



The National Inquiry into Missing and Murdered Indigenous Women and Girls
Institutional Hearing – Government Services, Health Services Panel, May 30-31, 2018

Overview of the First Nations and Inuit Health Branch Context and Select Key Activities Related to
Violence against Indigenous Women and Girls

1.0 INTRODUCTION

1.1 The Health Services Delivery Context

The Government of Canada is committed to pursuing a renewed Nation-to-Nation relationship based on recognition, rights, respect, cooperation and partnership with Indigenous peoples in Canada. The renewed relationship will support reconciliation and healing. This commitment is framing and guiding the actions of the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada (ISC).

FNIHB derives its overall authority from the *Department of Health Act* and the Indian Health Policy (1979). FNIHB's mandate is to ensure the availability of, or access to, health services for First Nations and Inuit communities; assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and build strong partnerships with First Nations and Inuit to improve health services.

FNIHB works with a wide range of partners' programs, services and partnership initiatives to improve health outcomes for First Nations and Inuit. Important steps have been taken to strengthen the relationship with First Nations and Inuit at national, regional, Nation and community levels. FNIHB signed a Protocol Agreement with the Assembly of First Nations (2014) and the Inuit Health Approach (2014) with the Inuit Tapiriit Kanatami. The Protocol Agreement outlines the relationship between FNIHB and the Assembly of First Nations to establish a culture of transparency and reciprocal accountability, as well as joint policy, planning and program development work. The Inuit Health Approach reflects FNIHB's commitment to work with Inuit, territorial and provincial governments, and other federal partners to develop an approach to Inuit health that informs planning and implementation with the Branch.

Provincial governments deliver hospital, physician and public health programs, but generally do not operate direct health services on reserve. FNIHB fills this gap by funding or providing basic primary health care services on reserve. Depending on various factors, communities have different levels of access to and integration with provincial services. Factors include geography, size of the community, and health needs and priorities identified in community health plans.

The territorial governments deliver hospital, physician and public health programs to all residents. While FNIHB does not provide primary health care services in the territories, it funds a suite of community-based health promotion and disease prevention programs, home and community care programming, and non-insured health benefits accessible to First Nations and Inuit. The delivery of programs for First Nations and Inuit varies across the Territories. Nunavut and the Northwest Territories currently



administer these programs as part of their territorial health systems. In the Yukon, 14 First Nations receive funding directly for these programs.

FNIHB works to improve the linkages among federally-funded health services in First Nations and Inuit communities with those funded by the provinces and territories and to help build multi-party partnerships to advance a continuum of services for individuals and communities to improve health outcomes.¹ FNIHB also participates at trilateral tables across the country to support greater alignment of services and to improve health access and outcomes for First Nations and Inuit.

In establishing ISC (2017), the Government of Canada seeks to support high quality services across inter-related sectors (e.g., health services, child and family services, and housing) for Indigenous peoples and facilitate a path to self-determination in all sectors. In her mandate letter, the Prime Minister directs the Minister of ISC to “take an approach to service delivery that is patient-centred, focused on community wellness, links effectively to provincial and territorial health care systems, and that considers the connection between health care and the social determinants of health.” ISC may be the first federal government department ever created with its own obsolescence as a goal.

1.2 Increasing First Nations and Inuit Control Through Transfer

As part of the renewed Nation-to-Nation relationship, the Government is committed to working with partners on a new fiscal relationship. The Government of Canada and the Assembly of First Nations have worked together to articulate a vision for a new fiscal relationship with First Nations communities. The Government has signed a Memorandum of Understanding with the Assembly of First Nations to jointly undertake a comprehensive review of the existing fiscal relationship. To support the new fiscal relationship, the Government is establishing a permanent advisory committee to provide further guidance and recommendations; co-developing ten-year grants for qualified First Nations; and co-developing a mutual accountability framework.

For decades now FNIHB has been working with partners to increase First Nations and Inuit control over the design, planning, delivery and evaluation of community programs and services. The aim of this increased First Nations and Inuit control is a better fit between programs and services and community needs in order to improve health outcomes. In this way, communities have been supported to customize or develop new services, leading to the emergence of more and more community-based promising practices (e.g., holistic approaches; culture and land-based programs). Increased First Nations and Inuit control has been an explicit focus of FNIHB since the 1980s. Through investments in governance, capacity and health infrastructure supports along with the wider array of health services, FNIHB is helping to continue to increase capacity in communities to increase their control over community, Nation or regional services. At this time, most First Nations and Inuit health programs are delivered by First Nations and Inuit organizations via multi-year contribution agreements involving variable levels of flexibility or as part of self-government or land claim agreements.

¹ FNIHB funds regional integration projects through the Health Services Integration Fund.



FNIHB currently has contribution agreements with 428 communities² that facilitate the delivery of FNIHB services in First Nations and Inuit communities. FNIHB has different types of funding arrangements with First Nations communities associated with different levels of administrative flexibility and governance. 177 communities are in block funding arrangements. These are the most administratively flexible arrangements outside of the self-government or land claim context; communities develop and implement their own health plans in response to their health priorities. Communities in flexible (169 communities) and set (82 communities) funding arrangements deliver programs and services using nationally described program guides.

In the last ten years, FNIHB has specifically invested in increasing First Nations and Inuit capacity to establish partnerships with provincial and territorial health authorities. Initiatives have shown promise in advancing smaller-scale incremental integration and coordination. There has also been growing momentum in advancing trilateral collaboration. Formal trilateral mechanisms to engage on common health priorities have been established in almost every province and territory, and these partnership tables cooperate on health issues of regional/cultural relevance on an ongoing basis.

The First Nations Health Authority in British Columbia is a notable example of trilateral collaboration leading to increased First Nations governance over their health services. The First Nations Health Authority plans, designs, manages and funds the delivery of First Nations health programs and services formerly administered by FNIHB. FNIHB operations were transferred to the new authority in 2013 in accordance with the terms and conditions of the British Columbia Tripartite Framework Agreement on Health Governance. FNIHB's role has shifted in this case to that of funder and governance partner and continues to build on this partnership model with new investments.

1.3 Health Services Funded or Directly Provided by FNIHB

FNIHB works closely with First Nations and Inuit partners to fund or provide health services that complement those provided by other jurisdictions. FNIHB's Senior Management Committee includes representatives from FNIHB's senior management from the national and regional offices (Atlantic, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and Northern Region) as well as representatives from the Assembly of First Nations and the Inuit Tapiriit Kanatami. Its mandate is to provide overall policy direction for the Branch, consistent with the goals and principles of the 2012 Strategic Plan; monitor and provide direction for the Plan's implementation, including collaboration and partnership initiatives; review, approve and provide direction on policy issues and approaches; and review and approve proposals for modernizing policies and programs. In addition to the Senior Management Committee, regional offices engage on plans and priorities at regional partnership tables.

FNIHB funded services are grouped into three overarching categories: Primary Health Care, Supplementary Health Benefits and Health infrastructure Support.

² Excludes communities in British Columbia where the First Nations Health Authority has assumed control over the management, delivery and funding of First Nations programs and services to communities.



- **Primary Health Care** funds a suite of services and strategies provided primarily to First Nations and Inuit individuals, families and communities living in their communities. It encompasses health promotion and disease prevention, including mental wellness, to improve health outcomes; public health protection, including surveillance of communicable diseases and environmental hazards; and primary care, including clinical and client care, where individuals are provided diagnostic, curative, rehabilitative, supportive, and referral services, and home and community care services. Although some services are mandatory, others may be tailored by communities to address local priorities.
- **Supplementary Health Benefits** are provided through the Non-Insured Health Benefits (NIHB) Program.³ NIHB is a national program that provides registered First Nations and recognized Inuit in Canada (approximately 867, 749 individuals) with a range of medically necessary health-related goods and services not provided through other private plans or provincial/territorial health or social programs. This includes prescription drugs, medical supplies and equipment, dental care, vision care, mental health counselling, and medical transportation to access medically required health services that are not available on reserve or in the community of residence. Clients are eligible whether living in or outside their communities.
- **Health Infrastructure Supports** underpin the long-term vision of an integrated health system with greater First Nations and Inuit control by enhancing their capacity to design, manage, deliver and evaluate quality health programs and services. Areas of investment include health planning and quality management, health services accreditation, health human resources, health careers, health facilities (e.g., health centres and nursing stations) and e-Health infrastructure.

In its efforts to fund or provide effective, sustainable, and culturally appropriate health services, FNIHB also applies a gendered lens. In the development of its funding proposals (e.g., Budget proposals, Memorandum to Cabinet), FNIHB engages in a formal Gender-Based Analysis Plus (GBA+) process, which address questions such as: What impacts did the assessment identify on the basis of gender and other intersecting identities? Are measures included in the initiative to address or mitigate identified impacts? Does this initiative aim to produce improved outcomes in gender equality and/or inclusiveness in general? If so, will these objectives be integrated in the department's performance measurement approach? The implementation of GBA+ in FNIHB is helping to ensure that the needs of Indigenous women and girls are addressed in a comprehensive and systematic way that can be monitored and improved over time. In fact, the Government of Canada is committed to supporting the full implementation of GBA+ across federal departments and agencies.⁴

2.0 ADDRESSING VIOLENCE AGAINST INDIGENOUS WOMEN AND GIRLS

³Some registered First Nations and recognized Inuit are provided with benefit coverage under a self-government agreement (Nisga'a, Nunatsiavut) and services for First Nations residents of BC are provided by the BC First Nations Health Authority. These clients are therefore not included in this count.

⁴ Information about the Government of Canada's GBA+ requirements can be found at <https://www.canada.ca/en/treasury-board-secretariat/services/treasury-board-submissions/gender-based-analysis-plus.html>



Family and gender-based violence have significant impacts on physical and mental health, both immediately and across the lifespan. Indigenous women and girls can be particularly vulnerable, including Indigenous women and girls who identify as lesbian, bisexual, transgender, queer or two-spirited. Working with Indigenous partners to help prevent and address violence is a shared responsibility across all jurisdictions.

Several federal departments (such as Status of Women Canada, Justice Canada, Public Safety Canada, and the Public Health Agency of Canada) have existing mechanisms to support engagement and collaboration with provincial and territorial colleagues on the issue of violence, including in Indigenous communities. ISC-Education and Social Development Programs and Partnerships Sector (formerly part of Indian and Northern Affairs Canada) has funding responsibility for family violence prevention. For FNIHB, there are two main areas of activity related to violence: primary care, which can prevent or respond to health needs of First Nations, including women and girls who have been victims of violence or are at risk of violence; and as a particular area of emphasis under primary health care, mental wellness services that reduce individual, family and community risk factors, increase individual, family and community protective factors, and support individuals, families and communities to advance mental wellness (see program descriptions in Annex A).

2.1 Access to Primary Care Services

Primary care is a coordinated system of health services required to maintain health and provide care and treatment services. Primary care is often the first point of individual contact with the health system at the community level. Primary care through FNIHB includes clinical client care and home and community care. Primary care programs are mandatory because they have a direct impact on the health and safety of community members and the population. Primary care service providers have appropriate provincial credentials, licensing and certification to meet practice standards to ensure quality services are delivered.

2.1.1 Delivery and Funding of Primary Care Services

FNIHB funds or delivers primary care services in 79 remote and isolated First Nation communities, serving a client base of approximately 110,000 persons where access to provincial services is limited or non-existent. Services are delivered directly by FNIHB in 51 communities through the Clinical and Client Care program. In the remaining 28 communities, primary care services are delivered through contribution agreements with First Nations organizations.

In the 51 communities directly served by FNIHB, clinical and client care services are delivered by a nurse-led team of interdisciplinary healthcare practitioners and include: assessments, diagnostics, and treatment of acute and/or chronic illnesses/diseases for emergent, urgent and non-urgent care, including public health, and coordinating care with provincial health care systems. Services include access to emergency services twenty four hours a day, seven days a week. In addition to providing routine and emergency primary care services, FNIHB-employed nurses are required to support the delivery of other federally funded services available in First Nations communities, such as home and



community care, health promotion and disease prevention programs, communicable disease control, and responses to emerging health issues such as opioids.

Nurses at nursing stations must be prepared to assess, manage and treat a broad range of conditions and symptoms from a primary care perspective. They consult with physicians and nurse practitioners (often by phone), work in collaboration with other interdisciplinary community-based care providers (e.g., mental wellness workers, community health workers), make referrals as required and coordinate care with provincial health care systems. Nurses also provide access to pharmacy services in remote and isolated First Nations communities. Access to physician services is made available on-site or remotely via telehealth/teleconference but much variation exists from community to community regarding the availability and frequency of physician and other specialty visits to the community.

Respecting the needs and preferences of individuals, families and communities is a crucial component of Clinical and Client Care. This includes providing staff with cultural competency training, improving hiring practices, and engaging the community in health service planning, provision and evaluation.

2.1.2 Clinical and Client Care Guidelines Related to Serving Vulnerable First Nations Women and Girls

Nurses employed by FNIHB working in isolated and remote communities are supported in their work by Clinical Practice Guidelines (Guidelines) on which they draw as a clinical resource and tool in delivering care. Nurses employed directly by First Nations (in transferred communities south of 60) and health services in the Yukon, Nunavut, Newfoundland and Labrador, and the British Columbia First Nations Health Authority have also used FNIHB's Guidelines as a resource. The Guidelines help nurses make evidence-based clinical decisions and determine the best approach for delivering care for specific situations. The Guidelines are relevant to the remote/isolated community context and recognize concepts and practices of cultural competence, cultural safety, client safety and trauma-informed care.

In terms of supporting women and girls at risk of violence, there are specific guidelines that provide nurses with guidance, resources and tools to support clients who disclose abuse/assault, who may be vulnerable to it, or where abuse/assault is suspected. The information includes assessment and treatment information, as well as information on risk factors and vulnerabilities; psychological, cultural and social considerations; appropriate consultation and referrals to assure comprehensive supports and care; client counselling and prevention strategies. These abuse/assault related guidelines also contain information on legal aspects, reporting requirements, and documentation protocols.

Several other condition-specific guidelines support nurses in their care and support of women and children who have experienced violence and trauma, including guidelines on the following key topics: Sexual Assault; Child Maltreatment (includes Sexual, Physical and Emotional Abuse); Domestic Violence; and Elder Abuse (abuse of the elderly). Introductory content to the Guidelines includes guidance on trauma-informed care, cultural competence and cultural safety. As part of regular updates, the Sexual Assault and Domestic Violence guidelines are being reviewed by an external contractor. A new guideline on Pre-pubertal Child Sexual Abuse is also being developed and will replace the sub-section of the



current Child Maltreatment Chapter. A new guideline on Trauma and Stressor-Related Disorders is also being developed for the Mental Health Chapter.

There are also condition specific guidelines in place to guide nurses in their care and support of women and children who may be particularly vulnerable to violence and abuse. These include but are not limited to numerous guidelines in the Mental Health Chapter addressing mental health issues and addictions and substance use, and the Adolescent Health Chapter addressing sexual health as well as youth mental health and substance use/addictions. The Guidelines include chapters specific to Women's Health and Gynecology, Obstetrics, Communicable Diseases, and General Emergencies and Major Trauma – all of which address numerous conditions and issues that may relate to vulnerabilities to violence and/or health outcomes of violence, and provide nurses with appropriate guidance and materials to support clients.

2.1.3 Promising Practices in Improving Access to Primary Care and Other Services

Digital Technologies

FNIHB funds, directly or through First Nations, access to various digital health technologies (described in the Guidelines for the FNIHB eHealth Infostructure Program, 2012) to make available a range of health care services to their members and training for providers in First Nation communities that would otherwise be inaccessible or significantly more costly. The 2018 Budget renewed \$99.8 million over five years (2018/19 – 2022/23) for FNIHB's funding of digital health technologies. Further, the 2017 Budget provided \$5 million over five years (2017/18 – 2021/22) for FNIHB funding of remote presence technologies.

Digital health technologies supported by FNIHB include:

- **Improved connectivity for health facilities**, which is a fundamental requirement for all digital health technologies. FNIHB investments in broadband have improved connectivity strength in approximately 140 health facilities over the past five years.
- **Telehealth**, which is the use of digital technologies to deliver clinical care, health education, and public health services by connecting multiple users in separate locations. Telehealth encompasses a broad range of telecommunications, health information, videoconferencing, and digital image technologies. Telehealth is used to deliver health services, transmit health information over both long and short distances, and provide access to education to support community staff. FNIHB supports 250 active telehealth sites at the community level, offering a wide range of services including tele-education for workers and community members, tele-diabetes and tele-mental health. Through these sites, over 14,000 telehealth sessions were delivered in First Nation communities since 2013, with mental health, dental and oncology being the most common types of sessions held in 2015-16.
- **Digital Health Records**, such as Electronic Medical Records (EMRs), which are used by nurses to store and analyze health information, and Electronic Health Records (EHRs), which enable the sharing of information between providers involved in a patient's care/jurisdiction(s);



- **Public health surveillance systems** (e.g., Panorama, an electronic public health surveillance system used by several provinces), which collect routine health data to guide public health action in a timely fashion; and,
- **Information Technology (IT)** technical support, maintenance and capacity development (e.g., governance and training) for First Nations to manage their digital health services, and integrate these services and planning with provinces.
- **The adoption of remote presence technologies**, including robotics and portable devices has enabled the expansion of real time access to primary care services by physicians.

2.1.4 Challenges and Barriers to Access

Despite an increase in the amount of investment and diversity of services offered, disparities in health outcomes and access to health care continue to be experienced by First Nations and Inuit. While not exhaustive, the following factors contribute to an ongoing need for Clinical and Client Care services funded or provided by FNIHB:

- **Geography:** Most remote and isolated First Nations communities do not have year-round road access. Physicians and other provincial health care services are often long distances away.
- **Higher rates of chronic and communicable diseases:** First Nations communities deal with increasingly complex medical conditions. Families may also experience addictions, mental health issues, and injuries related to acts of violence and accidents.
- **Demographic changes:** First Nations communities are experiencing population growth as well as an aging population. For example, the First Nations populations living on-reserve aged 45 and over will represent over 30% of the on-reserve population by 2026 compared to 21% in 2006.
- **Growing demand and needs:** Currently, about 44% of the on-reserve population access primary health care services in nursing stations and health centres funded by the Clinical and Client Care program.

There are also challenges in terms of recruitment and retention of FNIHB's community health workers and health professionals. A significant shortage of nurses willing and able to work in remote and isolated First Nations communities persists, where vacancy rates can be approximatively 20%. As such, the use of private agency employed nurses is required. FNIHB is implementing strategies to address the recruitment and retention challenges and reduce the reliance on agency nurses, and improvements to the vacancy rate have been made. Primary contributors to staff turnover include: work stress, availability of other opportunities, geographic and professional isolation, lack of readiness for working and living in a First Nation community, and overall working conditions. FNIHB is committed to continuing to support First Nation communities and nurses in ensuring that quality health services are delivered. As of January 2018, 24% of nurses employed directly by FNIHB self-identified as Indigenous.

2.1.5 Recent Investments in Clinical and Client Care

FNIHB will invest approximately \$216 million in Clinical and Client Care in 2018-2019. The funding ensures 24/7 access to services. FNIHB funding is helping to enhance accessibility through, for example,



investment in interdisciplinary models of care (e.g. more nurse practitioners and paramedics); first response vehicles and supports; and electronic pharmacy dispensing and tele-pharmacy.

2.2 Mental Wellness Services

Mental Wellness services, funded by FNIHB, are intended to provide First Nations and Inuit communities, families, and individuals with culturally appropriate mental wellness services and supports that are responsive to their needs and that recognize the intergenerational effects of residential schools and other consequences of colonization.

FNIHB has funded the co-development of two frameworks with First Nations partners to address First Nations mental wellness issues, specifically *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada (2011)* and the *First Nations Mental Wellness Continuum Framework (2015)*. FNIHB is working collaboratively with First Nations partners on the implementation of these frameworks. FNIHB is also working closely with Inuit partners to support Inuit-specific approaches to mental wellness programming, guided by the *National Inuit Suicide Prevention Strategy (2016)*, which was developed by the Inuit Tapiriit Kanatami. Co-development and joint implementation are best practices that ensure effective policies and tools.

Trilateral approaches are also showing promise in addressing mental wellness issues. Recently, in response to mental wellness crises, the federal Minister of Health (now the Minister of Indigenous Services Canada), the Ontario Minister of Health and Long-term Care, and the Nishnawbe Aski Nation (NAN) signed the Charter of Relationship Principles for Nishnawbe Aski Nation Territory (2017) to work together to support First Nations self-determination in the transformation of health services by and for NAN communities.

2.2.1 The Current Suite of Mental Wellness Services

FNIHB funds a variety of programs, services, initiatives, and strategies in the area of mental wellness, including:

- Mental wellness services in over 400 First Nations and Inuit communities (excluding British Columbia), including support for improved mental health, child development, parenting skills, healthy babies, and responding to mental health crises;
- Diverse community-based suicide prevention projects that focus on increasing protective factors such as resilience and reducing risk factors through prevention, outreach, education, and crisis response;
- A network of 45 treatment centres (excluding British Columbia), as well as drug and alcohol prevention services in the majority of First Nations and Inuit communities across Canada;
- Responding to prescription drug abuse in First Nations communities, including case management supports, prevention training, and a crisis intervention team co-located in Manitoba and Saskatchewan regions providing additional support to targeted communities;



- Multi-disciplinary, community-based mental wellness teams that provide culturally safe and competent mental health services and clinical supports to a cluster of First Nations and Inuit communities;
- Mental health counselling, emotional and cultural support services to former Indian Residential School students, their families and communities;
- Mental health counselling through the Non-Insured Health Benefits program; and
- Fetal Alcohol Spectrum Disorder programs in First Nations and Inuit communities, including education and awareness; mentoring support for women; access to earlier diagnosis; and prevention and intervention. This is part of larger maternal health and healthy child development programs and initiatives for First Nations and Inuit communities.

2.2.2 Access to Mental Health Counselling Services

Mental health counselling has been identified as an important need in relation to violence against Indigenous women and girls. FNIHB provides access to mental health counselling services in a variety of ways. Addressing violence will require enhanced coordination with provincial and territorial services, improved communication about available services, and, potentially new services to fill gaps.

Hope for Wellness Helpline

The most broadly available mental health counselling is through the Hope for Wellness Help Line, which offers immediate help to all Indigenous peoples across Canada. It is available 24 hours a day, 7 days a week to offer anonymous phone and/or chat counselling support and crisis intervention by experienced and culturally competent Help Line counsellors. If asked, counsellors can work with individuals to find other wellness supports that are accessible nearby. Telephone and online counselling are available in English and French. On request, telephone counselling is also available in Cree, Ojibway and Inuktitut.

Mental Health Counselling Benefit (NIHB)

The NIHB program's mental health counselling benefit is available to all registered First Nations and recognized Inuit. It provides coverage for professional mental health counselling and is intended to complement other mental wellness services that may be available in the community. These services are delivered in a number of ways: either by fee-for-service professionals in private practice (e.g. a psychologist or social worker), by professionals contracted by the program to travel to communities (e.g., to address a community-level event) or are delivered directly by a community via contribution agreements with communities themselves (or Tribal Councils, or similar organizations) who engage counsellors and deliver in-community services. Individuals or families receive coverage for 22 hours of counselling in each 12 month period, with more available as needed. Through the fee-for service model, more than 10,100 clients accessed mental health counselling benefits in 2016-17 (69,400 hours), which is an increase of 11% in clients and 22% in hours over the year before.

Mental Wellness Teams

These are multidisciplinary and community-based teams that aim to increase access to a range of culturally competent mental wellness services, including on-the-land activities, outreach, assessment, treatment, counselling, case management, referral and aftercare. They work to improve the healing



process through an integrated service delivery approach. Mental Wellness Teams are not available nationally in all First Nations and Inuit communities; however recent investments have significantly expanded their number (45 teams) and reach (326 communities). The services are available to all community members.

The Indian Residential Schools Resolution Health Support Program (IRS RHSP)

All former IRS students and their families are eligible for the IRS RHSP services regardless of status (First Nations, Inuit, Métis, non-status, or non-Aboriginal) or place of residence within Canada (living in or outside of their communities). The IRS RHSP provides eligible clients with access to mental health counselling by a psychologist or social worker; access to emotional and cultural supports provided by Indigenous organizations; and medical transportation when services are not locally available.

2.2.3 Access to Addictions Services

FNIHB is working collaboratively with partners to implement *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada (2011)*. As previously referenced, this framework was co-developed with the Thunderbird Partnership Foundation (formerly the National Native Addictions Partnership Foundation) and the Assembly of First Nations. Co-development is a best practice, leading to more effective policies and tools. The framework outlines a continuum of care in order to support strengthened community, regional, and national responses to substance use issues. This framework is intended to guide the design, coordination, and delivery of services at all levels of the system. It also provides guidance on an approach to community development that prioritizes mental wellness and relies upon community and cultural strengths.

Guided by the framework, FNIHB funds a range of addictions prevention and treatment services and supports. Community-based programming includes prevention, health promotion, early identification and intervention, referral, aftercare and follow-up services in the majority of First Nations and Inuit communities across Canada. These services are integrated with a network of 45 treatment centres (excluding British Columbia), which provide culturally-relevant in-patient and out-patient services as well as specialized services for people with unique service needs (e.g., youth, solvent abusers, women, and people with more than one disorder). The range of service providers includes outreach workers, child and youth workers, alcohol, drug and crisis counsellors, Elders and cultural practitioners, psychologists and social workers. Eligible clients include First Nations on-reserve and Inuit living in Inuit communities. Using funding from the Canada Drugs and Substances Strategy (formerly the National Anti-Drug Strategy), FNIHB has been able to support the expansion and refocusing of the services of treatment centres to more effectively meet community needs; support more centres to achieve accreditation; and train and certify more addictions workers. FNIHB-funded Youth Solvent Abuse Centres (YSAC) follow a continuum of care approach that encompasses pre-treatment, treatment, and post-treatment care for youth (12 to 25 years of age) and their families. Services include drug, alcohol and cross addictions, grief and loss, anger management, family violence, self-esteem, sexual abuse, life skills, and spirituality. Centres offer in-patient, out-patient, and day treatment as options to support youth in their healing journey.



FNIHB's approach to the opioid public health crisis aligns with the four pillars of the Canadian Drugs and Substances Strategy (2016), with a particular focus on: building the evidence base, prevention, treatment and harm reduction. Regional partners play a critical role in defining and implementing FNIHB's response. Current priorities include, for example: supporting Indigenous partners to address opioid specific priorities; strengthening community capacity with overdose response training and First Aid training; supporting comprehensive "wraparound care" care; and continuing coverage through NIHB of opioid agonist treatments to support treatment centre and community-based services.

2.2.4 Funding for Victims of Family Violence

In February 2015, Health Canada and the Public Health Agency of Canada launched a \$100M investment over 10 years, entitled, "Supporting Victims of Violence and Protecting Children: The Health Perspective". Of this, the Public Health Agency of Canada (PHAC) invests over \$6M per year to improve the public health response to victims of violence through guidance and training for professionals and to deliver and measure the impact of community-based initiatives that support the health of survivors. FNIHB invests \$3M per year through two funding streams: \$1.5M to enhance access to mental health counselling for victims of violence and \$1.5M for community-based programming to improve and strengthen access to trauma-informed and culturally-relevant health care services for First Nations and Inuit victims of violence and their children.

The following are just a few examples of how this funding is making a difference:

- The Nova Scotia Native Women's Association developed the "sisterhood toolkit" to work with women to support their sisters in addressing family violence and to provide mental health counselling to vulnerable women in high risk activities.
- The Fort Frances Health Authority developed "Connecting our Bundles", a toolbox of knowledge that is inclusive of traditional and western practices in capacity-building, resource development and forming partnerships. The project focuses on increasing trauma-informed care and culturally competent health care services for agencies who work closely with victims of family violence.
- In the Northwest Territories (NWT), Project Jewel offers a culturally sensitive, locally designed on-the land program that helps create a safe environment for women victims of violent trauma. It encourages personal growth, connections to culture and the land, and a sense of pride in one's heritage. Counsellors and Elders offer services to participants.
- \$300,000 of the Victims of Family Violence funding is earmarked for Inuit-specific projects. In 2017-18, the Inuit-specific funding went to the Government of Nunatsiavut for the ongoing implementation of the Family Visitor Program (2015 -2018) in Nain and Hopedale to support families at-risk and address the impact of intergenerational trauma through home visits and community and parenting supports.

2.2.5 Recent Investments in Mental Wellness

FNIHB provides over \$350M annually to support mental wellness. Included in this amount is funding as part of the \$69 million over three years that was announced in June 2016 to address immediate mental health needs of First Nations and Inuit. This additional funding is supporting:



Indigenous Services
Canada

Services aux
Autochtones Canada

- Additional Mental Wellness Teams serving more First Nations and Inuit communities,
- Training for existing community-based workers
- The Hope for Wellness Help Line (24-7 crisis intervention counselling)
- Implementation of Inuit Tapiriit Kanatami's (ITK) National Inuit Suicide Prevention Strategy

Building on this investment, Budget 2017 announced \$204 M over five years to support improved First Nations and Inuit mental wellness services, including the expansion of the NIHB mental health counselling benefits to include traditional healers.

3.0 Conclusion

FNIHB-ISC works with First Nations, Inuit, other federal departments and provincial and territorial partners to support healthy First Nations and Inuit individuals, families and communities. Working with partners, we strive to make a positive difference in improvement of health outcomes, provide better access to quality health services and support greater governance over health services delivery by First Nations and Inuit.



ANNEX A:

RELEVANT FNIHB PROGRAM DESCRIPTIONS

Program	Description	Service Providers	Eligibility Criteria (e.g. on and off reserve)
Clinical Client Care	<p>FNIHB funds or delivers primary care services in 79 remote and isolated First Nation communities, serving a client base of approximately 110,000 persons where access to provincial services is limited or non-existent. Services are delivered directly by FNIHB in 51 communities through the Clinical and Client Care program. In the remaining 28 communities, primary care services are delivered through contribution agreements with First Nations organizations. Clinical client care services are mandatory because they have a direct impact on the health and safety of community members and the population.</p>	<p>The mix of service providers varies across communities depending on local factors.</p> <p>Regulated health professionals: registered nurses, nurse practitioners, licenced practical nurses.</p> <p>Unregulated health professionals: health care aides, rehabilitation aides, pharmacy technicians, other support personnel. Transferred communities may also employ other types of service providers.</p>	<p>First Nations individuals living primarily in remote and isolated communities.</p>
Non-Insured Health Benefits (NIHB)	<p>NIHB is a national program that provides registered First Nations and recognized Inuit who are resident in Canada with coverage for a range of medically necessary health-related goods and services which are not otherwise available to them through other private plans, or provincial/territorial health or social programs. This includes prescription drugs, medical supplies and equipment, dental care, vision care, mental health counselling, and medical transportation.</p> <p>Some registered First Nations and recognized Inuit are provided with benefit coverage under a self-government agreement (Nisga'a, Nunatsiavut), as does the BC First Nations Health Authority for First Nations residents of BC.</p>	<p>Using NIHB coverage, eligible clients can access mental health counselling through regulated health professionals: (a) in private practice (e.g. psychologist or social worker enrolled for direct fee-for-service billing); (b) contracted by Indigenous Services Canada (ISC) to travel to communities (e.g., to address a community-level event); or (c) hired by community organization (e.g. a community or Tribal Council) to provide services directly, with the support of an ISC contribution agreement.</p> <p>Where the service is not available locally, transportation to access it is an eligible benefit.</p>	<p>Registered First Nations and recognized Inuit in Canada, except where provided under self-government or other agreements. Coverage is provided to those living both on and off reserve.</p>



Mental Wellness Services	<p>The mental wellness program administers contribution agreements and direct departmental spending that supports culturally appropriate, community-based programs, services, initiatives, and strategies related to the mental wellness of First Nations and Inuit (e.g., health promotion; addictions prevention, treatment and after care; and mental health counselling).</p>	<p>Mental wellness services are delivered primarily by First Nations and Inuit organizations who hire a mix of regulated and unregulated services providers to meet their needs.</p> <p>In the case of the Indian Residential Schools Resolution Health Support Program - the professional mental health counselling component - FNIHB provides eligible clients with access to fee-for-service professionals in private practice (e.g. a psychologist or social worker).</p>	<p>Community-based mental wellness services are primarily for First Nations living on reserve and Inuit in Inuit communities. There are exceptions: The First Nations Hope for Wellness Line is available to all Indigenous people in Canada; the Indian Residential School Resolution Health Support Program is available to all former Indian Residential School students and their families on and off reserve.</p>
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Exhibit: National Inquiry into Missing and
Murdered Indigenous Women and Girls

Location/Phase: Part 11: Calgary

Witness: Valérie Gideon

Submitted by: Anne Turley, Canada

Add'l info: P02 P01 P03 01

Date: MAY 30 2018

Initials

I/D

Entered

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