
- Identify current health priorities to inform health planning;
- Explore and prioritize current priorities, and compare them with the 2005 health priorities;
- Identify existing strengths and challenges to addressing health priorities, and what is needed to address health priorities; and
- Share what is heard broadly among First Nation communities and health partners to inform their health planning efforts.

### Methodology

The current project used three methods of gathering input:

1. **Community engagement sessions** – held in 12 of 13 First Nation communities in NS;
2. **Youth web surveys** – 49 completed surveys with youth from all 13 First Nation communities in NS; and
3. **Health system web surveys** – 63 completed surveys with partners who work with and/or represent First Nation communities in NS (survey response rate was 35.8%; all 13 First Nations were represented).







## Report Summary

These methods allowed the HWC to apply lessons learned in 2005, and ensure greater opportunities for dialogue with First Nations and health system partners. For example, the current project: *a)* offered opportunities for input from as many First Nations who wished to participate; *b)* allowed for a flexible dialogue approach to suit the needs of participants; *c)* provided a dedicated method of gathering input from First Nation youth (i.e., a web survey); and *d)* provided opportunity for input from a broad range of health system partners (i.e., through a web survey).

### Summary of Results

The following table provides an overview of the key results of the project – the top health priorities are listed, the method(s) in which the priority was identified are highlighted, and any overlap with the 2005 *Providing Health Care, Achieving Health* recommendations is noted.

Health Priority	Identified Issue as a Priority in Which Methods?			Identified as a Priority in the 2005 Report?	
<b>Mental Health</b> (#1 priority)	Community Engagement Sessions	✓	Page 15	✓	<i>Providing Health Care, Achieving Health</i> Pages 48 & 49
	Youth Web Surveys	✓	Page 63		
	Health System Web Surveys	✓	Page 71		
<b>Addictions/ Substance Abuse</b> (#2 priority)	Community Engagement Sessions	✓	Page 23	✓	<i>Providing Health Care, Achieving Health</i> Page 53
	Youth Web Surveys	✓	Pages 61, 62, 64 & 65		
	Health System Web Surveys	✓	Page 80		
<b>NIHB Coverage</b> (tied #3 priority)	Community Engagement Sessions	✓	Page 34	✓	<i>Providing Health Care, Achieving Health</i> Pages 49 & 51
	Youth Web Surveys	✗			
	Health System Web Surveys	✓	Page 90		
<b>Elder Care</b> (tied #3 priority)	Community Engagement Sessions	✓	Page 35	✓	<i>Providing Health Care, Achieving Health</i> Page 49
	Youth Web Surveys	✗			
	Health System Web Surveys	✓	Page 73		
<b>Obesity-Related Issues</b> (tied #3 priority)	Community Engagement Sessions	✓	Page 44		<i>Providing Health Care, Achieving Health</i> X
	Youth Web Surveys	✓	Page 66		
	Health System Web Surveys	✗			
<b>Funding</b> (tied #3 priority)	Community Engagement Sessions	✓	Page 54	✓	<i>Providing Health Care, Achieving Health</i> Page 47
	Youth Web Surveys	✗			
	Health System Web Surveys	✓	Page 82		

### Mental Health – #1 Priority

Mental health was rated as the number one overall top priority – it was identified as a priority in the community engagement sessions (10 communities, 83.3% of communities), the youth web survey (question 7 – 14 responses, 5.5% of responses), and the health system web survey (question 7 – 23 responses, 19.8% of responses).





## Report Summary

### What are the Community Impacts?

#### Community Engagement Sessions:

- Social impacts (e.g., crime; violence);
- Emotional impacts (e.g., rising stress/anxiety levels; anger; tolerance/numbness to tragic events); and
- Economic impacts (e.g., people are unable to work; people are more dependent on social assistance).

### What are the Challenges?

#### Community Engagement Sessions:

- Access to services (e.g., lack of on-reserve services; transportation challenges; wait times; access to information on what services are available);
- Service delivery (e.g., application forms are only quickly accessible to those with Internet access; after-hours services are not available; confidentiality concerns; lack of standard policies/procedures; NADACA workers need to see people several times before they can make a referral<sup>1</sup>);
- Lack of funding, infrastructure, and human resources to deliver mental health services;
- Need for culturally-safe prevention and treatment services; and
- Individual factors/stigma (e.g., people are in denial or too proud to seek help).

#### Youth Web Surveys:

- Youth do not have anyone to talk to; and
- Youth are unsure about where to find someone to talk to.

#### Health System Web Surveys:

- Mental health is an under-recognized issue in First Nation communities.

### Is There Overlap with the 2005 Report Recommendations?

Mental health services and facilities were also identified as priority issues in the 2005 report:

*“Access to mental health services, particularly in the area of crisis intervention and treatment programs for children and youth is lacking in urban and rural settings alike.” (page 48)*

*“Residential mental health facilities for youth in Atlantic Canada, with a focus on culturally relevant prevention, education, assessment, treatment and community-based follow up are lacking.” (page 49)*





## Report Summary

### What is Working Well?

#### Community Engagement Sessions:

- Human resource and staffing supports for mental health issues (e.g., NADACA workers; mental health and addictions professionals; Community Health Nurses; youth workers; other health professionals who make referrals);
- Support groups (e.g., groups run by Community Health Nurses; Alcoholics Anonymous; Narcotics Anonymous; youth groups);
- Mental health promotion/prevention supports (e.g., prevention programs run by Community Health Nurses; information through workshops, sessions, and newsletters);
- 'Safe houses' for people in crisis (in larger communities); and
- Strong supports for people in crisis from other community members.

#### Youth Web Surveys:

- Mental health promotion/prevention supports (e.g., programs to prevent youth stress/suicide).

#### Health System Web Surveys:

- Mental health programs;
- Aboriginal Health Transition Fund (AHTF) proposal (under development) for a Mental Health and Addictions Prevention and Promotion Initiative; and
- Implementation of the National Aboriginal Youth Suicide Prevention Strategy.

### What is Needed?

#### Community Engagement Sessions:

- Culturally-safe services (i.e., services relevant to language, culture, and life experiences);
- Traditional/holistic services (e.g., sweats; massage therapy; reflexology; acupuncture; naturopathic services; natural supplements; spirituality);
- Increased access to mental health services (e.g., after-hours services; on-reserve services; community outreach services; additional mental health professionals; transportation to services);
- Funding, infrastructure, and human resources to deliver more mental health services;
- Mental health promotion programs; and
- Increased awareness/education about mental health issues.

#### Health System Web Surveys:

- Increased access to mental health services (e.g., programs for children, youth, adults, and Elders; suicide prevention programs; teen stress and suicide programs); and





## Report Summary

- Mental health patient navigation services.

### Addictions & Substance Abuse – #2 Priority

Addictions and substance abuse was rated as the number two overall priority – it was identified as a priority in the community engagement sessions (9 communities, 75.0% of communities), the youth web survey (question 7 – 22 responses, 8.7% of responses; question 9 – 19 responses, 9.4% of responses) and the health system web survey (question 11 – 12 responses, 10.7% of responses).

### *What are the Community Impacts?*

#### Community Engagement Sessions:

- Links between addictions and mental health issues;
- Prescription drug abuse;
- Social impacts (e.g., crime; violence; teen pregnancy; bullying);
- Emotional impacts (e.g., stress; anxiety; mental abuse; suicide);
- Family impacts (e.g., negative role modeling; abuse);
- Physical impacts (e.g., poor health and nutrition; FAS/FAE; sexually transmitted infections); and
- Economic impacts (e.g., lower motivation to work and go to school).

### *What are the Challenges?*

#### Community Engagement Sessions:

- Access to services (e.g., transportation challenges; after-hours services are not available);
- Service delivery (e.g., confidentiality concerns; NADACA workers need to see people several times before they can make a referral; narcotics are being over-prescribed and are covered by non-insured health benefits; application forms are only quickly accessible to those with Internet access);
- Lack of funding resources to deliver addictions services;
- Need for culturally-safe prevention and treatment services;
- Need for positive role-modeling; and
- Individual factors (e.g., people are in denial).

#### Youth Web Surveys:

- Drugs and alcohol are easily accessible in communities.





## Report Summary

### Is There Overlap with the 2005 Report Recommendations?

Prescription drug abuse was also identified as a priority issue in the 2005 report:

*“The Tripartite Forum Chair should communicate with the President of the College of Physicians and Surgeons of Nova Scotia to invite that group to partner with the First Nations and Inuit Health Branch, the province and Aboriginals to address the issue of prescription drug abuse.” (page 53)*

*“The First Nations and Inuit Health Branch, First Nations, and the province should continue to work together to flag the drugs that are being over-prescribed in the system.” (page 53)*

### What is Working Well?

#### Community Engagement Sessions:

- Traditional teachings and sweat lodges to address addictions/substance abuse;
- Networking with other agencies to address addictions/substance abuse;
- Support/self-help groups (e.g., Alcoholics Anonymous; Narcotics Anonymous);
- NADACA workers and other addictions professionals;
- Medical drivers available to take people to detox/rehab;
- A fully staffed RCMP detachment; and
- Electronic patient records to make it harder to ‘double-doctor’ narcotics prescriptions.

#### Youth Web Surveys:

- Support groups (e.g., Alcoholics Anonymous);
- NADACA workers and other addictions professionals; and
- Youth addiction prevention programs (e.g., Cultural and Recreational Youth Program; DARE Program).

#### Health System Web Surveys:

- The College of Physicians and Surgeons of NS, First Nations and Inuit Health Branch, and the Atlantic Policy Congress of First Nation Chiefs have partnered on prescription drug abuse work;
- NIHB provides First Nations with drug profiles related to prescription drug abuse; and
- AHTF proposal (under development) for a Mental Health and Addictions Prevention and Promotion Initiative.





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### What is Needed?

#### Community Engagement Sessions:

- Increased access to addictions services (e.g., additional staff/professionals; after-hours services; on-reserve services; community outreach services; programs for youth; transportation to services);
- Culturally-safe services (i.e., services relevant to language, culture, and life experiences);
- Funding, infrastructure, and human resources to deliver more addictions services;
- Mental health promotion programs (i.e., mental health and addictions are closely related issues);
- Increased awareness/education about addictions issues; and
- Parenting programs.

#### Youth Web Surveys:

- Drug rehabilitation centre.

#### Health System Web Surveys:

- Plans for addressing prescription drug abuse issues (e.g., data/information on drug prescribing trends; tightened controls on prescribing behavior; partnerships between the Tripartite Forum and the College of Physicians and Surgeons of NS).

### NIHB Coverage – #3 Priority

Non-insured health benefits (NIHB) coverage tied for the number three overall priority – it was identified as a priority in the community engagement sessions (5 communities, 41.7% of communities) and the health system web survey (question 17 – 17 responses, 16.5% of responses).

### What are the Community Impacts?

#### Community Engagement Sessions:

- Health impacts (e.g., people are getting sicker because medications/services are not covered; less effective generic drugs are being prescribed; alternative therapies are not covered);
- Financial impacts (e.g., reimbursements are slow; people sometimes can't pay up front for drugs/services; up-front payments are taking money away from other needs);
- Challenges with the administration of benefits (e.g., lengthy approval process for non-generic drug prescriptions);
- Confusion about coverage (e.g., people don't know what is/is not covered; coverage changes happen without notice); and
- Impacts on other programs (e.g., Band helps to pay for services/drugs not covered by NIHB at the expense of other community programs).





## Report Summary

### What are the Challenges?

#### Community Engagement Sessions:

- Funding (e.g., Bands are having to fund drugs/services not covered by NIHB; Bands do not have enough funding to meet the demand);
- Administration of benefits (e.g., too much paperwork required; doctors charge fees to do paperwork; delays in finding a prescription on the approved list);
- Lack of coordination between NIHB and other health plans; and
- NIHB system is difficult to navigate (e.g., lack of information on travel benefits; confusion about who qualifies for what services/medications).

#### Health System Web Surveys:

- NIHB prescription drug appeals take too long – people need their drugs immediately.

### Is There Overlap with the 2005 Report Recommendations?

NIHB coverage was also identified as a priority issue in the 2005 report:

*“The appeal process and the time of emergency drug coverage under NIHB are inadequate and should be extended to match the time required for appeal.” (page 49)*

*“The First Nations and Inuit Health Branch and the Atlantic Policy Congress of First Nations Chiefs should be supported in continuing to gather specific information from the communities on the issue of prescriptions not covered in the approved drug list. Data should be collected to determine the prevalence of the problem as well as the prescriptions to which it most commonly relates. As part of the solution, this should result in an education program designed to provide physicians and pharmacists with alternatives where appropriate.” (page 51)*

### What is Working Well?

#### Community Engagement Sessions:

- Bands provide funding to address gaps in NIHB coverage;
- NIHB provides travel coverage for specialist services (e.g., transportation; lodging; meals);
- NIHB works to identify ‘double-doctoring’ of prescriptions; and
- Service providers (e.g., pharmacists) act as advocates by suggesting alternative medications and try to ‘better the system’ by identifying challenges with health benefits.





## Report Summary

### *What is Needed?*

#### **Community Engagement Sessions:**

- Better administration of benefits (e.g., doctor autonomy to prescribe what they feel is necessary; coordination with other health insurance programs; updated and publicized coverage/reimbursement guidelines);
- NIHB system navigator (i.e., someone who speaks in user-friendly, non-technical terms); and
- Increased funding (e.g., more funding to cover more services/drugs; fewer cutbacks).

#### **Health System Web Surveys:**

- Increased funding for insured health benefits (e.g., more funding to cover more services/drugs; fewer cutbacks); and
- Fair appeals process for those who are denied benefits.

### **Elder Care – #3 Priority**

Elder care tied for the number three overall priority – it was identified as a priority in the community engagement sessions (4 communities, 33.3% of communities) and the health system web survey (question 7 – 11 responses, 9.5% of responses).

### *What are the Community Impacts?*

#### **Community Engagement Sessions:**

- Isolation of Elders (e.g., health limits their ability to participate in community programs; they often have to live away from their families/communities in order to get service);
- Safety of Elders (e.g., lack of safe housing; lack of appropriate, safe home care; abuse from family members);
- Increasing demand for services for Elders (e.g., Bands do not have enough funds to meet the demand; home care cannot meet the demand); and
- The need for transportation supports (e.g., Elders sometimes do not have transportation to off-reserve services).

### *What are the Challenges?*

#### **Community Engagement Sessions:**

- Jurisdictional issues (e.g., confusion about who is responsible for what services);
- Lack of community-based supports (e.g., family supports; assisted living facilities; long-term care facilities); and
- Limited staffing and resources available for Elder services.







## Report Summary

### ***Is There Overlap with the 2005 Report Recommendations?***

Elder care was also identified as a priority issue in the 2005 report:

*“While cultural competency is an issue that touches almost every Aboriginal person at some point in their lives, it was pointed out that a culturally competent elder care program may be one of the highest health care support considerations.” (page 49)*

### ***What is Working Well?***

#### **Community Engagement Sessions:**

- Elder activities/groups (e.g., seniors' groups/clubs, trips, and dinners);
- Home care and community care;
- Transportation to medical appointments (available to many Elders); and
- The Lifeline program (for the emergency health needs of Elders).

### ***What is Needed?***

#### **Community Engagement Sessions:**

- Increased Elder services/supports (e.g., home care; system for checking on the welfare of Elders; long-term care facilities);
- Culturally-safe services (i.e., services relevant to language, culture, and life experiences);
- Community Elder centre;
- Financial and human resources to offer more Elder services; and
- Plans to prepare for the future needs of the growing aging population.

#### **Health System Web Surveys:**

- Increased health care services for Elders; and
- Strategic plans to address the growing demand for Elder care services.

### **Obesity-Related Issues (Physical Activity & Healthy Eating) – #3 Priority**

The obesity-related issues of physical activity and healthy eating tied for the number three overall priority – they were identified as a priority in the community engagement sessions (3 communities, 25.0% of communities) and the youth web survey (question 9 – 14 responses, 6.9% of responses).





## Report Summary

### *What are the Community Impacts?*

#### **Community Engagement Sessions:**

- Physical impacts (e.g., poor health; increases in chronic diseases, such as heart disease and diabetes; increases in obesity); and
- Financial impacts (e.g., people cannot afford to buy healthy foods).

### *What are the Challenges?*

#### **Community Engagement Sessions:**

- Lack of an on-reserve community nutritionist; and
- Need for more 'structured' physical activity programs for children/youth.

### *Is There Overlap with the 2005 Report Recommendations?*

Although these issues were not explicitly identified as priorities in the 2005 report, a related issue – community diabetes education programs – was identified as a priority:

*Core funding for diabetes education programs at the community level is lacking.” (page 50)*

### *What is Working Well?*

#### **Community Engagement Sessions:**

- Diabetes work (e.g., diabetes working group; school sessions on diabetes; individual nutritional counselling; diabetes workshops);
- Healthy eating and recreation groups for children/youth (e.g., Klubs for Kids; Kids in the Kitchen);
- Union of Nova Scotia Indians nutritionist;
- Meal support programs (e.g., a program funded by the Gaming Commission; home care meal programs);
- Food bank; and
- Canada Prenatal Nutrition Program workshops.

#### **Youth Web Surveys:**

- Physical activity programs for youth (e.g., recreation; sports; summer games); and
- Community youth centre.





## Report Summary

### *What is Needed?*

#### **Community Engagement Sessions:**

- Financial and human resources to offer programs;
- Dietitian or nutritionist to help people learn healthy eating habits; and
- Community survey to determine what wellness programs members need.

#### **Youth Web Surveys:**

- More youth activities; and
- More sports teams.

### **Improved Funding for Health Services – #3 Priority**

Improved funding for health services tied for the number three overall priority – it was identified as a priority in the community engagement sessions (3 communities, 25.0% of communities) and the health system web survey (question 7 – 16 responses, 15.4% of responses).

### *What are the Community Impacts?*

#### **Community Engagement Sessions:**

- Insufficient funding for appropriate programs and services (e.g., some programs not being offered and services not being available);
- Insufficient NIHB coverage (e.g., for some health procedures needed);
- The Band having to absorb costs to subsidize health services (usually redirecting funds from other programs and services);
- Negative impacts on community members (e.g., isolation and/or low self esteem, not being able to access programs/services probation orders require them to participate in ); and
- Cultural safety (e.g., not being able to access services relevant to culture, language, and life experiences).

### *What are the Challenges?*

#### **Community Engagement Sessions:**

- A perceived lack of commitment for stable, adequate funding from the federal government;
- The Band being forced to draw on other revenue to subsidize health services and programs;
- Not being able to offer some programs and services;
- Lack of transportation to services outside the community; and
- A lack of cultural safety in terms of the way services are offered outside the community.





## Report Summary

### Health System Web Surveys:

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- Reduced funding, tightened budgets, and/or a lack of resources;
- Funding formulas do not support First Nation access to the health services people need; and
- Cutbacks are creating a burden on grassroots people/projects trying to address the health issues in First Nations.

### Is There Overlap with the 2005 Report Recommendations?

Funding was also identified as priority issues in the 2005 report:

*“As a health strategy is seen through many cultural lenses, the health care system and the bureaucracy that shapes it are, perhaps inevitably, predisposed to episodic, crisis oriented, short term “fixes”. This culture is reflected in the approach to funding, which is heavily biased in favour of interventions and “grants” rather than to capacity building, prevention and long-term (core) development. This approach to funding is directly translated into the approach to health service planning and delivery, which tends to be based more on the opportunistic pursuit of program-specific resources than on a strategy that addresses identified health needs. Compounded by the Auditor General’s finding that some First Nation communities are required to complete more than 200 annual reports in order to comply with grant-driven accountability frameworks, and the magnitude of inefficiency and lost opportunity is apparent. Project activity is important but should not be the basis upon which local health care systems are planned, managed and delivered. Communities require sustained ‘core’ funding based on locally identified priorities in order to long-term health impacts.”*  
(Providing Health Care, Achieving Health, page 47)

### What is Working Well?

#### Community Engagement Sessions:

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- Bands address the funding gaps however they can to make sure community members get the health services they need (this often means the Bands are redirecting funds intended for other programs and services); and
- Communication between departments, Band staff, community members, and outside organizations can help bring in proper resources to offer services and programs.

### What is Needed?

#### Community Engagement Sessions:

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- Increased funding by the federal government (e.g., to offer more services);
- Funding for transportation (i.e., to access services outside the community); and
- Cultural safety (i.e., programs and services relevant to people’s language, culture, and life experiences).





## Report Summary

### Health System Web Surveys:

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- Long-term, stable funding and resources;
- Committed funding;
- Additional funding to ensure equitable health care services for First Nation communities;
- Additional funding for health care providers who serve both on-reserve and off-reserve populations; and
- Revised funding formulas to address First Nation health issues (e.g., shifting from rigid funding criteria to criteria that address the actual needs of individual communities).

### Considerations for Future Health Planning

Several considerations based on the health priorities identified in the current project are offered to First Nation communities, organizations, the Tripartite Forum Health Committee, and other health-system partners who may decide to incorporate them into their own health planning processes:

#### Mental Health Considerations

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- Continued focus is needed on community-based mental health crisis services for First Nation Elders, adults, and youth; and
- Community-based suicide prevention and mental health promotion programs should continue to be resourced, as they are important supports for First Nation communities in Nova Scotia.

#### Addictions/Substance Abuse Considerations

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- The Tripartite Forum and its partners should continue to address the issue of prescription drug abuse in First Nation communities in Nova Scotia;
- Consideration should also be given to developing initiatives for First Nation Elders, adults, and youth to address illicit drug use, solvent use, and alcohol abuse issues; and
- Stable funding and resources should be in place to support the important role that NADACA workers are playing to address addictions/substance abuse issues in First Nation communities in Nova Scotia.

#### NIHB Coverage Considerations

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- The issue of non-insured health benefits for First Nation communities in Nova Scotia should be addressed in a timely and proactive manner – many Bands are having to cover the costs of their members' medication and health transportation services, hindering their ability to resource other much-needed programs in their communities.

#### Elder Care Considerations

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- Elder care continues to be an important issue for First Nation communities in Nova Scotia – a range of culturally-appropriate, community-based services are needed to address the holistic needs of First Nation Elders; and





## Report Summary

- A number of successful programs/services for Elders currently exist in First Nation communities in Nova Scotia (e.g., Lifeline; medical transportation programs) – consideration should be given to opportunities that will allow communities and organizations to share what is currently working in the area of Elder care.

### Obesity-Related Considerations

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- Physical activity and healthy eating issues reflect a concern by Nova Scotia First Nations about the physical health of their community members (i.e., obesity rates; diabetes rates) – access to physical activity facilities, social marketing, and programs to address the physical activity and nutrition/healthy eating needs of First Nation Elders, adults, youth, and children all need to be considered.

### Funding-Related Considerations

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- Communities and health system partners identified the need for improved and committed funding for health services. Consideration should be given to working towards (or working together for) the development of a model for transparent, stable funding for health services that is accessible to all communities and based on a broad understanding of health and healthy communities.
- Within the development of a funding model, consideration should be given to incorporating core levels of service and programs (e.g., mental health, early childhood development), as well as ensuring communities strengths, priorities and needs can be addressed. This would reflect the understanding the communities have common areas of service, but also that communities are different – in size, demographics, service provision to on and off – reserve members, and health issues they wish to address.
- Concern about cultural safety was also expressed by communities. Consideration should be given to strengthening the cultural competence of health care workers providing service to First Nation communities.

### Consultant Reflections

Throughout this project, the consultants have had an ongoing dialogue with communities, with each other, and with project Sub-committee members about the experience of doing the community engagement process. Reflections from these discussions are shared here for consideration in future planning processes with First Nation communities:

- When the Health Directors were approached to invite their communities to participate in this process, a number expressed a sense of 'here we go again' or 'our communities are studied and focus-grouped to death'. They agreed to participate based on the hope and belief that something positive for their communities could come out of this process (e.g., strategic actions by planners; input from community members to inform their own health plans; engaging a variety of people in discussions so they could learn from each others' perspectives).
- Many community members have experienced processes where outsiders come to their community, gather the information they need, and vanish into thin air. Throughout this process, Health Directors and session participants have emphasized the importance of the information coming back to their communities, and not 'sitting on a shelf somewhere gathering dust' (i.e., all communities want to see the results of this process; several mentioned the importance of having someone discuss the findings with them and what they mean for them in their context).





## Report Summary

- Due to the challenging dynamic of a First Nation community having a non-First Nation outsider asking their community for information, it was helpful to have The Confederacy of Mainland Mi'kmaq (CMM) Health Advisor and one of the Union of Nova Scotia Indians (UNSI) Health Directors acting in a liaison role between the consultants and the Health Directors. As trusted colleagues with whom the Health Directors have long-standing relationships, they were able to lay the groundwork so that the Health Directors would know what to expect, and could appreciate the value of participating in this process. They were also able to provide guidance and advice to the consultants about how to best approach the Health Directors, and about balancing determination with respect for community processes and ways of doing things.
- Creating processes that are transparent and inclusive of communities and their perspectives is very important for building trusting relationships over the long-term, and for ensuring the integrity of the data reported. The process of asking First Nation communities to review and approve the summaries of their discussions about health priorities, and the process of inviting Health Directors and Chiefs and Councils to review a draft of this report demonstrate respect and openness to communities and their perspectives.

## Next Steps

The Tripartite Forum Health Working Committee has developed a distribution plan to broadly share the results of this project. It is anticipated that the distribution of the information will help raise awareness about First Nation health priorities and support actions that effectively respond to the health priorities of First Nation communities in Nova Scotia.







# 1 INTRODUCTION & BACKGROUND

Mi'kmaq • Nova Scotia • Canada

TRIPARTITE FORUM

**HEALTH WORKING COMMITTEE**

## *Exploring Health Priorities in First Nation Communities in Nova Scotia*



**HORIZONS**  
COMMUNITY DEVELOPMENT ASSOCIATES INC.



## Introduction & Background

### Health Service Context

The Canadian Health System shares responsibilities among several partners – federal and provincial and territorial governments, communities, and health practitioners<sup>2</sup>. First Nation communities are diverse and the health programs and resources for people on reserve come out of planning, delivering, and evaluating within this complex environment. The partners who share the commitment to improving the health of First Nations can find direction for their work by confirming and broadly distributing what they learn about current priorities for First Nation communities in Nova Scotia.

### The Mi'kmaq-Nova Scotia-Canada Tripartite Forum<sup>3</sup>

The Mi'kmaq-Nova Scotia-Canada Tripartite Forum (the Tripartite Forum) was formed in 1997 as a partnership between the Nova Scotia Mi'kmaq, the Province of Nova Scotia, and the Government of Canada. Its purpose is to strengthen relationships and resolve issues of mutual concern affecting the 13 Mi'kmaq communities in the province<sup>4</sup>.

The Tripartite Forum is comprised of the following committee levels:

- Executive Committee;
- Officials Committee;
- Steering Committee; and
- Working Committees (i.e., Culture & Heritage; Economic Development; Education; Health; Justice; Social; and Sports & Recreation).

Each committee level has representation from the three parties – the Nova Scotia Mi'kmaq; the Province of Nova Scotia; and the Government of Canada. All parties agree to work together by consensus to discuss and resolve issues of mutual concern.

### The Health Working Committee

The Health Working Committee (HWC) is one of the Tripartite Forum's seven working committees. Its mandate is to identify, discuss, provide recommendations on, and take action to improve the health of Mi'kmaq communities and individuals in Nova Scotia. The work of the HWC is guided by the principles of equity, transparency, confidentiality, and cultural relevance. Each year, the HWC establishes objectives that are aligned with the Strategic Directions set by the Executive Committee.

### Background and Rationale for the Current Project

In the fall of 2005, a sub-group of the HWC lead a community engagement process to inform the Nova Scotia submission to the National

<sup>2</sup> The federal government provides funding through cash and tax transfers to the provinces/territories, to help pay for health care services. Health Canada, through First Nations & Inuit Health Branch (FNIH), supports community programs, health protection, primary health care, supplementary health benefits, governance, and infrastructure on First Nation reserves, by providing funding through contribution agreements with individual Bands. The Province of Nova Scotia, through the Department of Health, sets the strategic direction and standards for provincial health services, ensures the availability of quality health care, and monitors, evaluates, reports on, and funds health services. The Department of Health holds overall responsibility for the performance of the health care system, including physician and pharmaceutical services, emergency health services, continuing care, and other publicly funded health programs and services. Nine District Health Authorities (DHAs) are directly responsible for the delivery of health services. Health services delivered by DHAs include acute and tertiary care, public health, mental health and addictions, and primary health care. DHAs are responsible for maximizing resources and forming partnerships to foster integrated care across the continuum, from health promotion to palliative care.

<sup>3</sup> More information about the Forum, its committees, and 2007-08 Strategic Directions can be found at: <http://www.tripartiteforum.com/about.html>.

<sup>4</sup> A map of First Nation communities in each District Health Authority in Nova Scotia is included on the inside of the front cover of this report.





## Introduction & Background

Aboriginal Blueprint. Over an eight-week period, six meetings were held throughout the province to collect input about Mi'kmaq health concerns. The resulting report, *Providing Health Care, Achieving Health*<sup>5</sup>, was submitted by the Tripartite Forum as input into the National Aboriginal Health Blueprint.

It should be noted that the process used in the *Providing Health Care, Achieving Health* project was limited and was not widely supported by some First Nation partners. Challenges with the 2005 process included:

- Five community-based meetings and one provincial meeting were held, and all input was combined. All 13 First Nation communities were invited to participate in one of the sessions; however, since each community did not have its own session, individual community-based recommendations did not emerge from the process;
- Fifty-eight recommendations for addressing First Nation health issues emerged from the 2005 process – none of which were prioritized for easy use by health system planners and First Nation communities; and
- The language used for the 2005 recommendations was not particularly easy to interpret and use at the community level.

The HWC acknowledges these challenges, and designed the current project to enhance the process used in 2005. The purposes of the current project were to:

- Hold community discussions on First Nation health issues with all communities and health partners;
- Identify current health priorities to inform health planning;
- Explore and prioritize current priorities, and compare them with the 2005 health priorities;
- Identify existing strengths and challenges to addressing health priorities, and what is needed to address health priorities; and
- Share what is heard broadly among First Nation communities and health partners to inform their health planning efforts.

The HWC anticipates that the results of the current project can be used to inform First Nation health planning processes in a variety of settings (e.g., for planning at the community, regional, provincial, and federal levels), and has created a comprehensive distribution plan to ensure the results of the project are shared widely.

One example of the anticipated uses for the report is for the Mi'kmaq Maliseet Atlantic Health Board (MMAHB). Each year, MMAHB identifies health priorities – in 2007-08, the focus was on mental health and addictions; in 2008-09, the focus is on Elder care; and in 2009-10, it will be working to build stronger partnerships with Regional and District Health Authorities. Input on health priorities gathered through the current process may be valuable for informing MMAHB's planning in its priority areas. Information in the report may also be used to inform the work plans of Tripartite Forum health partners including, Health Canada (First Nations and Inuit Health), the Nova Scotia Department of Health, and the District Health Authorities.





## 2 METHODOLOGY

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**HEALTH WORKING COMMITTEE**

### *Exploring Health Priorities in First Nation Communities in Nova Scotia*



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## Methodology

The current project used three methods<sup>6</sup> of gathering input on the health priorities of First Nation communities in Nova Scotia:

- Community engagement sessions;
- Youth web surveys; and
- Health system web surveys.

The use of these three methods allowed the HWC to apply the lessons learned in the 2005 process, and ensure they created greater opportunities for open dialogue with First Nation communities and health system partners in Nova Scotia (i.e., flexible timelines permitted dialogue with all First Nations who wanted to participate in the project; community dialogue format was tailored to meet the needs of individual communities; web survey was specifically designed to gather youth input; health system web survey provided opportunity for input from a broad range of partners).

### Community Engagement Sessions

#### Description of Method

In order to gather important input from First Nation community members in Nova Scotia, community engagement sessions in each First Nation community were held over an eight-week period (between March 6th and April 24th, 2008); and one session was held in August, 2008. These interactive and engaging sessions allowed community members to freely articulate and discuss the health priorities, successes, and challenges of their communities. A copy of the full community engagement session questions can be found in Appendix C.

One consultant facilitated each of the community engagement sessions using a participatory facilitation approach, and the specific methods were tailored to meet the interests of individual communities (see Appendix A for more details on the methods used). After each session, the consultants prepared a summary of the discussion, which was circulated to the participants for review and approval.

#### Participants

All thirteen (13) First Nation communities in Nova Scotia were approached to host a session; twelve (12) opted to participate<sup>7</sup>. One hundred and thirty-seven (137) people participated in the twelve (12) community sessions, as outlined in the following table:

**Table 1** – Number of Participants in Each First Nation Community Session

First Nation Community Session	Number of Participants
Acadia First Nation	19
Annapolis Valley First Nation	16
Bear River First Nation	10
Eskasoni First Nation	15
Glooscap First Nation	5
Membertou First Nation	11
Millbrook First Nation	11

**5**

**6** The detailed methodology can be found in Appendix A.

**7** The Chief and Council of Indian Brook stated that they view everything in their community is a priority; therefore going through a prioritization exercise would not be a useful process for them.





## Methodology

First Nation Community Session	Number of Participants
Paq'tnkek First Nation	11
Pictou Landing First Nation	12
Potlotek First Nation	14
Wagmatcook First Nation	7
We'koqma'q First Nation	6
<b>Total</b>	<b>137</b>

Participants represented a broad range of organizations and perspectives (e.g., Band Councillors; researchers; community members; Health Directors; health centre professionals; Elders; addictions counsellors; Education Directors; etc.). See Appendix D for more information on community session participants.

### Youth Web Survey

#### Description of Method

Youth from each of the thirteen (13) First Nation communities in Nova Scotia were invited to participate in an online web survey held over a three-week period (March 25th – April 11th, 2008). The web survey gathered input about the health priorities of youth in their communities, as well as the health priorities for their community as a whole. A copy of the full youth web survey can be found in Appendix C.

The consultants (*Horizons*) worked with *iSurvey Canada* (<http://www.isurvey.ca>) to design and administer the youth web survey. Since it was not possible to gather e-mail addresses for the youth in each First Nation community, the web survey used an open, non-password encrypted process. This meant that the consultants were not able to distribute e-mail messages directly to participants or use a unique password-protected link for each of the participants. Rather, an open website link was used that allowed all interested youth to complete the survey.

#### Participants

Forty-nine (49) youth from the following First Nation communities participated in the web survey:

**Table 2** – Number of Youth Web Survey Participants from Each First Nation Community

First Nation Community Session	Number of Participants	Percentage of Participants
Acadia First Nation	3	6.1
Annapolis Valley First Nation	2	4.1
Bear River First Nation	1	2.0
Eskasoni First Nation	5	10.2
Glooscap First Nation	2	4.1
Indian Brook First Nation	1	2.0





## Methodology

First Nation Community Session	Number of Participants	Percentage of Participants
Membertou First Nation	9	18.4
Millbrook First Nation	5	10.2
Paq'tnkek First Nation	3	6.1
Pictou Landing First Nation	8	16.3
Potlotek First Nation	6	12.2
Wagmatcook First Nation	1	2.0
We'koqma'q First Nation	3	6.1
<b>Total</b>	<b>49</b>	<b>100.0</b>

Thirty-nine percent (16 respondents) of the youth were male and 61% (25 respondents) were female. Their ages ranged from 12 years to 20 years (average 16 years). The majority of youth (42 respondents, 84.0% of respondents) reported they were currently attending school.

### Health System Web Survey

#### Description of Method

A targeted list of health system professionals/partners who work with First Nation communities was invited to participate in an online web survey held over a three-week period (March 25th – April 11th, 2008). The web survey was designed to elicit participants' feedback about the priority recommendations in *Providing Health Care, Achieving Health*. To a lesser degree, participants were also asked to provide input about their level of awareness of the report recommendations, actions taken since 2005, and what they believed is needed to address the recommendations. A copy of the full health system web survey can be found in Appendix C.

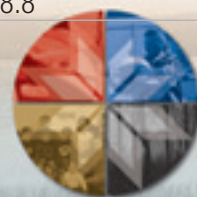
As with the youth web survey, the consultants (*Horizons*) worked with *iSurvey Canada* (<http://www.isurvey.ca>) to design and administer the health system web survey. Since a complete list of health system partners was available, this web survey used a controlled, password-encrypted process. This meant that the consultants were able to distribute e-mail messages directly to participants, use a unique password protected link for each of the participants, send out weekly reminder notices to those who had not completed the survey, and closely monitor the response rates.

#### Participants

Sixty-three (63) people participated in the health system web survey – a response rate of 35.8% (63 of 176 potential participants). Participants indicated that they worked with/represented the following First Nation communities in Nova Scotia:

**Table 3 – First Nation Communities with Whom Health System Web Survey Participants Worked**

First Nation Community Session	Number of Participants	Percentage of Participants
Acadia First Nation	11	6.4
Annapolis Valley First Nation	15	8.8







## Methodology

First Nation Community Session	Number of Participants	Percentage of Participants
Bear River First Nation	13	7.6
Eskasoni First Nation	13	7.6
Glooscap First Nation	5	2.9
Indian Brook First Nation	14	8.2
Membertou First Nation	10	5.8
Millbrook First Nation	8	4.7
Paq'tnkek First Nation	7	4.1
Pictou Landing First Nation	12	7.0
Potlotek First Nation	9	5.3
Wagmatcook First Nation	14	8.2
We'koqma'q First Nation	9	5.3
All of the Above	27	15.8
Other	4	2.4
<b>Total</b>	<b>171<sup>8</sup></b>	<b>100.0</b>

## Limitations

Although the consultants are confident with the quality of the information presented in this report, there are limitations that should be considered when applying what was heard to inform health planning:

- All 13 First Nation communities in Nova Scotia were approached to participate in the community engagement sessions. However, only 12 communities opted to participate. This means that the majority of First Nation communities are represented in the community engagement session results, but the opinions of one First Nation community is not. It should be noted, that all 13 communities are represented in the results of the youth and health system web surveys.
- Several of the community engagement sessions (i.e., Glooscap; Wagmatcook; We'koqma'q) had relatively low numbers of participants – winter weather and the need to reschedule some sessions may have contributed to this challenge.
- The youth web survey had a lower-than-desired participation rate – despite significant promotional efforts, only 49 youth completed the survey and three communities were only represented by one youth (i.e., Bear River; Indian Brook; Wagmatcook). Therefore, the opinions of youth from these three communities may not be accurately represented.
- Since it was not possible to gather e-mail addresses for all First Nation youth in Nova Scotia, a non-password encrypted, open process was used for the youth web survey. Therefore, it is not possible to say for certain that youth who completed the survey matched the target participation criteria (i.e., youth between the ages of 12 and 20 who live in a First Nation community). Although ‘filter’ questions were used to exclude participants who did not meet the participation criteria, it is possible that some participants may have re-entered the survey and changed their responses to the demographic questions in order to complete the survey and have a chance at winning the iPod incentive.



<sup>8</sup> Please note that this number is higher than the total number of health system partners who participated in the survey (63) because participants could select more than one community that they worked with/represented.



## Methodology

- The health system web survey also had a lower-than-desired response rate – only 63 of the 176 partners identified completed the survey. Although this response rate (35.8%) matches the response rates found in other similar web survey activities (e.g., *iSurvey Canada* typically sees a response rate of 25.0%-50.0% on their web surveys), a higher response rate would have been desirable to ensure the opinions of partners from all targeted organizations are accurately represented.

## Approach to Analysis

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Each method used in the current project (i.e., the community engagement sessions; the youth web survey; the health system web survey) yielded a relatively unique set of First Nation health priorities that the consultants needed to amalgamate together to create an overall set of priorities for the entire project. This meant that some priorities needed to be categorized for analysis purposes to extract themes/trends both within and between methods. Although the consultants attempted to preserve participants' wording of priorities as much as possible, it was sometimes necessary to place them into categories that did not match the exact wording provided. However, the consultants ensured that all categories used in the analysis accurately represented the intent behind the priorities described by participants.

It should also be noted that some communities combined two priority areas into one theme during their engagement session discussions because they believed the two issues were closely intertwined and/or related (e.g., addictions and mental health). The consultants needed to separate these combined priorities for the purposes of extracting overall themes/trends for the project, but the nature of their interconnectivity is described in the body of the report, and the combined priorities are maintained as collective themes in the community session summaries in Appendix D.







# 3 COMMUNITY ENGAGEMENT SESSION RESULTS

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## *Exploring Health Priorities in First Nation Communities in Nova Scotia*



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## Community Engagement Session Results

The results in this section are presented in the words of the communities. If necessary, the original wording has been paraphrased to provide context for the reader and two or more similar comments have been combined to avoid repetition; the meaning of the words remains unchanged. General summary statements have been prepared by the authors and the words of the communities following to explain/illustrate the points from the community members' perspectives. For detailed summaries of individual community responses, and to review comments on the priority areas made by specific communities, by please see Appendix D.

### Top Five Community Health Priorities

The top five health priorities identified in the community engagement sessions are summarized in the following table (in rank order). These are the priorities identified when the results of all 12 community sessions were combined:

**Table 4 – Top Five Health Priorities Identified by Communities**

Health Priority Identified	# of Communities	% of Communities
Mental Health (#1 priority)	10 of 12	83.3
Addictions/Substance Abuse (#2 priority)	9 of 12	75.0
Non-Insured Health Benefits (NIHB) Coverage (#3 priority)	5 of 12	41.7
Elder/Senior Services (#4 priority)	4 of 12	33.3
Water/Environment (tied for #5 priority)	3 of 12	25.0
Housing (tied for #5 priority)	3 of 12	25.0
Nutrition/Healthy Eating (tied for #5 priority)	3 of 12	25.0
Transportation to Services (tied for #5 priority)	3 of 12	25.0
Health Promotion Education (tied for #5 priority)	3 of 12	25.0
Health Services for Non-Natives Living on Reserve (tied for #5 priority)	3 of 12	25.0
Improved Funding for Health Services (tied for #5 priority)	3 of 12	25.0

The following table provides a summary of all priorities identified by all communities, regardless of ranking.

**Table 5 – Health Priorities Identified by All Communities**

Health Priority Identified	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Membertou	Millbrook	Paq'tnekek	Pictou Landing	Pottotek	Wagmatcook	We'koqma'q
Access to Health Care				+			+					
Addictions/Substance Abuse	+			+	+	+	+	+	+	+	+	
Communication									+			
Community Agencies Working Together/Partnerships							+					





## Community Engagement Session Results

Health Priority Identified	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Membertou	Millbrook	Paq'tnkek	Pictou Landing	Potlotek	Wagmatcook	We'koqma'q
Community Volunteers								+				+
Cultural Competency/Safety											+	
Culture/Language				+					+			+
Dependence on Social Assistance									+			
Diabetes								+				
Discharge Planning/Process			+									
Discrimination/Racism		+										
Early Intervention						+						
Education	+								+		+	
Elder Care/Services		+				+		+	+			
Family Violence/Unhealthy Relationships								+				
First Nation Power to Address Community Health Issues					+							
Funding for Health Care/Programs					+			+		+		
Green Economic Development										+		
Health Care Services for Members of Other Bands			+									
Health Promotion Education	+	+										+
Health Services for Non-Natives Living on Reserve		+										
Healthy Lifestyle Choices/Issues should be one more here										+		+
Home Care		+			+							
Housing							+	+			+	
Income/Poverty				+							+	
Infant Mortality										+		
Lack of Respect/Need to Come Together as a Community								+		+		
Leadership on Health Care Issues							+					
Low Self-Esteem								+				
Mental Health	+	+	+	+	+	+	+	+	+	+		
NIHB Coverage	+	+			+		+	+				
Nutrition/Healthy Eating				+		+	+					
Parenting Skills							+					
Patient Navigation			+									+
Physical Activity/Fitness Levels							+					
Policing										+		
Prenatal Misdiagnosis												+
Recreation/Physical Activity Facility						+						
Traditional Healers	+											
Transportation to Services			+		+						+	
Wait Times for Health Care												+
Water/Environment							+	+	+			





## Community Engagement Session Results

Please note that the results discussed in the following sections of the report focus on the combined top five overall priorities only – the top priorities that resulted when the input of all communities was combined – rather than a description of the priorities for each individual community. However, detailed summaries of the input provided by individual communities in each of the priority areas can be found in Appendix D<sup>9</sup>.

### Community Priority Issues

#### Priority Issue: **Mental Health**

Mental health was identified as a health priority in ten communities, or 83.3% of communities, as follows:

**Table 6 – Communities That Identified Mental Health as a Priority**

Community	Mental Health Identified as a Health Priority
Acadia First Nation	+
Annapolis Valley First Nation	+
Bear River First Nation	+
Eskasoni First Nation	+
Glooscap First Nation	+
Membertou First Nation	+
Millbrook First Nation	+
Paq'tnkek First Nation	+
Pictou Landing First Nation	+
Potlotek First Nation	+
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these ten community sessions identified children (1/10, 10.0% of communities), youth (3/10, 30.0% of communities), seniors (1/10, 10.0% of communities), men (1/10, 10.0% of communities), women (1/10, 10.0% of communities), people who have a mental illness (1/10, 10.0% of communities), and the whole community (7/10, 70.0% of communities) as those who are most affected by mental health issues.



### What are the Community Impacts?

The session participants described how their communities are affected by mental health issues:

<sup>9</sup> Appendix D contains each community's detailed comments about the top health priorities for their specific community. It should be noted that comments reported under each of the community priority areas often relate to other health priority areas. The reader is encouraged to read the engagement session summaries to get a full picture of the input provided by each of the 12 participating communities.







## Community Engagement Session Results

- Increases in crime and violence (2/10, 0.0% of communities);
- People expressing their frustrations through anger (2/10, 20.0% of communities);
- Community members have become numb to tragic deaths and tragic lives because of how much tragedy is present (1/10, 10.0% of communities), and as a result, do not always rally to support families who have experienced a tragedy (1/10, 10.0% of communities);
- It is a social, physical, emotional, and economic problem (1/10, 10.0% of communities);
- There is a lack of mental wellness (1/10, 10.0% of communities);
- Rising stress and anxiety levels (1/0, 10.0% of communities);
- There are people with chronic depression and anxiety who do not function well in the community (1/10, 10.0% of communities);
- People are unable to work because of addictions or mental health, which leads to more people requiring welfare [social assistance] (1/10, 10.0% of communities);
- Crisis has an impact on the whole community (1/10, 10.0% of communities);
- People with mental health issues are falling through the cracks (1/10, 10.0% of communities); and
- There is misunderstanding about mental illness – people need to know it's as normal as any other kind of illness (1/10, 10.0% of communities)

They also noted several factors that contribute to mental health problems:

- The lack of human and financial resources affects how we can and do respond to the health priorities. This in itself causes us to do the best we can with what we have to work with – we may not always meet our overall need (2/10, 20.0% of communities).
- Crisis situations in mental health (such as a suicide attempt) affect the family and the community (2/10, 20.0% of communities);
- Families who have experienced suicide have difficulty (2/10, 20.0% of communities);
- Poverty leads to depression and suicide (1/10, 10.0% of communities);
- Lack of cultural knowledge leads to depression and suicide (1/10, 10.0% of communities);
- Addictions are linked with mental health problems (1/10, 10.0% of communities);
- It is difficult to be mentally healthy with poor health and poor nutrition (1/10, 10.0% of communities);
- Children are possibly affected by Fetal Alcohol Syndrome (FAS) and adults are possibly affected by Fetal Alcohol Effects (FAE) (1/10, 10.0% of communities); and
- There are no support groups for children with anxiety problems (1/10, 10.0% of communities).



### What are the Challenges?

The ten communities that identified mental health issues as a priority talked about challenges to addressing mental health issues in relation to access to service, service delivery, lack of resources, the need for prevention, individual factors/stigma, the need for culturally-safe services, racism, awareness of resources, and bureaucratic insensitivity.

#### Access to Service

- Services are centralized – mental health services are not available on the reserve (3/10, 30.0% of communities);
- Access remains an issue (2/10, 20.0% of communities);





## Community Engagement Session Results

- Wait times for accessing mental health services mean that people don't get service when they need it and when they do finally get to see someone, they either don't need the support any more, or don't want it any more (1/10, 10.0% of communities);
- Mental health works on a business plan model. There are a number of people who can't afford private services (1/10, 10.0% of communities);
- Without Internet access, it is difficult to get access to forms, etc. that are needed to make referrals, and to request them by mail delays the process even more, making it very difficult for people to maintain their motivation to get help for addictions and mental health challenges (1/10, 10.0% of communities);
- It is challenging with support services being available only during office hours (1/10, 10.0% of communities); and
- Transportation is a big issue in relation to addressing mental health (1/10, 10.0% of communities).

### Service Delivery

- We have concerns about confidentiality [being maintained] (3/10, 30.0% of communities);
- There is a need for a protocol to follow when there is a critical incident (1/10, 10.0% of communities);
- NADACA workers have to see people five times before they are allowed to refer people for mental health and/or addictions treatment (1/10, 10.0% of communities);
- Mental health is a low priority to the District Health Authority (DHA) in this geographic area (1/10, 10.0% of communities);
- We need follow up communication (1/10, 10.0% of communities); and
- We need broader policies that think about health from the broader 'team' or holistic perspective (1/10, 10.0% of communities).

### Lack of Resources

- Lack of human and financial resources is a challenge (4/10, 40.0% of communities). We do not have enough human resources to meet the need for providing the alternative methods to achieving mental wellness. Also, a lack of space prevents having more than one healing method available at a time (1/10, 10.0% of communities). Funding covers only three sessions (1/10, 10.0% of communities). It is easier to get money for referrals than to get funding to pay someone to be in the community because we can't access the funds for the service efficiently, and the Band ends up paying up front (1/10, 10.0% of communities);

*"We have access to a mental health counsellor but there is not enough time in the community. When people need help immediately, they can't get it. Staff will try and make a referral to someone at Mental Health Services right away, but if the counsellor was just at the Health Centre that week, it's a whole month until the next scheduled office hours. People are told to go to the hospital if it's an emergency. People don't want to go to the hospital to begin with, because no one there understands their experiences, and even if they do go, they just sit there for hours and then get sent home without solving the problem. When this happens, we as workers look like we're not doing anything to try and help, even though we may be doing a lot to try and access help for the person – we just can't do it."*

(Community Engagement Session)

### Need for Prevention

Communities discussed the lack of prevention as a challenge to addressing mental health concerns:

- Youth are not getting the help they need early enough – this is leading to other problems (1/10, 10.0% of communities);





## Community Engagement Session Results

- We can offer our services to do prevention, but we can't force people to use them (1/10, 10.0% of communities); and
- Depending on the way suicide information is shared, it can make some youth think about it when they wouldn't have otherwise. Information about suicide has to be appropriate, so this doesn't happen (we don't want to put ideas in their heads) (1/10, 10.0% of communities).

### Individual Factors/Stigma

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Some of the challenges to addressing mental health problems identified related to people at the individual level:

- Suicide, suicide attempts, and suicide threats are under-reported (by the health centre, by the police, and also by the families, who feel ashamed), so the community and the public may not understand how big the problem really is (1/10, 10.0% of communities);
- We don't know what happens behind closed doors. Sometimes people feel bad for the kids so they allow the kids to do things (e.g., drugs/alcohol, violence) and then they don't report it because they feel ashamed. Then things don't get officially counted and people don't know how big the problem really is (1/10, 10.0% of communities);
- Peoples' pride can be a challenge (not wanting everybody knowing their business) (1/10, 10.0% of communities); and
- A lot of people are in denial and not open to new teachings (1/10, 10.0% of communities).

### Need for Culturally-Safe Services

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The importance of culturally-safe services was identified in relation to several health priorities, not only in relation to mental health. In terms of addressing mental health problems, communities said that:

- Services are not available in our own language and from our own cultural perspective (2/10, 20.0% of communities); and
- People do not want to go to the hospital for services (1/10, 10.0% of communities).

### Racism

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One community (1/10, 10.0% of communities) talked about its children feeling good about themselves until they go off-reserve to go to school:

- When children leave the community to go to school, their self-esteem goes down because they experience racism and discrimination (1/10, 10.0% of communities).

### Awareness of Resources

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One community (1/10, 10.0% of communities) identified lack of awareness of off-reserve services as a challenge to addressing mental health issues:

- Sometimes we don't know what is available, even though there may be some off-reserve supports that could be helpful (1/10, 10.0% of communities).





## Community Engagement Session Results

### Bureaucratic Insensitivity

One community (1/10, 10.0% of communities) identified the need for sensitivity on the part of bureaucrats as a challenge to addressing mental health issues:

- Federal department insensitivity (e.g., looking for statistics shortly after a crisis) (1/10, 10.0% of communities).



### What is Working Well?

The ten communities who identified mental health as a priority described what they think is working well to address mental health issues. They identified mental health and addictions counsellors, human resources and staffing, prevention/mental health promotion, community strengths, and the approach to health.

### Mental Health & Addictions Counsellors

- Recognizing a fundamental link between addictions and mental health, four communities reported that having addictions/Native Alcohol Drug Addictions Counselling Association (NADACA) workers in the community helps people deal with mental health problems (4/10, 40.0% of communities);
- Access to mental health professionals was identified as helpful for addressing mental health problems. Four communities (4/10, 40.0% of communities) identified the presence of a mental health worker who fits with the community as helpful. One community (1/10, 10.0% of communities) said it helps to have a doctor who can make referrals to private mental health professionals and arrange for Health Canada funding to cover the costs for 10-12 sessions in emergency situations; and
- Two communities (2/10, 20.0% of communities) talked about the importance of being able to access support groups (e.g., Alcoholics Anonymous; Narcotics Anonymous), and one community (1/10, 10.0% of communities) acknowledged that there may be some support groups off-reserve that could be helpful for dealing with some issues.

### Human Resources & Staffing

- Communities (3/10, 30.0% of communities) highlighted the important role their staff play in addressing mental health issues. In one session (1/10, 10.0% of communities), participants noted that the Community Health Representative and Community Health Nurse are starting to be able to educate community members and offer support groups, etc; one community (1/10, 10.0% of communities) mentioned human resources in the community as important; and one community (1/10, 10.0% of communities) pointed out the importance of having a youth group and a youth worker in the community;
- We have one person at the Health Centre (Wellness Coordinator) that can get a counsellor for people requiring assistance (1/10, 10.0% of communities);
- Addictions staff help address mental health issues (1/10, 10.0% of communities); and
- The We'koqma'q women's shelter people started coming here to be a support but we need the support here in the long term. People came for a couple of weeks and no community members showed up but if they were here in the long term people would show up and get the support they need (1/10, 10.0% of communities).





## Community Engagement Session Results

### Prevention/Mental Health Promotion

- Two communities (2/10, 20.0% of communities) said that having programs and services in place before people reach a crisis is effective and they emphasized the importance of being able to access information through workshops, information sessions, and newsletters;
- One community (1/10, 10.0% of communities) acknowledged the value of training opportunities (e.g., ASIST suicide prevention training) for the community; and
- One community (1/10, 10.0% of communities) said that a new organization called Two-Spirited Nation helps First Nation people across the province when they are 'coming out'.

### Community Strengths

- One community (1/10, 10.0% of communities) talked about its strength as a community in dealing with mental health issues. Participants said it is important that the community will come together to provide support to someone, people will receive the service they need, and the community has an independent attitude to try to make something happen.

### Approach to Health

- One community (1/10, 10.0% of communities) said it is very important to work within the concept of a holistic approach to health. This opens opportunities to learn how everything is interconnected and that one cannot be fixed without looking at the whole picture. Holistic provision of health options to wellness is one example of how this works well;
- In terms of services, one community (1/10, 10.0% of communities) said it helps to offer healing services (e.g., programs such as massage therapy; reflexology; acupuncture; spirituality); another (1/10, 10.0% of communities) said it is important to have services in place that people have expressed interest in and one said it helps to offer traditional healing (e.g., sweats); and
- One community (1/10, 10.0% of communities) commented that in larger communities there is a safe house – a place for people to go when they are in crisis. They can get support there, right in the community. Maybe there could be something like that in our community.

*“What helps? Sufficient staff, funding, resources, and a stable infrastructure to consistently offer programs to promote holistic health and well being and prevent/reduce the problems people have with drugs, alcohol, mental health, suicide, poor lifestyles, low motivation.”*  
(Community Engagement Sessions)



### What is Needed?

When asked what helps to address mental health issues, the nine communities identified culturally-safe services, access to services, mental health promotion, willingness to seek help, and life skills.

### Culturally-Safe Services

Participants discussed the importance of being able to access services and support relevant for their own language, culture, and life experiences:





## Community Engagement Session Results

- It would help to have support people (in the community and in hospital) who speak the language (and also understand medical terms), understand the culture, can be a spiritual leader, and can help the person who needs help feel more comfortable (2/10, 20.0% of communities);
- Mental health counselling and treatment is needed. This must be available from someone who is Native-speaking and understands the culture. This is important in the community and at the hospital (2/10, 20.0% of communities);
- Culturally-friendly treatment is needed for people who are dealing with these issues (2/10, 20.0% of communities);
- If we had a place for people to live and get support for mental illness (like in Waycobah), there could be a room set aside for someone who is in crisis and needs support from within the community. Support people would already be there (1/10, 10.0% of communities); and
- Sexuality needs to be approached in a culturally-sensitive manner as well (1/10, 10.0% of communities).

### Access to Services

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Participants stated that access to services is/would be helpful for addressing mental health issues:

- Support for both addictions and mental health problems has to be available when people need it (e.g., 24/7) and not just during office hours (1/10, 10.0% of communities);
- We need trained support people and a structured plan for them to work under so they can help other community members who are experiencing a crisis (1/10, 10.0% of communities);
- Proper assessment tools or access to assessments for people suspected of FAS/FAE would be helpful (1/10, 10.0% of communities); and
- It would be helpful to have treatment that is specific to youth in addictions and mental health (2/10, 20.0% of communities).

### Mental Health Promotion

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- Communities stated strongly that mental health promotion is needed to keep people healthy (4/10, 40.0% of communities).

### Seeking Help

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- Mental health problems can be more easily addressed if people are willing to use the services that are offered (1/10, 10.0% of communities).

### Life Skills

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- Developing life skills for chronic stress problems helps people address mental health issues (1/10, 10.0% of communities).

Community members also identified what they think is needed in order to address mental health issues, including the need for additional resources and professional services, awareness and education, culturally-safe services, autonomy, prevention for youth, and transportation.

### Additional Resources

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- More resources – money and staff, volunteers, support groups (3/10, 30.0% of communities);
- We need more funding and flexibility (2/10, 20.0% of communities);
- Core funding from the federal government (1/10, 10.0% of communities);





## Community Engagement Session Results

- More funding helps with providing more services and could help with providing more options (e.g., naturopathic services; natural supplements; detoxification methods that are linked to mental wellness). If you help mend the physical body, you improve the mental state of an individual. More resources gives more choice to those in need (1/10, 10.0% of communities); and
- More space would mean we could offer more services at one time, which helps meet the demand for services (1/10, 10.0% of communities).

### Additional Professional Services

- We need outreach mental health services in the community (4/10, 40.0% of communities) from the DHA (1/10, 10.0% of communities);
- We need a mental health worker on the reserve at least once a week (2/10, 20.0% of communities);
- We need on-reserve training for crisis intervention and suicide prevention (2/10, 20.0% of communities);
- In the past, we had funding for a counselor from outside the community to come in two days/week. It worked well because people were not concerned about the counselor breaking confidentiality, and they were comfortable talking with him because he was not from the community (1/10, 10.0% of communities);
- We need more qualified staff (1/10, 10.0% of communities);
- We need a visible person to address mental health full time – even one at the school (1/10, 10.0% of communities);
- We need more of a counsellor's time (1/10, 10.0% of communities);
- We have concerns about access to services for youth (1/10, 10.0% of communities);
- We need support for autism for families (1/10, 10.0% of communities);
- We need to be able to refer people to [Halifax] if someone is given a diagnosis (1/10, 10.0% of communities); and
- We need support for the whole family, not just the patient (1/10, 10.0% of communities).

### Awareness & Education

They also recognized the need for awareness and education about mental health issues in general:

- Awareness and education are needed so that people realize mental health problems and addictions are issues (awareness) and understand what they really are (education) (4/10, 40.0% of communities);
- Education is needed about FAS and FAE – knowing if people are dealing with FAE could be helpful for figuring out how to help them deal with things (1/10, 10.0% of communities);
- The community needs to know how to deal with issue appropriately (1/10, 10.0% of communities); and
- Community members need more education about taking care of ourselves (1/10, 10.0% of communities).

### Culturally-Safe Services

Community members identified the need for culturally-safe services:

- It is important that the counsellor fit with the community (2/10, 10.0% of communities);
- We need mental health resources and service that are timely, culturally-appropriate, and accessible (1/10, 10.0% of communities); and
- We need more cultural connections – we need a worker hired to facilitate cultural awareness and activities (1/10, 10.0% of communities).





## Community Engagement Session Results

### Autonomy

Community members discussed the need for autonomy in dealing with mental health (and other) issues:

- First Nation people need to be running our own systems – we would not be facing many of these challenges and complications if we were making the decisions and the rules about how the system operates (2/10, 20.0% of communities).

### Prevention for Youth

Communities recognize the value of mental health promotion for youth:

- We need to be able to work with teens to increase their self confidence (1/10, 10.0% of communities); and
- It would be good to have a teen counsellor – someone who can relate to youth and they can relate to, who understands mental health issues affecting youth (1/10, 10.0% of communities).

### Transportation

- We need to eliminate the complications with transportation and getting people to the services they need (1/10, 10.0% of communities).

## Priority Issue: Addictions/Substance Abuse

Addictions/substance abuse was identified as a health priority in nine communities, or 75.0% of communities, as follows:

**Table 7 – Communities That Identified Addictions/Substance Abuse as a Priority**

Community	Addictions/Substance Abuse Identified as a Health Priority
Acadia First Nation	+
Annapolis Valley First Nation	
Bear River First Nation	
Eskasoni First Nation	+
Glooscap First Nation	+
Membertou First Nation	+
Millbrook First Nation	+
Paq'tnkek First Nation	+
Pictou Landing First Nation	+
Potlotek First Nation	+
Wagmatcook First Nation	+
We'koqma'q First Nation	







## Community Engagement Session Results

Participants in these nine community sessions identified women (1/9, 11.1% of communities), men (1/9, 11.1% of communities), children and youth (6/9, 66.7% of communities), the whole community (8/9, 88.9% of communities), and Elders (1/9, 11.1% of communities) as the groups most affected by substance abuse and its associated behaviours.



### What are the Community Impacts?

When these communities described how their communities are affected by addictions/substance abuse, they talked about links between addictions and mental health, and prescription drug abuse.

#### Links with Mental Health

Communities see a definite link between addictions/substance abuse and mental health:

*“The problems identified all collaborate with one another. For example, prescription drug abuse causes many mental health issues within the community. There have been many suicide attempts/successes, school drop outs, child welfare problems (such as neglect, parental issues) related to addictions and substance abuse.” (Community Engagement Session)*

- Addictions behaviours affect families – for example, there may be abuse (2/9, 22.2% of communities), parents aren't able to show their children how to be healthy, to live a healthy lifestyle and this is 'bad' role modeling for the children and youth, so they go on to have lots of problems themselves (2/9, 22.2% of communities);
- There is an increase in crime and violence with addictions/substance abuse (2/9, 22.2% of communities);
- Youth are affected because they do risky behaviours – sometimes this leads to teen pregnancy, sexually transmitted infections, drug and alcohol abuse, violent behaviour, bullying behaviour, sexual and mental abuse (2/9, 22.2% of communities);
- When people are intoxicated, they are honest, and they may talk about suicide or abuse, but others don't believe them, don't think it's going to happen, don't want to get involved, or don't know how to handle it. Then no one knows whose responsibility it is to do something to help or intervene. And each person needs a place to go for support (1/9, 11.1% of communities);
- Addictions, poor mental health, and poor health take away people's motivation to go to work, go to school, and to improve their lives (2/9, 22.2% of communities), therefore there are higher welfare rates (1/9, 22.2% of communities);
- Most people who are mentally healthy do not have addictions, so mental health and addictions should always be tied together (1/9, 11.1% of communities);
- Stress and anxiety levels rise (1/9, 11.1% of communities);
- Poor health/nutrition is connected with substance abuse (1/9, 11.1% of communities);
- Some people gamble because they need money and there is nothing else to do to get money (1/9, 11.1% of communities);
- Children are possibly affected by FAS, and adults are possibly affected by FAE (1/9, 11.1% of communities); and
- It is a social, physical, emotional, and economic problem (1/9, 11.1% of communities).

#### Prescription Drug Abuse

Four communities (4/9, 44.4% of communities) see prescription drug abuse as the most important issue related to addictions/substance abuse:





## Community Engagement Session Results

- The main concern is prescription drugs – people are double-doctoring (1/9, 11.1% of communities);
- The issue is prescription drug abuse – people are affected by stealing, selling, buying prescription drugs (1/9, 11.1% of communities);
- Prescription drugs – people are affected if they don't know how to take their prescriptions properly (1/9, 11.1% of communities) and in terms of how the community as a whole is being impacted;
- NIHB is being drained by double-doctoring and prescription drug abuse, so fewer funds are available for other coverage (1/9, 11.1% of communities); and
- Some people are pushing pills, including oxycontin (e.g., one youth had a heart attack from taking pills he had bought off the Internet to make himself strong) (1/9, 11.1% of communities).

Three communities (3/9, 33.3% of communities) also noted factors that contribute to addictions/substance abuse:

- Lack of cultural knowledge leads to alcohol and drugs (1/9, 11.1% of communities);
- Poverty leads to alcohol and drugs (1/9, 11.1% of communities); and
- There is a broken link among the generations, and this contributes to drug and alcohol abuse. Without meaningful activities that connect youth to the community and the other generations, the youth get bored, they vandalize property, use drugs, and then even more problems develop (1/9, 11.1% of communities).



### What are the Challenges?

Communities experience several challenges to addressing addictions/substance abuse. They identified challenges related to service delivery/access to services, transportation, the need for role modeling, the need for culturally-safe services, funding, impact of the addictions, and individual factors.

#### Service Delivery/Access to Services

- We have concerns about confidentiality [being maintained] (3/9, 33.3% of communities);
- Access [to services] remains an issue (2/9, 22.2% of communities);
- The closest substance abuse treatment services for youth are CHOICES in Halifax or a treatment centre in NL (1/9, 11.1% of communities);
- One of the challenges is that doctors are prescribing narcotics to people – what problems do people have to present with in order to get these prescriptions? (1/9, 11.1% of communities);
- Narcotic drugs are covered through NIHB, but some antibiotics are not – this is contributing to prescription drug abuse (1/9, 11.1% of communities);
- NADACA workers have to see people five times before they are allowed to refer people for mental health and/or addictions treatment (1/9, 11.1% of communities);
- Without Internet access, it is difficult to get access to forms, etc. that are needed to make referrals, and to request them by mail delays the process even more, making it very difficult for people to maintain their motivation to get help for addictions and mental health challenges (1/9, 11.1% of communities);
- One challenge is that support services are available only during office hours (1/9, 11.1% of communities);
- We need follow-up communication (1/9, 11.1% of communities);





## Community Engagement Session Results

- Access to welfare at age 18 is an issue – young people start getting money at that young age and use it for drinking and drugs (1/9, 11.1% of communities); and
- We can offer our services to do prevention, but we can't force people to use them (1/9, 11.1% of communities).

### Transportation

- Lack of transportation makes it hard to get to services to help people deal with addictions. NADACA workers are not allowed to transport people to services (e.g., detox) and the closest detox centres are Middleton and Halifax. They are not insured to drive people and not supposed to even if they incur the cost of the insurance themselves. Without public transportation, NADACA workers are forced to suck up the costs themselves to get the person to the services they need. This would not happen if First Nation people were administering the program (1/9, 11.1% of communities);
- NIHB will fund travel for some services, but it is very difficult to navigate the system to help people get funding for travel to the services. NIHB will not, for example, fund NADACA workers to get people to services and will pay families only a very low km rate if they take their family member to services. If an advocate has this much difficulty connecting people to the services, most people would just give up if they were trying to do this on their own (1/9, 11.1% of communities); and
- Transportation is a big issue (1/9, 11.1% of communities).

### Need for Role Modeling

- Nobody goes to the Elders anymore (1/9, 11.1% of communities);
- Children and youth see unhealthy role models – we need to address their parents' experiences (2/9, 22.2% of communities); and
- Drinking alcohol is still a problem – parents (2/9, 22.2% of communities) and community leaders (1/9, 11.1% of communities) make it look okay to drink alcohol, but they can't deal with their own problems effectively (1/9, 11.1% of communities). Parents are condoning drug and alcohol use by their kids – they may let their kids drink with them, and sometimes they even give pills to the kids (1/9, 11.1% of communities).

*“We don't know what happens behind closed doors. Sometimes people feel bad for the kids so they allow the kids to do things (e.g., drugs/alcohol, violence) and then they don't report it because they feel ashamed. Then things don't get officially counted and people don't know how big the problem really is.”* (Community Engagement Sessions)

### Need for Culturally-Safe Services

The importance of culturally-safe services was identified in relation to several health priorities, not only in relation to addictions/substance abuse. In terms of addressing addictions/substance abuse problems, communities said that:

- Services are not available in our own language and from our own cultural perspective (2/9, 22.2% of communities); and
- People do not want to go to the hospital for services (1/9, 11.1% of communities).

### Funding

- There is a lack of funding, good leadership, education, and interested individuals to address addictions/substance abuse (2/9, 22.2% of communities); and





## Community Engagement Session Results

- Without these things, community members won't join things (e.g., activities) even if they are interested, because they know the activities won't last long (1/9, 11.1% of communities).

### Impacts of the Addictions/Substance Abuse

- Addictions make people lose their motivation to go to school and improve their lives (1/9, 11.1% of communities); and
- Smoking is often overlooked, and it is a serious problem too (1/9, 11.1% of communities).

### Individual Factors/Stigma

One of the challenges identified to addressing addictions/substance abuse issues related to individual factors:

- Some people are in denial about having addictions (1/9, 11.1% of communities); and
- We don't know what happens behind closed doors. Sometimes people feel bad for the kids so they allow the kids to do things (e.g., drugs/alcohol, violence) and then they don't report it because they feel ashamed. Then things don't get officially counted and people don't know how big the problem really is (1/9, 11.1% of communities).



### What is Working Well?

Communities described what they think is working well to address addictions/substance abuse:

- Having an addictions/NADACA worker as a support person helps people, and can get them into a treatment facility if they want help (8/9, 88.9% of communities);
- Having a mental health counselor in the community works well to help address addictions/substance abuse (2/9, 22.2% of communities);
- Support groups/self-help groups (e.g., Alcoholics Anonymous; Narcotics Anonymous) (2/9, 22.2% of communities);
- Electronic patient records make it harder to double-doctor (2/9, 22.2% of communities);
- Using traditional teaching and sweat lodges help address addictions/substance abuse (2/9, 22.2% of communities);
- Networking with other agencies works well to help address addictions/substance abuse (1/9, 11.1% of communities);
- It works well to have medical drivers available for people to get to a detox facility or rehabilitation facility if they get a bed (1/9, 11.1% of communities); and
- Having full time staffing of the RCMP detachment for enforcement available in the community (1/9, 11.1% of communities).



### What is Needed?

When asked what helps to address addictions/substance abuse, participants identified professional services, culturally-safe services, mental health promotion, awareness and education, resources for services, and transportation.





## Community Engagement Session Results

### Professional Services

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- It helps to have treatment that is specific to youth in addictions and mental health (2/9, 22.2% of communities);
- We have one person at the Health Centre (Wellness Coordinator) who can get a counsellor for people requiring assistance (1/9, 11.1% of communities);
- It helps to have addictions staff (1/9, 11.1% of communities);
- It helps to have proper assessment tools or access to assessments for people suspected of having FAS/FAE (1/9, 11.1% of communities);
- Education is needed about FAS and FAE – knowing if people are dealing with FAE could be helpful for figuring out how to help them deal with things (1/9, 11.1% of communities);
- Support for both addictions and mental health problems has to be available when people need it (e.g., 24/7) and not just during office hours (1/9, 11.1% of communities); and
- It helps to have trained support people and a structured plan for them to work under so they can help other community members who are experiencing a crisis (1/9, 11.1% of communities).

### Culturally-Safe Services

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- First Nation people need to be running our own systems – we would not be facing many of these challenges and complications if we were making the decisions and the rules about how the system operates (1/9, 11.1% of communities);
- Having support people (in community and in hospital) who speak the language (and also understand medical terms), understand the culture, can be a spiritual leader, help the person who needs help feel more comfortable (1/9, 11.1% of communities); and
- Culturally-friendly treatment is needed for people who are dealing with these issues (1/9, 11.1% of communities).

### Mental Health Promotion/Programs

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- Mental health promotion helps keep people healthy (2/9, 22.2% of communities);
- Mental health counselling and treatment is needed. This must be available from someone who is Native-speaking and understands the culture. This is important in the community and at the hospital (2/9, 22.2% of communities);
- Prevention of mental health problems helps so people don't become addicted (2/9, 22.2% of communities); and
- It would help if people could learn life skills for chronic stress problems (1/9, 22.2% of communities).

### Awareness & Education

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- Education helps so that people realize mental health problems and addictions are issues (awareness) and understand what they really are (education) (4/9, 44.4% of communities); and
- It helps when people who need the services are willing to use them (1/9, 11.1% of communities).

### Resources for Services

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- It helps to have more funding and flexibility (2/9, 22.2% of communities); and
- If we had a place for people to live and get support for mental illness/addictions (like in Waycobah), there could be a room set aside for someone who is in crisis and needs support from within the community. Support people would already be there (2/9, 22.2% of communities).





## Community Engagement Session Results

### Transportation

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- It would help to eliminate the complications with transportation and getting people to the services they need (1/9, 11.1% of communities).

Community members also identified what they think is needed in order to address addictions/substance abuse. They identified resources for services, cultural connections, programs for children and youth, parental involvement, and programs for the community.

### Resources for Services

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- We need core funding from the federal government (2/9, 22.2% of communities);
- We need additional resources for staff, volunteers, support groups (e.g., Alateen) (2/9, 22.2% of communities);
- We need more qualified staff (1/9, 11.1% of communities) and more effective addictions workers (1/9, 11.1% of communities);
- We need outreach mental health/addictions services in the community from the DHA (1/9, 11.1% of communities); and
- In larger communities there is a safe house – a place for people to go when they are in crisis. They can get support there, right in the community. Maybe there could be something like that in our community (1/9, 11.1% of communities).

### Cultural Connections

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- We need more cultural connections – we need a worker hired to facilitate cultural awareness and activities (1/9, 11.1% of communities);
- More programs, more funding, more emphasis is needed on recruitment of Mi'kmaq/Aboriginal doctors, nurses, dentists. There should be more Mi'kmaq/Aboriginal programs (health) for interested individuals (1/9, 11.1% of communities); and
- We need Native youth treatment centres (the closest one is in Newfoundland and Labrador) (1/9, 11.1% of communities).

### Programs for Children & Youth

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- We need a prevention program to stop children and youth from developing addictions/substance use problems (2/9, 22.2% of communities);
- Youth need their own space (1/9, 11.1% of communities); and
- We need to make the program interesting so kids will come (1/9, 11.1% of communities).

### Parental Involvement

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- We need parenting support programs and education so that parents can have healthy lives and show their kids the proper way (1/9, 11.1% of communities);
- We need more help at dances to keep kids involved (1/9, 11.1% of communities); and
- We need to involve parents in the school – get them engaged with the children in the school so they know what's going on. They've never been invited to be part of daily life in the school (e.g., helping in a classroom) (1/9, 11.1% of communities).

### Programs for the Community

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- We need on-reserve substance abuse workshops (1/9, 11.1% of communities);
- We need to be able to use our facilities – the school could be open for after school and weekend programs (1/9, 11.1% of communities);
- We need education on prescription drugs – people need to know how to follow their prescriptions (1/9, 11.1% of communities);
- We need funding for a recreation director and paid staff to offer programs (1/9, 11.1% of communities); and
- The fitness centre needs to be staffed so people can use it (1/9, 11.1% of communities).





## Community Engagement Session Results

### Priority Issue: Non-Insured Health Benefits (NIHB) Coverage

Non-insured health benefits (NIHB) coverage problems were identified as a health priority in five communities, or 41.7% of communities, as follows:

**Table 8** – Communities That Identified NIHB Coverage as a Priority

Community	NIHB Coverage Identified as a Priority
Acadia First Nation	+
Annapolis Valley First Nation	+
Bear River First Nation	
Eskasoni First Nation	
Glooscap First Nation	+
Membertou First Nation	
Millbrook First Nation	+
Paq'tnkek First Nation	+
Pictou Landing First Nation	
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these five community sessions identified the groups most affected by NIHB coverage problems as people who need transportation to and from nursing care (1/5, 20.0% of communities), people who need medication or services but can't afford to pay for it themselves (1/5, 20.0% of communities), people with disabilities (1/5, 20.0% of communities), Elders (2/5, 40.0% of communities), and the whole community (all ages) (4/5, 80.0% of communities).



### What are the Community Impacts?

Community session participants described how their communities are affected by NIHB coverage problems, including health impacts, financial impacts, administration of benefits, confusion about coverage, and impacts on other programs.

#### Health Impacts

- Prescriptions are not always covered through non-insured health benefits – there is a lack of federal commitment to assisting community members with various health programs (1/5, 20.0% of communities);





## Community Engagement Session Results

- Community members are getting sicker because they are unable to get the services or medications needed (1/5, 20.0% of communities);
- Sometimes coverage changes to include generic drugs only and they may not always work as well for some people (1/5, 20.0% of communities);
- People are getting drugs that are less expensive, that are not really what they need, so these drugs can be covered under First Nations Health (1/5, 20.0% of communities); and
- Some non-drug therapies such as chiropractor and physiotherapy are not covered by Health Canada. These services could keep some people off unnecessary medications (1/5, 20.0% of communities).

### Financial Impacts

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- Payment to service providers is very slow, so some (e.g., dentists) have now started asking individuals to pay up front because they can't afford to wait for reimbursement from NIHB. This means people are having to either do without other necessities so they can cover the costs for services until NIHB reimburses the service provider, or go without service because they need the money for other things (3/5, 60.0% of communities). For example, in one case, a family is expected to cover the costs of three sets of braces (\$20,000) up front, and get half reimbursed when the braces go on their kids' teeth, and the other half when the braces come off – years later! How are people supposed to cover these costs?;
- Some necessary services are not covered (e.g., dental services are covered only if the problem interferes with people's ability to eat). If something is considered 'cosmetic' (by NIHB), it will not be covered. What about crooked teeth and how that affects the self-esteem and well being of a young person? It's not only cosmetic and we should be the ones to decide what services are necessary (1/5, 20.0% of communities);
- When our medications aren't covered, we end up paying for them out of our own pockets because we need them. That takes away money from other things we need (1/5, 20.0% of communities); and
- NIHB is being drained by double-doctoring and prescription drug abuse, so fewer funds are available for other coverage (1/5, 20.0% of communities).

### Administration of Benefits

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- The 'prior approval' process doesn't work – a pharmacist/doctor has to write NIHB to advocate for a non-generic drug if that will work better, because even if the drug is approved, you have to wait too long to get the approval – in the meantime, you need the medication (1/5, 20.0% of communities);

### Confusion about Coverage

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- Coverage for drugs changes, and we don't know what is going to be covered (2/5, 40.0% of communities). For example, someone could be taking a drug that's been covered for the past five years, then suddenly when they go to renew their prescription, the drug isn't covered. Another example, smoking cessation drugs used to be covered, but they are not covered now. Why wouldn't they be – especially considering narcotics and addictive medications are covered and leading to prescription drug abuse? Shouldn't the system be helping people reduce dependency on addictive substance?;
- Narcotic drugs are covered through NIHB, but some antibiotics are not. Why is this? (1/5, 20.0% of communities); and
- Sometimes NIHB won't pay dispensing fees – not sure whether this is an overall change, or it just occurs in some cases (1/5, 20.0% of communities).







## Community Engagement Session Results

### Impacts on Other Programs

- Because the Band steps in to help people pay for things NIHB won't cover, other programs go without funding or attention (2/5, 40.0% of communities).



### What are the Challenges?

Communities experience several challenges to addressing NIHB coverage problems, including: funding, administration of benefits, lack of collaboration with other health plans, access to doctors on a timely basis, and access to opportunities.

### Funding

- There is a lack of funding (2/5, 40.0% of communities);
- Funding is provided only for people who are on reserve – our Band funds for people on and off reserve (1/5, 20.0% of communities);
- Instead of waiting 2-3 weeks to get in to see a doctor to do paperwork because the original prescription was not covered, people end up coming to the Band for funds to cover drugs, and the Band doesn't have the funding to cover the costs (1/5, 20.0% of communities);
- NIHB will fund travel for some services, but it is very difficult to navigate the system to help people get funding for travel to the services (1/5, 20.0% of communities);
- NIHB is a very expensive program each year. Not everyone gets the same benefits because they are not always known to the whole community, especially off-reserve Band members (1/5, 20.0% of communities); and
- There is a lack of commitment from the federal government for programs that are to be delivered (1/5, 20.0% of communities).

### Administration of Benefits

- Doctors are generally too busy to do the paperwork needed – some charge a \$15 fee for completing the forms and we have to cover those costs ourselves (1/5, 20.0% of communities);
- You wait 2-3 weeks to get into your doctor, then they prescribe something you need, you go to the pharmacy to get it and you find out that it's not covered. So you have to make another appointment to go back to your doctor so you can get a different prescription, wait another couple of weeks, then go back to the pharmacy... meanwhile you're getting sicker and sicker, and treatment could end up costing more. Or you end up paying for the drug yourself even though you can't afford it, because you know you need it to get better. This means you have to go without other things (1/5, 20.0% of communities); and
- Sometimes doctors are forced to prescribe generic drugs because they are cheaper and NIHB will cover them, even though these drugs may not work as well as brand name drugs in some cases. Doctors have to be able to prescribe the medications that will help us get better. Some doctors will insist on a particular drug vs. generic, but again, that comes down to whether an individual service provider is willing to advocate for her/his patient (1/5, 20.0% of communities).

### Lack of Collaboration with Other Health Plans

- NIHB doesn't coordinate with other drug plans to make sure that between them they cover more, instead of both covering the same thing.





## Community Engagement Session Results

So if someone's partner has health insurance coverage and we are on it, the coverage covers the same thing NIHB covers, plus since the other company is the first co-pay, we have to pay a \$5 fee (1/5, 20.0% of communities).

### Access to Doctors on a Timely Basis

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- Sometimes you have to wait quite a while for a doctor's appointment – so even if the doctor can fill out the forms and we can pay the fee, it takes too long to get the forms filled out when we need them (1/5, 20.0% of communities).

### Access to Opportunities

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- Pilot projects go to Bands with larger populations (1/5, 20.0% of communities).



### What is Working Well?

Communities described what they think is working well to address NIHB coverage problems. These factors include the Band addressing gaps in coverage, transportation coverage, advocacy by service providers, and system benefits.

### Band Addressing Gaps in Coverage

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- The Band will pay for medications and medical services not covered by Health Canada (3/5, 60.0% of communities).

### Transportation Coverage

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- Medical transportation is paid by non-insured for specialists (e.g., transportation; lodging; meals) (1/5, 20.0% of communities).

### Advocacy by Service Providers

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- Some good pharmacists will call doctors directly if a prescription isn't covered and suggest something else. This comes down to an individual pharmacist being willing to do it though, not because the system is designed to make sure we get the prescriptions we need promptly (1/5, 20.0% of communities).

### System Benefits

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- The NIHB system is identifying double-doctoring (1/5, 20.0% of communities).





## Community Engagement Session Results



### What is Needed?

When asked what helps to address NIHB coverage problems, participants identified administration of benefits and having a system navigator.

#### Administration of Benefits

- It helps if NIHB trusts our doctors, and doesn't challenge what they prescribe because the NIHB doctor (who doesn't know the patient) disagrees with what the doctor (with whom we have a relationship) prescribes (1/5, 20.0% of communities);
- Services not covered under NIHB are covered by other insurance companies. Why shouldn't NIHB cover the same services? (1/5, 20.0% of communities);
- There are guidelines for reimbursement, but they need to be updated and publicized (1/5, 20.0% of communities); and
- If First Nation people had control of the NIHB system, we would make it work for our communities (for example, we would pay promptly so that service providers wouldn't have to ask individuals to cover the costs) (1/5, 20.0% of communities).

#### System Navigator

- It helps to have someone to help navigate this system. There is now someone in place but it's new so it hasn't helped us yet. It's important that this person speaks in user-friendly (i.e., non-jargon; non-technical) terms that everyone can understand (1/5, 20.0% of communities).

Community members also identified what they think is needed in order to address NIHB coverage problems, including administration of benefits and funding.

#### Administration of Benefits

- We need clear communication about what is covered by whom (NIHB? INAC?) and how it all works – Chief & Council are confused, we're confused, off-reserve service providers are confused (1/5, 20.0% of communities);
- We need more information to go to the whole Band membership so there is equal access to programs and services as much as possible and practical (1/5, 20.0% of communities);
- It would help to have a liaison person come to each reserve to work all this through and be available to help make things clear and answer questions when needed (1/5, 20.0% of communities);
- Coverage needs to be consistent and fair (1/5, 20.0% of communities);
- We need a willingness to listen and a commitment by the federal government to allow community members to make the necessary changes in the various determinants of health (e.g., funding; resources) (1/5, 20.0% of communities); and
- We (First Nation people) need to have control of the system (1/5, 20.0% of communities).

#### Funding

- We need more funding – federal government has a fiduciary responsibility to fund Aboriginal people (1/5, 20.0% of communities); and
- We need fewer cuts by federal government, not only funding but services, medications, etc. (1/5, 20.0% of communities).





## Community Engagement Session Results

### Priority Issue: Elder Care/Services

Elder care and services was identified as a health priority in four communities, or 33.3% of communities, as follows:

**Table 9** – Communities That Identified Elder Care/Services as a Priority

Community	Elder Care Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	+
Bear River First Nation	
Eskasoni First Nation	
Glooscap First Nation	
Membertou First Nation	+
Millbrook First Nation	
Paq'tnkek First Nation	+
Pictou Landing First Nation	+
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these community sessions said that the groups most affected by the need for Elder care/services are people who are aging (1/4, 25.0% of communities), people with disabilities (1/4, 25.0% of communities), people who have medical conditions (1/4, 25.0% of communities), home care workers (1/4, 25.0% of communities), adult children caring for Elders (1/4, 25.0% of communities), and Elders (4/4).



### What are the Community Impacts?

Community session participants described how their communities are affected by the need for Elder care/services. Impacts include isolation of Elders, safety of Elders, the aging population and demand for services, and the need for transportation supports.

#### Isolation

- Many Elders' health limits their access to community programs (1/4, 25.0% of communities) and they are alone (1/4, 25.0% of communities);
- Some people have to go off-reserve to get the services, and then they are away from their community and their family (1/4, 25.0% of communities); and
- When elderly people go into nursing homes, etc. off-reserve, they usually give up and they die within a couple of months (1/4, 25.0% of communities).





## Community Engagement Session Results

### Safety of Elders

- Elders need services like home care and health care, and their families need to learn how to be good caregivers for them. This is tied in with Elders' safety and well-being – which includes the physical conditions of their houses and whether they are safe to live in (e.g., bad state of repair; uneven floors; drafty; mouldy) and get around in (1/4, 25.0% of communities); and
- Elders are experiencing economic abuse by younger family members. For example, they may receive a visit once a month from their grandchildren at the time their monthly cheque arrives because the grandchildren want money from them (1/4, 25.0% of communities).

### Aging Population & Demand for Services

- As people age and need more services, more funding will be needed to cover the services (2/4, 50.0% of communities). The Band does not have the funding to cover these services, and the Band's funding keeps decreasing; and
- The needs of Elders are greater than Home Care can provide (1/4, 25.0% of communities).

### Need for Transportation Supports

- Sometimes people don't have transportation to get to medical services off-reserve, even if they are willing to go and can get in for an appointment (1/4, 25.0% of communities).



### What are the Challenges?

Communities experience several challenges to addressing Elder care and services including jurisdictional issues, community-based supports, resources for services, and intimidation of Elders.

### Jurisdictional Issues

- Jurisdictional issues – who is responsible for what? It's not clear whether, or where, people can get help putting supports in place (e.g., wheelchair ramps) so they can stay in their homes (1/4, 25.0% of communities).

### Community-Based Supports

- There is a lack of family involvement (1/4, 25.0% of communities);
- It might be easier to build a facility on the reserve where several people who need supports (assisted living) can live together and share resources/supports, but people want to stay in their own homes (1/4, 25.0% of communities); and
- There are no long-term care facilities for Mi'kmaq people only (1/4, 25.0% of communities).

### Resources for Services

- There are limited staff and resources within Home Care (2/4, 50.0% of communities);





## Community Engagement Session Results

- The demand for services is increasing with the aging baby boomers (2/4, 50.0% of communities); and
- There is a lack of trained workers (1/4, 25.0% of communities).

### Intimidation of Elders

- Elders are intimidated at times (1/4, 25.0% of communities); and
- We have to have caring, respectful support workers (1/4, 25.0% of communities).

### What is Working Well?

Communities described what they think is working well to address Elder care and services. These factors include social support and medical supports.

#### Social Support

- It helps for Elders to have social supports, such as seniors' groups/clubs, trips, and dinners (2/4, 50.0% of communities).

#### Medical Supports

- It helps care for Elders when they have transportation to medical appointments (1/4, 25.0% of communities), home and community care (1/4, 25.0% of communities), and Lifeline – a way for Elders to call for help if they need it in an emergency (1/4, 25.0% of communities)



### What is Needed?

Participant identified existing services and supports, planning for future needs and culturally-safe services as helpful for addressing Elder care and services.

#### Existing Services & Supports

- It would help to have adequate homecare – so the Elder has someone to help look after them and their home, has someone to talk to and has someone to check on them regularly to make sure they are okay. This is also needed for people who are ill or recovering from an illness, even though they may not be elderly (1/4, 25.0% of communities);
- Having a Community Health Nurse consistent and here working 'hands on' with the community helps (1/4, 25.0% of communities); and
- It helps to have Lifeline, or some other regular system for checking in with Elders to make sure they are okay (1/4, 25.0% of communities).

#### Planning for Future Needs

- Knowing that the aging population is increasing and knowing that in 10 years people will have to access more services, planning ahead, now, would help us prepare and be ready when people do need more services (2/4, 50.0% of communities); and
- It would help to review the job description of support staff for Elders and adjust them where necessary (1/4, 25.0% of communities).





## Community Engagement Session Results

- It would help to review the job description of support staff for Elders and adjust them where necessary (1/4, 25.0% of communities).

### Culturally-Safe Services

- Elders need people to speak to them in their own language and someone who understands their life experience from their own culture (1/4, 25.0% of communities); and
- It would help to have an Elder Centre in the community (1/4, 25.0% of communities), or an Elders' room in an existing community building (2/4, 50.0% of communities).

Community members also identified what they think is needed in order to address Elder care and services, including supports, resources, and planning for future needs.

### Supports

- We need long-term care (nursing homes) (1/4, 25.0% of communities) and home care service and health care services in communities (1/4, 25.0% of communities);
- We need supports and learning opportunities for families to learn how to take care of Elders (1/4, 25.0% of communities); and
- We need transportation to medical appointments (1/4, 25.0% of communities).

### Resources

- We need additional financial and human resources (1/4, 25.0% of communities); and
- We need sufficient funding for the Band to cover the services people need/will need (1/4, 25.0% of communities).

### Planning for Future Needs

- We need to be planning ahead so we are prepared to deal with the increased need for services we know is coming (1/4, 25.0% of communities).

## Priority Issue:

**Water/Environment**

Water and environmental issues were identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 10 – Communities That Identified Water/Environment as a Priority**

Community	Water/Environment Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	
Bear River First Nation	





## Community Engagement Session Results

Community	Water/Environment Identified as a Priority
Eskasoni First Nation	
Glooscap First Nation	
Membertou First Nation	
Millbrook First Nation	+
Paq'tnkek First Nation	+
Pictou Landing First Nation	+
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these three sessions said that the whole community is affected by water and environmental issues.



### What are the Community Impacts?

Community session participants described how their communities are affected by water and environmental issues:

#### Water

- The quality of the drinking water is a concern and it has to be monitored and maintained (2/3, 66.7% of communities). We need people trained to monitor the water quality (2/3, 66.7% of communities), and we need a back-up person trained (1/3, 33.3% of communities);
- If there were water contamination it could potentially have very serious results (e.g., as in Walkerton, Ontario) (1/3, 33.3% of communities);
- Chemicals are added to the water to treat it and the chemicals are too strong for some people, and are making them sick (1/3, 33.3% of communities);
- Due to strong chlorine smell and taste, people choose not to drink the community water (1/3, 33.3% of communities);
- People use limited money to buy water filters and bottled water (1/3, 33.3% of communities), and the bottles the water comes in are said to be made of harmful chemicals as well (1/3, 33.3% of communities); and
- Due to our close proximity to the boat harbour, the community members have the impression the water is unfit for consumption or domestic use (1/3, 33.3% of communities).

#### Air Quality

- Community members experience breathing problems due to the poor air quality and the pollution from the county's industrial businesses (1/3, 33.3% of communities).







## Community Engagement Session Results



### What are the Challenges?

Communities experience several challenges to addressing water and environmental issues, including:

- We have only one person trained, so far there is not a back-up person. There is also no one from the Council who attends the training and information sessions to help with getting the community to understand how important this issue can be if there are water quality problems in the community (1/3, 33.3% of communities);
- Pollution contributes to global warming, which affects this community greatly (e.g., the boat harbour and local industry) (1/3, 33.3% of communities);
- Is soil testing being done? (1/3, 33.3% of communities); and
- It is challenging to get the government to listen to our health concerns (1/3, 33.3% of communities).



### What is Working Well?

Communities described what they think is working well to address water and environmental issues. These factors include:

- Having community-based water monitors trained to test the water regularly and consistently (3/3, 100.0% of communities);
- Having a Joint Environmental & Health Committee (with community, provincial, and federal government representatives) that meets monthly (1/3, 33.3% of communities);
- Having ongoing discussions about the boat harbour clean up with all levels of government (1/3, 33.3% of communities); and
- Having an air quality monitoring station in the community (1/3, 33.3% of communities).



### What is Needed?

Participants in the community sessions said that ongoing information sharing would help address water and environmental issues.

### Ongoing Information Sharing

- It would help if one of the Councillors or the Band Administrator would attend the information sessions provided by Health Canada on a regular basis (1/3, 33.3% of communities);
- We had more communication/discussion involving community (1/3, 33.3% of communities);
- We had updates on new research, studies – water testing, air monitoring, etc. (1/3, 33.3% of communities); and
- It would help to have up-to-date training for water monitors as needed (1/3, 33.3% of communities).





## Community Engagement Session Results

Community members (1/3, 33.3% of communities) said that they think the Chief and Council having information about the importance of the water monitoring program and the potential for problems is needed in order to address water and environmental issues.

### Priority Issue: **Housing**

Housing was identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 11** – Communities That Identified Housing as a Priority

Community	Housing Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	
Bear River First Nation	
Eskasoni First Nation	
Glooscap First Nation	
Membertou First Nation	
Millbrook First Nation	+
Paq'tnkek First Nation	+
Pictou Landing First Nation	
Potlotek First Nation	
Wagmatcook First Nation	+
We'koqma'q First Nation	

Participants in these community sessions said that seniors (1/3, 33.3% of communities), people who have disabilities (1/3, 33.3% of communities), and the whole community (3/3, 100.0% of communities) are affected by housing issues.



### What are the Community Impacts?

Community session participants described how their communities are affected by housing issues; specifically they discussed the impact of housing on seniors, housing allocation, state of repair, and overcrowding.

#### Impact on Seniors

- Seniors need to know where to go when they need something related to Housing (as well as for other lifestyle issues) (1/3, 33.3% of communities);





## Community Engagement Session Results

- We have improper housing/living conditions for seniors/community members (1/3, 33.3% of communities); and
- Housing is tied in with Elders' safety and well-being – which includes the physical conditions of their houses and whether they are safe to live in (e.g., bad state of repair; uneven floors; drafty; mouldy) and get around in (1/3, 33.3% of communities).

### Housing Allocation

- People who have disabilities need houses with supports to assist them in daily living – yet some people who do not have disabilities are living in homes with these supports (1/3, 33.3% of communities); and
- Housing has sometimes gone to very young people, not necessarily the neediest. The Housing Authority decides on who gets housing based on a set of criteria – this has to be followed and supported by Council (1/3, 33.3% of communities).

### State of Repair

- When people don't know how to – or simply don't – look after their homes properly, it gets unhealthy and in need of repair (1/3, 33.3% of communities). Safety becomes an issue, especially for children (1/3, 33.3% of communities) and Elders (1/3, 33.3% of communities) living in the home; and
- Mould is a big problem in some houses and people don't understand how to prevent it or fix it (2/3, 66.7% of communities), and many houses also have worms (1/3, 33.3% of communities).

### Overcrowding

- People are living in multi-generational homes that were designed for one family because there is not enough housing for everyone and young people have no options (e.g., apartments; smaller homes) when they are ready to leave home, so they end up living with their parents/grandparents (2/3, 33.3% of communities).



### What are the Challenges?

The challenges communities experience with regard to housing are based on the state of repair and maintenance of the houses and on allocation of housing:

#### Repairs/Maintenance

- When the repair person arrives, people want other things fixed. We need a letter or form letter from the Band Administrator to go to the residents to say which repairs are approved (and which repairs are not approved) (1/3, 33.3% of communities);
- People receive an amount each year for maintenance of their homes – but often have to dip into this money for diapers, things for their kids. It's not clear that the checks and balances are for this maintenance money – if people need less one year and more the next year, how is the money distributed? (1/3, 33.3% of communities); and
- Some people are still living in houses that were condemned a couple of years ago (1/3, 33.3% of communities).





## Community Engagement Session Results

### Housing Allocation

- It is unclear how housing is allocated (1/3, 33.3% of communities).



#### What is Working Well?

Communities described what they think is working well to address housing issues. Specifically they noted that:

- Our housing program has a repair person (1/3, 33.3% of communities); and
- The Band provides free repairs to people living in Band-owned homes (1/3, 33.3% of communities).



#### What is Needed?

When asked what helps to address housing issues, participants identified the following supports:

- Health staff (especially the Community Support and Family Enrichment Worker) needs to be involved in housing issues – when the house continually needs repairs because of the lack of discipline of the children by the parent(s). Parents have to teach their children by example of how to respect their home and look after it properly, and health staff can help with this (1/3, 33.3% of communities);
- It helps to have educational programs to help people understand they need to learn how to look after their own homes (1/3, 33.3% of communities);
- A maintenance department with staff that come and work on preventative maintenance and repairs in the homes (1/3, 33.3% of communities); and
- It helps to look at the needs of the people living in the homes (1/3, 33.3% of communities).

Community members also identified what they think is needed in order to address housing issues, including information about how people can care for their homes and support from community leaders to require that people look after their homes.

### Information about Caring for Homes

- If we have a check-off list for homeowners with information about home maintenance and we can help people learn to do routine maintenance, the houses will be better looked after in the long run and last longer (1/3, 33.3% of communities);
- We need guidelines for people to follow for house maintenance and for dealing with mould at different stages (1/3, 33.3% of communities); and
- When people get a new home, they need to be shown how to look after it, how and when to use and clean the equipment (e.g., air exchanger; furnace) (1/3, 33.3% of communities).





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### Leadership

- We need leadership and policy to back us up when we try to address something. For example, when we go into a house for some reason and notice that it needs to be cleaned, maintenance work or repaired, we need to be able to make sure that it happens – people need a letter or something from Council to say that they have to do things to look after their places. They should sign an agreement when they get the keys to their new house (1/3, 33.3% of communities); and
- A meeting is needed to develop some sort of guidelines about what types of information the tenants need to have when they are allocated a new home, also details about who will organize the information and in what format it will be given to the new tenants (1/3, 33.3% of communities).

### Priority Issue: Nutrition/Healthy Eating

Nutrition and healthy eating were identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 12** – Communities That Identified Nutrition/Healthy Eating as a Priority

Community	Nutrition/Healthy Eating Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	
Bear River First Nation	
Eskasoni First Nation	+
Glooscap First Nation	
Membertou First Nation	+
Millbrook First Nation	+
Paq'tnkek First Nation	
Pictou Landing First Nation	
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these community sessions said that the groups most affected by nutrition/healthy eating are children (2/3, 66.7% of communities) and everyone in the community (2/3, 66.7% of communities).





## Community Engagement Session Results



### What are the Community Impacts?

Community session participants described how their communities are affected by nutrition/healthy eating:

- Poor health (3/3, 100.0% of communities) because people can't afford to buy healthy, natural foods (1/3, 33.3% of communities);
- Parents, children, and youth are not eating healthy, not getting enough exercise, which leads to increased chronic diseases, such as obesity (2/3, 66.7% of communities), diabetes (2/3, 66.7% of communities), and increased heart disease (1/3, 33.3% of communities); and
- Poor health/nutrition is linked to addictions and mental health problems (1/3, 33.3% of communities).



### What are the Challenges?

Communities experience several challenges to addressing nutrition/healthy eating including:

- We don't have an onsite community nutritionist – there is currently one nutritionist for all Bands in the Union of Nova Scotia Indians (UNSI) (1/3, 33.3% of communities); and
- We need very structured physical activities at the gymnasium for children and youth and we are not always able to offer this – we need accountability for offering these structured activities to all kids (1/3, 33.3% of communities).



### What is Working Well?

Communities described what they think is working well to address nutrition/healthy eating. These factors include meal support programs, a food bank, diabetes information sessions, and groups for kids:

- A limited meal program currently exists funded by the Gaming Commission. A number of home care clients receive meals prepared in their homes (1/3, 33.3% of communities);
- A Food Bank in the community was helping until it recently closed (1/3, 33.3% of communities);
- Canada Prenatal Nutrition Program (CPNP) workshops help pregnant women understand how nutrition affects their babies (1/3, 33.3% of communities);
- Having a diabetes working group (1/3, 33.3% of communities), school sessions on diabetes (1/3, 33.3% of communities), one-to-one nutritional counselling on diabetes (1/3, 33.3% of communities), and diabetes workshops (1/3, 33.3% of communities);
- Physical activity 'Klubs for Kids' program is working well to help children in elementary and junior high be active (1/3, 33.3% of communities); and





## Community Engagement Session Results

- Healthy eating – 'Kids in the Kitchen' – program has been offered and was well received (1/3, 33.3% of communities).



### What is Needed?

When asked what helps to address nutrition/healthy eating, participants in one community noted that:

- The UNSI nutritionist is currently working close by – she is part of our Diabetes Working Group (1/3, 33.3% of communities).

Community members also identified what they think is needed in order to address nutrition/healthy eating including:

- More financial and human resources (1/3, 33.3% of communities);
- A dietician or nutritionist to help everyone (not just diabetics) learn about eating healthy. We need to make 1:1 referrals for this – people won't go to the hospital to see someone usually (1/3, 33.3% of communities); and
- We could do a survey with the community to see what people would like for wellness programs (1/3, 33.3% of communities).

### Priority Issue: Transportation to Services

Transportation to services was identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 13** – Communities That Identified Transportation to Services as a Priority.

Community	Transportation to Services Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	
Bear River First Nation	+
Eskasoni First Nation	
Glooscap First Nation	+
Membertou First Nation	
Millbrook First Nation	
Paq'tnkek First Nation	
Pictou Landing First Nation	
Potlotek First Nation	
Wagmatcook First Nation	+
We'koqma'q First Nation	

Participants in these community sessions said that the whole community is affected by the need for transportation to services.





## Community Engagement Session Results



### What are the Community Impacts?

Community session participants described how their communities are affected by lack of transportation to services:

#### Lack of Access to Services

- We have no medical drivers to help people get to and from medical appointments (e.g., bone scans are done only in Halifax or another distant town). People can't get to medical appointments and we don't have enough medical drivers or funding for medical drivers (3/3, 100.0% of communities);
- We cannot access a public transportation system from the reserve – the closest access point is [town] (1/3, 33.3% of communities);
- People can't access transportation to get groceries (e.g., no grocery store on-reserve) or prescriptions (1/3, 33.3% of communities);
- Youth cannot access off-reserve recreational opportunities (1/3, 33.3% of communities); and
- People working in the Health Centre are spending time trying to find rides for people because they don't have access to transportation (1/3, 33.3% of communities).

*"Many people miss appointments, procedures, and appointments with medical specialists, because they don't have any way to get there. They want to go, but maybe their drive didn't show up, or the car broke down, so they end up missing. This is a big burden on the health care system. This also feeds the stereotype many health care workers have about First Nations people not bothering to show up for appointments. Then people are not treated well when they finally are able to get to appointments."* (Community Engagement Sessions)



### What are the Challenges?

Communities experience several challenges to addressing transportation to services including problems with existing transportation support services.

#### Problems with Existing Transportation Supports Systems

- Health Canada's transportation program doesn't fit a community of this size. The program is limited, and doesn't cover time drivers wait, going to the drug store, the increased price of gas (1/3, 33.3% of communities);
- Insurance requirements limit the number of people who are willing to drive (1/3, 33.3% of communities);
- Lack of transportation makes it hard to get services to help people deal with addictions. NADACA workers are not allowed to transport people to services (e.g., detox) and the closest detox centres are [town] and Halifax. They are not insured to drive people and not supposed to even if they incur the cost of the insurance themselves. Without public transportation, NADACA workers are forced to suck up the costs themselves to get the person to the services they need. This would not happen if First Nation people were administering the program (1/3, 33.3% of communities);







## Community Engagement Session Results

- Non-insured health benefits (NIHB) will fund travel for some services, but it is very difficult to navigate the system to help people get funding for travel to the services. NIHB will not, for example, fund NADACA workers to get people to services and will pay families only a very low km rate if they take their family member to services. If an advocate has this much difficulty connecting people to the services, most people would just give up if they were trying to do this on their own (1/3, 33.3% of communities);
- Health Canada will pay for some travel, but only to the closest medical specialist. So for example, someone may have been going to the same eye doctor in [town] for 10 years, but Health Canada will pay for travel only to [closer town] – the person then has to leave a doctor they have a relationship with, or pay the difference in travel costs to stay with their own doctor (1/3, 33.3% of communities);
- Some people will not pay the costs of blood collection on-reserve or pay for gas to get to the city or [town] for medical services because they can't afford it or they choose to use the money for something else, when other people (off-reserve) are getting the service for free (1/3, 33.3% of communities); and
- The Band office has to issue cheques to pay for transportation when it is covered and the cheques need two signers. Sometimes there aren't two signers around, so a cheque can't be signed and the driver can't cash it to buy gas to take someone to an appointment (1/3, 33.3% of communities).



### What is Working Well?

Communities described what they think is working well to address the need for transportation to services:

- The pharmacy in [town] will deliver prescription drugs to the reserve (1/3, 33.3% of communities);
- Blood collection is done on the reserve. Even though we have to pay \$10 for the service – which we shouldn't have to – it's still cheaper than having to take a taxi because we don't have a public transportation option to get to the pharmacy (1/3, 33.3% of communities); and
- We have one driver designated for taking people to detox. That works well as long as he is available (1/3, 33.3% of communities).



### What is Needed?

When asked what helps to address transportation to services, participants identified three things:

- Funding to cover transportation costs (1/3, 33.3% of communities);
- Service providers coming to the reserve (1/3, 33.3% of communities); and
- Eliminating the complications with transportation and getting people to the services they need (1/3, 33.3% of communities).

Community members also identified what they think is needed in order to address transportation to services, including having a community-controlled system, flexibility to current supports, and access to services.





## Community Engagement Session Results

### Community Controlled System

- We need a transportation system with a structured schedule and route so people can access the services they need (1/3, 33.3% of communities);
- We could have one car in the community that could be used for health appointments and/or social opportunities, and prevent depreciation of personal vehicles (2/3, 66.7% of communities); and
- Having a salaried driver(s) (1/3, 33.3% of communities).

### Flexibility to the Current Supports

- We need changes to the existing policy to make it more flexible (1/3, 33.3% of communities); and
- The Band could provide the Health Centre with emergency funds to pay drivers for medical appointments and the Health Centre and the Band could sort out the paperwork afterwards, so people wouldn't have to miss their appointments (1/3, 33.3% of communities).

### Access to Services

- We need to have access to services close, instead of travelling to [town] or [town] – 1 1/2 hours away. It would be easier to find someone to take people to appointments if they were closer (1/3, 33.3% of communities).

**Priority Issue: Health Promotion Education**

Health promotion education was identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 14** – Communities That Identified Health Promotion Education as a Priority

Community	Health Promotion Education Identified as a Priority
Acadia First Nation	+
Annapolis Valley First Nation	+
Bear River First Nation	
Eskasoni First Nation	
Glooscap First Nation	
Membertou First Nation	
Millbrook First Nation	
Paq'tnkek First Nation	
Pictou Landing First Nation	
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	+





## Community Engagement Session Results

Participants in these community sessions said that the whole community is affected by health promotion education (2/3, 66.7% of communities) and that focusing on youth (1/3, 33.3% of communities) can prevent them from developing health issues.



### What are the Community Impacts?

Community session participants described how their communities are affected by the need for health promotion education:

- People miss out on learning/educational information and opportunities if the information isn't shared in a systematic way. Some people (e.g., those with cable TV) may get the information when others (e.g., those without cable TV) don't get it, depending on how the information is shared (2/3, 66.7% of communities); and
- People are not as healthy as they could be if they understood the importance of looking after themselves (1/3, 33.3% of communities).



### What are the Challenges?

Communities experience several challenges to addressing health promotion education including:

- People have very unhealthy habits and it's hard to get them to change (1/3, 33.3% of communities);
- It can be difficult to get people to attend workshops (1/3, 33.3% of communities);
- You have to consider literacy levels (written information isn't the best form for some people), income (e.g., some people have cable TV and can see information there and others don't), and access to the Internet (some people get information from the Internet and through e-mail and others don't) (1/3, 33.3% of communities); and
- Sometimes things get started (e.g., community newsletter) and they go as long as a volunteer has energy for it, then it stops because the volunteer gets burned out (1/3, 33.3% of communities).



### What is Working Well?

Communities described what they think is working well to address health promotion education including:

- Various workshops (1/3, 33.3% of communities);
- Community newsletters (for people who read written information) (1/3, 33.3% of communities);
- Community website, for the people who have Internet access and feel comfortable getting information this way (1/3, 33.3% of communities); and
- The community channel is a good tool for people who have cable TV (1/3, 33.3% of communities).





## Community Engagement Session Results



### What is Needed?

When asked what helps to address health promotion education, participants identified health centre staff (1/3, 33.3% of communities) and having health information available (1/3, 33.3% of communities).

Community members also identified what they think is needed in order to address health promotion education including having an effective communication system, education and awareness initiatives, and qualified staff.

#### Effective Communication System

- We need a way to let the community know about things and get information out there about all issues (1/3, 33.3% of communities); and
- We need a central area for getting information back and forth. This has to be done in a planned coordinated way that looks at the big picture of the community. This system has to be consistent and last. Communication and education can't just be done until people burn out – it has to be part of the way the community works (1/3, 33.3% of communities).

#### Education & Awareness

- We need to be able to educate people about health issues – for example, healthy diet, importance of exercise, the proper way to take medication (understand and follow prescriptions accurately), the harmful effects of drug abuse, smoking, and alcohol during pregnancy (1/3, 33.3% of communities); and
- We need more awareness in general about health and how important it is for people to look after themselves (1/3, 33.3% of communities).

#### Qualified Staff

- We need more qualified staff (1/3, 33.3% of communities).

### Priority Issue: Health Services for Non-Natives Living on Reserve

Health services for non-Natives living on reserve was identified as a health priority in three communities, or 25.0% of communities, as follows:

**Table 15** – Communities That Identified Health Services for Non-Natives Living on Reserve as a Priority

Community	Services for Non-Natives Living on Reserve Identified as a Priority
Acadia First Nation	
Annapolis Valley First Nation	+
Bear River First Nation	





## Community Engagement Session Results

Community	Services for Non-Natives Living on Reserve Identified as a Priority
Eskasoni First Nation	
Glooscap First Nation	+
Membertou First Nation	
Millbrook First Nation	
Paq'tnkek First Nation	
Pictou Landing First Nation	+
Potlotek First Nation	
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these community sessions said that the groups most affected by health services for non-Natives living on reserve are non-Native people living on reserve with Native partners/children (1/3, 33.3% of communities) and the whole community (3/3, 100.0% of communities).



### What are the Community Impacts?

Community session participants described how their communities are affected by health services for non-Natives living on reserve:

#### Lack of Funding to Cover Services for Non-Natives

- The Band doesn't have funding to provide services to Non-Native people and no one else covers costs for them as long as they are living on-reserve. How is their health supposed to be looked after? (1/3, 33.3% of communities);
- People living on the reserve who do not have status require health services, and coverage for home care, medications, social assistance. The Band does not receive funding to cover these costs. Because of the social guidelines, the Band would pay for the costs, even without needed funding to do so. This means the Band does not have the funds to pay for other necessities (1/3, 33.3% of communities); and
- Children born on the reserve without status still need education and services that everyone else on the reserve needs. The community makes sure the children have the services they need, but we do not receive the funding to cover the costs of providing the services (this means that we have less money to pay for other things we have responsibility for) (1/3, 33.3% of communities).

#### Rights of Non-Native Community Members

- If a non-Native's partner dies, the non-Native would lose their home and have to move off the reserve (some changes to the *Indian Act* vis-à-vis the *Charter of Human Rights and Freedoms* may be changing this). Even if this didn't happen, if a Chief and Council weren't good, they could make the person's life on the reserve a living hell – this shouldn't be left up to chance. Communication about the rights of and services for non-Natives living on reserve is very poor – Chief and Council are not informed about the regulations, and can't then inform people in the community. Furthermore, Chief and Council express their concerns, but they fall on deaf ears (1/3, 33.3% of communities).





## Community Engagement Session Results



### What are the Challenges?

Communities experience several challenges to addressing health services for non-Natives living on reserve including funding implications, jurisdictional issues, and cultural implications.

#### Funding Implications

- We are paying for services we don't have funding for – this means that we have less money to pay for other things we need to cover on the reserve (1/3, 33.3% of communities); and
- The formula funding not changed to reflect community numbers or increase in services (1/3, 33.3% of communities).

#### Jurisdictional Issues

- Jurisdictional issues – off-reserve service providers and organizations think that the Band covers the costs of services for non-Natives living on-reserve, so the off-reserve organizations do not cover the costs. In fact, the Band does not receive funds for this. Who has responsibility and who is willing to take responsibility? (2/3, 66.7% of communities).

#### Cultural Implications

- What will happen down the road in terms of identity for the children who are born on-reserve without status and for people on the reserve with status? We are concerned about assimilation if we are told that our children are not native, and not eligible for services...we need to keep our language and culture and make sure the children learn it (1/3, 33.3% of communities).



### What is Working Well?

One community identified that what is working to address health services for non-Natives living on reserve is that the community will look after all people with no status in the community. This is not [the system] working well, but is a community sacrifice (1/3, 33.3% of communities).



### What is Needed?

When asked what helps to address health services for non-Natives living on reserve, participants stated that:

- The public system would pay for non-status people's education and health services if they were living off-reserve, so why not if they live on-reserve? We need to be able to charge the public system for the costs of providing service to non-status people living on the reserve (1/3, 33.3% of communities);





## Community Engagement Session Results

- Funding formulas need to increase to provide monies for non-status community members, or obtain the funding from the appropriate provincial system (1/3, 33.3% of communities); and
- We need to encourage interaction [information sharing] between First Nation communities (1/3, 33.3% of communities).

Community members also identified what they think is needed in order to address health services for non-Natives living on-reserve including:

- A clear funding arrangement for services for non-Natives living on reserves (1/3, 33.3% of communities); and
- Communication between Chief/Council and the appropriate level of government about the funding rules (1/3, 33.3% of communities).

**Priority Issue: Improved Funding for Health Services**

Improved funding for health services was identified as a priority in three communities, or 25.0% of communities, as follows:

Community	Mental Health Identified as a Health Priority
Acadia First Nation	
Annapolis Valley First Nation	
Bear River First Nation	
Eskasoni First Nation	
Glooscap First Nation	+
Membertou First Nation	
Millbrook First Nation	
Paq'tnkek First Nation	+
Pictou Landing First Nation	
Potlotek First Nation	+
Wagmatcook First Nation	
We'koqma'q First Nation	

Participants in these three community sessions stated that the whole community is affected by the need for improved funding for health services (3/3, or 100.0% of communities), and one community (1/3, or 33.3% of communities) also identified Elders and youth as the most vulnerable.



### What are the Community Impacts?

Community session participants described how their communities are affected by the need for improved funding for health services, including: insufficient funding for appropriate programs and services; insufficient NIHB coverage; the Band having to absorb costs; negative impacts on individual community members; and lack of cultural safety.





## Community Engagement Session Results

### Insufficient Funding for Appropriate Programs and Services

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- There is a lack of funding to adequately provide the programs and services that are needed in the community, and a lack of funds to cover additional time needed to offer additional programs and services. This lack of resources means we can't employ people to do what needs to be done to help our community (1/3, 33.3% of communities);
- We don't have funding for recreational facilities, to keep our youth active and healthy and give them something to do (and we don't have access to public transportation to get them to off-reserve activities) (1/3, 33.3% of communities); and
- The population is increasing but the funding amounts don't change, so the amount of funding is actually decreasing (1/3, 33.3% of communities).

### NIHB Coverage Insufficient

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- Prescriptions are not always covered though non-insured health benefits – there is a lack of federal commitment to assisting community members with various health programs (1/3, 33.3% of communities);
- There is no coverage for physiotherapy, orthotics, occupational therapy, a lot of orthodontic work. What are people who need these services supposed to do? (1/3, 33.3% of communities); and
- Follow through is not done – e.g., if someone has a root canal, they need a crown, but crowns are not covered (1/3, 33.3% of communities).

### Band Absorbs Costs

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- The Band does not receive adequate funding for the services the community needs. Our Band has to support families with gaming money (1/3, 33.3% of communities);
- We don't receive enough funding to cover our staff (for example the Band has to use some of its funds to cover some staff positions in the Health Centre) (1/3, 33.3% of communities); and
- The community expects the Chief and Council to be accountable if there are no services. If the Band then pays for the services when it doesn't have the money, it has to go to the federal government to make sure we have enough funding to offer the programs and services we need, in the community, in our language, in a way that is culturally appropriate for the community (1/3, 33.3% of communities).

### Negative Impacts on Community Members

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- As a result of not having programs and services that people need, some people are isolated and their self esteem is low, parenting skills aren't what they need to be, parents aren't involved in their children's lives, people aren't active, they are using drugs and alcohol, and there is abuse and family violence, and vandalism. People also don't have respect for each other or themselves (1/3, 33.3% of communities).
- Probation orders may require people to participate in services or supports, but these supports may not even be available in the community. So the person is in breach of probation even if s/he wants to access the services (1/3, 33.3% of communities).

### Cultural Safety

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- We can't speak our own language when we go to the hospital or for services outside the community (1/3, 33.3% of communities); and
- People are concerned about confidentiality when they get services in the community – and it is sometimes broken. Our workers need to be trained to follow a professional code of conduct, and we need outside professionals to come to the community for some services (e.g., mental health) (1/3, 33.3% of communities).







## Community Engagement Session Results



### What are the Challenges?

Communities perceive several challenges related to the need for improved funding for health services, including: a lack of commitment from federal government for stable, adequate funding; the Band being forced to draw on other revenue to subsidize health services and programs; the inability to offer some programs; difficulty accessing transportation to obtain services outside the community; and a lack of cultural sensitivity outside the community.

#### Lack of Commitment for Stable, Adequate Funding from Federal Government

- There is a lack of commitment from the federal government for programs that are to be delivered (1/3, 33.3% of communities); and
- The challenge is the lack of funding for health services/medication (1/3, 33.3% of communities).

#### Band Forced to Draw on Other Revenue to Subsidize Health Services and Programs

- Fishing and gaming is used to subsidize funding from the federal government, when it should be used to support the industries. We are robbing Peter to pay Paul (1/3, 33.3% of communities); and
- The community doesn't understand cuts to welfare and education, and they look to the Band to cover things (1/3, 33.3% of communities).

#### Some Programs and Services Cannot Be Offered

- There isn't enough funding so some needed programs and services are not offered, and the ones that are offered are not offered consistently (1/3, 33.3% of communities).

#### Transportation to Services Outside the Community

- We have to travel outside the community for services, and many people don't have access to vehicles. We rely on a medical carrier, and we might be running late, but we're not going to cancel an appointment because we're running late, yet people may expect us to (1/3, 33.3% of communities).

#### Lack of Cultural Safety Outside the Community

- We're not going to stay away from the hospital when one of our community members is there dying or has died. We need to go be there and hospital staff need to understand and respect that it is part of our culture (1/3, 33.3% of communities).





## Community Engagement Session Results



### What is Working Well?

Communities described what they think is working well to address the need for improved funding for health services, namely the Band addressing gaps in coverage, and the Band arranging for programs and services.

#### Band Addressing Gaps in Coverage

- The Band came up with funds to put in a pool in the community. There is a lot of single parents in the community – having a recreational facility (pool) on the reserve means that their children can participate (1/3, 33.3% of communities); and
- The community provides what it can – e.g., in the school we provide breakfast, lunch, snacks, transportation, we provide as much home care as people need when they come out of the hospital (1/3, 33.3% of communities).

#### Band Providing/Arranging Programming

- Communications between departments, Band staff, and community members, outside organizations to start to bring in proper resources, etc. (e.g., Mi'kmaq Family & Children's Services, RCMP, Women's Resource Centre) (1/3, 33.3% of communities).



### What is Needed?

When asked what helps to address the need for improved funding for health services, participants identified increased funding by federal government; a willingness to listen on the part of the federal government; funding to cover transportation costs; and cultural safety.

#### Increased Funding by Federal Government

- Adequate, consistent, secure funding from the federal government (3/3, 100.0% of communities) to allow our community the flexibility to be self-sufficient (1/3, 33.3% of communities), to offer supports and programs for different age groups in the community (1/3, 33.3% of communities), and to have trained workers who can offer services such as home care (1/3, 33.3% of communities).

*"My cousin may be willing to help look after my Mom, but Mom needs someone who is trained to give her the care she needs."*  
(Community Engagement Sessions)

- Willingness to listen, and a commitment by the federal government to allow community members to make the necessary changes in the various determinants of health (e.g., funding, resources) (1/3, 33.3% of communities).

#### Funding for Transportation

- Need funding to cover transportation costs (1/3, 33.3% of communities)





## Community Engagement Session Results

### Cultural Safety

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- We need to have interpreters in hospitals and health centres, so we can have culturally sensitive care are in our own language, and we need to have the health care system be culturally sensitive to our needs (2/3, 66.7% of communities).





# 4 YOUTH WEB SURVEY RESULTS

Mi'kmaq • Nova Scotia • Canada

TRIPARTITE FORUM

**HEALTH WORKING COMMITTEE**

## *Exploring Health Priorities in First Nation Communities in Nova Scotia*



**HORIZONS**  
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## Youth Web Survey Results<sup>10</sup>

### Top Five Community Health Priorities

Participants in the First Nation youth web survey were asked to identify the health issues that they believed were most important to their community. These priority health issues (in order of priority) are outlined in the following table:

**Table 16 – Top Five Community Health Priorities Identified by Youth**

Health Priority Identified	# of Responses	% of Responses
Drug/Solvent Misuse/Abuse (#1 priority)	22	8.7
Alcohol Misuse/Abuse (#2 priority)	21	8.3
Loss of Culture (#3 priority)	17	6.7
Education (#4 priority)	15	5.9
Mental Health (#5 priority)	14	5.5

#### Priority Issue: Drug and/or Solvent Misuse/Abuse

*“You mostly see people abusing drugs and alcohol and you want so much for them. You want people you care about being healthy.”*  
(Youth Web Survey Participant)

Drug and/or solvent misuse/abuse was the number one community health priority identified by web survey participants (22 responses, 8.7% of responses<sup>11</sup>). It was also the top priority<sup>12</sup> identified by youth from Potlotek, Millbrook, and We'koqma'q First Nations. Relevant comments provided by participants included:

- Drug/alcohol abuse is a problem in our community (question 8 – 7 responses, 8.1% of responses);
- Drug abuse/addiction is an important topic (question 18 – 3 responses, 20.0% of responses);
- Drugs/alcohol are easy to get in the community (question 13 – 1 response, 3.6% of responses); and
- Need a drug rehabilitation centre (question 14 – 1 response, 2.6% of responses).

When asked what is working well in their community to address this issue, youth provided the following comments:

- A drug and alcohol worker is available in the community who works with youth (question 12 – 1 response, 2.8% of responses);
- A Cultural and Recreational Youth Program is offered on the reserve that offers drug/alcohol free events for youth and gets youth involved in sports and events (question 12 – 1 response, 2.8% of responses); and
- The DARE program is offered in the community (a life-skills program for youth to help them avoid involvement in drugs, gangs, and violence) (question 12 – 1 response, 2.8% of responses).

<sup>10</sup> The detailed results of the youth web survey can be found in Appendix E.

<sup>11</sup> Please note that the percentages included in this report represent the number of responses to each item vs. the number of participants who selected/reported each item. This approach was necessary to account for the fact that participants could select/report more than one item for most of the survey questions.

<sup>12</sup> Please note that several of the First Nation communities represented in the youth web survey had more than one top priority (i.e., the items ranked exactly the same). It was sometimes not possible to determine top priorities for other First Nation communities, due to relatively low survey response rates from these communities.





## Youth Web Survey Results

### Priority Issue: Alcohol Misuse/Abuse

*“Alcoholism is a big issue seen on the Rez which is quite sad if you ask me. That goes along with suicide. I don’t want to lose another family member, friend or neighbor to suicide.”* (Youth Web Survey Participant)

Alcohol misuse/abuse was the second highest community health priority identified by participants (21 responses, 8.3% of responses). It was also the top priority identified by youth from Membertou First Nation. Relevant comments provided by participants included:

- Drug/alcohol abuse is a problem in our community (question 8 – 7 responses, 8.1 % of responses); and
- Drugs/alcohol are easy to get in the community (question 13 – 1 response, 3.6% of responses).

When asked what is working well in their community to address this issue, youth provided the following comments:

- There are Alcoholics Anonymous (AA) meetings in the community (question 12 – 1 response, 2.8% of responses);
- A drug and alcohol worker is available in the community who works with youth (question 12 – 1 response, 2.8% of responses); and
- A Cultural and Recreational Youth Program is offered on the reserve that offers drug/alcohol free events for youth and gets youth involved in sports and events (question 12 – 1 response, 2.8% of responses).

### Priority Issue: Loss of Culture

*“With the loss of tradition people lose who they are which I believe makes anger in their lives, and most people that go back to traditions seem to be happier and don’t abuse their selves and others.”* (Youth Web Survey Participant)

Loss of culture was the third highest community health priority identified by participants (17 responses, 6.7% of responses). It was also the top priority identified by youth from Eskasoni and Pictou Landing First Nations. Relevant comments provided by participants included:

- Loss of culture/tradition is a problem in our community (question 8 – 4 responses, 4.7% of responses);
- Loss of culture/tradition leads to anger, unhappiness, abuse, etc. (question 8 – 2 responses, 2.3% of responses);
- Loss of culture/tradition means we are losing the culture of the first people in North America (question 8 – 1 response, 1.2% of responses);
- Need more cultural teachings (question 18 – 1 response, 6.7% of responses); and
- Need a building for cultural events (question 18 – 1 response, 6.7% of responses).

When asked what is working well in their community to address this issue, one youth reported that young children in his/her community are starting to become interested in bringing culture back to life (question 12– 1 response, 2.8% of responses).





## Youth Web Survey Results

### Priority Issue: Education

*“Education is also important. Especially for youth. It is their path to a good future.” (Youth Web Survey Participant)*

Education was also a highly ranked community health priority identified by participants (15 responses, 5.9% of responses). It was also the top priority identified by youth from Annapolis Valley and Membertou First Nations. Relevant comments provided by participants included:

- Education is important because it sets youth on a good future path (question 8 – 2 responses, 2.3% of responses); and
- Need to improve education (question 12 – 1 response, 2.6% of responses).

When asked what is working well in their community to address this issue, four youths responded that the schools in their communities are working well to address this issue (question 12 – 4 responses, 11.1% of responses).

### Priority Issue: Mental Health

*“Suicide and self-esteem would kinda go hand in hand. If kids had good self-esteem they wouldn’t want to end their life. It’s the pressure of living in the reserve, the feeling you’ll always be here and not become anything.” (Youth Web Survey Participant)*

Mental health was also a highly ranked community health priority identified by participants (14 responses, 5.5% of responses)<sup>13</sup>. Relevant comments provided by participants included:

- Suicide and stress are problems in our community (question 8 – 5 responses, 5.8% of responses); and
- There is no one for youth to talk to or youth are unsure of who to talk to (question 13 – 2 responses, 7.1% of responses).

When asked what is working well in their community to address this issue, two youth reported that programs to prevent suicide and stress among youth are available in their community (question 12 – 2 responses, 5.6% of responses).

## Top Five Youth Health Priorities

Participants in the First Nation youth web survey were also asked to identify the health issues that they believed were most important to youth their community. These priority health issues (in order of priority) are outlined in the following table:

**Table 17 – Top Five Youth Health Priorities**

Health Priority Identified	# of Responses	% of Responses
Education (#1 priority)	21	10.3
Drug/Solvent Misuse/Abuse (#2 priority)	19	9.4







## Youth Web Survey Results

Health Priority Identified	# of Responses	% of Responses
Alcohol Misuse/Abuse (#3 priority)	17	8.4
Bullying/Violence (#4 priority)	16	7.9
Physical Activity/Recreation (#5 priority)	14	6.9

### Priority Issue: Education

*"Many youth don't see a future in the community as well as them becoming anything. Going to a white school (high school) doesn't help as well because of tensions between students."* (Youth Web Survey Participant)

Education was the number one youth health priority identified by the web survey participants (21 responses, 10.3% of responses). It was also the top priority identified by youth from Annapolis Valley, Potlotek, Eskasoni, Millbrook, and Pictou Landing First Nations. Relevant comments provided by participants included:

- Youth need to recognize the value of education (question 10 – 2 responses, 2.7% of responses);
- Youth dropping out of school is a problem in our community (question 10 – 2 responses, 2.7% of responses);
- Youth in our community have to attend a 'white high school' and there are race tensions (question 10 – 2 responses, 2.7% of responses);
- Youth need education to help them get good jobs (question 10 – 1 response, 1.4% of responses);
- Education will help keep youth busy and out of trouble (question 10 – 1 response, 1.4% of responses);
- Education will help raise the self-esteem of youths (question 10 – 1 response, 1.4% of responses); and
- Need to improve education (i.e., school education) (question 14 – 1 response, 2.6% of responses).

When asked what is working well in their community to address this issue, four youth reported that the schools in their communities are working well to address this issue (question 12 – 4 responses, 11.1% of responses).

### Priority Issue: Drug and/or Solvent Misuse/Abuse

*"I believe these issues are important mainly because I see so many of my peers throwing their lives away over drugs. Because of the drugs they do not finish school and I think the main reason they turn to the drugs is because we are losing our culture."* (Youth Web Survey Participant)

Drug and/or solvent misuse/abuse was the second highest youth health priority identified by participants (19 responses, 9.4% of responses). It was also the top priority identified by youth from Annapolis Valley, Eskasoni, and Membertou First Nations. Relevant comments provided by participants included:

- Youth alcohol/drug use is a problem in our community (question 10 – 7 responses, 9.6% of responses);
- Drug abuse/addiction is an important topic (question 18 – 3 responses, 20.0% of responses);





## Youth Web Survey Results

- Drugs/alcohol are easy to get in the community (question 13 – 1 response, 3.6% of responses); and
- Need a drug rehabilitation centre (question 14 – 1 response, 2.6% of responses).

When asked what is working well in their community to address this issue, youth provided the following comments:

- A drug and alcohol worker is available in the community who works with youth (question 12 – 1 response, 2.8% of responses);
- A Cultural and Recreational Youth Program on the reserve that offers drug/alcohol free events for youth and gets youth involved in sports and events (question 12 – 1 response, 2.8% of responses); and
- The DARE program is offered in the community (a life-skills program for youth to help them avoid involvement in drugs, gangs, and violence) (question 12 – 1 response, 2.8% of responses).

### Priority Issue: Alcohol Misuse/Abuse

*"I would have to say there is a big alcoholism problem with teens in my community, a really big problem. Kids start drinking as early as 13-14. It's just sad to see our youth's innocence being corrupted like that because of liquor." (Youth Web Survey Participant)*

Alcohol misuse/abuse was the third highest youth health priority identified by participants (17 responses, 8.4% of responses). It was also the top priority identified by youth from Membertou First Nation. Relevant comments provided by participants included:

- Youth alcohol/drug use is a problem in our community (question 10 – 7 responses, 9.6% of responses); and
- Drugs/alcohol are easy to get in the community (question 13 – 1 response, 3.6% of responses).

When asked what is working well in their community to address this issue, youth provided the following comments:

- There are AA meetings in the community (question 12 – 1 response, 2.8% of responses);
- A drug and alcohol worker is available in the community who works with youth (question 12 – 1 response, 2.8% of responses); and
- A Cultural and Recreational Youth Program on the reserve that offers drug/alcohol free events for youth and gets youth involved in sports and events (question 12 – 1 response, 2.8% of responses).

### Priority Issue: Bullying and/or Violence

*"Bullying needs attention because youth sometimes suicide because of bullying and it affects them for a long time." (Youth Web Survey Participant)*

Bullying and/or violence was also a highly ranked youth health priority identified by participants (16 responses, 7.9% of responses). It was also the top priority identified by youth from Eskasoni First Nation. Relevant comments provided by participants included:

- Bullying sometimes leads to suicide (question 10 – 2 responses, 2.7% of responses);
- Bullying is a challenge in our community (question 13 – 1 response, 3.6% of responses);
- Bullying affects youth for a long time (question 10 – 1 response, 1.4% of responses); and





## Youth Web Survey Results

- Need to teach youth about the impacts of bullying (question 14 – 1 response, 2.6% of responses).

Participants did not provide any comments on what is working well in their community to address this issue.

### Priority Issue: Physical Activity & Recreation

*“Activities help as well so people won't be bored, because what else is there to do on a Rez besides smokin' weed and gettin' drunk. With activities this also makes positive choices in people and helps battle obesity.” (Youth Web Survey Participant)*

Physical activity and recreation were also highly ranked youth health priorities identified by participants (14 responses, 6.9% of responses). It was also the top priority identified by youth from Eskasoni and Membertou First Nations. Relevant comments provided by participants included:

- Youth physical inactivity is a problem in our community (question 10 – 4 responses, 5.5% of responses);
- Physical activity will help keep youth busy and out of trouble (question 10 – 1 response, 1.4% of responses);
- Need more youth activities (question 14 – 1 response, 2.6% of responses); and
- Need sports teams (question 14 – 1 response, 2.6% of responses).

When asked what is working well in their community to address this issue, youth provided the following comments:

- Physical activity programs for youth (e.g., recreation; sports; summer games) are available in the community (question 12 – 5 responses, 13.9% of responses); and
- There is a youth centre in the community (question 12 – 1 response, 2.8% of responses).

## Additional Youth Web Survey Results

As an additional point of interest, youth web survey participants were also asked if they thought they would be interested in having a health profession career in the future. Forty percent of the youth participants (question 15 – 12 responses, 40.0% of respondents) reported they would be interested in a health career in the future. Their explanations included:

- To help my community/other First Nation communities become healthy (question 16 – 6 responses, 22.2% of responses);
- To help youths of tomorrow have healthier, successful lives (question 16 – 4 responses, 14.8% of responses);
- I would be proud of my job and the help I provided to my community (question 16 – 3 responses, 11.1% of responses);
- I like to help other people (question 16 – 2 responses, 7.4% of responses);
- I would be able to work with people (question 16 – 2 responses, 7.4% of responses);
- I am proud of my culture (question 16 – 2 responses, 7.4% of responses);
- To help future youths have a better experience than I did growing up (question 16 – 2 responses, 7.4% of responses);
- To act as a role model to youth living unhealthy lives (question 16 – 1 response, 3.7% of responses);
- To teach youths to become positive role models (question 16 – 1 response, 3.7% of responses);
- To help Elders (question 16 – 1 response, 3.7% of responses);
- I want to become a Mi'kmaq studies teacher to teach others about my culture (question 16 – 1 response, 3.7% of responses);





## Youth Web Survey Results

- I want to become a Mi'kmaq studies teacher to teach others about my culture (question 16 – 1 response, 3.7% of responses);
- To help clean the environment on the reserve (question 16 – 1 response, 3.7% of responses); and
- It sounds like a fun field (question 16 – 1 response, 3.7% of responses).

Only twenty percent of the youth (question 15 – 6 responses, 20.0% of respondents) said they would not be interested in a health career in the future. Their explanations included:

- I would rather work in another field (question 17 – 3 responses, 50.0% of responses);
- I don't like germs, blood, needles, and/or sick people (question 17 – 2 responses, 33.3% of responses); and
- I don't have the patience required (question 17 – 1 response, 16.7% of responses).

Forty percent of the youth (question 15 – 12 responses, 40.0% of respondents) reported they were unsure if they would be interested in a health career in the future.







# 5 HEALTH SYSTEM WEB SURVEY RESULTS

Mi'kmaq • Nova Scotia • Canada

TRIPARTITE FORUM

**HEALTH WORKING COMMITTEE**

## *Exploring Health Priorities in First Nation Communities in Nova Scotia*



**HORIZONS**  
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## Health System Web Survey Results<sup>14</sup>

### Top Health Priorities Related to Child, Youth, Family & Elder Programs/Services

Health system web survey participants were asked to select their priorities for First Nation child, youth, family, and Elder programs/services from a series of related *Providing Health Care, Achieving Health* recommendations. The themes identified in their top priorities (in order of priority) were:

- Mental health services (#1 priority);
- Parent education programs (#2 priority);
- Early intervention and/or early childhood development (#3 priority); and
- Elder care (#4 priority).

#### Priority Issue: **Mental Health Services**

*“Mental health is probably one of the most under-recognized and invisible challenges and one that can have incredible impact on the individual. It has the potential to de-rail even the most capable people (without needed support). I don't believe this is a uniquely First Nations issue as much as First Nations need to be included in provincial or federal programming and have increased access to services.”*  
(Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to mental health services emerged as high priorities:

- a) *“Access to mental health services, particularly in the area of crisis intervention and treatment programs for children and youth is lacking in urban and rural settings alike”* (question 7 – 23 responses, 19.8% of responses); and
- b) *“Residential mental health facilities for youth in Atlantic Canada, with a focus on culturally relevant prevention, education, assessment, treatment and community-based follow up are lacking”* (question 7 – 10 responses, 8.6 % of responses).

Participants reported that:

- First Nations need access to mental health services (i.e., programs for children, youth, adults, and Elders) (question 8 – 8 responses, 8.1% of responses);
- Mental health is an under-recognized challenge that can have a huge impact on a First Nation person's life (question 8 – 3 responses, 3.0% of responses);
- First Nations need suicide prevention programs (question 8 – 1 response, 1.0% of responses);
- First Nations need to know what mental health services/resources they are entitled to and what alternatives are available to them (i.e., patient navigation) (question 10 – 1 response, 1.2% of responses); and
- Access to mental health services is needed in First Nation communities to address teen stress and suicide issues (question 12 – 1 response, 1.5% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:







## Health System Web Survey Results

- An Aboriginal Health Transition Fund (AHTF) project is working on First Nation cultural competencies in mental health workers (question 20 – 1 response, 2.0% of responses)<sup>15</sup>;
- The National Aboriginal Youth Suicide Prevention Strategy has been implemented (question 20 – 1 response, 2.0% of responses);
- Mental health programs have been established in First Nation communities (question 20 – 1 response, 2.0% of responses); and
- An AHTF proposal is being developed for a Mental Health and Addictions Prevention and Promotion Initiative – project will partner with First Nation communities to understand mental health and addictions issues, identify what is already working in their communities, and move planning and programming opportunities forward (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Parent Education Programs

*“Give parents tools to be nurturing, be able to provide direction, be disciplinarians, know the importance of setting goals and following through, and the children may have a better start and brighter futures.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to parent education programs emerged as a high priority – *“Parenting education programs that are culturally relevant and delivered by trusted mentors are required, as is a more formal system of role modeling”* (question 7 – 18 responses, 15.5% of responses).

Six participants reported that First Nations need parenting programs (question 8 – 6 responses, 6.1% of responses). Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Early Intervention/Early Childhood Development

*“Early intervention because those children who are the most fragile should receive all possible assistance as early as possible to ensure they are school ready (and the school is ready for them). Missing key time (developmentally) is enough of a hurdle with regular or average children...it is even more critical with those who will require extra assistance.”* (Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to early intervention/early childhood development emerged as high priorities:

- “Achieving health in First Nations communities requires that investments be made in their youngest residents. Greater focus on early child development, including skilled use of assessment tools that are culturally appropriate is required”* (question 7 – 15 responses, 12.9% of responses); and
- “Early intervention programs must be in place (re: early child development) to give every child their best possible start in life”* (question 7 – 15 responses, 12.9% of responses).

Participants reported that:

- First Nations need early intervention programs for children and their parents to help set the stage for their future development (question 8 – 12 responses, 12.1% of responses); and



<sup>15</sup> Please note that the scope of this AHTF project has changed since the data was collected for the current report. The AHTF project referred to is now addressing cultural competencies in general, not specifically with mental health workers.



## Health System Web Survey Results

- Early intervention in First Nation communities is a high priority (question 10 – 3 responses, 3.6% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- Early intervention programs have been established (e.g., in Eskasoni) (question 20 – 4 responses, 8.0% of responses); and
- A new Maternal and Child Health Program has been implemented to find supports for special needs First Nation children and their parents (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Elder Care

*“Our Elders are also affected by hunger. Meals on wheels should be in place for our Elders and others who cannot feed themselves. These are basic needs but they need to be addressed. Sometimes it is mismanagement of the caregivers but the ones who suffer are the children and Elders. These people need some safety net that they can turn to when needed.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to Elder care emerged as a high priority – “While cultural competency is an issue that touches almost every Aboriginal person at some point in their lives, it was pointed out that a culturally competent Elder care program may be one of the highest health care support considerations” (question 7 – 11 responses, 9.5 % of responses).

Participants reported that:

- Health care services are need for First Nation Elders (question 8 – 4 responses, 4.0% of responses; question 10 – 2 responses, 2.4% of responses); and
- Need strategic plans to address the growing demand for Elder care services in First Nations (question 8 – 1 response, 1.0% of responses).

Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

## Top Health Priorities Related to Access to Health Care Services/Programs

Web survey participants were also asked to select their priorities related to First Nation access to health care services/programs. The themes identified in their top priorities (in order of priority) were:

- Continuity in family physician care (tied for #1 priority);
- Access to continuing care services (tied for #1 priority);
- Equal access to provincial health care programs/services (tied for #2 priority);
- Patient navigation supports (tied for #2 priority);
- Application of the occupational therapy project model (#3 priority);
- Cultural competency (tied for #4 priority); and
- Expansion of the Nova Scotia Native Women’s Association project (tied for #4 priority).





## Health System Web Survey Results

### Priority Issue: Continuity in Family Physician Care

*“While primary care is generally provided in the same manner outside of the First Nations community, the complimentary services are often not. Because of the way in which First Nations communities are funded, these services are not always available on reserve and if they are available are not always given in a consistent manner.”* (Health System Web Survey Participant)

One *Providing Health Care Achieving Health* recommendation related to continuity in family physician care emerged as a high priority – *“Achieving family-doctor-based continuity of care is a vital aspect of an improved health care system”* (question 9 – 19 responses, 11.0% of responses). Participants did not provide any comments related to this priority area, nor did they provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Access to Continuing Care Services

*“[Access to] continuing care continues to cause difficulties to First Nations people but particularly the elder population.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to access to continuing care services emerged as a high priority – *“Every Nova Scotian, regardless of where they live, should be confident of their access to continuing care services”* (question 9 – 19 responses, 11.0% of responses).

Participants reported that:

- Access to continuing care and long-term care for First Nations is a high priority (question 10 – 2 responses, 2.4% of responses); and
- Home care is a high priority for First Nations (question 14 – 1 response, 1.8% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, two participants reported that the Nova Scotia AHTF Integrated Project is working to address continuing care services and home care discharge planning for First Nations on-reserve – it has established a policy forum, is evaluating discharge plans, and has developed a home care framework (question 20 – 2 responses, 4.0% of responses).

### Priority Issue: Equal Access to Provincial Health Care Programs/Services

*“If a provincially funded health service is not available to a First Nations Nova Scotian, the reasons must be transparent and it must be clear as to how the First Nations patient can obtain the needed service.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to equal access to provincial health care programs/services emerged as a high priority – *“Although Aboriginal people are reflected in the population-based funding formula to Nova Scotia under the Health and Social Transfer, in practice, First Nations people are eligible for access to some provincial health programs but not others. A rational*





## Health System Web Survey Results

and consistent policy addressing this dilemma is required, to be developed in collaboration with First Nations communities” (question 9 – 18 responses, 10.4% of responses).

Participants reported that:

- All Nova Scotians should have equal access to health care/services (question 10 – 5 responses, 6.0% of responses; question 12 – 4 responses, 5.9% of responses; question 14 – 1 response, 1.8% of responses; question 21 – 1 response, 1.5% of responses);
- Everyone should be entitled to the same health care whether they live on-reserve or off-reserve (question 10 – 4 responses, 6.0% of responses);
- Need to address First Nation access to equitable provincial health care services (question 22 – 4 responses, 6.8% of responses);
- More funding is needed to ensure equitable health care services for First Nation communities (question 10 – 3 responses, 3.6% of responses);
- Funding to First Nation communities to deliver services in lieu of provincial health programs is not working (question 23 – 1 response, 4.2% of responses); and
- First Nations need to be included in provincial and federal health programs (question 8 – 1 response, 1.0% of responses).

Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Patient Navigation Supports

*“First Nations people need to know what they entitled to in regard to health and mental health services and resources. The gaps continue to grow and more and more people are falling between the cracks and many have given up. When people give up on things this leads to disharmony and increases stress which lead to further health and mental health problems. Navigation is vital but too many people are not aware of this service and do not even know it exists. Again gaps will continue to grow.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to patient navigation supports emerged as a high priority – “Navigation supports are lacking throughout the health care system to help people find their way to the services they need. Regardless of where the patient navigation function resides, or what their professional background, Aboriginal people must know at the very least how to access health care services and have confidence in them” (question 9 – 18 responses, 10.4% of responses).

Participants reported that:

- First Nations need to know what health services/resources they are entitled to and what alternatives are available to them (i.e., patient navigation) (question 10 – 7 responses, 8.4% of responses);
- The health care system is difficult for First Nations to navigate (question 21 – 1 response, 1.5% of responses);
- Need navigation tools to help First Nation people with literacy issues (question 10 – 1 response, 1.2% of responses); and
- Need navigations tools that are culturally-appropriate for First Nations (question 10 – 1 response, 1.2% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, one participant reported that an AHTF project is working on improved navigation to cancer care services for First Nations (question 20 – 1 response, 2.0% of responses).





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### Priority Issue: Application of the Occupational Therapy Project Model

*“We need to attract more young people into the health sciences whether it be nursing, home health worker, occupational therapy, etc. Without people to work, all the efforts in any area of health will be weak at best. We need to look at this very serious issue before we have a crisis...”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to the Occupational Therapy Project model emerged as a high priority – *“Based on an evaluation of the Occupational Therapy Project, presently under development between The Confederacy of Mainland Mi'kmaq and Dalhousie University's School of Occupational Therapy program, this model should be applied to other academic programs”* (question 9 – 11 responses, 6.4% of responses).

One participant reported that access to occupational therapy for First Nations is a high priority (question 10 – 1 response, 1.2% of responses). Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Cultural Competency

*“Culture safety and competency should be mandatory for all who work with Native health. This includes hospitals and health care workers. It should be part of any exams they write...”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to cultural competency emerged as a high priority – *“Physician remuneration models which enable practice approaches that are relevant to First Nations populations are needed”* (question 9 – 10 responses, 5.8% of responses).

Participants reported that:

- Need to strengthen the cultural competency skills of health care workers and offer culturally-appropriate tools/services to First Nations (question 21 – 4 responses, 6.1% of responses);
- Culturally-relevant, holistic programs/services are needed for First Nations (question 10 – 2 responses, 2.4% of responses);
- Health care workers should be trained (and tested) on skills to provide culturally-safe care to First Nations (question 10 – 1 response, 1.2% of responses);
- Education for health care providers to provide culturally-safe care to First Nations should be mandatory (question 12 – 1 response, 1.5% of responses);
- Home care workers in First Nation communities need cultural, holistic training (question 8 – 1 response, 1.0% of responses);
- The provincial primary health care competency guidelines need to be fully utilized (question 10 – 1 response, 1.2% of responses); and
- First Nations need to be able to provide input on how programs will be delivered in their communities to help ensure culturally-aware services/programs (question 14 – 1 response, 1.8% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:





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- An AHTF project is working on First Nation cultural competencies in mental health workers (question 20 – 1 response, 2.0% of responses)<sup>16</sup>; and
- The Aboriginal Health Human Resources Initiative has issued an RFP to post-secondary institutions to address the needs of Aboriginal students and improve cultural competency in their curricula (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Expansion of the Nova Scotia Native Women's Association Project

*"We should work together to not only address health concerns but also social ones."* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to the expansion of the Nova Scotia Native Women's Association project emerged as a high priority – *"Nova Scotia Native Women's Association has identified the need to expand the pilot project to address more social/health issues and to expand the service to more communities"* (question 9 – 10 responses, 5.8% of responses). Participants did not provide any comments related to this priority area, nor did they provide any feedback on work currently being done in First Nation communities to address this priority health issue.

## Top Health Priorities Related to Partnerships & Collaborative Efforts

Web survey participants were also asked to select their priorities related to First Nation partnerships and collaborative efforts. The themes identified in their top priorities (in order of priority) were:

- Multi-sectoral chronic disease platforms/strategies (tied for #1 priority);
- Jurisdictional responsibilities (tied for #1 priority);
- District Health Authority (DHA) engagement (#2 priority);
- Partnerships on prescription drug abuse issues (#3 priority); and
- Collaborative primary health care models (#4 priority).

### Priority Issue: Multi-Sectoral Chronic Disease Platforms/Strategies

*"[I]ntersectoral collaboration is needed to make chronic disease prevention work."* (Health System Web Survey Participant)

One *Providing Health Care Achieving Health* recommendation related to multi-sectoral chronic disease platforms/strategies emerged as a high priority – *"Truly effective chronic disease prevention strategies lie outside the scope of the health care system and speak to social, economic and environmental influences on the wellbeing of communities, families and individuals. Appropriately resourced multi-sectoral platforms with targeted and long-term strategies are required"* (question 11 – 26 responses, 23.2% of responses).

Participants reported that:

- Intersectoral collaboration is needed to address health issues in First Nation communities (question 12 – 3 responses, 4.4% of responses);





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- Need partnerships across all levels – with a common vision, clearly defined roles and responsibilities, and a commitment to achieve progress in the health of First Nations (question 22 – 3 responses, 5.1% of responses);
- Links between the Tripartite Forum Working Committees (e.g., Health; Education; Sport/Recreation; Social; Justice) are needed to address the health of First Nation communities (question 12 – 2 responses, 2.9% of responses);
- Governments and agencies need to work collaboratively on First Nation health issues (question 10 – 1 response, 1.2% of responses); and
- Organizations are working in silos and not engaging/communicating with other partners working on similar priorities (question 21 – 1 response, 1.5% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- The AHTF project on early intervention is a good example of partners coming together to provide a much needed integrated service to First Nations (question 20 – 2 responses, 4.0% of responses); and
- Many AHTF projects have engaged all three levels of government in planning for key First Nation health priorities (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Jurisdictional Responsibilities

*“While many First Nations communities may not identify jurisdictional difficulties as one of the main health priorities, many of the unresolved issues associated with funding and responsibility are preventing progress in other much needed areas such as health promotion and protection, access to primary health care services and chronic disease management.” (Health System Web Survey Participant)*

Another *Providing Health Care Achieving Health* recommendation related to jurisdictional responsibilities emerged as a high priority – “A process should be developed to resolve issues of jurisdictional responsibilities at the provincial, First Nations and federal levels” (question 11 – 26 responses, 23.2% of responses).

Participants reported that:

- Political and/or jurisdictional agendas must be resolved to improve the health of First Nation communities – it is hindering services (question 10 – 3 responses, 3.6% of responses; question 12 – 7 responses, 10.3% of responses; question 14 – 1 response, 1.8% of responses);
- There is a lack of clearly defined roles and responsibilities among federal, provincial, district, and First Nation partners (need to resolve jurisdictional issues and funding roles) (question 21 – 9 responses, 13.6% of responses);
- Health care providers need clear roles and responsibilities for providing health services to First Nation communities (question 12 – 7 responses, 10.3% of responses);
- There is a lack of understanding by health care workers and/or partners on what services they can deliver to First Nation individuals, and what federal and provincial programs that First Nation people can access (question 21 – 2 responses, 3.0% of responses);
- Provincial and federal governments should be mandated to resolve jurisdictional issues so First Nations receive the same level of care as other Nova Scotians (question 22 – 2 responses, 3.4% of responses);





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- Jurisdictional boundaries and the impacts of labels (i.e., on-reserve/off-reserve; status/non status) on health service access needs to be resolved to achieve better First Nation health outcomes (question 16 – 1 response, 3.3% of responses);
- Governments need to make decisions and establish clear mandates for First Nation health (question 12 – 1 response, 1.5% of responses);
- Need effective policies/direction around jurisdictional issues related to First Nation health (question 22 – 1 response, 1.7% of responses);
- Tripartite Forum would be an effective mechanism for resolving jurisdictional issues (question 12 – 1 response, 1.5% of responses); and
- The Mi'kmaq Rights Initiative would be an effective mechanism for resolving jurisdictional issues (question 12 – 1 response, 1.5% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- The AHTF Discharge Planning Project is working on creating clear roles and responsibilities for health care workers across jurisdictions (question 12 – 1 response, 1.5% of responses); and
- Negotiations are beginning around First Nation health jurisdictional issues in Nova Scotia (question 14 – 1 response, 1.8% of responses).

### Priority Issue: District Health Authority Engagement

*“Improvements in First Nations health service delivery must involve DHAs. The Tripartite Health Committee could be an effective mechanism to bring DHA attention to First Nations health service delivery issues.”* (Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to the engagement of DHAs emerged as high priorities:

- “The Tripartite Forum Health Working Committee should develop effective approaches to facilitate the engagement of District Health Authorities in a Nova Scotia Aboriginal health strategy”* (question 11 – 15 responses, 13.4% of responses); and
- “The Tripartite Forum Health Working Committee should develop effective approaches to facilitate the engagement of District Health Authorities in its planning”* (question 11 – 14 responses, 12.5% of responses).

Participants reported that:

- The Tripartite Forum Health Committee would be an effective mechanism for bringing First Nation health issues to the attention of DHAs (question 12 – 1 response, 1.5% of responses);
- DHAs need to work with Health Canada to identify gaps and improve quality of health service to First Nations (question 14 – 1 response, 1.8% of responses);
- DHAs need education on First Nation health issues (question 14 – 1 response, 1.8% of responses); and
- Gaining DHA attention to First Nation health issues is challenging when the communities in their jurisdictions are so small (question 21 – 1 response, 1.5% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, one participant reported that the Tripartite Forum Health Committee has been engaging DHAs in their quarterly meetings (question 20 – 1 response, 2.0% of responses).







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### Priority Issue: Partnerships on Prescription Drug Abuse Issues

*“The Tripartite Forum Chair should communicate with the President of the College of Physicians and Surgeons of Nova Scotia to invite that group to partner with the First Nations and Inuit Health Branch, the province and Aboriginals to address the issue of prescription drug abuse. This is especially important because this is a problem that can be prevented if the right steps are taken.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to partnerships on prescription drug abuse emerged as a high priority – *“The Tripartite Forum Chair should communicate with the President of the College of Physicians and Surgeons of Nova Scotia to invite that group to partner with the First Nations and Inuit Health Branch, the province and Aboriginals to address the issue of prescription drug abuse”* (question 11 – 12 responses, 10.7% of responses).

Participants reported that:

- Need information/data on drug use, misuse, and abuse, as well as information on drug prescribing trends in order to target appropriate interventions for First Nations (e.g., programs for youth and Elders) (question 18 – 4 responses, 16.7% of responses);
- The Tripartite Forum needs to address the issue of First Nation prescription drug abuse with the College of Physicians and Surgeons of Nova Scotia because this is a preventable problem (question 12 – 2 responses, 2.9% of responses);
- Addressing the issue of prescription drug abuse in First Nation communities is a high priority (question 12 – 1 response, 1.5% of responses); and
- Need to tighten controls on doctors' prescribing behaviours with First Nations (question 22 – 1 response, 1.7% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- The College of Physicians and Surgeons of Nova Scotia, FNIHB, and APCFNC have partnered on provider intervention work related to prescription drug abuse (question 12 – 2 responses, 2.9% of responses; question 20 – 1 response, 2.0% of responses);
- Non-insured health benefits program is providing First Nation communities with drug profiles to help them take action on prescription drug abuse issues (question 20 – 1 response, 2.0% of responses); and
- An AHTF proposal is being developed for a Mental Health and Addictions Prevention and Promotion Initiative – project will partner with First Nation communities to understand mental health and additions issues, identify what is already working in their communities, and move planning and programming opportunities forward (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Collaborative Primary Health Care Models

*“I believe it is important to make full utility of existing resources such as the provincial primary health care cultural competence guidelines. In addition, it is essential that different levels of government and agencies work more collaboratively on issues pertaining to the well being of Aboriginal people.”* (Health System Web Survey Participant)





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Another *Providing Health Care Achieving Health* recommendation related to collaborative primary health care models emerged as a high priority – “Support is needed for models of primary care in which family doctors work collaboratively with other physicians, pharmacists and other health service providers” (question 11 – 11 responses, 9.8% of responses).

Two participants reported that Community Health Nurses are not included in the planning for the health of their communities even though they are the ones who have to implement the programs – they know what the needs of their communities are and should be involved in planning (question 21 – 2 responses, 3.0% of responses). Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Top Health Priorities Related to Health Planning Processes

Web survey participants were also asked to select their priorities related to First Nation health planning processes. The themes identified in their top priorities (in order of priority) were:

- DHA attention to First Nation health issues (#1 priority);
- Funding and/or resources (#2 priority);
- Provincial Aboriginal health policy (#3 priority); and
- First Nation joint planning (#4 priority).

#### Priority Issue: District Health Authority Attention to First Nation Health Issues

*“Health Authorities must be engaged with all First Nations across the province. I am only aware of three DHAs that are working with First Nations and one is only in the early stages of this collaboration.”* (Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to DHA attention to First Nation health issues emerged as high priorities:

- “Regardless of the model by which Aboriginal input is achieved in the development of health plans and policy in Nova Scotia, any Community Health Board and District Health Authority with a First Nations community within its jurisdiction should include in its community health plan or business plan respectively the specific strategies it intends to employ to address the health needs of its Aboriginal population”* (question 13 – 19 responses, 18.3% of responses); and
- “District Health Authorities and government departments represented on the Tripartite Forum should include Aboriginal health priorities within their own business planning and reporting mechanisms”* (question 13 – 10 responses, 9.6% of responses).

Participants reported that:

- All DHAs must be engaged with the First Nation communities in their jurisdictions (question 12 – 6 responses, 8.8% of responses);
- DHAs need to work closely with First Nations to understand their health needs and the impacts that their work has on First Nation communities – collaborative planning is needed (question 14 – 5 responses, 8.9% of responses);
- Only three DHAs are working with First Nation communities in Nova Scotia (one is just beginning the process) (question 12 – 1 response, 1.5% of responses);





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- DHAs and Bands should be mandated to do joint health planning (question 22 – 1 response, 1.7% of responses); and
- Need a First Nation health authority in Nova Scotia that will work with the DHAs (question 14 – 1 response, 1.8% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- The Mi'kmaq Cape Breton DHA Working Committee has been formed to address the lack of resources/services provided to First Nations by the DHA – it is a diverse partnership where the voices of First Nations in Cape Breton are being heard (question 12 – 1 response, 1.5% of responses; question 20 – 1 response, 2.0% of responses); and
- An AHTF project is developing memorandums of understanding between DHAs and First Nations for planning, communication, and service delivery (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Funding/Resources

*“Too much is funded on a pilot basis and does not lead to sustainable programs and change. Appropriate funding is required...”* (Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to funding and/or resources emerged as high priorities:

- “Project activity is important but should not be the basis upon which local health care systems are planned, managed and delivered. Communities require sustained “core” funding based on locally identified priorities in order to address long-term health impacts”* (question 13 – 16 responses, 15.4% of responses); and
- “The Mi'kmaq-Nova Scotia-Canada Tripartite Forum lacks the necessary financial and human resources to achieve its full potential as a platform to contribute to policy development, long term strategic planning and relationship building”* (question 13 – 11 responses, 10.6% of responses).

Participants reported that:

- Reduced funding, tightened budgets, and/or a lack of resources is a challenge (question 21 – 6 responses, 9.1% of responses);
- Need long-term, stable funding and resources (question 22 – 4 responses, 6.8% of responses);
- Committed funding is needed for providing health care services to First Nations (question 14 – 4 responses, 7.1% of responses);
- Diabetes in First Nation communities is a high priority – need core funding (question 10 – 4 responses, 4.8% of responses);
- More funding is needed to ensure equitable health care services for First Nation communities (question 10 – 3 responses, 3.6% of responses);
- Pilot projects do not lead to sustainable programs and healthy outcomes for First Nations – need funding for long-term programs (question 14 – 2 responses, 3.5% of responses);
- Need revised funding formulas to address First Nation health issues – need to shift from rigid funding criteria to criteria that address the actual needs of individual communities (question 22 – 2 responses, 3.4% of responses);
- Funding formulas do not support First Nation access to the health services they need (question 21 – 1 response, 1.5% of responses);





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- More funding is needed for health care providers who serve both on-reserve and off-reserve populations (question 10 – 1 response, 1.2% of responses); and
- Cutbacks are creating a burden on grassroots people/projects trying to address the health issues in First Nations (question 23 – 1 response, 4.2% of responses).

Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Provincial Aboriginal Health Policy

*“Collaboration among service providers and core funding are critical to achieving a realistic long-term strategy for improving the health of First Nations populations.”* (Health System Web Survey Participant)

Two *Providing Health Care Achieving Health* recommendations related to a provincial Aboriginal health policy emerged as high priorities:

- “There is an opportunity for the Nova Scotia Department of Health to lead the development of a Provincial Aboriginal Health Policy in collaboration with the Tripartite Forum and with close and meaningful Aboriginal engagement”* (question 13 – 13 responses, 12.5% of responses); and
- “A Nova Scotia Aboriginal Health policy and ten-year plan for health, which is developed on the strength of meaningful Aboriginal input is needed”* (question 13 – 11 responses, 10.6% of responses).

Participants reported that:

- Need core funding for a long-term First Nation health strategy (question 14 – 1 response, 1.8% of responses);
- Need to develop intermediate and long-term health plans for First Nations (question 14 – 1 response, 1.8% of responses);
- A 10-year plan for First Nation health is too big – need to focus on shorter, higher-quality plans (question 23 – 1 response, 4.2% of responses); and
- There is a lack of understanding that First Nations in Nova Scotia do not want ‘provincial Aboriginal health plans’ or ‘FNIHB health plans’ – they want their own ‘Mi’kmaq health plans’ that are developed and controlled by their people (question 21 – 1 response, 1.5% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, one participant reported that an AHTF project is developing a provincial Aboriginal Health Policy (question 20 – 1 response, 2.0% of responses).

### Priority Issue: First Nation Joint Planning

*“Our biggest enem[y] is ourselves, we can't seem to reach a consensus on issues that affect our daily lives.”* (Health System Web Survey Participant)





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Another Providing Health Care Achieving Health recommendation related to joint planning among First Nations emerged as a high priority – “Opportunities for joint health planning mechanisms among groups of First Nations communities should be identified and resourced” (question 13 – 14 responses, 13.5% of responses).

Participants reported that:

- First Nations need planning to provide direction in their work – planning needs to be done by them not for them (question 16 – 4 responses, 13.3% of responses);
- First Nation leaders need the authority and supports to identify the needs of their own communities and plan for their future (question 22 – 3 responses, 5.1% of responses);
- First Nation health plans and partnerships will only be effective if there is a mechanism to support/implement the planned work (question 14 – 2 responses, 3.5% of responses);
- Planning for future health care needs is critical for First Nation communities (question 10 – 1 response, 1.2% of responses); and
- First Nations need to reach consensus about what health issues in their communities need addressing (question 14 – 1 response, 1.8% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, one participant reported that First Nation Bands in Cape Breton are partnering with each other and having monthly management meetings – they are looking at infrastructure supports for Health Directors (question 20 – 1 response, 2.0% of responses).

## Top Health Priorities Related to First Nation Input & Leadership

Web survey participants were also asked to select their priorities related to First Nation input and leadership. The themes identified in their top priorities (in order of priority) were:

- First Nation input and/or engagement in health planning processes (#1 priority);
- First Nation community health planning (tied for #2 priority);
- Leveraging of assistance programs (tied for #2 priority);
- Peer education and/or mentorship (tied for #2 priority); and
- Planning of professional primary health care services/programs (#3 priority).

### Priority Issue: First Nation Input/Engagement in Health Planning Processes

*“Participation in planning and program delivery is essential for First Nations communities which addresses both how will programs be delivered in communities and how will First Nations people access programs not in their communities.” (Health System Web Survey Participant)*

Three Providing Health Care Achieving Health recommendations related to First Nation input and/or engagement in health planning processes emerged as high priorities:





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- a) *“A multi-pronged approach which supports and optimizes Aboriginal input at all levels of the health care system such that the principle of inclusion in policy development and decision-making is achieved is required” (question 15 – 19 responses, 17.4% of responses);*
- b) *“Aboriginal communities must be included in the Nova Scotia Department of Health’s development of a strategic framework for continuing care services and be supported in participating as a stakeholder in the public consultation process planned for 2005” (question 15 – 16 responses, 14.7% of responses); and*
- c) *“Greater Aboriginal involvement is required in planning and implementing federal and provincial health programs and services” (question 15 – 15 responses, 13.8% of responses).*

### Participants reported that:

- Partnerships and collaborations with First Nation communities are essential for improving health – they must be ‘true’, equal partnerships (question 12 – 9 responses, 13.2% of responses; question 22 – 2 responses, 3.4% of responses; question 23 – 1 response, 4.2% of responses);
- First Nations need to be active, equal partners in health planning and program development (question 14 – 8 responses, 14.3% of responses);
- First Nation communities need to be broadly, equitably engaged as partners to improve their health (question 16 – 7 responses, 23.3% of responses);
- Need to support/nurture continued partnerships between First Nations and the provincial and federal governments (question 14 – 3 responses, 5.4% of responses);
- Need to ensure integrated, inclusive planning for First Nation health (question 14 – 3 responses, 5.4% of responses);
- Health planning processes need to be reflective of First Nation interests, values, and long-term self-determination goals (i.e., follow OCAP principles<sup>17</sup>) (question 16 – 3 responses, 10.0% of responses);
- First Nation communities need to be linked with provincial, district, and local organizations to help them address gaps in health service (question 14 – 1 response, 1.8% of responses);
- First Nations need to be able to provide input on how programs will be delivered in their communities to help ensure culturally-aware services/programs (question 14 – 1 response, 1.8% of responses);
- First Nations need to be able to provide input on how they can access health services outside their communities (e.g., transportation issues) (question 14 – 1 response, 1.8% of responses);
- Partnerships and collaborations with First Nation communities would facilitate cultural exchange (question 12 – 1 response, 1.5% of responses);
- Partnerships and collaborations with First Nation communities would foster better working relationships (question 12 – 1 response, 1.5% of responses); and
- Federal and provincial health partners need to be more flexible to allow for true consultation and engagement with First Nations (question 23 – 1 response, 4.2% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, one participant reported that many AHTF projects have engaged all three levels of government (including First Nation governments) in planning for key First Nation health priorities (question 20 – 1 response, 2.0% of responses).





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### Priority Issue: First Nation Community Health Planning

*“Planning is critical in meeting the future needs of its people. We need more health planners to assist our communities on awareness, empowerment and future infrastructure needs, human resources development. . .”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to First Nation community health planning emerged as a high priority – *“Local leaders must be supported in guiding their communities through multi-year, holistic strategies for health, provided with global resources to implement those plans and have a political framework to implement it”* (question 15 – 13 responses, 11.9% of responses).

Participants reported that:

- Need inclusive community health planning projects, that include supports for building the planning capacity of First Nations (question 22 – 5 responses, 8.5% of responses);
- First Nations need planning to provide direction in their work – planning needs to be done by them not for them (question 16 – 4 responses, 13.3% of responses);
- First Nation leaders need the authority and supports to identify the needs of their own communities and plan for their future (question 22 – 3 responses, 5.1% of responses);
- First Nation leaders need to know what health issues exist in their communities and plan to address them effectively (question 16 – 2 responses, 6.7% of responses);
- First Nation Health Directors need to know what health issues exist in their communities and plan to address them effectively (question 16 – 1 response, 3.3% of responses);
- Planning for future health care needs is critical for First Nation communities (question 10 – 1 response, 1.2% of responses); and
- First Nations need health planners to help them with health awareness/empowerment issues, as well as future infrastructure and human resource needs (question 10 – 1 response, 1.2% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- A new community health planning process is beginning in several First Nations in Nova Scotia – this process supports communities to assess their needs, map their assets, establish health management structures, and create health plans that include goals, objectives, activities, and success indicators (question 20 – 2 responses, 4.0% of responses); and
- FNIHB has established three new positions to assist First Nations in their community health planning processes – these workers help them navigate federal programs, and understand new policies and funding arrangements (question 20 – 1 response, 2.0% of responses).

### Priority Issue: Leveraging of Assistance Programs

*“Communities are not funded to provide many of the services needed (and evidence of need is scarce)...communities have different priorities, capacities, needs and goals...therefore, a range of options and customized responses are needed to effectively work with First Nations populations to improve their health outcomes.”* (Health System Web Survey Participant)





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Another *Providing Health Care Achieving Health* recommendation related to the leveraging of assistance programs emerged as a high priority – “Community leadership should be supported in developing creative strategies to leverage assistance programs for long-term social and economic development” (question 15 – 13 responses, 11.9% of responses).

Participants did not provide any comments related to this priority area, nor did they provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Peer Education/Mentorship

*“Early Intervention by trained First Nations mentors is important as this helps young parents recognize who they are and what their potentials are. I too was a young single mother and if not for my parents, siblings and other mentors in my community I would not have been able to achieve what I have today. We all need guidance sometime in our lives...”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to peer education and/or mentorship emerged as a high priority – “Local leaders, especially youth, for peer health education and mentorship activities require mobilization” (question 15 – 13 responses, 11.9% of responses).

Participants reported that:

- Children and parents need strong First Nation mentors to help raise their self-esteem and empower them (question 8 – 2 responses, 2.0% of responses); and
- Local First Nation leaders need to support/empower their communities to make health changes (question 16 – 1 response, 3.3% of responses).

Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Priority Issue: Planning of Professional Primary Health Care Services/Programs

*“Involvement of First Nations in planning and implementation of new programs has been very limited which will have long term impacts on First Nations’ ability to participate in the new programs in a meaningful way (i.e., Midwifery).”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to the planning of professional primary health care services/programs emerged as a high priority – “As Nova Scotia expands the scope and membership of interdisciplinary primary health care teams, Aboriginal communities must be involved in the planning and implementation of professional roles, such as midwifery” (question 15 – 11 responses, 10.1% of responses). Participants did not provide any comments related to this priority area, nor did they provide any feedback on work currently being done in First Nation communities to address this priority health issue.







## Health System Web Survey Results

### Top Health Priorities Related to Health Data & Monitoring

Web survey participants were also asked to select their priorities related to First Nation health data and monitoring. The themes identified in their top priorities (in order of priority) were:

- Health data and indicators (#1 priority); and
- Monitoring of non-insured health benefits (#2 priority).

#### Priority Issue: Health Data & Indicators

*“The use of good quality health information for health surveillance, population health assessment and health status reporting. This is fundamental for all aspects of public health in a community in order to facilitate community health planning, evidence based decision making and priority setting.”* (Health System Web Survey Participant)

Three Providing Health Care Achieving Health recommendations related to health data and indicators emerged as high priorities:

- “New approaches to evaluation and monitoring in the realm of Aboriginal health policy and clinical practice should be customized. We need to identify contemporary indicators that guide us to an understanding of systems for health rather than only measuring the management of illness”* (question 17 – 21 responses, 20.4% of responses);
- “Capacities need to be built and mechanisms created for First Nations communities to collect, analyze and control their own health information”* (question 17 – 21 responses, 20.4% of responses); and
- “Tripartite Forum annual reporting should mark progress being made toward a provincial vision, based on indicators of success that are measurable, evidence-based and culturally appropriate. Similarly, District Health Authorities and government departments represented on the Tripartite Forum should include Aboriginal health priorities within their own business planning and reporting mechanisms”* (question 17 – 15 responses, 14.6% of responses).

Participants reported that:

- Need to build capacity (i.e., appropriate skills and technology) in First Nation communities to help them gather, manage, and analyze health information (question 18 – 4 responses, 16.7% of responses);
- First Nation communities (and partners) need health information/data to inform their health planning efforts (question 8 – 1 response, 1.0% of responses; question 14 – 1 response, 1.8% of responses; question 18 – 3 responses, 12.5% of responses; question 22 – 1 response, 5.1% of responses);
- Need participatory community health research projects to build the evidence for First Nation health issues (question 22 – 3 responses, 5.1% of responses);
- First Nations need to be engaged in developing and collecting health status indicators for their communities and for government – capacity-building is needed in this area (question 18 – 2 responses, 8.3% of responses; question 22 – 3 responses, 5.1% of responses);





## Health System Web Survey Results

- First Nations need to own/hold/control their own health information/data (question 18 – 2 responses, 8.3% of responses);
- Electronic patient records would greatly contribute to improved and integrated health services for First Nations (question 18 – 2 responses, 8.3% of responses);
- Applying OCAP principles is difficult when trying to collect/retrieve First Nation data from the provincial system – many First Nation people fear electronic data collection and do not want unique identifiers to be used (question 21 – 2 responses, 3.0% of responses);
- First Nations need data/evidence to support their requests for programs and resources (question 16 – 1 response, 3.3% of responses);
- Linking health researchers/academia with First Nation communities would provide benefits to both sides (question 12 – 1 response, 1.5% of responses);
- Need accountability and performance measurement for all joint planning projects (question 14 – 1 response, 1.8% of responses);
- First Nation Bands need to be accountable to their communities and funders for the quality of their health services and their health outcomes – not just the number of programs/services they provide or their management of funding (question 12 – 1 response, 1.5% of responses; question 21 – 1 response, 1.5% of responses);
- First Nation Bands need to share health data with the DHAs to support effective health planning (question 14 – 1 response, 1.8% of responses);
- The collection of community health data should be built into First Nation programs, so that staff collect it on an ongoing basis (question 18 – 1 response, 4.2% of responses);
- It is important to not disaggregate First Nation health data down to the community level – the numbers are too small and are not meaningful (question 18 – 1 response, 4.2% of responses);
- Monitoring/collecting of First Nation health data is an area that needs work (question 18 – 1 response, 4.2% of responses);
- Monitoring and evaluation efforts need to focus on broader, health promotion/prevention indicators in First Nations (holistic and culturally-relevant), rather than on the incidence of disease (question 18 – 1 response, 4.2% of responses);
- Need leadership at the provincial level to support the idea that First Nation health should be a key indicator of success for the overall provincial health system (question 21 – 1 response, 1.5% of responses);
- Need to gather solid evidence of the gaps in health services to First Nations (question 21 – 1 response, 1.5% of responses); and
- Need to use unique identifiers on the health cards of First Nation people to support surveillance efforts (question 22 – 1 response, 1.7% of responses).

When asked if they knew of any work currently being done in First Nation communities to address this priority health issue, participants reported:

- FNIHB Atlantic Health Information Management Strategy has been implemented to build capacity of First Nations to collect, analyze, disseminate, and control their own health information (question 20 – 3 responses, 6.1% of responses);
- The Atlantic Aboriginal Health Research Program has effectively built to health research capacity of First Nations through supporting students and community-based research projects (question 20 – 1 response, 2.0% of responses);
- First Nation communities in Cape Breton have been using the Population Health Research Unit at Dalhousie University to gather health data from provincial databases (question 20 – 1 response, 2.0% of responses);
- Electronic medical records are being used in five Cape Breton First Nation Bands to allow them to track actual health outcomes versus simply tracking the number of visits – data clerks are being trained at each health centre (question 20 – 1 response, 2.0% of responses);
- FNIHB is working with the provincial government to implement Panorama – a pan Canadian surveillance tool – in First Nation communities in the province (question 20 – 1 response, 2.0% of responses); and
- The Tui'kn project is collecting data and supporting First Nation planning processes (question 20 – 1 response, 2.0% of responses).





## Health System Web Survey Results

### Priority Issue: Monitoring of Non-Insured Health Benefits

*“I feel that First Nations are losing their rights to health benefits as the cost of non-insured health benefits is sky-rocketing in the social services. Health benefits are denied at an alarming rate and costs are absorbed by Bands. There needs to be a direct process in place for clients that are denied benefits to appeal and ensure that clients are treated equally.”* (Health System Web Survey Participant)

Another *Providing Health Care Achieving Health* recommendation related to the monitoring of non-insured health benefits (NIHB) emerged as a high priority – *“The First Nations and Inuit Health Branch and the Atlantic Policy Congress of First Nations Chiefs should be supported in continuing to gather specific information from the communities on the issue of prescriptions not covered in the approved drug list. Data should be collected to determine the prevalence of the problem as well as the prescriptions to which it most commonly relates. As part of the solution, this should result in an education program designed to provide physicians and pharmacists with alternatives where appropriate”* (question 17 – 17 responses, 16.5% of responses).

Participants reported that:

- First Nations need greater access to insured health benefits (question 8 – 1 response, 1.0% of responses);
- Drug coverage for First Nations needs to be addressed (question 12 – 1 response, 1.5% of responses);
- Need to stop cutbacks on drugs deemed too expensive for First Nation coverage (question 18 – 1 response, 4.2% of responses);
- First Nations need a fair appeals process if they are denied insured health benefits (question 8 – 1 response, 1.0% of responses); and
- Prescription drug appeals take too long – people need drugs immediately (question 10 – 1 response, 1.2% of responses; question 12 – 1 response, 1.5% of responses).

Participants did not provide any feedback on work currently being done in First Nation communities to address this priority health issue.

### Additional Health System Web Survey Results

As an additional point of interest, health system web survey participants were asked to rate their awareness of the recommendations in the *Providing Health Care, Achieving Health* report:

- 28.6% (14) were aware of the recommendations (i.e., they selected “4” or “5” on a scale of 1-5, with 1 being “not at all aware” and 5 being “very aware”);
- 36.7% (18) were not aware of the recommendations (i.e., they selected “1” or “2” on the scale); and
- 34.7% (17) rated their awareness at the scale midpoint (i.e., they selected “3” on the scale).

Participants were also asked if their organization had undertaken any activities to address the health priorities outlined in the report, or if their organization had used the report to inform its work:

- 47.7% (21) said “yes”;
- 9.1% (4) said “no”; and
- 43.2% (19) said “don’t know”.





## Health System Web Survey Results

Participants who reported that their organization had undertaken activities to address the health priorities in the report, outlined the following ways in which the report had been used:

- Used report to build relationships with First Nation communities (question 6 – 7 responses, 12.7% of responses);
- Used report to help in planning for First Nation health (question 6 – 6 responses, 10.9% of responses);
- Used report to learn about First Nation health priorities/trends (question 6 – 5 responses, 9.1% of responses);
- Report informed discussions with partners about First Nation health issues (question 6 – 4 responses, 7.3% of responses);
- Report helped the Tripartite Forum Health Committee structure its priorities/plans (question 6 – 2 responses, 3.6% of responses);
- Used report to inform us on First Nation health research/data/surveillance priorities (question 6 – 2 responses, 3.6% of responses);
- Use report priorities for planning AHTF projects and creating selection criteria (question 6 – 2 responses, 3.6% of responses);
- Used report to develop home care resources/projects/studies (e.g., First Nation falls prevention tool; AHTF home care project; pediatric home care project; scan of home care projects/services for First Nations) (question 6 – 2 responses, 3.6% of responses);
- Used report to support the work of the Mi'kmaq Maliseet Atlantic Health Board (question 6 – 2 responses, 3.6% of responses);
- The health recommendations relate/overlap with our social and education programs, so we read them to keep up-to-date on issues (question 6 – 1 response, 1.8% of responses);
- Used report as an example of the collaborative approach used by the Tripartite Forum (question 6 – 1 response, 1.8% of responses);
- Report created a foundation for the province's work on Aboriginal health and health promotion (question 6 – 1 response, 1.8% of responses);
- Report helped the DHAs develop proactive approaches to working with First Nations (question 6 – 1 response, 1.8% of responses);
- Participated on the working committee who developed the hearings leading up to the report (question 6 – 1 response, 1.8% of responses);
- Contributed background information to report from the First Nations Regional Health Survey (question 6 – 1 response, 1.8% of responses);
- Used report to develop FNIHB Atlantic's strategic plan (question 6 – 1 response, 1.8% of responses);
- Circulated report to all FNIHB Atlantic program managers for use in their program development (question 6 – 1 response, 1.8% of responses);
- Used report as an orientation tool for FNIHB program/policy staff (question 6 – 1 response, 1.8% of responses);
- Used report to prepare for the Aboriginal Health Summit (question 6 – 1 response, 1.8% of responses);
- Use report as a basis for FNIHB Health Information Management Strategic Plan and its associated activities (e.g., education sessions; community data needs assessments; etc.) (question 6 – 1 response, 1.8% of responses);
- Recommendations were used by FNIHB to identify processes that needed to be developed (but we still need tools/bureaucratic support to do the actual work) (question 6 – 1 response, 1.8% of responses);
- Established a First Nations Advisory Committee on the DHA (reps also sit on other committees) (question 6 – 1 response, 1.8% of responses);
- Invited Bands to provide data for DHA accountability reports (question 6 – 1 response, 1.8% of responses);
- DHA provided a Registered Nurse position for a youth health centre on a reserve (question 6 – 1 response, 1.8% of responses);
- DHA provided funding/resources for a team-building retreat for Band members within its jurisdiction (question 6 – 1 response, 1.8% of responses);
- Recruited First Nation people as CHB members (question 6 – 1 response, 1.8% of responses);
- Used report to develop a mental health and addiction strategic plan (question 6 – 1 response, 1.8% of responses);
- Palliative care training was provided to home care and health staff on-reserve (question 6 – 1 response, 1.8% of responses);
- Used report to identify collaborative service provision opportunities (question 6 – 1 response, 1.8% of responses);
- Used report to develop an AHTF proposal to address mental health and addictions issues (question 6 – 1 response, 1.8% of responses);
- Used report as a tool to help integrate the Chiefs' regional priorities set out through the Mi'kmaq Maliseet Atlantic Health Board (question 6 – 1 response, 1.8% of responses); and
- Used report as a capacity development tool (question 6 – 1 response, 1.8% of responses).







# 6 DISCUSSION & CONCLUSIONS

Mi'kmaq • Nova Scotia • Canada

TRIPARTITE FORUM

**HEALTH WORKING COMMITTEE**

## *Exploring Health Priorities in First Nation Communities in Nova Scotia*



**HORIZONS**  
COMMUNITY DEVELOPMENT ASSOCIATES INC.



## Discussion & Conclusions

Six groups of related health issues emerged as combined overall priorities when the results from all three project input methods (i.e., the community engagement sessions; the youth web survey; the health system web survey) were compared. These priority areas, the methods in which they were identified as a priority, and any overlap with the 2005 *Providing Health Care, Achieving Health* recommendations are outlined in the following table:

**Table 18** – Overall Priority Health Issues

Priority Area	Identified Issue as a Priority?			Identified as a Priority in the 2005 Report?
	Community Engagement Sessions	Youth Web Survey	Health System Web Survey	
Mental Health (#1 priority)	+	+	+	+
Addictions/Substance Abuse (#2 priority)	+	+	+	+
NIHB Coverage (tied for #3 priority)	+		+	+
Elder Care (tied for #3 priority)	+		+	+
Obesity-Related Issues (tied for #3 priority)	+	+		
Improved Funding for Health Services (tied for #3 priority)	+		+	+

### #1 Priority : Mental Health

Mental health was rated as the number one overall top priority – it was identified as a priority in the community engagement sessions, the youth web survey, and the health system web survey:

- Mental health was the highest rated priority in the community engagement sessions (10 communities, 83.3% of communities);
- Mental health was the fifth highest community health priority identified by youth web survey participants (14 responses, 5.5% of responses); and
- Mental health services were the highest rated priority in the health system web survey section on “Child, Youth, Family, & Elder Programs/Services” (23 responses, 19.8% of responses).

When community session participants described how their communities are affected by mental health issues, they described social impacts (e.g., crime; violence), emotional impacts (e.g., stress; anxiety; anger), and economic impacts (e.g., people are unable to work; people are more dependent on social assistance).

Several challenges to addressing mental health issues exist in First Nation communities. For example, community session participants discussed challenges related to access to services (e.g., lack of on-reserve services; transportation challenges; wait times; access to information on what services are available) and service delivery (e.g., application forms are only quickly accessible to those with Internet







## Discussion & Conclusions

access; after-hours services are not available; confidentiality concerns; lack of standard policies/procedures; NADACA workers need to see people several times before they can make a referral<sup>18</sup>). Other challenges reported included lack of funding, infrastructure, and human resources to deliver mental health services, the need for culturally-safe prevention and treatment services to encourage service uptake, and individual factors/stigma (e.g., people are in denial about their mental health issues or are too proud to seek help).

Youth participants discussed the idea that youth do not have anyone to talk to or they are unsure about where to find someone to talk to. Health system participants reported that they were concerned that mental health is an under-recognized issue in First Nation communities, and that the issue needs to be recognized for its significant impacts on the lives of First Nations people.

In the 2005 report, mental health services and facilities were also identified as a priority issues for First Nation communities:

*“Access to mental health services, particularly in the area of crisis intervention and treatment programs for children and youth is lacking in urban and rural settings alike.” (Providing Health Care, Achieving Health, page 48)*

*“Residential mental health facilities for youth in Atlantic Canada, with a focus on culturally relevant prevention, education, assessment, treatment and community-based follow up are lacking.” (Providing Health Care, Achieving Health, page 49)*

Participants reported that several actions have been taken to address mental health issues since the release of the 2005 report. For example, community session participants reported that human resource and staffing supports are in place to deal with mental health issues in their communities (e.g., NADACA workers; mental health and addictions professionals; Community Health Nurses; youth workers; other health professionals who make referrals). They also reported that support groups were in place (e.g., groups run by Community Health Nurses; Alcoholics Anonymous; Narcotics Anonymous; youth groups), ‘safe houses’ were available in larger communities where people in crisis can go for supports, and strong supports were available from other community members when someone is in crisis.

Community session and youth participants also reported that various mental health promotion/prevention supports were in place in their communities (e.g., prevention programs run by Community Health Nurses; information through workshops, sessions, and newsletters; programs to prevent youth stress and suicide). Health system participants reported that mental health programs have been established in First Nation communities, an AHTF proposal is being developed for a Mental Health and Addictions Prevention and Promotion Initiative, and the National Aboriginal Youth Suicide Prevention Strategy has been implemented.

In terms of what is needed to help address mental health issues, community session participants identified culturally-safe services (i.e., services relevant to language, culture, and life experiences) and traditional/holistic services (e.g., sweats; massage therapy; reflexology; acupuncture; naturopathic services; natural supplements; spirituality). They also reported a need for increased access to mental health services (e.g., after-hours services; on-reserve services; community outreach services; additional mental health professionals; transportation to services), as well as funding, infrastructure, and human resources to deliver more mental health services. Other needs included mental health promotion programs and increased awareness/education about mental health issues.

Health system participants also reported a need for increased First Nation access to mental health services (e.g., programs for children, youth, adults, and Elders; suicide prevention programs; teen stress and suicide programs). They also discussed the need for patient navigation services to help First Nations understand what services they are entitled to and what alternatives are available to them.



<sup>18</sup> Please note that community session participants reported that they believed mental health and addictions issues are closely linked/related.



## Discussion & Conclusions

### #2 Priority : Addictions & Substance Abuse

Addictions and substance abuse were rated as the number two overall priority – they were identified as a priority in the community engagement sessions, the youth web survey, and the health system web survey:

- Addictions and substance abuse was the second highest rated priority in the community engagement sessions (9 communities, 75.0% of communities);
- Drug and solvent misuse/abuse was the number one community health priority identified by youth web survey participants (22 responses, 8.7% of responses), as well as the second highest youth health priority identified (19 responses, 9.4% of responses); and
- Partnerships on prescription drug abuse was the fifth highest rated priority in the health system web survey section on “Partnerships & Collaborative Efforts” (12 responses, 10.7% of responses).

When community session participants described how their communities are affected by addictions/substance abuse, they described the important links between addictions and mental health (i.e., the idea that most people who are mentally healthy do not have addictions), and they highlighted the impacts of prescription drug abuse (e.g., illegal trade of prescription drugs; NIHB is being drained). They also reported social impacts (e.g., crime; violence; teen pregnancy; bullying), emotional impacts (e.g., stress; anxiety; mental abuse), family impacts (e.g., negative role modeling; abuse), physical impacts (e.g., poor health and nutrition; FAS/FAE; sexually transmitted infections), and economic impacts (e.g., lower motivation to work and go to school).

Several challenges to addressing addictions/substance abuse issues exist in First Nation communities. For example, community session participants discussed challenges related to access to services (e.g., transportation challenges; after-hours services are not available) and service delivery (e.g., confidentiality concerns; NADACA workers need to see people several times before they can make a referral; narcotics are being over-prescribed and are covered by NIHB; application forms are only quickly accessible to those with Internet access). Other challenges reported included lack of funding resources to deliver addictions services, the need for culturally-safe prevention and treatment services to encourage service uptake, the need for positive role-modeling, and individual factors (e.g., people are in denial about addictions). Youth participants indicated that they found it challenging that drugs and alcohol are so easily accessible in their communities.

In the 2005 report, prescription drug abuse was also identified as a priority issue for First Nation communities:

*“The Tripartite Forum Chair should communicate with the President of the College of Physicians and Surgeons of Nova Scotia to invite that group to partner with the First Nations and Inuit Health Branch, the province and Aboriginals to address the issue of prescription drug abuse.” (Providing Health Care, Achieving Health, page 53)*

*“The First Nations and Inuit Health Branch, First Nations and the province should continue to work together to flag the drugs that are being over-prescribed in the system.” (Providing Health Care, Achieving Health, page 53)*

Participants reported that several actions have been taken to address addictions and substance abuse issues since the release of the 2005 report. For example, community session participants identified that people in their communities are using traditional teachings and sweat lodges help address addictions/substance abuse issues, and are networking with other agencies to help address the issue.





## Discussion & Conclusions

They also reported having medical drivers available to take people to detox/rehab, a fully staffed RCMP detachment to help deal with the issues, and using electronic patient records to make it harder to 'double-doctor' narcotics prescriptions.

Community session and youth participants identified that important addictions supports are in place in their communities in the form of support/self-help groups (e.g., Alcoholics Anonymous; Narcotics Anonymous) and services from NADACA workers and other addictions professionals. Youth participants identified that youth addiction prevention programs (e.g., Cultural and Recreational Youth Program; DARE Program) are working to address these issues with youth in their communities.

Health system participants reported that the College of Physicians and Surgeons of NS, FNIHB, and APCFNC have partnered on prescription drug abuse work. They also reported that NIHB is providing First Nation communities with drug profiles to help them take action on prescription drug abuse issues, and that an AHTF proposal is being developed for a Mental Health and Addictions Prevention and Promotion Initiative.

In terms of what is needed to help address addictions/substance abuse issues, community session participants identified increased access to addictions services (e.g., additional staff/professionals; after-hours services; on-reserve services; community outreach services; programs for youth; transportation to services), culturally-safe services (i.e., services relevant to language, culture, and life experiences), and funding, infrastructure, and human resources to deliver more addictions services. They also reported a need for mental health promotion programs (i.e., mental health and addictions are closely related issues), increased awareness/education about addictions issues, and parenting programs.

Youth participants reported a need for a drug rehabilitation centre, and health system participants discussed the need to address prescription drug abuse issues in First Nation communities (e.g., data/information on drug prescribing trends; tightened controls on prescribing behaviour; partnerships between the Tripartite Forum and the College of Physicians and Surgeons of NS).

### #3 Priority :

### NIHB Coverage

Non-insured health benefits (NIHB) coverage tied for the number three overall priority – it was identified as a priority in the community engagement sessions and the health system web survey:

- NIHB coverage was the third highest rated priority in the community engagement sessions (5 communities, 45.5% of communities); and
- Monitoring of NIHB benefits was the fifth highest rated priority in the health system web survey section on “First Nation Health Data/Monitoring” (17 responses, 16.5% of responses).

When community session participants described how their communities are affected by NIHB coverage issues, they described health impacts (e.g., people are getting sicker because medications/services are not covered; less effective generic drugs are being prescribed; alternative therapies such as chiropractors/physiotherapists are not covered) and financial impacts (e.g., reimbursements are slow; people sometimes can't pay up front for drugs/services; up-front payments are taking money away from other needs). They also described challenges with the administration of benefits (e.g., service providers need to go through a lengthy approval process in order to prescribe non-generic drugs), confusion about coverage (e.g., people don't know what is/is not covered; coverage changes happen without notice), and impacts on other programs (e.g., Band helps to pay for services/drugs NIHB won't cover at the expense of other community programs).





## Discussion & Conclusions

Several challenges to addressing NIHB coverage issues exist in First Nation communities. For example, community session participants discussed challenges related to funding (e.g., Bands are having to fund drugs/services not covered by NIHB; Bands do not have enough funding to meet the demand) and the administration of benefits (e.g., too much paperwork required; doctors charge fees to do paperwork; delays in finding a prescription on the approved list). Other challenges reported included lack of coordination between NIHB and other health plans and the idea that the NIHB system is difficult to navigate (e.g., lack of information on travel benefits; confusion about who qualifies for what services/medications). Health system participants discussed the idea that NIHB prescription drug appeals take too long for people who need their drugs immediately.

In the 2005 report, NIHB coverage was also identified as a priority issue for First Nation communities:

*“The appeal process and the time of emergency drug coverage under NIHB are inadequate and should be extended to match the time required for appeal.” (Providing Health Care, Achieving Health, page 49)*

*“The First Nations and Inuit Health Branch and the Atlantic Policy Congress of First Nations Chiefs should be supported in continuing to gather specific information from the communities on the issue of prescriptions not covered in the approved drug list. Data should be collected to determine the prevalence of the problem as well as the prescriptions to which it most commonly relates. As part of the solution, this should result in an education program designed to provide physicians and pharmacists with alternatives where appropriate.” (Providing Health Care, Achieving Health, page 51)*

Participants reported that several actions have been taken to address NIHB coverage issues since the release of the 2005 report. For example, community session participants reported that their Bands provide funding to address gaps in NIHB medication and service coverage. They also reported that NIHB provides travel coverage for specialist services (e.g., transportation; lodging; meals) and is working to identify ‘double-doctoring’ of prescriptions. Service providers (e.g., pharmacists) who act as advocates for community members by suggesting alternative medications, and who work to ‘better the system’ by identifying challenges with health benefits were also identified as an important support for addressing NIHB coverage issues.

In terms of what is needed to help address NIHB coverage issues, community session participants identified the need for better administration of benefits (e.g., doctor autonomy to prescribe what they feel is necessary; coordination with other health insurance programs; updated and publicized coverage/reimbursement guidelines) and having a NIHB system navigator (i.e., someone who speaks in user-friendly, non-technical terms). The need for increased funding was also identified (e.g., more funding to cover more services/drugs; fewer cutbacks). Health system participants also identified the need for increased funding for insured health benefits for First Nations (e.g., more funding to cover more services/drugs; fewer cutbacks), as well as the need for a fair appeals process for those who are denied insured health benefits.

### #3 Priority :

#### Elder Care

Elder care tied for the number three overall priority – it was identified as a priority in the community engagement sessions and the health system web survey:

- Elder care/services was the fourth highest rated priority in the community engagement sessions (4 communities, 36.4% of communities); and

”





## Discussion & Conclusions

- Elder care was the fourth highest rated priority in the health system web survey section on “Child, Youth, Family, & Elder Programs/Services” (11 responses, 9.5% of responses).

When community session participants described how their communities are affected by Elder care issues, they described the isolation of Elders (e.g., their health limits their ability to participate in community programs; they often have to live away from their families/communities in order to get service) and the safety of Elders (e.g., lack of safe housing; lack of appropriate, safe home care; abuse from family members). They also described the impacts of the increasing demand for services for the aging (e.g., Bands do not have enough funds to meet the demand; home care cannot meet the demand) and the need for transportation supports (e.g., Elders sometimes do not have transportation to off-reserve services).

Several challenges to addressing Elder care issues exist in First Nation communities. For example, community session participants discussed challenges related to jurisdictional issues (e.g., confusion about who is responsible for what services), lack of community-based supports (e.g., family supports; assisted living facilities; long-term care facilities), and limited staffing and resources available for services to Elders.

In the 2005 report, Elder care was also identified as a priority issue for First Nation communities:

*“While cultural competency is an issue that touches almost every Aboriginal person at some point in their lives, it was pointed out that a culturally competent Elder care program may be one of the highest health care support considerations.” (Providing Health Care, Achieving Health, page 49)*

Participants reported that several actions have been taken to address Elder care issues since the release of the 2005 report. For example, community session participants reported that Elder activities/groups are offered in their communities (e.g., seniors’ groups/clubs, trips, and dinners), home care and community care is offered, transportation to medical appointments is available to many Elders, and that the Lifeline program is working well to address the emergency health needs of Elders.

In terms of what is needed to help address Elder care issues, community session participants identified increased Elder services/supports (e.g., home care; system for checking on the welfare of Elders; long-term care facilities), culturally-safe services (i.e., services relevant to language, culture, and life experiences), and a community Elder centre. Other needs included financial and human resources to offer more Elder services, as well as plans to prepare for the future needs of the growing aging population. Health system participants also identified a need for more health care services for First Nation Elders, as well as the need for strategic plans to address the growing demand for Elder care services.

### #3 Priority :

### Obesity-Related Issues (Physical Activity & Healthy Eating)

The obesity-related issues of physical activity and healthy eating tied for the number three overall priority – they were identified as a priority in the community engagement sessions and the youth web survey:

- Nutrition and healthy eating was one of the fifth highest rated priorities in the community engagement sessions (3 communities, 27.3% of communities); and





## Discussion & Conclusions

- Physical activity and recreation was fifth highest rated youth health priority identified in the youth web surveys (14 responses, 6.9% of responses).

When community session participants described how their communities are affected by the obesity-related issues of physical activity and healthy eating, they described physical impacts (e.g., poor health; increases in chronic diseases, such as heart disease and diabetes; increases in obesity) and financial impacts (e.g., people cannot afford to buy healthy foods).

Challenges to addressing physical activity and healthy eating issues exist in First Nation communities. For example, community session participants discussed challenges related to the lack of an on-reserve community nutritionist and the need for more 'structured' physical activity programs for children/youth.

Obesity, physical activity, and healthy eating were not explicitly identified as priorities in the 2005 report. However, a related issue – community diabetes education programs – was identified as a priority issue for First Nation communities:

*“Core funding for diabetes education programs at the community level is lacking.” (Providing Health Care, Achieving Health, page 50)*

Participants reported that several actions have been taken to address obesity-related issues since the release of the 2005 report. For example, community session participants reported that diabetes work is happening (e.g., diabetes working group; school sessions on diabetes; individual nutritional counselling; diabetes workshops), healthy eating and recreation groups for children/youth are offered in their communities (e.g., Klubs for Kids; Kids in the Kitchen), and a UNSI nutritionist is available. They also reported that meal support programs (e.g., a program funded by the Gaming Commission; home care meal programs), a food bank, and Canada Prenatal Nutrition Program workshops are offered in their communities. Youth participants reported that there are physical activity programs for youth (e.g., recreation; sports; summer games) and a youth centre available in their community.

In terms of what is needed to help address obesity-related issues, community session participants identified increased financial and human resources to offer programs, a dietitian or nutritionist to help people learn healthy eating habits, and a community survey to determine what wellness programs members need. Youth participants identified a need for more youth activities and sports teams.

### #3 Priority : Improved Funding for Health Services

Improved funding for health services tied for the number three overall priority – it was identified as a priority in the community engagement sessions and the health system web survey:

- Improved funding for health services was one of the fifth highest rated priorities in the community engagement sessions (3 communities, 25.0% of communities); and
- Funding/resources was the second highest rated priority in the health system web survey section on “Health Planning Processes” (16 responses, 15.4% of responses).

When community session participants described how their communities are affected by the need for improved funding for health services, they described insufficient funding for appropriate programs and services (e.g., some programs not being offered and services not being available);





## Discussion & Conclusions

insufficient NIHB coverage (e.g., for some health procedures needed); the Band having to absorb costs to subsidize health services (and therefore not being able to cover other programs/services); negative impacts on community members (e.g., isolation and/or low self esteem, not being able to access programs/services probation orders require them to participate in); and cultural safety (e.g., not being able to access services in their own language).

Several challenges to addressing the need for improved funding for health services in First Nation communities. For example, community session participants discussed challenges related to a perceived lack of commitment for stable, adequate funding from the federal government; the Band being forced to draw on other revenue to subsidize health services and programs; not being able to offer some programs and services; lack of transportation to services outside the community; and a lack of cultural safety in terms of the way services are offered outside the community.

Health system partners identified challenges in addressing funding/resources related to health planning. They noted that reduced funding, tightened budgets, and/or a lack of resources is a challenge; that funding formulas do not support First Nation access to the health services people need; and that cutbacks are creating a burden on grassroots people/projects trying to address the health issues in First Nations. They also noted that the Mi'kmaq-Nova Scotia-Canada Tripartite Forum lacks the necessary financial and human resources to achieve its potential as a platform to contribute to policy development, long term strategic planning, and relationship building.

In the 2005 report, funding issues were also identified as a priority for First Nation communities:

*“As a health strategy is seen through many cultural lenses, the health care system and the bureaucracy that shapes it are, perhaps inevitably, predisposed to episodic, crisis oriented, short term “fixes”. This culture is reflected in the approach to funding, which is heavily biased in favour of interventions and “grants” rather than to capacity building, prevention and long-term (core) development. This approach to funding is directly translated into the approach to health service planning and delivery, which tends to be based more on the opportunistic pursuit of program-specific resources than on a strategy that addresses identified health needs. Compounded by the Auditor General’s finding that some First Nation communities are required to complete more than 200 annual reports in order to comply with grant-driven accountability frameworks, and the magnitude of inefficiency and lost opportunity is apparent. Project activity is important but should not be the basis upon which local health care systems are planned, managed and delivered. Communities require sustained ‘core’ funding based on locally identified priorities in order to long-term health impacts.” (Providing Health Care, Achieving Health, page 47)*

Participants reported on actions taken to address the need for improved funding for health services. For example, community session participants reported that Bands address the funding gaps however they can to make sure community members get the health services they need (this often means the Bands are redirecting funds intended for other programs and services); and communication between departments, Band staff, community members, and outside organizations can help bring in proper resources to offer services and programs.

In terms of what will help address improved funding for health services, community session participants identified the need for increased funding by the federal government (e.g., to offer more services); funding for transportation (i.e., to access services outside the community); and cultural safety (i.e., programs and services relevant to people’s language, culture, and life experiences).

Health system participants reported the need for long-term, stable funding and resources; committed funding; additional funding to ensure equitable health care services for First Nation communities; additional funding for health care providers who serve both on-reserve and off-reserve populations; and revised funding formulas to address First Nation health issues (e.g., shifting from rigid funding criteria to criteria that address the actual needs of individual communities).







# 7 CONSIDERATIONS FOR FUTURE HEALTH PLANNING

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## Considerations for Future Health Planning

The following section outlines considerations for future First Nation health planning processes, based on the health priorities identified in the current project. These considerations are offered to First Nation communities, organizations, the Tripartite Forum Health Committee, and other health-system partners who may decide to incorporate them into their own health planning processes. The Tripartite Forum Health Working Committee has developed a distribution plan to broadly share the results of this project and provide opportunities for partners to respond to the following considerations for action:

### Mental Health Considerations

- Continued focus is needed on community-based mental health crisis services for First Nation Elders, adults, and youth; and
- Community-based suicide prevention and mental health promotion programs should continue to be resourced, as they are important supports for First Nation communities in Nova Scotia.

### Additions/Substance Abuse Considerations

- The Tripartite Forum and its partners should continue to address the issue of prescription drug abuse in First Nation communities in Nova Scotia;
- Consideration should also be given to developing initiatives for First Nation Elders, adults, and youth to address illicit drug use, solvent abuse, and alcohol abuse issues; and
- Stable funding and resources should be in place to support the important role that NADACA workers are playing to address addictions/substance abuse issues in First Nation communities in Nova Scotia.

### NIHB Coverage Considerations

- The issue of non-insured health benefits for First Nation communities in Nova Scotia should be addressed in a timely and proactive manner – many Bands are having to cover the costs of their members' medication and health transportation services, hindering their ability to resource other much-needed programs in their communities.

### Elder Care Considerations

- Elder care continues to be an important issue for First Nation communities in Nova Scotia – a range of culturally-appropriate, community-based services are needed to address the holistic needs of First Nation Elders; and
- A number of successful programs/services for Elders currently exist in First Nation communities in Nova Scotia (e.g., Lifeline; medical transportation programs) – consideration should be given to opportunities that will allow communities and organizations to share what is currently working in the area of Elder care.





## Considerations for Future Health Planning

### Obesity-Related Considerations

- Physical activity and healthy eating issues reflect a concern by Nova Scotia First Nations about the physical health of their community members (i.e., obesity rates; diabetes rates) – access to physical activity facilities, social marketing, and programs to address the physical activity and nutrition/healthy eating needs of First Nation Elders, adults, youth, and children all need to be considered.

### Funding/Resource-Related Considerations

- Communities and health system partners identified the need for improved and committed funding for health services. Consideration should be given to working towards (or working together for) the development of a model for transparent, stable funding for health services that is accessible to all communities and based on a broad understanding of health and healthy communities.
- Within the development of a funding model, consideration should be given to incorporating core levels of service and programs (e.g. mental health, early childhood development), as well as ensuring communities strengths, priorities and needs can be addressed. This would reflect the understanding the communities have common areas of service, but also that communities are different – in size, demographics, service provision to on and off – reserve members, and health issues they wish to address.
- Concern about cultural safety was also expressed by communities. Consideration should be given to strengthening the cultural competence of health care workers providing service to First Nation communities.





# 8 CONSULTANT REFLECTIONS

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## Consultant Reflections

Throughout this project, the consultants have had an ongoing dialogue with communities, with each other, and with project Sub-committee members about the experience of doing the community engagement process. Reflections from these discussions are shared here for consideration in future planning processes with First Nation communities.

When we approached the Health Directors to invite their communities to participate in this process, a number expressed a sense of 'here we go again' or 'our communities are studied and focus-grouped to death'. They agreed to participate based on the hope and belief that something positive for their communities could come out of this process, for example:

- The positive outcome(s) could be strategic actions by planners about First Nation communities in Nova Scotia in general;
- Several Health Directors found it helpful to have had this discussion with their community members in terms of informing their own health plans;
- Others found it beneficial to have brought together people with a range of roles and responsibilities in the community for this discussion, so they could learn from each others' perspectives;
- For some communities, it was helpful to frame the discussion in terms of the *population health approach*, which helped community members and workers build their knowledge about the bigger picture of health, and understand better the potential role they play in their community's health; and
- Finally, in some places, community members who do not typically participate in health planning processes participated, which could increase the likelihood of them engaging in future health planning processes.

Many community members have experienced processes where outsiders come to their community, gather the information they need from the community for their purposes, and vanish into thin air. Throughout this process, Health Directors and session participants have emphasized the importance of the information coming back to their communities, and not 'sitting on a shelf somewhere gathering dust':

- All communities said that they want to see the results of this process; and
- Several communities mentioned the importance of having someone to discuss the findings with them and help them think through what the findings mean for them in their context – they do not simply want a copy of the report mailed to them.

Due to the historical context of Europeans and Mi'kmaq peoples in Nova Scotia, it can be a challenging dynamic for a First Nation community to have a non-First Nation outsider asking their community for information (and being paid to do so). This can also be a challenging experience for a consultant who appreciates the context and genuinely wants to make a positive contribution to the well-being of First Nation communities.

In this case, it was very helpful to have The Confederacy of Mainland Mi'kmaq (CMM) Health Advisor and one of the Union of Nova Scotia Indians (UNSI) Health Directors acting in a liaison role between the consultants and the Health Directors. As trusted colleagues with whom the Health Directors have long-standing relationships, they were able to lay the groundwork so that the Health Directors would know what to expect, and could appreciate the value of participating in this process. They could also answer questions or address concerns that the Health Directors may have been reluctant to communicate to the consultants.





## Consultant Reflections

The CMM Health Advisor and UNSI Health Director were also able to provide guidance and advice to the consultants about how to best approach the Health Directors, and about balancing determination with respect for community processes and ways of doing things.

A capacity-building approach is very relevant for working with First Nation communities. This type of approach builds in (and budgets for) opportunities for First Nation community members to be involved in planning, conducting, and analyzing planning and research processes. In *Horizons'* experience, this can be done in a number of ways. It is first important to acknowledge that communities may already have the skills and expertise needed to carry out the work, and may just need to be asked to be part of the team doing it. In other cases, it is possible to create supports for interested community members to learn about how to do this kind of work as they are involved in the doing of it. Either way, using this kind of approach can be very valuable in terms of engaging communities in a respectful manner, increasing community capacity, relationship-building over time, and increasing the buy-in and engagement of communities to a process.

Creating processes that are transparent and inclusive of communities and their perspectives is very important for building trusting relationships over the long-term, and for ensuring the integrity of the data reported. The process of asking First Nation communities to review and approve the summaries of their discussions about health priorities, and the process of inviting Health Directors and Chiefs and Councils to review a draft of this report demonstrate respect and openness to communities and their perspectives.

The Tripartite Forum Health Working Committee has also developed a distribution plan to broadly share the results of this project. It is anticipated that the distribution plan will help raise awareness about First Nation health priorities and support actions that effectively respond to the health priorities of First Nation communities in Nova Scotia.







# 9 Appendices

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