North Simcoe Muskoka
LOCAL HEALTH INTEGRATION NETWORK

Aboriginal Community Engagement

October, 2006

Ontario

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Executive Summary

The Aboriginal community engagement process provided an opportunity for health service providers and administrators to voice their opinions about how they perceived the future of health service provision in the region, as the Ministry of Health and Long Term Care (MOHLTC) transfers control over planning, coordination and funding of health care services to the North Simcoe Muskoka LHIN. The consultation also focused on other areas closely affiliated with addressing matters related to healing and wellness at the community level.

A total of 45 people participated in the engagement process either through an interview or in a focus group setting. Areas of focus for these discussions included:

1. *Anticipated changes* resulting from the establishment of LHINs
2. *Potential impacts* on local service delivery
3. *Partnership development* between the LHIN and the Aboriginal community
4. *Health priorities* facing Aboriginal people in the region
5. *Integration and coordination* – viewpoints in relation to services
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Based on an analysis of the results of the consultation, 20 areas of focus were developed. These were presented at a focus group session where the participants were asked to further prioritize and come to agreement on primary areas that would be identified in the integrated health services plan. These primary areas of focus are:

1. Establishment of a regional health planning body/secretariat
2. Representation on the LHIN Board of Directors
3. Maintain the level of Aboriginal specific programming
4. Affirmation and Integration of wholistic healing practices
5. The need for increased mental health and addictions resources
6. Funding and commitment to reach goals

The priority areas reflect the community's desire for a planned approach to collectively address the health concerns prevalent in the broader Aboriginal community. There was a need expressed for greater coordination and communication among the communities and agencies in the region. They envision a regional Aboriginal health planning body that would build on the infrastructure that has been worked on over the years and function as a key linkage mechanism between the Aboriginal health service providers and the mainstream health system. It was viewed as a catalyst for creating and moving the Aboriginal health agenda forward in upcoming years.

There was also a need expressed to maintain an Aboriginal perspective on the Board of Directors to help facilitate potential developments resulting from the increased level of partnership and collaboration anticipated in the future.

There was discussion in regard to change and transition. There was a sense of scepticism expressed by some that the transition to a new system could lead to a step backward in terms of advancements that have been made over the years at the provincial and local level. The importance of maintaining and enhancing Aboriginal specific services was highlighted by all participants.

It was indicated that the number of people looking for alternative health care is on the increase. There was strong sentiment expressed that the local health care system should work toward establishing an environment where there is a greater choice available in terms of treatment that best suits individual health needs. It was felt that it is not prudent planning, if all services are integrated into one philosophy of health care provision. Many looked to the LHIN development as an opportunity for traditional healing practices to become more recognized and accepted in mainstream health agencies. There was a strong sense that traditional concepts and practices in relation to providing a wholistic model of care needed to be resourced in order to address the growing demand.

There was concern expressed for the increase in addictions in all forms across the region as well as an increase in the number of people requiring various forms of mental health support. These have combined to dramatically increase the number of people living with concurrent disorders. Providers point to their full caseloads as testament to the need for increased resources to address the needs. Respondents felt that these two primary health concerns will have serious detrimental effects in the short term and for generations to come without proactive measures being undertaken immediately.

There were those who held a sense of optimism and viewed the shift to the LHIN model as an opportunity to demonstrate how coordination and collaboration at the local level could move the Aboriginal health agenda forward. However, it was also pointed out that in order to achieve this goal there will be a requirement of a commitment from the Ministry and the LHIN to move forward on the priorities contained in this report.

Most of the participants had been through numerous forms of consultation in regard to the health and social status of Aboriginal people. On many occasions, the good thoughts and ideas shared during the consultation went no further than the interview. There was a sincere hope that this process would not follow in this pattern and that health care consumers could experience tangible results in the near future as a result of this community engagement process.

The following action items were developed based on the results of the consultation.

- That financial support be identified and set aside for the purpose of establishing an Aboriginal Health Planning Secretariat for the North Simcoe Muskoka LHIN to begin operation in the 2007 - 2008 fiscal year.
- Prior to April 2007, a working committee comprised of LHIN senior staff and representatives from the local Aboriginal health service provider groups undertake a process that would address the following milestones in the establishment of the regional health planning body / secretariat
    - Designate the lead on organizing preliminary phases
    - Establish goals and timeframes for the working committee
    - Define the terms of reference for the health planning body
    - Establish the mission, purpose and goals
    - Determine the financial and human resources required
    - Establish an office location
    - Establish timeframes and critical path
    - Develop short and long term goals

  - Confirm reporting procedures
  - Address other logistical and organizational matters

- That action is taken as soon as possible to initiate the appointment process to fill the vacant seat on the North Simcoe Muskoka LHIN Board of Directors with a person of Aboriginal ancestry who is knowledgeable of Aboriginal health issues in the region.
- The Board of Directors and staff of the NSM LHIN work to ensure that the level of Aboriginal specific programming currently delivered in the region is maintained as a result of the devolution of authority and control to the local level. Further, that Aboriginal health service enhancements be developed and resourced to address the gaps that have been identified through the community engagement process.
- That the Board of Directors and staff along with members of the Aboriginal community undertake a cross-cultural training process that would increase awareness and knowledge of Aboriginal culture based wholistic healing practices. Further, that a strategy be developed in conjunction with the proposed secretariat that would raise the level of awareness, acceptance and integration of traditional healing practices in mainstream health agencies across the region.
- That funding and resources be allocated for the provision of additional programming and services to address the increase in demand for mental health and addictions support across the NSM LHIN catchment area. Further, that planning exercises be undertaken to determine the feasibility for the creation of residential services to treat addictions and concurrent disorders among the Aboriginal community.
- That the North Simcoe Muskoka LHIN Board of Directors and Staff commit to the establishment of an ongoing partnership with the Aboriginal communities and organizations for the purpose of moving the Aboriginal health agenda forward and addressing goals established by the group.

There is definitely a greater awareness about the North Simcoe Muskoka Local Health Integration Network as a result of this community engagement process. Those who participated indicated that they will be keeping abreast of developments as they occur in terms of the NSM LHIN and looked forward to feedback from the Ministry in relation to the Aboriginal community consultation process and findings that have been put forward by the participants in this process.

1 Introduction

The Ministry of Health and Long Term Care (MOHLTC) is currently in the process of implementing a significant shift in the way health services are administered and delivered throughout Ontario through the *Local Health System Integration Act* (Bill 36). The preamble to the Act sets out ten principles by which the legislation was enacted. One of these principles states that:

> "*The people of Ontario and their government, recognize the role of First Nations and Aboriginal people in the planning and delivery of health services in their community."*

Further to this, the Act states that the Local Health Integration Network (LHIN) shall consult the Aboriginal community within their region as part of the community engagement process in relation to the implementation of the Act. The intention is stated as follows:

> *"In carrying out the community engagement, the local health integration network shall engage the Aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed."*
>
> Bill 36 - Planning and Community Engagement Section 16 (4)

The North Simcoe Muskoka Local Health Integration Network (NSM LHIN) undertook a process whereby representatives of Aboriginal communities, organizations and key informants were engaged in discussions regarding potential developments surrounding the creation and implementation of the LHIN's The primary purpose of this consultation was to gain insight into how health service provision can be more effective in meeting the needs of Aboriginal people in the region and how the NSM LHIN can address these priorities within their legislated mandate.

Over the course of the past year, the NSM LHIN Board of Directors and Staff have been actively engaged in public consultation with all local health related stakeholders. A great deal of information was generated through this community engagement process. The information has been organized, analyzed and prioritized. Based on the analysis, the NSM LHIN has developed the vision, mission, values, strategic directions and goals for the organization as it moves forward over the next three years. Three strategic directions have been agreed upon:

1. Improving the health status of the residents
2. Improving access to the right care, in the right place, at the right time
3. Promoting sustainability through the most efficient use of available resources

In order to facilitate these directions, eleven strategic goals were established. Strategic goal 1.3 served to reinforce the mandate by "*working with Aboriginal and First Nation communities."* This approach was designated under Strategic direction # 1, *Improving the health status of residents of the NSM LHIN.* There was agreement that strategic goal 1.3 is applicable to all three of the strategic directions and the basis from which future planning would be undertaken.

A requirement on the part of the LHIN is to report on the results of the engagement exercise with the Aboriginal community in the initial Integrated Health Service Plan (IHSP) due to be finalized and forwarded to the Ministry by the end of October 2006.

This report presents the analysis of information gathered through the Aboriginal community engagement process. Community engagement activities took place during the period from June until early September 2006. The consultation process ended with a focus group meeting where community engagement participants prioritized the findings into primary areas.

Throughout the report, use of the term "Aboriginal "shall refer to Metis people, non-status Indians, status Indians and Inuit people regardless of their residency.

1.1 Project Goals

Pursuant to the deliverables established at the onset of this project, the goals of the Aboriginal community engagement report were to:

- Provide an overview of the local Aboriginal health care system
- Identify gaps and barriers
- Establish planning priorities
- Address integration and coordination related to Aboriginal health services
- Assist with IHSP development specific to the needs of the Aboriginal community
- Report on the findings of the community engagement process as per IHSP requirements

1.2 Health Indicators

Numerous research studies and reports produced over the years have consistently concluded that Aboriginal people in all regions of the country have a health status that is well below the national average. Although some progress has been made through various initiatives as communities attempt to respond to the situations at hand, Aboriginal health indicators continue to be alarming.

Research was undertaken to determine if these indicators are reflective of health status in the North Simcoe Muskoka region. While research provides overall health indicators on a provincial and national scope, very little data was available that dealt specifically with the Aboriginal community in the North Simcoe Muskoka LHIN.

The most current information was obtained from *Health Status of Canada's First Nations, Metis and Inuit Peoples.* This background document was published in January 2005 by the Health Council of Canada to accompany their report, *Health Care Renewal in Canada: Accelerating Change*. Findings contained in this report were garnered from research undertaken across the country. This research documents data specific to Ontario which of course includes the NSM LHIN region. It can be assumed that the findings are also reflective of the present health indicators in this region with some of the major findings highlighted as follows:

- Life expectancy of Aboriginal people continues to be lower compared to the rest of Canadian society
- The incident of infants with low birth weights are increasing - infant mortality rates are higher
- The mortality rates for Aboriginal people are higher compared to Canadian and provincial rates with the four leading causes of death being: injury and poisoning, circulatory diseases, cancer and respiratory diseases
- Lung cancer is the most common kind of cancer followed by prostate cancer for men and breast cancer for women
- Heart disease is the primary cause of death for Aboriginal people over the age of 45
- Tuberculosis is still prevalent and is six times higher than the national average
- Sexually transmitted diseases and HIV are significantly higher in the Aboriginal population
- Diabetes is steadily rising
- Teenage smoking rate is higher than the national average

- All forms of addictions are at a higher rate than mainstream Canada
- Major depression is becoming increasingly common place
- Obesity rates are twice as high as for the rest of the country
- Many older adults can not receive adequate levels of home support

Over the years, the First Nations and Aboriginal service organizations in the Southern Georgian Bay region have steadily worked toward accessing resources to implement programmes and services that would address these issues on behalf of their respective membership.

2 Section 2

2.1 Demographics

There is great diversity among the Aboriginal community within the North Simcoe Muskoka region. Aboriginal people in the area are predominantly comprised of Pottawotomi, Mohawk, Chippewa, Ojibway, Cree or Metis ancestry with the majority residing in communities outside of the First Nation.

There are four First Nations and nine Aboriginal service organizations in the NSM LHIN catchment area. These are:

1. Beausoleil First Nation (commonly known as Christian Island)
2. Moose Deer Point First Nation
3. Rama Mnjikaning First Nation
4. Wahta Mohawk Territory
5. Barrie Native Friendship Centre
6. Georgian Bay Native Friendship Centre
7. Georgian Bay Metis Council
8. Georgian Bay Native Women's Association
9. Orillia Native Women's Group
10. Enaahtig Healing Lodge and Learning Centre
11. Barrie Area Native Advisory Circle
12. Southern Ontario Aboriginal Diabetes Association
13. B'saani Bimaadsiwin Mental Health Service

There is a possibility that another group may become operational in the future. This group, the Moon River Metis Council is currently in its early stages of organizational development.

Each community and organization has worked hard to achieve a level of accomplishment regarding the enhancement of health and wellness for their communities and membership. The following is a brief history of each, along with a synopsis of the health related programs and services that they currently deliver.

2.2 First Nations

2.2.1 Beausoleil First Nation

The members of Beausoleil First Nation are descendants of a larger Band known as the Chippewas of Lake Huron and Lake Simcoe. In the 1800's the Band subdivided into three distinct groups and settled onto separate reserves with Chief Assance and his group moving to present area in 1838.

Beausoleil First Nation is comprised of three islands: Hope, Beckwith and Christian Island all located in southern Georgian Bay. The main community is located on Christian Island. There is a total membership of 1,715 with approximately 700 people living on the First Nation.

There are many challenges associated with living in an island environment. To address the considerations that remoteness and isolation present in the area of health service provision, the First Nation has established a Health Department which administers health service within its scope in

meeting the needs of the community. The department has increased its capacity over the years and currently has a staff complement of ten positions. These staff members provide a range of services which strive to ensure that quality care is provided to people in their homes on the Island. When required, they also function as a linkage for the membership to access services only available on the mainland.

Regular visits, either weekly or bi-weekly are made by physicians, a psychologist and massage therapist to the community. Members requiring dialysis treatment or other forms of treatment beyond the scope of the Health Centre are required to travel outside of the community.

Currently, Beausoleil has an agreement in place with the Ministry of Health and Long Term Care (MOHLTC) to provide long term care and the community support services component of their program. They receive funds from the Aboriginal Healing and Wellness Strategy for the diabetes initiative, Community Wellness Worker and Healthy Babies/Healthy Children Program. They also receive Federal funding from Health Canada for a range of programmes.

Beausoleil First Nation is politically affiliated with the Union of Ontario Indians as well as with the Chiefs of Ontario. For more information on the scope of programming provided and the source of funding for each, see Appendix 4 - Aboriginal Specific Health Services Chart.

2.2.2 Moose Deer Point First Nation

The members of Moose Deer Point First Nation are descendents of the Pottawatomi people of the American mid-west. The Pottawatomi were forced out of their traditional territories and settled in southern Ontario in the late 1830's, eventually joining the Beausoleil Band when they resided at what is now Beausoleil Island National Park near present day Honey Harbour. In later years, a group moved north and established a settlement at Moose Point. In 1917, the Moose Deer Point First Nation was vested as an Indian reserve. The community is located approximately 50 kilometres south of Parry Sound on the shores of Georgian Bay.

The total Band membership consists of 667 members with approximately 170 people residing in the First Nation. The community currently employs one Community Health Representative (CHR) funded through Health Canada. The primary role of the CHR is to take a proactive approach in planning, developing and implementing health promotion and health education activities at the community level. Members requiring services beyond the scope of the CHR are required to travel outside the community, generally north to Parry Sound, or south to the City of Barrie.

Moose Deer Point is politically affiliated with the Union of Ontario Indians. They are also a member of the Chiefs of Ontario. They have recently entered into a service agreement with MOHLTC to provide community support services to their members residing in the community.

2.2.3 Rama Mnjikaning First Nation

The members of the Chippewas of Rama Mnjikaning First Nation are descendants of a larger Band known as the Chippewas of Lake Huron and Lake Simcoe. In the 1800’s, the Band subdivided into three distinct groups and settled onto separate reserves with Chief Yellowhead and his group moving to present day Rama Mnjikaning in 1838.

Today, the total Band membership is comprised of 1,492 people with approximately 600 members residing in the community. The First Nation has political affiliation with the Chiefs of Ontario.

Over the years, the First Nation has developed a solid infrastructure in the delivery of health and social services. The Health and Social Services Department provides a wide range of services to members

residing on the First Nation. The Department provides these services with funding support from Health Canada, MOHLTC and the Aboriginal Healing and Wellness Strategy.

Currently, there is an agreement in place with MOHLTC to provide the community support services component of their program. They also recently established a state of the art Emergency Medical Service in their community.

One of the more significant accomplishments that the community has seen come to fruition is the creation of the Getsijig Endaawaad Seniors Centre. This facility contains eighteen independent living units as well as an extended care unit for up to eight people. It is operated and funded by the First Nation without financial support from either Federal or Provincial government sources.

For more information on the types of service provided, see Appendix 4 - Aboriginal Specific Health Services chart.

2.2.4 Wahta Mohawk Territory

Wahta Mohawk Territory was established in 1881 when a group of Mohawk people moved from what is now Oka, Quebec to the Muskoka district due to civil, religious and economic reasons. The community is located at the midway point between Barrie and Parry Sound just off Highway 400. The total Band membership is 663 with approximately 185 people currently residing in the community.

Since 1984, health programming has been coordinated by the Community Health Representative (CHR) through a contribution agreement with Health Canada. The CHR program focuses on education and health promotion and provides a focal point for program development. Services are also accessed from outside sources that include: mental health, foot care, HIV/AIDS as well as services originating from the Community Care Access Centre and private practitioners in the area. The Band currently maintains an agreement with MOHLTC to provide the community support services component of their program.

Wahta Mohawk Territory has political affiliation with the Association of Iroquois and Allied Indians based out of London, Ontario as well as with the Chiefs of Ontario.

2.3 Friendship Centres

Friendship Centres are urban based, not-for-profit corporations mandated to serve the needs of all Aboriginal people regardless of legal definition. They were established in the early 1960's to respond to the growing numbers of people who were moving from First Nations to the urban environment. In an effort to address the social needs that evolved from this movement, concerned individuals advocated for the establishment of specialized agencies to meet the health, social and cultural needs that were becoming more apparent as Aboriginal people struggled to cope with their new environment.

Originally, Friendship Centres were developed to provide a meeting place for Aboriginal people and foster a sense of community within cities and towns across the country. This role greatly expanded in the subsequent years. Friendship Centres have evolved to become multi-purpose organizations that provide a variety of programs and services. However, their core mission continues to be the administration and provision of health and social programming to Aboriginal people regardless of their status or legal definition.

Friendship Centres are defined as community based and community directed Aboriginal institutions which serve the interests of urban Aboriginal people in the areas of social, cultural, economic and community development. They serve as primary information referral agencies, direct service agencies and training institutions.

Centres continue to be dependant to a large degree on volunteers and the organizations ability to raise operating funds though various fundraising events, private donations and grants from foundations or provincial and federal governments. Like many other organizations in the non-profit sector, they struggle to make ends meet in an effort to maintain a social safety net for the community they serve.

The Ontario Federation of Indian Friendship Centres (OFIFC) was established in the early 1970's to represent the interests of the growing number of Centres that were developing. As a Provincial Territorial Organization, the OFIFC represents a total of 27 Friendship Centres located in various towns and cities across the province. Two of these Friendship Centres (Barrie and Midland) are located within the North Simcoe Muskoka LHIN catchment area.

2.3.1 Barrie Native Friendship Centre

The Barrie Native Friendship Centre (BNFC) was established in 1988 to provide a location from which a variety of support services and programming could be delivered. Since its inception, the Centre has grown to serve the community through the provision of a variety of services that include: recreation, employment, cultural activities, and health and social related programs. The Centre is not in receipt of core funding and as such, must rely on a variety of sources to ensure that a level of programming and services are maintained.

The 2001 census indicated that 2,030 people of Aboriginal ancestry were living in the City of Barrie and environs. These numbers are expected to rise as the population of Barrie continues to grow at a steady pace for the foreseeable future.

The OFIFC has negotiated a number of health related programmes with MOHLTC, Health Canada and other Provincial ministries that are delivered through the Centres. Four health programs are delivered from the Barrie Native Friendship Centre that include:

- Health Outreach Worker (AHWS)
- Healing and Wellness Coordinator (AHWS)
- Healthy Babies/ Healthy Children (AHWS)
- Life Long Care Coordinator

All of these programs are funded either entirely, or partially, from MOHLTC. Three of the four programs originate from the Aboriginal Healing and Wellness Strategy, (AHWS) which is a cost shared inter-ministerial initiative. Further information on the AHWS is provided later in the report. The Life Long Care program is funded entirely from MOHLTC and administered by the OFIFC.

2.3.2 Georgian Bay Native Friendship Centre

The Georgian Bay Native Friendship Centre was established in 1984 to address the needs of the urban Aboriginal population in the Midland and Penetanguishene area. The Centre also delivers a variety of services ranging from recreation, employment, culture, health and social programs. Presently, three of these programs are health related and include:

- Healing and Wellness Coordinator (AHWS)
- Drug and Alcohol Worker
- Life Long Care Coordinator

The Healing and Wellness Coordinator program originates from AHWS. The Life Long Care Program and the Drug and Alcohol Worker are funded entirely by MOHLTC. All three programmes are currently administered by the OFIFC.

2.4 Métis Representation

The Métis are of mixed First Nation and European lineage. They have their own language and culture and are distinct from the other two Aboriginal peoples (First Nation and Inuit) identified in the Canadian Constitution. They account for 30% of the Aboriginal population in the country and had the greatest population growth of all Aboriginal groups between 1996 and 2001.

The Southern Georgian Bay region holds historic importance for Métis people. The Métis in this area are made up of families who are direct descendants of the Drummond Island voyageurs, many who originated in the historic Red River settlement. Over 200 years ago, Drummond Island was a British military post located just south of Sault Ste.Marie. It was home to a diverse group of voyageurs made up of Métis people of Cree, Ojibway, French Canadian, Scottish, British and Red River descent.

This group was forced from Drummond Island in 1828 as it was turned over to the United States under the terms of the Treaty of Ghent. The entire population of the Drummond Island community including British soldiers, Métis voyageurs and their First Nations wives withdrew to the naval station at Penetanguishene. For their devotion to the monarchy, the voyageurs received land and settled in and around the Penetanguishene area where they have maintained a strong presence to this day.

2.4.1 Georgian Bay Métis Council

The Georgian Bay Métis Council (GBMC) was established in 1995 and became a chartered member of the Métis Nation of Ontario (MNO) representing over 2,400 Métis citizens in the area. The GBMC was formed to bring Métis people together to share their culture and heritage and forward their aspirations. The Council delivers a range of programming from their office located in Midland. Three programmes are health related:

- Community Wellness Worker
- Healthy Babies / Healthy Children
- Long Term Care Program

All programs are delivered through their Provincial Territorial Organization, the Métis Nation of Ontario.

According to data from the 2001 census, there are 2,835 people of Aboriginal descent living in the Midland / Penetanguishene area. Of this total, 2,095 people identified themselves as being of Métis heritage. This figure constitutes 74% of the total number of Aboriginal people in the region.

On a regional scale, statistics gathered in the 2001 census from the Simcoe County District Health Unit which takes in much of the NSM LHIN, indicate that a significant percentage of the total Aboriginal population (44%) in the region identified themselves as being of Métis heritage.

2.5 Aboriginal Women's Groups

Numerous studies have documented that Aboriginal women experience higher levels of violence, inadequate housing and income, lower levels of employment, education, and overall challenges in economic advancement than any other segment of Canadian society. They rely more heavily on social assistance and are more likely to head up a single parent family. Aboriginal women face socioeconomic challenges unlike those faced by other women in the country.

Urban based Aboriginal women's organizations have been established across the province to try and address these concerns. There are three Aboriginal Women's groups in the NSM LHIN catchment area located in Midland, Barrie and Orillia.

The Rising Sun Women's Support Group located in Barrie does not access funding to provide specific health related programming. This group is primarily dedicated to supporting women through dialogue and discussion while endeavouring to involve women in the planning of community functions. Offering peer support and information exchange are predominant roles of this organization.

The other two groups receive financial support from Health Canada to administer the Community Action Program for Children (CAP-C) and the Canada Prenatal Nutrition Program (CPNP). They do not currently receive funding from the MOHLTC.

CAP-C addresses the health and development of children (0-6 years) who are living in conditions of risk. It places a strong emphasis on establishing partnerships and community capacity building.

CPNP is designed to develop or enhance programs for vulnerable pregnant women to reduce the incidence of low birth weight and improve the health of both infant and mother.

2.5.1 Georgian Bay Native Women's Association

The Georgian Bay Native Women's Association (GBNWA) was established in 1989 as a non-profit organization to serve the needs of native women and children in the Midland area. Since its inception, the GBNWA has maintained an action oriented approach to addressing the needs of families through the provision of a range of services. The GBNWA is not in receipt of core funding to assist with the operational costs or core management functions of the organization. This makes it difficult for the Association to respond to other health related issues that arise in the course of their service provision.

The Provincial Territorial Organization (PTO) affiliation is with the Ontario Native Women's Association (ONWA). Unlike the other PTO's, ONWA does not flow health related program funds as does AHWS to the local level through the GBNWA.

2.5.2 Orillia Native Women's Group

The Orillia Native Women's Group (ONWG) was established in 1998. Similar to their sister group in Midland, they currently deliver the Community Action Program for Children and the Canada Prenatal Nutrition Program.

The ONWG is currently the only organized Aboriginal program delivery group in Orillia. Many in the Aboriginal community of Orillia have come to look to the ONWG for the provision of a variety of services that extend beyond the mandate of the currently funded programs. In response, the ONWG coordinated a range of community activities. However, limited space and a shortage of human and financial resources hinder this effort. The organization operates without the benefit of core funding which is a significant barrier to providing a more comprehensive form of intervention for their membership and clients, particularly in health related circumstances.

The ONWG is not affiliated with a Provincial Territorial Organization and as such are not in receipt of programming funds similar to the other urban based Aboriginal organizations.

The most recent population statistics (2001 census) indicate that 1,225 people of Aboriginal ancestry live in the Orillia area. This figure does not include Rama Mnjikaning First Nation. People who identified as being of Metis heritage constituted 29% of the total number of Aboriginal people living in the region.

2.6 Service Provision and Advocacy

2.6.1 Enaahtig Healing Lodge and Learning Centre

The Enaahtig Healing Lodge and Learning Centre was established in 1995. The Lodge grew out of a community vision to develop a facility where healing and wellness needs of Aboriginal people could be

addressed in a wholistic, culturally appropriate setting, utilizing a combination of western and traditional methodology.

In the past ten years, thousands of individuals and families have participated through a combination of residential and day programming. Initially, the organization was funded primarily through the Aboriginal Healing and Wellness Strategy and Health Canada.

Through the course of its development, Enaahtig has expanded its range of services and recently reached an agreement with the MOHLTC to administer a mental health program. The program provides mental health treatment care and support to community members in partnership with other service providers in a shared care model of delivery.

The Lodge also delivers a residential trauma recovery program funded through the Aboriginal Healing Foundation (Federal) to address the legacy of Residential School Syndrome which has resulted in widespread post traumatic stress disorder among the Aboriginal community. This program offers direct treatment involving therapy and support to clients province wide.

The Lodge provides a variety of health related programming to Aboriginal people regardless of status. Many non-Aboriginal people, generally those of cross cultural families, have utilized the services and programming of the lodge as well. For more information on the types of service provided see the Appendix - Aboriginal Specific Health Services chart.

2.6.2 Barrie Area Native Advisory Circle

The Barrie Area Native Advisory Circle (BANAC) was established in 1989 as an organization that would function as a catalyst to bring Aboriginal communities and organizations together from across Simcoe County and northern York Region. BANAC's role is to plan and take action on areas of common concern to people living both on and off reserve. Priorities that were established included: health, education, economic development, culture, language retention, employment and information technology. A number of initiatives were developed based on these identified priorities.

In the mid 1990's, BANAC undertook the establishment of a health planning circle for the purpose of addressing health related matters in the region. The District Health Council and the MOHLTC Aboriginal Health Unit were members of the Circle as well. Regular meetings were held and a number of areas of focus were identified. A crucial support identified at that time was acquiring the services of a health planner to undertake action on initiatives being discussed around the table. The MOHLTC was viewed as the logical place to approach for the resources to support this position. A position paper and proposal were prepared and presented to MOHLTC officials. BANAC was unsuccessful in gaining support for a health planner position, thus it was difficult to move the health agenda forward on behalf of the group. Consequently, many areas identified as health related priorities were not acted upon. In spite of this setback, the health planning circle was still able to be a catalyst for change and experienced some degree of success, particularly in the area of enhanced mental health programming.

BANAC currently delivers a long term care program designed to meet the needs of people residing in rural and under serviced areas of the region not serviced by First Nations or urban based Aboriginal organizations. They are also funded through Health Canada to work in the area of HIV/AIDS. Since its inception, BANAC has operated without the benefit of core funding. This lack of long term support has been an impediment to reaching many of the goals identified by the members.

2.6.3 Southern Ontario Aboriginal Diabetes Initiative

The Southern Ontario Aboriginal Diabetes Initiative (SOADI) is funded by MOHLTC for the development and enhancement of programs and services with a focus on the education, prevention

and management of diabetes in Aboriginal communities both on and off-reserve. The high prevalence of diabetes in Aboriginal society has placed this disease among the top health priorities.

There is regional diabetes coordinator based out of the Georgian Bay Native Friendship Centre in Midland. This person is responsible for providing diabetes training and awareness to the Aboriginal communities and organizations in the North Simcoe Muskoka LHIN. The coordinator is also responsible for the Peterborough district.

The SOADI head office is located in St. Catharines. To date, there has not been a decision announced in regard to how SOADI funds will be distributed from the LHIN's. The NSM LHIN may be required to enter into a transfer agreement in regard to the programme operating in the area.

2.6.4 B'saanibamaadsiwin Native Mental Health Service

This program was approved for funding in 1990 to meet the increasing demand for mental health services in Aboriginal communities in the Parry Sound District. The program has its own advisory board that consists of a representative from each First Nation Community and the Parry Sound Friendship Centre. B'saanibamaadsiwin is affiliated with the Muskoka Parry Sound Community Mental Health Service. Their office is located in Parry Sound from where they provide a range of mental health interventions to the community. Two of the First Nations they service are located in the NSM LHIN, these being Wahta Mohawk Territory and Moose Deer Point.

The head office for the Muskoka Parry Sound Community Mental Health Service is located in Bracebridge. The transfer agreement with MOHLTC flows through this office. Consequently, B'saanibamaadsiwin falls under the jurisdiction of the NSM LHIN even though they primarily provide services in LHIN 13.

When fully staffed there is a staff complement of four who provide service for the moderate and seriously mentally ill. They also do work in the area of Capacity Building and Community Development for the communities that they serve. They also provide a 24/7 Crisis Service to all seven First Nation Communities and urban aboriginal population in the Parry Sound area.

2.7 Population

Statistics gathered by MOHLTC indicate that the population in the North Simcoe Muskoka region is approximately 416,900 people of this total there are roughly 11,256 people of Aboriginal ancestry. This figure comprises 2.7% of the total population. This percentage is higher than the provincial average. It is also a higher percentage than other LHIN's in the province with the exception of the two LHIN's in northern Ontario.

To provide further depth to these numbers, the following population statistics were compiled based on information gathered from the 2001 census, along with consultation with personnel responsible for Band membership within the four First Nations.

2.7.1 First Nations Population

Community	On First Nation	Off First Nation	Total
Rama Mnjikaning	608	884	1,492
Beausoleil	635	1,080	1,715
Wahta Mohawk Territory	185	478	663
Moose Deer Point	171	496	667
Totals	1,599	2,938	4,537

2.7.2 Urban / Rural Areas

Based on statistics from the 2001 census, the Aboriginal population for NSM LHIN catchment area is as follows:

Simcoe County	9,520
Muskoka District	1,055
Total	10,575

The census also indicated there was a population of 1,065 people of Aboriginal descent residing in Grey County. Due to the fact that the North Simcoe Muskoka LHIN takes in a relatively small portion of Grey County (southeast corner) these statistics were not factored into the calculations. However, a number Aboriginal people likely reside in the area of Grey County that is encompassed by the NSM LHIN.

The following table provides an indication of locations where Aboriginal people reside in the region.

Community	Population
Orillia and environs	1,225
Barrie and environs	2,030
Midland/Penetanguishene	2,835
Huntsville	210
Bracebridge	195
Collingwood	190
Clearview Township	120
Ramara Township	190
Total	6,995

2.7.3 Population Trends

The population totals based on the charts indicate where major pockets of the Aboriginal population are located within the NSM LHIN region. When added together, the population residing on the four First Nations and urban areas that have a high number of Aboriginal residents totals 8,594 people. The remaining Aboriginal population of approximately 2,700 people reside in the rural areas and the smaller communities throughout the region.

The actual population figures are most likely higher than those given in the 2001 census. This is due to the fact that many Aboriginal people do not participate in the census or do not self identify if they are of Aboriginal ancestry during the census.

3 Section 3

3.1 Provincial Territorial Organizations

As mentioned, the Provincial Territorial Organizations (PTO) have played a key role in establishing community based programmes and services on behalf of their respective membership. The future role of PTO's, in terms of LHIN implementation should be taken into consideration as well.

Currently, there are nine Provincial Territorial Organizations that represent different constituencies within the Aboriginal communities across Ontario. Five of these PTO's are affiliated with local organizations in the North Simcoe Muskoka LHIN. For further detail see Appendix 6 - PTO flow chart.

3.1.1 Ontario Federation of Indian Friendship Centres

The Ontario Federation of Indian Friendship Centres (OFIFC) represents the collective interests of 27 member Friendship Centres located in towns and cities throughout the province. The OFIFC administers a number of programs which are delivered by local Friendship Centres in areas related to health, justice, family support, employment and training education, economic development, children and youth initiatives, as well as cultural awareness.

The OFIFC administers a number of locally delivered programmes which originate from the Aboriginal Healing and Wellness Strategy (AHWS). These programmes include: Health Outreach Worker, Healing and Wellness Coordinator and the Healthy Babies / Healthy Children. Services coordinated by the OFIFC to staff at the local level include: reporting, training and field support.

The OFIFC also have an agreement with the MOHLTC to administer the Lifelong Care and the Alcohol and Drug worker program. Funding for these programs is sourced solely from the MOHLTC. The future status of this arrangement is yet to be determined. For more information on AHWS related programs see the Appendix 4 and 7 (Aboriginal Specific Health services and the PTO flow chart).

3.1.2 Métis Nation of Ontario

The Provincial Territorial Organization for the Georgian Bay Métis Council is the Métis Nation of Ontario (MNO). The MNO head office is located in Ottawa. They currently deliver a range of programming from 16 locations across the province. Primary services in the area of health include: Long Term Care, Healthy Babies / Healthy Children and AHWS related programmes.

3.1.3 Union of Ontario Indians - (Anishinabek Nation)

Founded in 1949, the Union of Ontario Indians (UOI) is a political advocate and secretariat to 43 member First Nations across Ontario. Their territory encompasses First Nations along the north shore of Lake Superior, the north shore of Lake Huron, Manitoulin Island, east to the Algonquians of Golden Lake (east of Ottawa) and through southern Ontario to the Chippewas of Sarnia First Nation. Currently, two of four First Nations in the catchment area are affiliated with the UOI: Beausoleil and Moose Deer Point.

3.1.4 Association of Iroquois and Allied Indians

The Association of Iroquois and Allied Indians (AIAI) was established in 1969 to represent member First Nations in negotiations with any level of government in matters affecting the membership as a whole. AIAI provides political representation in the following areas: health, social services, education, economic development, Intergovernmental Affairs, and treaty research. The Association currently

represents eight First Nations with a membership of approximately 20,000 people. Wahta is the only First Nation community in the catchment area that is affiliated with AIAI.

3.1.5 Chiefs of Ontario

The Chiefs of Ontario (COO) was established in 1976 and is the leading political organization for First Nations in the province, representing 134 First Nations across Ontario. COO represents the Provincial Territorial Organizations through the Political Confederacy composed of Grand Chiefs of the four First Nation PTO's and the other independent First Nations.

3.2 Potential Implications for Provincial Territorial Organizations

In developing strategic directions for the Provincial plan, the Minister will seek advice from a soon to be established Aboriginal and First Nations Health Council. Bill 36 states that:

> "*The Minister shall establish the following councils; an Aboriginal and First Nations health council to advise the Minister about health and service delivery issues related to Aboriginal and First Nations peoples and priorities and strategies for the provincial strategic plan related to those peoples" (Planning and Community Engagement, Pg. 16).*

The terms of reference and regulations for the health planning council are currently under development. The Provincial Territorial Organizations will be involved in setting the course for future direction during these discussions. This council will play a key role in Aboriginal specific developments in regard to health with the potential to have an impact on the LHIN in the future. The Ministry is scheduled to finalize the parameters of this council by the fall of 2006.

3.3 Funding Sources

Considerable mention has been made of the different sources of funding for Aboriginal programmes currently being delivered at the local level. The following section provides a brief synopsis of the major funding sources in regards to health delivery and services in the region.

3.3.1 Aboriginal Healing and Wellness Strategy

The Aboriginal Healing and Wellness Strategy (AHWS) brings together Aboriginal people and the Government of Ontario in a unique partnership to promote health and healing among Aboriginal people. In 1990, Aboriginal organizations and government ministries expressed a commitment to combat the alarming conditions of poor health and family violence. In 1994, the Aboriginal Healing and Wellness Strategy was launched with a mandate and strategy that represents a unique approach to addressing health and healing issues in Ontario.

AHWS fosters and promotes integration of traditional and culturally appropriate approaches to healing and wellness with contemporary strategies. An important feature centres on the fact that programs and services are designed, delivered and managed by the Aboriginal community.

The Strategy designed a framework to improve Aboriginal Health by establishing programmes and services that deliver culturally appropriate community-based primary care, health education and outreach. This framework includes mechanisms to improve access to health care by establishing translation services, out-patient medical hostels, health advocacy and by identifying legislative, policy and program barriers which affect Aboriginal health.

The AHWS is governed by a Joint Management Committee (JMC) composed of representatives of 15 First Nations/Aboriginal Provincial Territorial Organizations and four Provincial ministries. JMC members represent the following partners:

First Nations and PTO's

- Akwesasne First Nation
- Association of Iroquois and Allies Indians (AIAI)
- Chippewas of Nawash First Nation
- Chippewas of Saugeen First Nation
- Grand Council Treaty #3 (GCT#3)
- Metis Nation of Ontario (MNO)
- Nishnawbe-Aski Nation (NAN)
- Ontario Federation of Indian Friendship Centres (OFIFC)
- Ontario Metis Aboriginal Association (OMAA)
- Ontario Native Women's Association (ONWA)
- Shawanaga First Nation
- Six Nations of the Grand River
- Temagami First Nation
- Union of Ontario Indians (UOI)
- Walpole Island First Nation

Provincial Ministries

- Ministry of Community and Social Services
- Ministry of Health and Long-Term Care (MOHLTC)
- Ontario Native Affairs Secretariat (ONAS)
- Ontario Women's Directorate (OWD)

In 2004, the Provincial government committed an additional $25 million to AHWS, increasing its five year investment to $191.5 million dollars. The additional funding supports new mental health and addiction services. In addition, it strengthens primary health care and crisis intervention services. The strategy has established more than 250 health and family violence prevention programs across Ontario and created over 650 jobs in Aboriginal communities and agencies. The AHWS is in the third year of a five year agreement and is currently exempt from the LHIN process.

The four aforementioned Ministries provide core funding for the strategy. The Ministry of Children and Youth Services funds the Aboriginal Healthy Babies Healthy Children program which has been delivered through the strategy since 2000.

For further details see Appendix 7 - AHWS flow chart

3.3.2 Health Canada

Health Canada's role in First Nations health dates back to 1945 when Indian health services were transferred from the Department of Indian Affairs to the Department of National Health and Welfare In 1962, the federal government provided direct health services to First Nations people on reserve through the Medical Services Branch. This relationship carried on through to the mid 1980's. At this point, the

Medical Services Branch started to work towards transferring control of health services to First Nations and Inuit communities and organizations with the goal of First Nations and Inuit communities gaining more control over health services through health transfer agreements.

In 2000, the Medical Services Branch was renamed the First Nations and Inuit Health Branch (FNIHB).

The First Nations and Inuit Health Branch supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It also provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence. The Branch also provides primary care services on-reserve in remote and isolated areas where there are no provincial services readily available.

Currently, Health Canada (FNIHB) provides funding to eight of the twelve organizations and communities in the region. Funded programs and services are highlighted in the Appendix 4 - Aboriginal Specific Health Services chart)

3.3.3 Ministry of Health and Long Term Care

Federal cutbacks to health care in the mid 1980's led Aboriginal organizations to look to the provincial government for support to fill health gaps. In 1985, the Ontario government created a corporate native affairs policy framework indicating a shift in participation of Aboriginal organizations where a more active role in regard to health planning, design, implementation and service delivery of programmes occurred.

In 1987, the Ministry of Health created the Aboriginal Coordination Unit, later changed to the Aboriginal Health office and currently called the Aboriginal Health Unit. The mandate of this unit is to *advocate and promote changes within the MOHLTC to improve the province's ability to meet Aboriginal people's needs*.

One of the first major projects undertaken by the unit was the creation of an Aboriginal specific Health Policy. The Aboriginal Health Policy (AHP) was instituted in 1994. Subsequent governments have not repealed it, therefore it remains the policy of the government of Ontario today. The AHP is an excellent resource that must be reviewed by the LHIN Board and staff to gain a greater sense of how Aboriginal people feel health status can be improved in the province. The AHP was worked on extensively by all of the PTO's as a means to address Aboriginal health concerns.

The Aboriginal Family Healing Strategy (AFHS) went before the Provincial Cabinet to address issues of family violence at the same time as the AHP. The Ontario Cabinet approved the joint Aboriginal Health and Wellness Strategy in 1994 which combined the two initiatives (AHP and AFHS) with a five year funding commitment that was renewed in 1999 and 2004.

The Ministry provides support to a number of Aboriginal specific health initiatives including:

- HIV/Aids
- Cancer care
- Tobacco use
- Diabetes (Southern Ontario Aboriginal Diabetes Initiative)
- Telehealth
- Aboriginal Health Human Resources
- Aboriginal Health Transition Fund
- Mental health programmes

- Long Term Care flowed through the OFIFC and MNO
- Drug and Alcohol Workers (OFIFC)

Currently, there are a total of seven service accountability agreements in place between MOHLTC and Aboriginal health service providers in the region. Four are with First Nations: Rama Mnjikaning, Moose Deer Point, Wahta, and Beausoleil. The others are with Enaahtig Healing Lodge and Learning Centre, Barrie Area Native Advisory Circle and B'saanibamaadsiwin Native Mental Health Service.

The total amount of funding related to these seven agreements for 2006-2007 was $938,796.

There has not been an official announcement on the logistics or the timeframe for the LHIN's in terms of assuming responsibility for programmes currently being administered from the PTO's.

For further details on MOHLTC agreements see Appendix 4 - Aboriginal specific health services

4 Section 4

4.1 Community Engagement

A critical component in achieving the goals set out for this project was undertaking a process whereby the Aboriginal community would be consulted and engaged in dialogue in regard to developments surrounding the North Simcoe Muskoka LHIN.

4.1.1 Methodology

A consultant experienced in the field of Aboriginal health in the region was contracted to take the lead in coordinating community engagement and information gathering activities. Planning meetings were held with the Senior Director of Planning, Integration and Community Engagement to define the parameters, goals and timelines for the consultation.

A literature review was undertaken and a list of potential key informants was established. Information gathering instruments were developed, field tested and amended. Interviews were scheduled and carried out. Three focus groups were coordinated with a list of key informants. This list is attached as appendix 1. During the consultation phase, a total of 45 people were contacted either in person or by telephone. Areas that were addressed during the interviews and focus groups included the following:

- *Anticipated changes* resulting from the establishment of LHINs
- *Potential impacts* on local service delivery
- *Partnership development* between the LHIN and the Aboriginal community
- *Health priorities* facing aboriginal people in the region
- *Integration and coordination* – viewpoints in relation to services
- *Gaps and barriers* currently faced
- *Root causes* of gaps and barriers
- *Collaboration* among the Aboriginal community
- *Areas of focus* for the future
- *Key components* to be addressed in the Integrated Health Services Plan

A wide range of topics and concerns were raised throughout the discussions. This information was organized, analyzed and prioritized into 20 preliminary areas of focus. A group session was held where the initial list of priorities/area of focus identified from the consultation were further discussed. Based on these discussions, six primary areas were agreed upon. These areas are identified as priorities in section five of this report.

An analysis of information gathered during the consultation and workshop record with the larger focus group, formed the basis for the agreed upon priority areas of focus that have been put forward in the initial Integrated Health Service Plan. Summaries of points that were most prevalent during interviews are outlined under Summary of Findings section.

4.2 Summary of Findings

Each of the key informants was asked for their perspectives in relation to ten specific areas regarding LHIN development. These comments were recorded, summarized and analysed. Trends were identified and are highlighted in this f section. Many of the comments that were shared crossed over into different areas of focus. The summary has taken this into consideration and is written in a format that tries to avoid repetition or going over the same ground twice.

4.2.1 Anticipated Changes

As a result of the establishment of the Local Health Integration Network, it was important to determine the perceptions of those working in the health sector in regard to potential changes at the local level. The following is a synopsis of the comments that were most often shared in terms of potential impacts.

Provincial Territorial Organizations

- Currently, the Provincial Territorial Organizations (PTO's) administer a number of existing health programs that are operating in the region. The PTO's have negotiated program parameters, funding levels and reporting procedures with the MOHLTC and play a role in the delivery of a number of programs including Long Term Care, Alcohol and Drug Worker as well as the Southern Ontario Aboriginal Diabetes Initiative. If these programs are transferred to the LHIN, it will mean a diminished role for the PTO's in the current local delivery of programs and services.
- Reporting procedures, field support, training and financial implications will all need to be considerations if programs are shifted and brought under the LHIN jurisdiction.
- The Aboriginal and First Nation health council that is being established to advise the Minister will likely be discussing the implications of shifting health programmes from the PTO's to the various LHIN's across the province.

Aboriginal Healing and Wellness Strategy

- A number of programmes and services currently delivered originate from the Aboriginal Healing and Wellness Strategy (AHWS). There was speculation as to whether these programmes would be shifted over to the LHIN at some point in the future and if so, what the ongoing role of AHWS would be.

Existing Programs and Services

- There were strong sentiments shared that existing programs and services funded through MOHLTC such as the Long Term Care Programmes, Mental Health, Alcohol and Drug Worker, Southern Ontario Aboriginal Diabetes Initiative and Community Support Service, should not be jeopardized through this process. The possible review and renegotiation of existing contracts was a concern for some.

Reporting

- There was concern expressed that this shift may result in duplication of reporting, particularly for agencies that have agreements in place with offices located in two separate LHIN's. There will need to be coordination in regard to this, so as not to unnecessarily increase the reporting workload for staff.

New Relationship

- There were many who envisioned the potential for a revitalized, stronger relationship where greater input into key decisions around Aboriginal health concerns would be made. Greater participation on key committees and working groups by Aboriginal stakeholders was seen as a potential outcome as well. The possibility of additional programs and services to address shortfalls in service provision was also mentioned.

4.2.2 Impacts on Local Service Delivery

Those interviewed were asked for feedback on whether programmes and services currently offered at the local level could be affected by the shift to the LHIN model. The following comments were brought forward through these discussions.

Funding

- There was concern that the larger agencies in the region would have a distinct advantage over smaller, less resourced groups in terms of accessing future funding and support. Concerns were expressed that possible impacts may be felt if funds currently targeted to Aboriginal service providers are incorporated and integrated into larger funding streams. It was the general consensus that smaller groups are at a disadvantage in this scenario.

Existing Transfer Agreements

- It was indicated that if existing agreements remain status quo in terms of reporting and budgets and the change was more of an administrative nature, the impacts would be minimal and service provision would carry on as per the norm. However, there may be new transfer agreements that will need to be signed as a result of moving programmes that were administered by the PTO's to the LHIN. In these instances respondents felt strongly that the programmes and services must remain under the auspices of the Aboriginal community or organization.

Potential for Growth

- The two Aboriginal women's groups do not have transfer agreements in place with MOHLTC. It was generally felt that the immediate impact on their current level of involvement in providing health related services would be minimal. However, these organizations did see opportunity in the future to increase their role and capacity as a greater sense of coordination and cooperation was brought to the local health system.

Best Practices

- It was highlighted that successful models of service delivery have been designed and delivered by Aboriginal people in the region. In some instances, these best practices had to be discontinued due to lack of funding support. It was strongly suggested that proven best practices be revived in the future through the LHIN process. These include mental health, cancer care, diabetes prevention etc

4.2.3 Establishing Partnership with the LHIN

The timeframe for the LHIN to become fully operational is relatively short. By April 2007, the first stages of the transfer of responsibility will be well underway. Respondents were asked to share thoughts on the partnership that should be developed with the Board of Directors and staff of the North Simcoe Muskoka LHIN in both the short term and long term. Ideas and concepts that were expressed include the following:

Health Planning Body / Secretariat

- This was viewed as a top priority over the next three years. There was a great deal of support for the establishment of a regional Aboriginal health secretariat/health planning council that would assume a key coordination role at the local and regional level. Further details are provided in the priority focus area section of the report.

Representation on the NSM LHIN Board of Directors

- This was the second ranked area of focus identified. It was recommended that a person of Aboriginal ancestry be appointed as a member of the LHIN Board of Directors and that the process for selection should be undertaken as soon as possible in order to ensure participation in the developmental stages of the LHIN. This is further covered in the priority focus area section of the report.

Cultural Training and Awareness

- Cross-cultural training between the Aboriginal community and the LHIN Board of Directors and Staff was seen as key to building a strong foundation for the future. This exercise would lay the groundwork for establishing a common understanding of the Aboriginal view on wholistic health and how the two parties could work together to achieve common goals from a partnership perspective.

Jurisdictional Issues

- It was important that the Board and Staff of the LHIN along with the Aboriginal service providers gain an understanding of the different jurisdictions and funding streams within the mosaic of Aboriginal health service provision currently delivered in the region. In order to plan effectively, it was considered important that the different jurisdictions be clarified amongst all stakeholders.

4.2.4 Health Priorities

The health challenges facing Aboriginal people have been well documented in numerous reports and studies. These multi-faceted challenges encompass individual, social, economic and political dimensions. It was important to gather viewpoints from those working at the front lines on whether the findings identified in prevailing national health statistics were being experienced in the North Simcoe Muskoka region as well. The following areas were identified as key health issues during these discussions, not ranked in order of priority but seen as equally important:

- Diabetes and dialysis treatment
- Lack of awareness about good health practices
- Early cancer detection
- Young mothers and families lack of parenting skills, Low birth weight
- Wait times, Doctor shortages
- Addictions, i.e. smoking, alcoholism, gambling, food
- Nutrition and healthy eating (getting out of the fast food mentality)
- CCAC cutbacks
- Children's mental health
- Lack of services to deal with concurrent disorders

- Mental health – need more resources, psychiatric needs are high
- Patient advocacy
- Lack of capacity development
- Transportation and remoteness
- Traditional methods of healing not recognized
- Existing programs under resourced

All of the priorities expressed require a degree of coordination, planning and additional resources to begin to be acted upon. There was some frustration expressed that these issues have been known for an extended period of time and are still not being addressed in a coordinated fashion. Otherwise, they would not continue to be ongoing issues for generation after generation.

4.2.5 Integration and Coordination

The integration and coordination of services will be one of the key responsibilities of the LHIN. Integration in terms of the LHIN legislation is defined as including the coordination services and interactions; partnering for services and operations; transferring, merging or amalgamating services; starting or ceasing to provide services and dissolving or winding up operations.

In general, service providers express a degree of nervousness and trepidation when the concept of integration is brought up in regard to work that their particular agency performs. Respondents were asked to comment on the concept of integration and coordination and how these factors may impact on their service delivery in the foreseeable future.

Integration

Many respondents indicated that out of necessity, integration of their services is occurring now. A shortage in financial and human resources requires that smaller service providers integrate with mainstream health agencies in order to meet client needs. They shared that they are able to provide the cultural aspect of the intervention and work with mainstream agencies to provide a balanced spectrum of service in addressing a wholistic approach to health and wellness. There was a strong belief that culture based programming is not easily integrated into mainstream services. The distinct nature of this health service delivery needs to be maintained for the benefit of people that require this form of health intervention and support.

Culture Based Services and Programs

Maintaining and enhancing culturally relevant programmes and services was viewed as a priority area of focus. These programs provide a cultural approach to health service that is necessary to ensure health outcomes are achieved. These services meet the needs of a distinct group within society and can not be integrated easily without ramifications being felt by those that seek out Aboriginal service providers.

Alternative Health Practices / Wholistic Health

It was mentioned that an increasing number of people are looking for alternatives to mainstream health practices. Many of those interviewed strongly believe that a choice in treatment needs to be made available to Aboriginal people seeking help.

4.2.6 Gaps and Barriers

A determination of the types of gaps and barriers currently being experienced would be beneficial in comprehending the primary areas that need to be addressed as the LHIN moves forward. The following points are a synopsis of the gaps and barriers identified by the respondents.

Transportation and Remoteness

The North Simcoe Muskoka LHIN has a mix of both urban and remote areas. It was stated that transportation and ready access to medical services are critical issues for many residents who live in the remote regions of the LHIN. This coupled with the fact that many do not have a support network or the necessary financial means to access transportation, places a greater responsibility and workload on service providers expected to ensure care for these individuals.

Addictions

There was concern expressed by those working in a front line capacity in regard to what they view as a dramatic increase in addictive behaviour associated with gambling, hard drugs, prescriptive medications and alcohol. This situation is not restricted solely to the Aboriginal community but is of concern throughout the cross-section of society in the area. There was concern that immediate action needed to be undertaken to address this matter before more families are seriously impacted. Additional resources in the form of an increase in the number of addictions counsellors and the creation of an addictions treatment centre were recommended. Currently, there is only one Aboriginal addictions worker in all of central Ontario to address the addictions needs of Aboriginal people residing off reserve.

Cultural Awareness and Sensitivity

It was mentioned that stereotypical and inappropriate attitudes are still being demonstrated on the part of some personnel in the health sector toward Aboriginal people. When these incidents occur, whether intentional or not, they have a negative ripple effect that shakes the confidence and trust that people have in the health care system. It was suggested that cultural awareness and sensitivity training is required and that major health service providers in the region should ensure training is provided and available to their staff.

Salary and Security Inequities

There was a level of frustration expressed in the salary and job security inequities in the system for Aboriginal health professionals. People shared that the level of security in terms of pension and benefits for Aboriginal people working in the health and social service sector was much lower in comparison to their mainstream counterparts.

Coordination

A need was expressed for better cohesion, communication and coordination among the Aboriginal health service provider agencies in the region. Many jurisdictional issues are at play in terms of funding for different initiatives within the Aboriginal community. The lack of coordination and consultation creates competition for limited resources and duplication of service. Over the years, a number of contributing factors have caused a silo system of Aboriginal health service provision to become prevalent throughout the area.

Alternative Medicine

Concerns were expressed among some that under the present system, people don't have access to natural medicines or Aboriginal approaches to healing and wellness. In addition, it was felt that only those who could afford alternative medicine and treatment can take advantage of these services. These include the services of homeopaths, chiropractors and naturopaths for example.

Shortage of Aboriginal Health Professionals

There was general consensus that there continues to be a serious lack of Aboriginal health personnel at key points within the health system across the region and that a long term vision to address this fact needs to be established. There is an immediate need to graduate more Aboriginal health professionals and offer incentives for people to enter the health professions. It was also shared that graduates in the health care field choose to work for mainstream agencies for a variety of reasons which include financial security and benefits.

4.2.7 Root Causes

It was important to discuss root causes for gaps and barriers identified through the consultation. Some of the root causes can be addressed through the new LHIN process while others are the responsibility of Aboriginal communities, families and individuals. Others will need to be addressed through a variety of government agencies. When asked to identify the root causes for the gaps and barriers that exist, a wide range of thoughts were shared.

Poverty

Respondents shared that the cycle of poverty is intergenerational. This creates a ripple effect that impacts the social infrastructure throughout the system. Ultimately, this touches on many areas: housing, judicial, child welfare and homelessness, etc. People get stuck in a rut and it is hard to break the cycle of a subsidized lifestyle that they exist in and have become accustomed to. Ways to empower those at the bottom of the social scale, particularly young Aboriginal women are needed to achieve long term change. Aboriginal women are seen as key to the overall changes in achieving good health for the nation.

Lack of Resources

Many of those who responded felt there was a significant lack of resources to address the diverse needs across the region in a comprehensive manner. There was a sense that historically, mainstream agencies have been able to access resources more readily than their Aboriginal counterparts. There was a shared perception that Aboriginal service providers have had to adapt to getting by on limited resources while their counterparts in the mainstream system are able to access resources for family health teams and Community Care centres. There was a degree of frustration expressed around what is perceived as a systemic inequity.

Health Sector Shortages

Many emphasized the critical shortage of doctors in the area. This was also recognized as an issue that goes beyond the local level. Respondents indicated there was a need for more nurse practitioners, particularly in rural areas to address the gap in service. Frustration was expressed that while solutions continue to be debated, the problem still exists and vulnerable people living in remote areas of the region are at risk. More assertive action on the part of the LHIN in terms of raising attention about these matters, doctor shortage and the need for increased resources for under serviced areas was mentioned as an important goal.

Jurisdictional Issues

The creation of the Indian Act caused the Aboriginal community across Canada to become divided into distinct groups including: status Indians, non-status Indians, Inuit and Metis people. Only those individuals registered with the Department of Indian Affairs and Northern Development, or recognized in various treaties are entitled to certain benefits that include health related services. Due to government designation, many Aboriginal people do not have status which impacts the services they can access as it determines their eligibility.

Over time, Provincial Territorial Organizations were formed to negotiate and advocate on behalf of their respective members with various levels of government on a wide range of issues including health. As new health and social initiatives were established, local organizations and First Nation communities began to deliver services to their members.

This has lead to the present system by which health services are delivered through a myriad of funding streams to Aboriginal people in the region. Complex jurisdictional issues further complicate health matters particularly when interwoven with mainstream systems of health planning and governance.

4.2.8 Coordination among communities and organizations

Respondents were asked to comment on the level of coordination among the Aboriginal communities and organizations in the region in regard to health related matters. The following points were highlighted:

- A commitment is necessary from each of the communities to work collectively in areas where a shared effort is required. This will be particularly true if the proposed secretariat becomes a reality. A transition from working independently, to working with greater emphasis on collaboration will be required.
- An infrastructure is required to bring people together in order to plan collectively and facilitate plans into the action phase. This can not be done without some form of organization and cohesiveness. Without an infrastructure, the effort becomes disorganized and usually loses its focus and energy.
- The LHIN must be realistic in terms of the financial and human resource requirements that will be necessary to create substantive change.
- There is a need to have a common mission, goal and plan to achieve small victories in the first year of the LHIN development. Larger initiatives will require a phased approach for development.
- Use of the team model where there is an integrated team approach capable of addressing a range of needs. A multi-disciplinary team that could work together could substantially improve the overall health outcomes of Aboriginal people.

4.2.9 Areas of Focus

Respondents were asked what priorities needed to be identified in the Integrated Health Services Plan. A wide range of comments and ideas were shared. After an analysis of the information, the following areas were identified:

- A secretariat / health planning body is required to provide structure and a planned approach to addressing health related priorities in the region. It would need to be adequately resourced to achieve the goals set out for the initial three year period.
- Address the rural nature of the North Simcoe Muskoka LHIN and the unique issues that distance creates. Telehealth should be supported and looked upon as a key to addressing many of the issues created by the remoteness factor in our region. More doctors and nurse practitioners are required in isolated areas.
- A long term vision is needed to address the shortage of Aboriginal people in the health professions. Strategies to recruit, train and sustain more Aboriginal health professionals to our area should be examined. Recruitment needs to be increased and incentives need to be

provided. There is a need to heighten awareness among young people about the rewards of working in the health professions.

- Funding levels in existing transfer agreements should not be jeopardized in the move to the LHIN process.
- There is a need for the following facilities:
    - Aboriginal focused Community Health Centre
    - Residential addictions treatment centre
    - Residential Facility to treat the seriously mentally ill

These are all larger initiatives that require a degree of research and preparation in order to become a reality in the future.

- Examine opportunities for MOHLTC and Health Canada to work cooperatively in order to increase funding and opportunities for smaller agencies that require support to enhance their health related service provision.
- The MOHLTC has the responsibility to be the health planner for the region. This includes the responsibility for addressing Aboriginal health concerns. They have the ability to integrate and coordinate the system. By working together, a win - win situation could be realized and together this region could become a leader for the rest of the province. Strong relationships ensure that goodwill turns into action.
- The concepts put forward in this consultation need to be acknowledged and acted upon in some fashion over the next three years. The LHIN will need to provide commitment and the financial and human resources to implement the strategies that have been identified.
- Many respondents would like to see wholistic health become more recognized and accepted by mainstream health service agencies as viable alternatives to the standard methods of health provision.
- Representation on the LHIN Board of Directors is important in order to provide an Aboriginal and Metis perspective to discussions. Cross-cultural training should be undertaken for Aboriginal service providers and for the LHIN Board of Directors and staff.
- Recognition that addictions in all forms are on the increase, requiring additional resources to help people improve their lives through treatment and prevention.
- Aboriginal women’s groups play a key role in maintaining good health for children and in families. Their role, along with that of other small organizations could be strengthened to meet the diverse needs.
- More personal support workers are required to help cancer patients and those who are most vulnerable.
- The ongoing role of the Provincial Territorial Organizations will need to be clarified over the course of the next three years as more responsibility is devolved to the LHIN. As well, developments surrounding the Aboriginal Healing and Wellness Strategy will need to be monitored.
- Proven best practices need to be supported and implemented.

5 Section 5

5.1 Priority Areas

All the people who were interviewed were invited to participate in a focus group session held September 7, 2006, at the Enaahtig Healing Lodge and Learning Centre. The primary purpose of the session was to review and discuss the areas of focus brought forward during the consultation phase. A prioritization exercise was undertaken to identify which of the areas would be put forward as priorities in the IHSP.

Based on these discussions, six primary areas were identified as priorities that would go forward in the North Simcoe Muskoka Integrated Health Services Plan.

1. Establishment of a regional health planning body / secretariat
2. Representation on the LHIN Board of Directors
3. Maintain the level of Aboriginal specific programming
4. Affirmation and Integration of wholistic healing practices
5. The need for increased mental health and addictions resources
6. Funding and commitment to reach goals

5.1.1 Establishment of a Regional Health Planning Body / Secretariat

There was a great deal of support for the establishment of a secretariat/health planning body that would assume a key coordination role at the local level. It was felt that quick wins could be achieved and work could begin on long term goals if the secretariat/health planning body is resourced adequately and a clear mission and achievable goals are established. People indicated that it is important for planning bodies to be empowered and resourced to facilitate the process beyond the planning stage and into the action phase.

In the short term, the secretariat would play a key role in building linkages with LHIN Board and staff and other mainstream service providers in the region. It was also viewed as providing the infrastructure necessary to bring the 13 Aboriginal groups together to plan collectively and address areas previously identified but not advanced due primarily to a lack of human resources.

The need for better communication and coordination among the Aboriginal groups in the area was also stressed. The secretariat was viewed as the infrastructure necessary to bring all parties together on a consistent basis to plan and coordinate activities. The secretariat would also play a key role in providing a forum for the smaller organizations that do not have the opportunity or resources to have their voices heard.

A number of objectives have been set out for the LHIN's in the legislation; some of these are as follows:

- Planning for local health service needs
- Engaging the community in planning and setting priorities
- Ensuring there are appropriate processes for responding to concerns
- Helping to develop and implement provincial priorities and services
- Working with others to improve access to and coordination of health services
- Disseminating information on best practices

- Improving the efficiency of health service delivery

A health planning body working in partnership with the LHIN would provide a key component in meeting these objectives on behalf of the Aboriginal community.

This NSM LHIN has an advantage in that there is an established Aboriginal organization, the Barrie Area Native Advisory Circle (BANAC) with a mandate to be a health and social planning body for the region. It was suggested that the secretariat / health planning body function could be undertaken by this agency.

It was generally agreed that the human resource requirement for the secretariat would involve at minimum; a manager, health planner(s) and administrative support. Overhead expenses would need to be factored in as well.

5.1.2 Representation on the LHIN Board of Directors

It was suggested that the LHIN Board of Directors should ensure that a person of Aboriginal ancestry, with background knowledge of Aboriginal health issues is on the Board. It was understood that appointed Board members do not represent a particular constituency or cultural group when they are conducting the business of the Board. However, it was felt the Board of Directors as a whole would be strengthened by having an individual on the team knowledgeable about local Aboriginal health priorities and could speak to these matters as they arise.

In the initial round of Board appointments an Aboriginal person had been appointed. However, this person subsequently resigned and the seat remains vacant. There were others who expressed interest during the initial call for applications. There were suggestions that this list should be revisited and the process put into motion to appoint another Aboriginal person from the candidates who put their name forward.

5.1.3 Maintain the Level of Aboriginal Specific Programming

There was a strong sentiment that existing programs and services currently funded through MOHLTC should not be jeopardized through this process. The possible review and potential renegotiation of existing terms and funding levels was a concern for some. Respondents also wanted to ensure that Aboriginal specific initiatives that have been negotiated and are currently in place, are protected in the future. This includes the program dollars flowing out of the Aboriginal Healing and Wellness Strategy.

There was concern that impacts may be felt if funds that currently flow to Aboriginal service providers are rolled into a larger funding stream. There was a sentiment expressed that smaller groups would be disadvantaged in this scenario. Funds that have been dedicated as Aboriginal specific need to be acknowledged as such and not rolled into any other stream of funding.

Maintaining culturally relevant services was viewed as a priority. The current programs are based from a cultural approach and delivered in a way that is in keeping with a traditional approach to intervention. It was stated that there are many people who absolutely require culturally sensitive health programming.

The high case loads that most front-line workers currently maintain, attest to the fact that people are seeking out culturally appropriate services. Help for the people, by the people, is an important cultural concept that needs to be supported.

The services currently delivered by the existing Aboriginal health staff provide a valuable and critical link to mainstream health services. The role of patient advocate and support mechanism can not be underestimated.

5.1.4 Integration of Wholistic Healing Practices

The terms “traditional medicine” and “wholistic healing” were mentioned extensively throughout the consultations. These terms have been conceptualized and defined in several ways. The definitions developed by the World Health Organization (2001) and from the Royal Commission on Aboriginal Peoples (1996) are closely linked to the concepts that were shared by the respondents in this initiative.

The term” traditional medicine,” as identified by the World Health Organization,

> “Is the sum total of knowledge, skills and practices based on the theories, beliefs, and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness.”

Volume 3 of The Report of the Royal Commission on Aboriginal Peoples (1996) defines traditional healing as:

> “Practices designed to promote mental, physical and spiritual well being that are based on beliefs which go back to the time before the spread of western scientific bio-medicine. When Aboriginal peoples in Canada talk about traditional healing, they include a wide range of activities, from the physical cures, using herbal medicines and other remedies, to the promotion of psychological and spiritual well- being using ceremony, counselling and the accumulated wisdom of the elders.”

Interviewees shared that the number of people looking to access culture based alternatives to mainstream health practices is on the rise. There was strong sense that the health care system should work toward establishing an environment which is sufficiently flexible, allows community members to access culturally appropriate services in the Aboriginal and a complementary sensitive service in the mainstream system of treatment based on the needs of the individual.

It was felt that it is not prudent planning if all services are integrated into the western philosophy of health provision. Many looked to the LHIN development as an opportunity for traditional healing practices to become more recognized and accepted in mainstream health agencies.

A common sentiment shared was that the use of natural medicines or alternative healing techniques were not viewed with the same sense of validity by the health system as western based practices of medicine. Currently, natural / traditional medicines, psychological assistance, homeopaths, chiropractors, naturopaths, acupuncture, etc. fall on the side of the ledger that isn’t covered by OHIP or the First Nations and Inuit Health Branch (FNIHB). These are often the types of services Aboriginal people and an increasing number of non-Aboriginal people are most comfortable with. It was felt that in general, only those who could afford alternative medicine can take advantage of this type of treatment.

The key question respondents had in regard to wholistic health had to do with how the concept could be more commonly applied in the health care system and what tangible action could be done on the part of the LHIN to support this concept in the region.

Gaining answers to these questions will need to be done as a separate process and could be a major piece of work for the proposed health secretariat. As the LHIN moves forward there is a need to understand and acknowledge the distinct role that wholistic health has in the Aboriginal community.

5.1.5 The Need for Increased Mental Health and Addictions Resources

There was concern expressed about the increase in addictive behaviour not only in the Aboriginal community but throughout the LHIN catchment area. There is an immediate requirement of resources to address this situation with suggestions as follows:

- Increased prevention through training and education
- Establishment of a residential treatment centre
- More front-line workers

These all require a commitment of financial resources. However, there is a need to address the growing addiction problems in the region. There is a need for more people and front-line resources in the area of mental health and addictions. It was felt that the number of people dealing with concurrent disorders has increased dramatically in recent years. The development of a residential treatment centre for the seriously mentally ill was suggested as a long term goal.

It would be advisable to build on the work that has already been accomplished through previous endeavours. Great strides have been made over the years through the work of people on the Bimaadsiwin Mental Health Planning Committee, the Central East Mental Health Implementation Task Force and the Aboriginal Mental Health Task Force. This region has proven to be a leader in this important work. As initiatives move forward there is a requirement to build from the strongest point. The proven track record established in regard to mental health service provision is one of these strong points.

There are successful models of service delivery in the field of mental health that have had to be discontinued due to lack of funds. Perhaps there is the opportunity that these best practices could be revived through the LHIN process. As well, comprehensive community mental health plans have been crafted through previous planning exercises. These strategies only require resources and support to be implemented.

In addition, it is critical that immediate steps be taken to address significant deficiencies in the area of mental health supports and services for young Aboriginal people struggling with mental health and addiction issues. Aboriginal children in the region do not have access to a continuum of services and supports.

5.1.6 Funding and Commitment to Reach Goals

People envisioned a new, stronger relationship where the possibility of greater input into key decisions around Aboriginal health concerns would be made. Greater participation on key committees and working groups was seen as a possible outcome as well. The possibility of more programs and services to address shortfalls in service provision was also mentioned.

For the most part, people looked at this as an opportunity to revitalize the way in which health services are delivered, to refocus and make up for lost ground. It was felt that this was an opening to examine opportunities for MOHLTC and Health Canada to develop partnerships in order to increase opportunities for Aboriginal agencies that desperately need support to enhance their service. Resources to expand services are always needed. This is particularly true of the smaller organizations that are operating without the benefit of stable funding, yet come face to face with health related issues and struggle to address these matters in spite of their own funding challenges.

There was a level of frustration expressed in the overall shortage of funding and salary inequities in the system. It was indicated that job security and salary levels are not as strong in comparison to mainstream services. Much of the funding in the Aboriginal non-profit sector is on a contract to contract basis. A pension plan in urban Aboriginal agencies is non- existent. The effects of this are many with a major factor being the high turnover of staff within the Aboriginal health and social service sector.

All parties will need to be realistic in terms of the financial and human resource requirements that will be needed to address the areas of focus. Funding levels need to be realistic and sustained to meet the

targets set out. In terms of future planning, there is a need to ensure that funds are secured to meet the existing and future needs of Aboriginal health services.

5.2 Action Items

In order to address the primary areas of focus both in the short and long term, the Board of Directors of the North Simcoe Muskoka LHIN would require a sense of the logical sequence of actions that could be undertaken. The following action items address the primary areas of focus that were identified. These recommendations are starting points for development. As the initiative moves forward and goals are established there will be a requirement to review the goals and amend priorities as part of sound organizational development and to respond to changing environments.

5.2.1 Health Planning Body / Secretariat

- That financial support be identified and set aside for the purpose of establishing an Aboriginal Health Planning Secretariat for the North Simcoe Muskoka LHIN which would begin operation in the 2007 - 2008 fiscal year.
- Prior to April 2007, a working committee comprised of LHIN senior staff and representatives from the local Aboriginal health service provider groups undertake a process that would address the following milestones in the establishment of the health planning body / secretariat
    - Designate the lead on organizing preliminary phase
    - Establish goals for the working committee
    - Define the terms of reference for the health planning body
    - Establish the mission, purpose and goals
    - Determine the financial and human resources required
    - Establish an office location
    - Establish timeframes and critical path
    - Develop short and long term goals
    - Confirm reporting procedures
    - Address other logistical matters

5.2.2 Representation on the Board of Directors

- That action is taken as soon as possible to fill the vacant seat on the North Simcoe Muskoka LHIN Board of Directors with a person of Aboriginal ancestry knowledgeable of Aboriginal health issues in the region.

5.2.3 Maintain the Level of Aboriginal Specific Programming

- The Board of Directors and staff of the NSM LHIN work to ensure that the level of Aboriginal specific programming currently delivered in the region is maintained as a result of the devolution of authority and control to the local level. Further, that Aboriginal health service enhancements be developed and resourced to address the gaps that have been identified through the community engagement process.

5.2.4 Wholistic Healing Practices

- That the Board of Directors and staff along with members of the Aboriginal community undertake a cross-cultural training process that would increase awareness and knowledge of Aboriginal based wholistic healing practices. Further, that a strategy be developed in conjunction with the proposed secretariat that would raise the level of awareness, acceptance and integration of traditional healing practices in mainstream health agencies across the region.

5.2.5 Increased Mental Health and Addictions Resources

- That funding and resources be allocated for the provision of additional programming and services to address the increase in demand for mental health and addictions support across the NSM LHIN catchment area. Further, that planning exercises be undertaken to determine the feasibility for the creation of residential treatment services to treat addictions and serious mental health conditions among the Aboriginal community.

5.2.6 Funding and Commitment

- That the North Simcoe Muskoka LHIN Board of Directors and Staff commit to the establishment of an ongoing partnership with the Aboriginal communities and organizations for the purpose of moving the Aboriginal health agenda forward and addressing goals established by the group.

5.2.7 Summary

As a direct result of the community engagement exercise there is definitely a greater awareness about the North Simcoe Muskoka Local Health Integration Network and the critical phase of development it is currently going through. All of those who participated indicated that they will be keeping abreast of developments as they occur and looked forward to receiving feedback from the Ministry in relation to the findings that are being put forward as a result of this initiative. There is a sincere hope that this new way of delivering health service will be one that has long term positive effects in the Aboriginal community.

Appendix 1 - List of Participants

The following individuals participated in the community engagement process either through personal interviews or in focus group sessions.

Georgian Bay Metis Council

9170 County Road 93 West

RR#2, Box 50

Midland, ON

L4R 4K4

Telephone – (705) - 526-6335

Mary Mackie - Healthy Babies/Healthy Children Coordinator

Michelle Foster - Long Term Care Program Coordinator

Natalie Peltier – Volunteer – Long Term Care

Georgian Bay Native Women's Association

317 Midland Avenue

Midland, ON

L4R 3K5

Telephone – (705) - 527-7043

Sheri Charlebois - Canada Prenatal Nutrition Programme

Nicole Thibodeau – Community Action Programme -Children

Southern Ontario Aboriginal Diabetes Initiative

c/o Georgian Bay Native Friendship Centre

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Telephone – (705) - 527-1560

Peggy Monague – Regional Diabetes Worker

Roslyn Baird - Manager

Enaahtig Healing Lodge and Learning Centre

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Victoria Harbour, ON

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Telephone – (705) - 534 -3724

Nena LaCaille – Executive Director

Yvon Lamarche - Children's Mental Health

Steve Beaupre – Programme Coordinator

Marilyn Groulx – Senior Counsellor

Penetanguishene Mental Health Centre

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Penetanguishene, ON

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Tel: (705) - 549 -3181

John Rice – Aboriginal Spiritual Services Coordinator

Georgian Bay Friendship Centre

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Midland, ON

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Telephone: (705) - 526 -5589

Carrie Black - Life Long Care Programme

Brian George - Healing and Wellness Coordinator

Ernie Matton – Alcohol and Drug worker

Barrie Area Native Advisory Circle

431 Huronia Road, Unit 10

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Telephone: (705)- 734-1818

Donna MacDonald – Executive Director

Simcoe Urban Native Housing

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Tel: (705) -737-3532

Kim Sandy – Executive Director

Barrie Native Friendship Centre

175 Bayfield Street

Barrie, ON

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Tel: (705) -721 -7689

Dave Martin – Executive Director

Pat Shaver –Health Outreach worker

Bernice Trudeau –Healing and Wellness Coordinator

Marie Dokis –Lifelong Care Worker

Diane Sheridan –Healthy Babies Healthy Children

Patricia Jacko – Nursing student

Canadian Mental Health Association

39 High Street

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Tel: (705) -726 -5033

Thomas Puddicombe – Assertive Community Treatment Team

Orillia Native Women's Group

105 Douglas Street

Orillia, ON

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Tel: (705) - 329 - 7755

Dawn Ireland Noganosh – Executive Director

Denise Mathew – Community Action Program -Children

Raven Cotnam – Canada Prenatal Nutrition Program

Jimelda Johnston - Work placement

B'saanibimaadsiwin Native Mental Health Service

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Debbie Pegahmahgabow – Manager

Laureen Pawis – Program Coordinator

Rama Mnjikaning First Nation

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Beausoleil First Nation

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Peggy McGregor Monague – Health Director

Dagmar Sandy – Home and Community Care Coordinator

Mary Paille – Community Health Nurse

Shawn Williams – Finance Manager

Wahta Mohawk Territory

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Tel: (705) - 762-2354

Phillip Frank - Community Health Representative

Ontario Federation of Indian Friendship Centres

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Tel: (416) - 956- 7575

Jessica Hill – Policy Analyst

Lori Flynn - Lifelong Care Manager

Métis Nation of Ontario

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Tel: (613) - 7981488

Doug Wilson – Health Director

Other Key Informants

Cindy Marsden – Health Director – Alderville First Nation

Ed Conners – Onkwatenro'shon:'a Health Planners

Cam Agowissa - Children's Aid Society Aboriginal Case Worker

Norm Beavais – Post secondary student placement

Jamie Mishibinishima – Manager, Urban Aboriginal Task Force

Leslie McGregor – Executive Director, Noojimawin Health Authority

Appendix 2 - Priority Areas of Focus

Appendix 3 - Glossary of Terms

Aboriginal refers to persons descending from the original inhabitants of Canada. The Canadian constitution recognizes three groups of Aboriginal people. They are defined as Indian (First Nations), Inuit and Metis

Aboriginal community is defined as a group of Aboriginal people who share similar beliefs, traditions and cultural identity. These groups share political, cultural, spiritual and/or other affiliations. Aboriginal communities include but are not limited to: First Nations, people who share a Metis identity, Friendship Centres, community based organizations/locals, women's groups or any other collection of Aboriginal individuals who share identity, regardless of geography

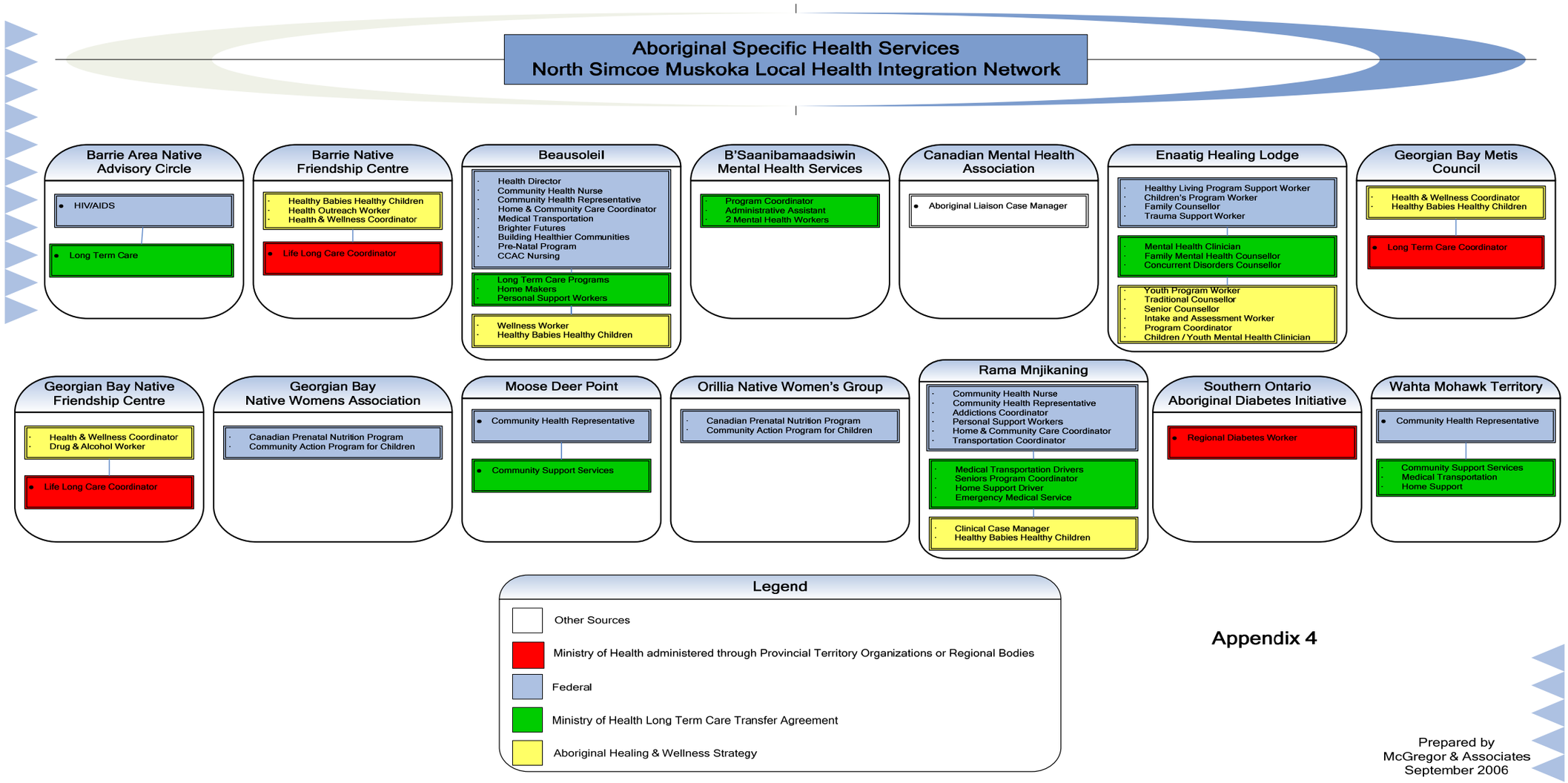
Aboriginal specific refers to services that are exclusive to Aboriginal people whether in receiving a service or in its provision.

Culturally appropriate health care reflects the values, traditions and experiences of Aboriginal people

Indian Act refers to Canadian government legislation first passed in 1876. It sets out certain Federal government obligations and regulates the management of Indian reserve lands, money and other resources.

Métis refers to people of mixed First Nation and European ancestry.

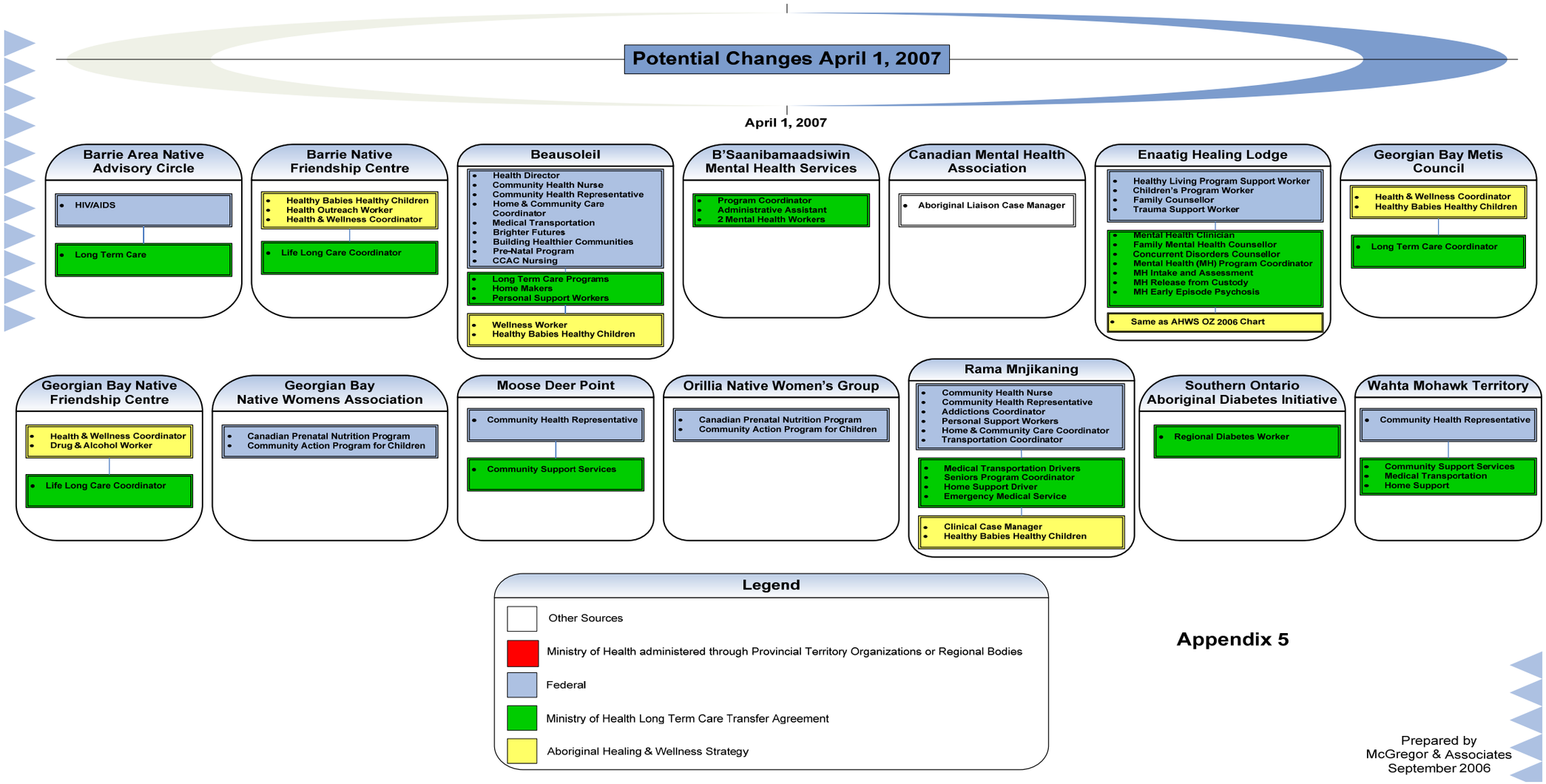
Appendix 4 - Aboriginal Specific Health Services - NSM LHIN



Appendix 4

Prepared by
McGregor & Associates
September 2006

Appendix 5 - Potential Changes in Transfer Agreements – April 2007



Appendix 5

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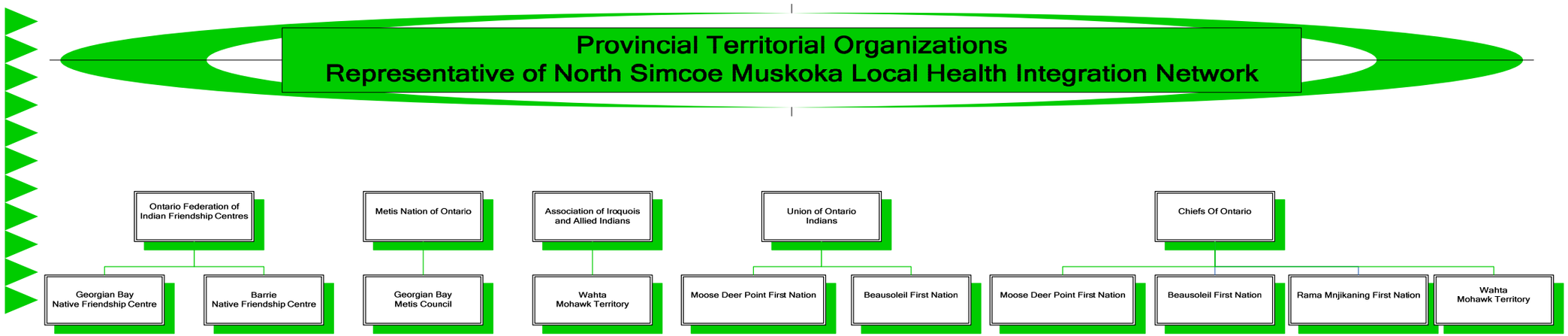
September 2006

Appendix 6 - Provincial Territorial Organizations flow chart



Appendix 6

Prepared by
McGregor & Associates
September 2006

Appendix 7 - Aboriginal Healing and Wellness Strategy flow chart

Appendix 7

Prepared by
McGregor & Associates
September 2006

First Nations & Aboriginal Service Organizations of North Simcoe Muskoka LHIN

North Simcoe Muskoka
LOCAL HEALTH INTEGRATION NETWORK

North Simcoe Muskoka Local Health Integration Network
210 Memorial Avenue, Suites 127 – 130
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Website: www.lhins.on.ca
Email: northsimcoemuskoka@lhins.on.ca

Ontario