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Board Education Session

Introduction to Aboriginal Cultural Competency/Safety in Health Care Delivery

April 15, 2015 -- 1:00 PM to 3:00PM
Champlain LHIN Office, 1900 City Park Drive, Suite 500, Ottawa

AGENDA

TOPIC	TIME
Welcome and introduction	1:00 – 1:15
Historical Context & Impact of Colonization on Health of First Nations, Inuit and Métis	1:15 – 2:00
Providing Health Services from a Cultural Competency and Safety Framework	2:00 – 2:30
Discussion	2:30 – 3:00

NOTE : Unfortunately, this session will not be available via OTN.

Champlain **LHIN**

Introduction to Aboriginal Cultural Competency and Cultural Safety in Health Care Delivery

Presenter(s): *Donna Lyons, Aboriginal Engagement Specialist*
Dr. Sandi de la Ronde, Director of Health Services, Wabano Centre for Aboriginal Health
Event: *Champlain LHIN Board Education Session*
Date: *April 15, 2015*

Ontario
Local Health Integration Network

Objectives of Training

To enhance current understanding of the Champlain LHIN Board on:

- The unique history of First Nations, Inuit and Métis
- The impact of colonization on the health of First Nation, Inuit and Métis today
- The health care needs of First Nation, Inuit and Métis people and approaches to health care delivery

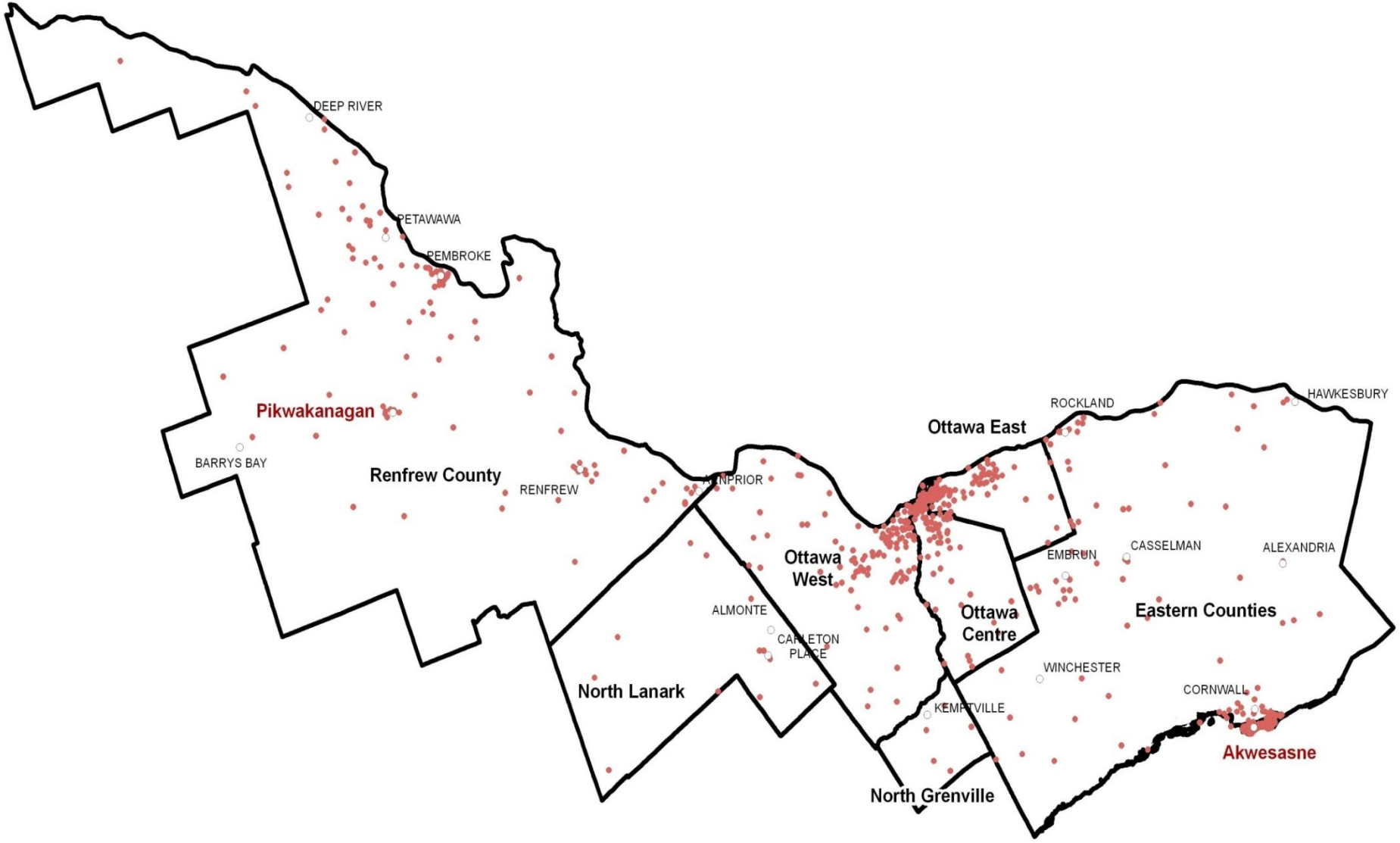
Overview of Presentation

- First Nation, Inuit and Métis Population in the Champlain region
- Historical Context
- Impacts of Colonization on the Health of First Nations, Inuit and Métis Today
- Providing Health Services from a Cultural Competency and Cultural Safety Framework

First Nations, Inuit and Métis Population in Health Links Areas

- Approx. 41,000 Aboriginal people in Champlain
  - incl. ~ 31,000 off-reserve (2011 Census) and approximately 10,000 Mohawks of Akwesasne
- Ottawa (NHS, 2011)
  - First Nations 10,300
  - Métis 6,400
  - Inuit 710
- Ottawa is home to largest number of Inuit outside the north (2011 Census indicates 710, actual estimations of 3,700)

First Nation, Inuit and Métis Population by Health Link



First Nation, Inuit and Métis Population

- We need to exercise ***CAUTION*** as Canadian sources of health assessment data systematically underestimate the inequities in health determinants, health status and health care access between Indigenous and non-Indigenous people in Canada

- Population statistics vary substantially, depending on sources and limitations of data

Population Profiles

- There are 5 main cultural groups living in Ontario:
  - Anishnawbek Nation: Ojibway, Potawatomi, Chippewa, Odawa, Algonquin, Mississauga and Delaware
  - Haudenoshaunee : MohawkConfederacy/Iroquois also referred to as Six Nations Confederacy: Mohawk, Onondaga, Oneida, Cayuga, Tuscarora, Seneca
  - Cree
  - Métis
  - Inuit

Historical Context

HISTORY provides a vital context for understanding the poor health outcomes many First Nation, Inuit and Métis people suffer from today

Historical Context: Prior to Colonization

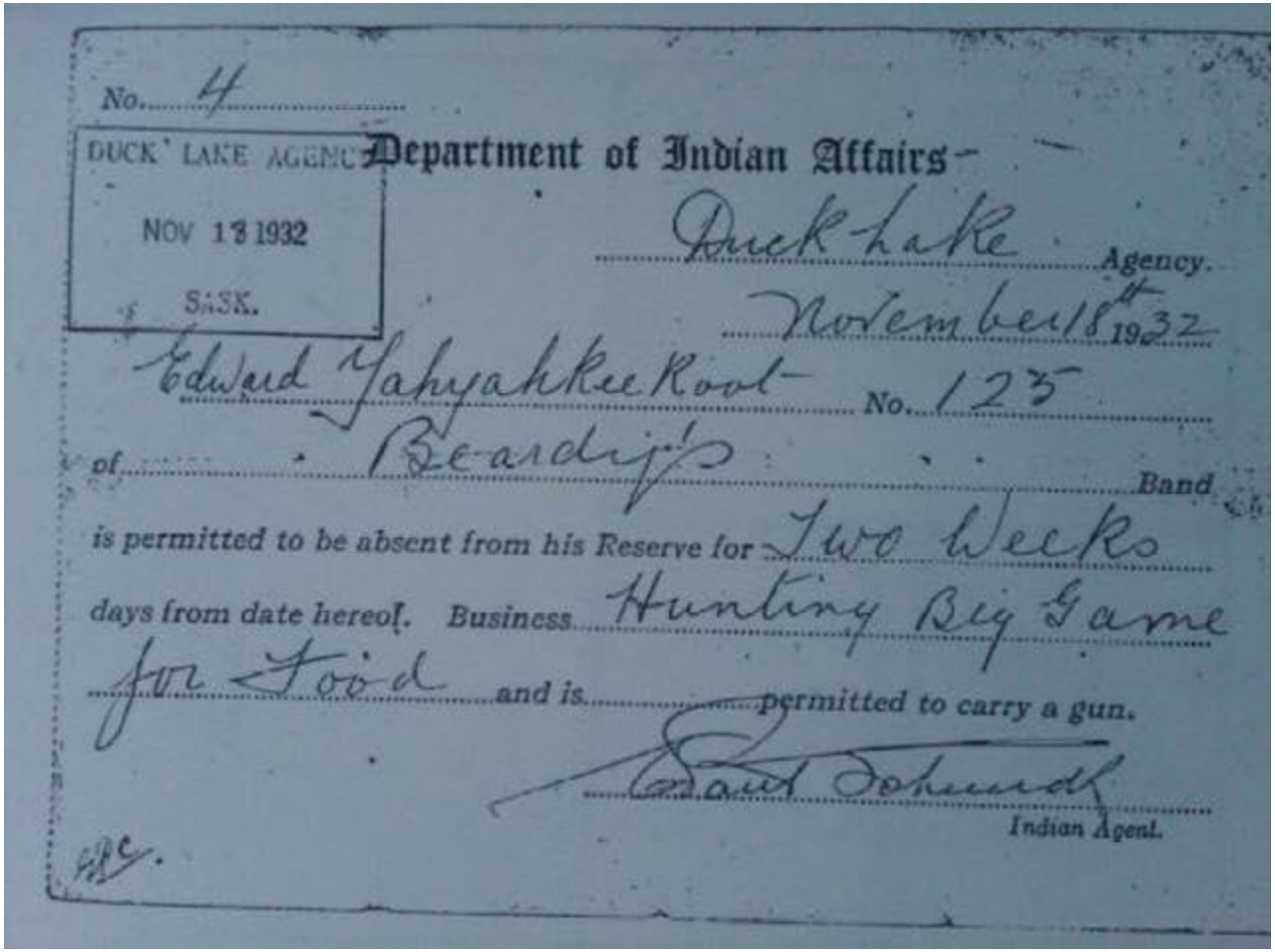
- Prior to colonization Aboriginal people enjoyed good health, had well functioning societies and used their traditional wisdom and ecological knowledge as foundations for maintaining and restoring their well-being
- Cultural values included a sense of community, diversity in personal expression, dignity and respect for all sacred life, social responsibility, harmony and balance
- First Nations and Inuit had their own world views toward health and wellness and their own methods of healing

Historical Context – Treaties

- Section 35 of the Constitution Act of 1982 both recognizes and affirms existing Aboriginal and treaty rights
- The Indian Act, enacted in 1876 by the Parliament of Canada provides Canada's federal government exclusive authority to legislate in relation to "Indians and Lands Reserved for Indians"
- The Act defines who is an "Indian" and contains certain legal rights for registered Indians (status)
- The federal government has assumed responsibility for health care for First Nations, however does not recognize it as a treaty right
- First Nation, Inuit and Métis people are NOT a cultural group to Canada nor should be viewed as a diversity, but rather a *distinct* constitutionally recognized peoples with Aboriginal and treaty rights

Historical Context - Colonization

- Population prior to colonization was estimated at $7ml - 90% wiped out by disease - terra nullius – concept of empty land
- Conflict of interest – 1867 BNA Act transferred responsibility for Indians from British to Canadian government - negotiating treaties and purchasing land vs looking after best interests of Indians
- Various amendments and policies were made to the Indian Act over the years, aimed at the aggressive assimilation of Indigenous people into the more dominant settler society
- Paternalistic - only allowed to vote, own property, hire lawyer, serve in juries if willing to enfranchise
- Indian Agent had power to make decisions – Indians could not sell or produce goods/could not leave reserve without permission



No. 4

DUCK LAKE AGENCY
NOV 18 1932
SASK.

Department of Indian Affairs

Duck Lake Agency.

November 4 1932

Edward Yahyahkee Root No. 125

of Beardy's Band

is permitted to be absent from his Reserve for Two Weeks

days from date hereof. Business Hunting Big Game

for Food and is permitted to carry a gun.

David Johnson

Indian Agent.

ABC.

Historical Context – Indian Residential Schools & 60s Scoop

- One of the most devastating legislative changes made Indian residential schools attendance mandatory for all First Nations children (150,000 First Nation, Inuit and Métis children attended residential schools from earliest in 19th century to 1996)
- TRC is bringing the stories to life, aim is to acknowledge residential school experiences, impacts and consequences
- Widespread apprehensions and adoptions of Aboriginal children occurred referred to as the 60s scoop
- AANDC reveal a total of 11,132 status Indian children adopted between the years of 1960-1990, however there is still a high high representation of Aboriginal children in CAS care

Historical Context – Impacts of Colonization

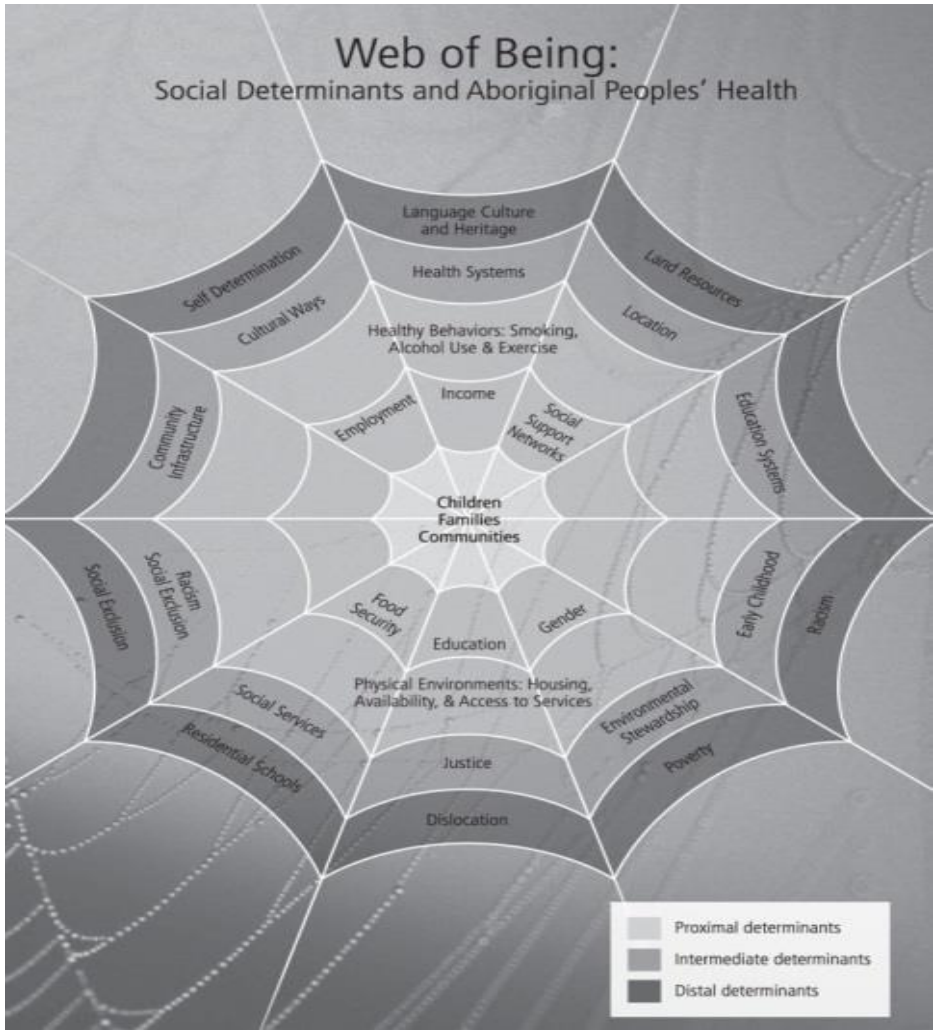
- Way of life changed substantially
- Grief and Loss – Relationship to the land, governance, language, culture, roles in society, ties to community, and family were disconnected
- Children taught shame and rejection of their heritage, ancestors, family, traditional foods and spiritual traditions
- Parents and grandparents roles were disrupted
- Intergenerational losses and trauma have created dependency roles and underdevelopment of personal growth of the individual, families and communities
- Impacts are still felt today and the trauma continues to occur

Discussion

Reflections on the information provided:

- Does the information provided today vary from what you learned through educational, work experiences, media and other sources?
- What value do you see for yourself personally in learning about First Nation, Inuit and Métis history of colonization today?
- How might this benefit your working relationship with Aboriginal people?

Aboriginal Social Determinants of Health



Aboriginal Social Determinants of Health

- Colonial legacies are determinants impacting Aboriginal children's lives and can only be accounted for by applying a social determinants of health lens that is inclusive of multiple realities and considerate of Aboriginal peoples' distinct sociopolitical, historical and geographical contexts
- **Proximal** include employment, income and education
- **Intermediate** determinants are inclusive of community infrastructure, cultural continuity and health care systems
- **Distal** includes colonialism, racism, social exclusion and self-determination
- If transformed, distal determinants are constructed and the most difficult to change, yet if transformed may yield the greatest health impacts and long-term change to Aboriginal child health inequities

Health of First Nation, Inuit and Métis Today

Aboriginal people report much higher incidence of chronic and acute health conditions versus other Canadians:

- Diabetes – FN on reserve 17.2%, FN off reserve 10.3%, Métis 7.3% and Inuit 5.0%, General Population 5.0%
  - Higher rates of co-morbidities and complications
  - Earlier age of onset, greater severity of disease, reduced access to health care, high risk factors
- Arthritis - Significant for Aboriginal women – 70% aged 65 and older compared with 50% compared with non-Aboriginal – FN women off reserve similar rates, Métis 21% vs 13%

Health of First Nation, Inuit and Métis Today

- High blood pressure FNIM women higher at 5.0 FN off reserve, 6.7% Inuit and 9.8% Métis compared to general population of 4.7%
- Cancer (women) – FN off reserve 5.0%, Inuit 6.7%, Métis 5.3%, General Population 1.6%
- Infant Mortality – 2x higher (First Nations) 4x higher (Inuit)
- Life expectancy for Aboriginal 5-7 years lower, 15 years lower for Inuit

Mental Health of First Nation, Inuit and Métis Today

- Aboriginal people report much higher incidences of depression
- Higher levels of suicide in some First Nations 5x higher and Inuit which is 11 x higher than the national average
- My Life My Wellbeing study of Aboriginal youth in Champlain region show higher rates of depression, suicidal ideation and anxiety
- Also show higher rates of substance abuse, crime and violent behaviour, and being victims of violence and abuse
- Aboriginal youth in the Champlain region state that they need more culturally based and culturally appropriate services

Introduction to Political Structures and Appropriate Terminology

- National, provincial and local approaches and policies have an impact at the local level
- First Nation, Inuit and Métis – distinctions based approach
- Overview of terminology

Health Service Delivery for FNIM

- Federal government responsibility for First Nations on-reserve health care
- Federal government responsibility for Inuit health care – transferred to territorial governments
- Provincial government responsibility for off-reserve status/non-status Indians and urban Inuit
- NIHB available to status Indians both on and off-reserve and Inuk recognized by land claim org'n
- Provincial government responsibility for Métis health care – same as all other Canadians – not eligible for NIHB
- Limited federal government responsibility for mental health – crisis intervention through NIHB

Health Service Delivery in Champlain region

Where do Aboriginal people access health services in the Champlain Region?

- On Reserve First Nation – Primary health care clinics/social service delivery & wellness programs/long term care and others/hospital and other services accessed from urban centres
- Off Reserve First Nation – Urban, mainstream, Aboriginal-specific organizations/programs
- Inuit – Urban, mainstream, Aboriginal and some Inuit specific services available
- Métis – Urban, mainstream, some Aboriginal and some Métis specific services available

Health Service Delivery in Champlain region

Where do Aboriginal people access health services from in the Champlain Region?

- Wabano Centre for Aboriginal Health, Akausivik Inuit FHT, Akwesasne and Pikwàkanagàn provide primary health care
- Wabano – mental health counselling and a wide variety of programs and services
- Métis Nation of Ontario – telepsychiatry clinics (weekly) and community services
- 1 women's shelter, 1 Inuit treatment centre (northern focus)
- Wide variety of community programs and services provided by other Aboriginal organizations

Aboriginal Health Circle Forum (AHCF)

- LHINs are required by legislation to engage Aboriginal communities/organizations and effectively plan for Aboriginal health with their regions
- Aboriginal Health Circle Forum (First Nations, Métis and Inuit representation) works in partnership with the Champlain LHIN to improve the health status of Aboriginal peoples in the Champlain region
- Input into health service planning and priority setting
- Working on identified health system improvements

AHCF Priorities

- Mental Health & Addictions in Children & Youth
- Cultural Training
- Chronic Disease & Wellness
- Engagement & Advocacy

Discussion

Reflections on the information provided:

- Does the information provided in the slides above vary from what you learned through educational or work experiences or even what you hear in the media?
- What insights came to you as you listened to this presentation?
- How might this benefit your working relationship with Aboriginal people?

Providing Health Services from a Cultural Competency and Cultural Safety Framework

Relevance to Champlain LHIN – Why Is This Important?

- FNIM may be reluctant to self-identify based on their beliefs or past experiences that a lower level of care provided as a result
- Studies have repeatedly shown that when care is delivered with competence and the patient feels safe, health care outcomes are better
- Patients who feel unsafe do not access care or access it late in the illness

Cultural Safety

- Nursing organizations conducted workshops and promoted hiring of Maori nurses.
- Developed curriculum to teach culturally safe care
- Definitions developed by Nursing council of NZ
    - Safe = nursing or midwifery action to “reduce risk to patient from hazards to health and well being”
    - Unsafe = “any action or omission..., demeans the person or disempowers the cultural identity”

Cultural Safety

- Concept first discussed in New Zealand nursing community in 1980s
- New Zealand has many similarities to Canada
  - Colonized by Great Britain
  - Treaty of Waitangi in 1840 guaranteed certain rights to the indigenous peoples (Maori)
  - Subsequent government Acts in the 1970s and 1980s have reaffirmed these rights
  - Despite this, Maori peoples have been found to be culturally, socially and economically disadvantaged with higher rates of physical and mental illnesses than non-Maori population

Definitions

- Culture: a set of activities, values and experiences surrounding an individual which are considered to be real and normal. (Nursing Council of New Zealand). A way to experience life and view the world.
  - most often includes a common language, spirituality, teachings
  - dynamic; cultures keep what continues to work in daily life, adapt to outside influences and sometimes adopt new language or practices.
  - people view and evaluate individuals or communities of another culture through their own sense of normal

Culture

In the medical world, we deal with at least 3 cultures

- The practitioner's own culture
- The patient's culture
- The medical culture
  - maybe the most ingrained in practitioners and the most difficult to identify the components and their influence on how we act.

Definitions

- **Cultural awareness**
  - First step in recognizing that there are differences between one's own culture and that of a patient
- **Cultural competence**
  - Through education, grow in competence in applying cultural understanding to the services provided
- **Cultural safety**
  - Needs and voice of the patient take the dominant role

Culturally Appropriate Care

- Focus of the presentation is on Aboriginal population but concepts can/should be applied to all interactions between patients and health care providers
  - Be aware of how one's culture influences one's view of "the other"
  - Practice respect; concept that the individual will do what works best for him/her at the current time
  - Practice humility; all individuals in the interaction have equal worth
  - Listen actively;
  - Tune in to non-verbal communication cues


Cultural blindness
Cultural humility
Cultural destructive-ness
CULTURAL SAFETY
Cultural competency
Cultural awareness

Discussion

Reflections on the information provided:

- What insights came to you as you listened to the information provided on cultural competency and cultural safety?
- How might this benefit your working relationship with Aboriginal people?

AHCF Role in Cultural Training

- Cultural Training is one of the four priorities of the AHCF
- AHCF has identified that LHIN staff, board and HSPs particularly mental health should receive cultural competency/cultural safety training
- ABP activities include exploring how the online ICC training can be made available more widely in Ontario/Champlain region
- Wabano is currently piloting cultural safety training, explore how the training once finalized can be made available to HSPs

AHCF and Health Links

Discussion:

1. Questions/Reflections

2. What should the focus of future board training be?

Meegwetch/
Thank you