Aboriginal Conversation on Health
Held on March 8, 2007

Vancouver Coastal Health wishes to acknowledge
Western Economic Diversification Canada for providing funding for this important event.
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Executive Summary

While British Columbians are among some of the healthiest people in the world, many Aboriginal people living in the province cannot say the same. For many complex reasons, including the historical loss of cultural and political institutions, colonialism, racism, and traumatic residential school experiences resulting in multigenerational impacts, Aboriginal people continue to be challenged by both the poorest health status among identified populations, and serious inequities in health when compared to other British Columbians. ¹

The unique perspective of Aboriginal people is an important one to incorporate into the Conversations on Health process currently underway in the Province of British Columbia (see www.bcconversationonhealth.com). On March 8, 2007, thirty-five representatives from approximately one hundred invited urban Aboriginal organizations and fifteen First Nation communities attended the Vancouver Coastal Health, Aboriginal Conversation on Health (see Appendix 1, attendee list). This process mirrored the public forum process that is taking place across the province, and will prove useful as the B.C. government develops plans to respond to issues raised during the year-long Conversation on Health.

Process

On March 8, during the morning session (see Appendix 2, ‘Agenda’), participants prioritized four key Aboriginal health issues from the following eleven conversation starters:

1. Pressures on the health care system
2. Health care delivery
3. The Canada Health Act
4. Primary health care
5. Seniors and aging
6. Chronic disease prevention and management
7. Health human resources
8. End-of-life care
9. Emergency departments
10. Mental health and addictions
11. Problematic substance use

¹ BC Ministry of Health website (Aboriginal Health).
An additional “issue station” was created in order to capture priority Aboriginal health issues that may not have been represented in the eleven aforementioned conversation starters (see Appendix 3, ‘Unedited Flip Chart Notes). Issues included:

- Several Aboriginal health reports and their recommendations have been undertaken with little or no tangible results;
- The need for increased management and stewardship of Aboriginal health by Aboriginal people;
- Outstanding issues with the non-insured health benefits program;
- Multiple discharge planning concerns;
- The need to address other health determinants like housing and poverty, and more.

Arising from the morning discussions, five priority Aboriginal health issues were identified and are listed in order of priority as follows: (1) Addiction/mental health; (2) Primary health care; (3) Health education and human resources; and tied for fourth place, (4a) Elder Care, and (4b) Chronic disease management.

During the afternoon of March 8, participants contributed to three out of a possible four small group sessions in order to further elaborate on and discuss the health priorities identified during the morning session from which the following key themes for reform emerged: (1) Access to health services; (2) Cultural competency and sensitivity; (3) Governance and accountability; and (4) Sustainability and resourcing. These important themes have consequently informed the Vancouver Coastal Health, Aboriginal Health Transition Fund and Adaptation Plan, and it is hoped they will provide the B.C. government with a framework for some of the recommendations coming from the Conversations on Health.

<table>
<thead>
<tr>
<th>B.C. Government Conversation Starters</th>
<th>Priority Issues identified in Conversation</th>
<th>Key Themes for Reform</th>
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<tbody>
<tr>
<td>1. Pressures on the Health Care System</td>
<td>1. Addictions/Mental Health</td>
<td>1. Access to Health Services</td>
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<tr>
<td>2. Health Care Delivery</td>
<td>2. Primary Health Care</td>
<td>2. Cultural Competency and Sensitivity</td>
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<td>3. The Canada Health Act</td>
<td>3. Health Education and Human Resources</td>
<td>3. Governance and Accountability</td>
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<td>4. Primary Health Care</td>
<td>4. Elder Care/Chronic Disease Management</td>
<td>4. Sustainability and Resourcing</td>
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<td>5. Seniors and Aging</td>
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<td>6. Chronic Disease Prevention and Management</td>
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<td>7. Health Human Resources</td>
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<tr>
<td>8. End-of-Life Care</td>
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<tr>
<td>9. Emergency Departments</td>
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<tr>
<td>10. Mental Health and Addictions</td>
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<tr>
<td>11. Problematic Drug Abuse</td>
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</table>
Priority Issues

1. **Addictions and Mental Health**
   Residential school trauma was identified as a major cause of mental health and addiction concerns within Aboriginal communities. For various reasons, mental health and addiction needs are not being addressed adequately within Aboriginal population and requires special attention.

2. **Primary Health Care**
   Key concerns that were identified in the area of primary care were transportation challenges, lack of accessible medical and community health personnel, and the need to integrate traditional healing methods into current primary health practices.

3. **Health Education and Human Resources**
   Increasing the number of Aboriginal health care practitioners was a priority and this included adequate resourcing, setting targets for training, developing programs to attract Aboriginal health care practitioners to remote areas, linking secondary and post secondary education avenues, and expanding e-health and telehealth.

4. **Elder Care/Chronic Disease Management**
   Diabetes, HIV/AIDS and rheumatoid arthritis in Aboriginal populations are identified to be higher than national averages in non-Aboriginal populations and targeted strategies are urgently needed to address this. Elder care issues include abuse, access to services, care-giving and funding. Several recommendations were made to address multiple health service concerns.

Key Themes for Reform

1. **Access to Health Care Services**
   As Aboriginal people continue to ‘fall through the cracks,’ it was clearly recommended to address outstanding access to health service issues. In the areas of addiction and mental health as well as Elder care, related recommendations were made for more Aboriginal specific treatment and assisted living beds, respectively.

   Furthermore, it was emphasized that those who live in rural communities and/or in communities with limited road access must not continue to pay
heavy penalties in health care because of where they reside. Creative solutions identified included expanding primary care and health campus models, like the facility scheduled to be constructed in Lytton, B.C., that can serve as centers for health care excellence and offer a comprehensive range of advanced health acute and outpatient services.

2. Cultural Competency and Sensitivity
Participants stressed the need for Aboriginal health services to be delivered in a culturally sensitive manner. A key part of this is increasing the number of Aboriginal service delivery providers. It was recommended that Employee Engagement departments within Health Authorities, for example, must play a more proactive role in their recruitment and retention practices.

Moreover, there is a general consensus that traditional native healing practices be more formally recognized. Traditional healers are well positioned to perform key roles in the health and well being of Aboriginal health service recipients as well as informing conventional health service delivery practice.

3. Governance and Accountability
Jurisdictional issues were a key concern for participants. For example, services to those who live ‘on reserve’ must be equitable for Aboriginal people who live ‘off reserve.’ In addition, the ‘fragmentation’ of systems that are otherwise well positioned to serve Aboriginal people must be addressed. These systems include but are not necessarily restricted to: education, justice, health, and child and family services.

4. Resourcing and Sustainability
Participants believed there remains a chronic lack of funding for Aboriginal health services, regardless of where Aboriginal people choose to reside, that must be addressed. Creative solutions to overcoming geographic barriers can only be realized if long term sustainable funding is made available.

Conclusion
Overall, outstanding Aboriginal health service issues and ideas to address them were put forward by significant cross-representation of the Aboriginal constituency of the Vancouver Coastal Health Authority. Recommendations are achievable and specific in addressing both short and long term concerns. What follows is a complete report of the successful Aboriginal Conversation on Health event.
Profile of Vancouver Coastal Health Aboriginal Communities

It’s estimated that 45,000 or more Aboriginal people live in the VCH region with 30,000 urban Aboriginal community members based off reserve in Vancouver and Richmond. This number appears to be growing at 2 per cent per year, faster than the 1.4 per cent rate for the general population. These numbers are higher than the 2001 Statistics Canada Census data which we believe understate actual numbers of Aboriginal people living in the VCH region.

Compared to the general population, Aboriginal people live on average seven years less and have an infant mortality rate between two to four times higher; their rate of diabetes is triple; AIDS/HIV deaths are double; alcohol-related deaths are 4 to 9 times higher; and drug-induced deaths are 1.7 to 6.9 times higher. Aboriginal use of residential care in Vancouver is twice as high as the rate for the general population. Hospitalization rates and preventable admissions are likewise higher.

Within VCH boundaries, there are 15 First Nations - 12 Rural, 2 Suburban, 1 Urban with 80 per cent of these urban Aboriginal community members identify as status First Nations.
Vancouver Coastal Health, Aboriginal Conversation on Health: Highlights of Participant Conversations

Four Priority Aboriginal Health Issues

As described earlier, participants in the Aboriginal Conversation on Health were asked to identify four priority Aboriginal health issues from eleven ‘conversation starters.’ The four priority areas identified by the group were:

1. Addiction/Mental Health
2. Primary Health Care
3. Health Education and Human Resources
4. Chronic Disease Management and Elder Care
1. Addiction/Mental Health:

Residential school trauma was identified as a major cause of mental health and addiction concerns within Aboriginal communities. For various reasons, mental health and addiction needs are not being addressed adequately.

"A suicidal patient went to the hospital and was assessed. They said he was fine and asked that the addictions counsellor pick him up. She did not feel comfortable taking him home. He was suicidal, had an addiction, a disability and chronic health and mental health issues. The challenge is how do we work together better. The addictions counsellor was frightened to be the last person to talk to this person because he was suicidal.

The First Nation did not have the resources to support the employee. The emergency line was good in that there was someone to contact, but they had nothing for us. Even if there was someone to watch the person so they wouldn’t be alone. The hospital would be a good place to start, but they said no." - As described by an Aboriginal health director.

Issues

- Residential school trauma is a multi-generational concern that affects all First Nation communities. Few resources are available to address this root cause of much of the mental health and addiction concerns in our communities.
- Families in remote communities have limited access to and funding for family outreach services.
- As a result of jurisdictional issues, there is lack of inter-connectedness and fragmented approach to health care. The federal government is responsible for health care on reserves, and off the reserves there is a big gap in care.

Recommendations

- Create a dedicated health portfolio to focus on Aboriginal needs.
- Funds must be made available for prevention to address how we focus on upstream initiatives to mitigate mental health and addiction issues.
- Make available Provincial, Federal and Regional government staff who are connected and have relationships with Aboriginal communities.
- Aboriginal children need to be assessed earlier to provide the right supports at the right time to improve outcomes.
- Respect and honour traditional practices and individual beliefs.
- Establish a mental health pathway for First Nations and Aboriginals at all levels of health care and families need to be engaged. Too many have fallen through the cracks. There are young people sitting in psychiatric wards waiting for a place to go, removed from family, sitting day after day.
- Get more resources ‘on the street’ - i.e. more nurses and teams of youth walking around and meeting people where they live.
2. Primary Health Care:

Key factors to address in the area of Primary Health Care are transportation challenges, lack of medical and health personnel, and the need to integrate traditional healing methods into current health practices.

“I was in high school when HIV/AIDS was just coming out, in the 80s. The most effective thing was to have a core group of influential kids to help educate. They were focused on educating and put a positive spin on education. Very different than authoritative person saying you must do this and that. Have training programs for elders and youth that could go on the road and spread the word.” – In the words of one of the participants

Issues

- Transportation to Primary Health Care services and programs remains difficult:
  - Ambulance won’t respond in rural and remote communities.
  - Two day trip to get diagnostics and appointments in town.
  - Hard to get bus tickets or taxi to services.
- Lack of doctors and other health care professionals.
- No recognition of traditional healing methods.

Recommendations

- Make Aboriginal (or non-Aboriginals in the interim) doctors and nurse practitioners available in the community.
- Provide community specific primary care health programs to address primary health care issues;
- Ensure equal access or even better services on reserve that currently are available off reserve such as occupational therapy, child mental health, safe clinics, bullying programs, transportation for seniors, support groups, bereavement programs, etc.
- Create centers that are client-centered and holistic in approach:
  - From medical to cultural (medical only one part).
  - Community gardens.
  - Dental care.
  - Mental health services.
  - Child services.
  - Look to the medicine wheel to balance spiritual, mental, physical, emotional aspects of health.
  - The above do not have to be physician-centered.
• Education for range of professionals on how to work together and in partnership with clients.
• Connection between traditional and western medicine, needs to have policy and dollars behind it.
• Continuity over time of service; receive funding, and then it ends.
• Make Primary Care Centres more welcoming, nurturing and inclusive:
  o Traditions, resources, drumming, smudging, traditional dietary foods and medicines.
  o Foster community partnerships to help address issues such as transportation.
3. Health Education and Human Resources

Several issues in this vital area of concern are identified and offered recommendations for: budget allocations, setting targets for training, attracting Aboriginal health care practitioners to remote areas, linking secondary and post secondary education avenues, and e-health, to name a few.

Issues
- Good ideas are put forth and people give up on it, a “token approach”
- Lack of Aboriginal presence in health care at all levels, not just in the health care professions.
- Lack of access to appropriate education needs such as science labs.
- HR systems don’t always support the hiring of Aboriginal peoples.
- Inequities in budget allocation and for programs.
- Ongoing Aboriginal health services staff recruitment and retention issues.

Recommendations
- Review recommendations in previous consultations
  - Seton Report/Commission
  - Healing Ways, VCH Report
  - The Health and Well Being of Aboriginal People in British Columbia by Provincial Health Officer, Dr. Perry Kendall
- Attract Aboriginal health care practitioners to remote B.C.
  - Cultural sensitivity, “Boot Camp”
  - Set quotas for all HCP’s
  - Create a feedback processes
  - Shadowing programs for new non-Aboriginal nurses
  - Incentive programs
- Set realizable targets:
  - Training dollars for committed employees – Adults
  - Laddering programs
- Budget
  - 4% of population, 4% of budget should be allocated to Aboriginal health.
  - 18% of hospital usage, numbers of employees need to reflect that.
  - Regionalization hasn’t worked so perhaps we need to re-jig structure, i.e., Health Boards.
o Aboriginal health authority, like in Toronto, Winnipeg, Saskatchewan, Tulalip or Aboriginal Health Secretariat.

- Link high school and post secondary education
  o Decrease segregation of students into “trades streams” early in high school.
  o Create awareness around options in elementary school.
  o Need to acknowledge Aboriginal expertise in hiring, training and decision-making.
  o Accreditation to recognize expertise in traditional health approaches.

- Career Ladders
  o Skills development for those who come.
  o Succession planning – mentoring programs.
  o Continuous evaluations/monitoring skills for administrators to plan in implement programs.
  o Priority for health professional funding.
  o Equitable access to funds for education.

- Electronic – e-health
  o Committed dollars for training/support these systems.
4 Chronic Disease Management & Elder Care

Diabetes, HIV/AIDS and Rheumatoid Arthritis in Aboriginal populations are identified to be higher than national averages. Elder care issues include abuse, access to services, care giving and funding. Several recommendations were made to address multiple health service concerns.

<table>
<thead>
<tr>
<th>In order to set up a local chronic disease management program, have a traveling team that spends one week with each community with the following objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Meet with the heads of each Clan in the community to find out what is important to them.</td>
</tr>
<tr>
<td>• Train community members in chronic disease management. For example, how to monitor blood sugars, weigh babies, infant health, heart disease, high blood pressure, cholesterol.</td>
</tr>
<tr>
<td>• Go to the social gathering where there is music, tradition, and arts and add a health component.</td>
</tr>
<tr>
<td>• Have the Heads of Clans bless the health program and gain nod of approval for participation in fitness programs.</td>
</tr>
<tr>
<td>• Have community members trained as leaders to organize social fitness groups such as walking, soccer, road hockey, basketball. - As recommended by an urban Aboriginal health service provider</td>
</tr>
</tbody>
</table>

Issues – Chronic Disease Management

• Rates of diabetes are triple compared to the general population.
  o High salt consumption.
  o Junk food is too readily available.

• HIV/AIDS
  o Increase in incidence of HIV/AIDS through migration.

• Rheumatoid Arthritis
  o Few options for effective pain management.

Recommendations

• Develop programs on diabetes that start early in life.
  o Education about chronic disease prevention in schools and communities.
  o Ensuring that the ActNow BC initiatives are being implemented on reserves.
  o Education on traditional foods and cooking practices.
• Key Points on Chronic Disease Management
  o Subsidies and support.
  o Self-care management and support.
  o Engage and find role models in the community.

• Improve food security, especially access to healthy and traditional foods and encourage physical activity.

Issues – Elder Care
• Elder abuse, including financial and physical abuse.
• Overcrowding in the home environment.
• There is no weekend or holiday relief for caregivers.
• Caregiver burnout, caregivers get sick, leaving elders on their own.
• Funding is based on number of residents on reserves.
• Few designated home support workers.
• NIHB reduced dispensing fee, people now have to see a doctor/pharmacist every month to receive a prescription.
• Transportation issues of getting to and accessing services every month.
• Concerns around inappropriate prescription drug use.

Recommendations
• Elders should be made a priority and have appropriate care.
• Increase the number of assisted living beds. (*note: Sliammon and Nuxalk have had a community engagement process on this already*).
• Find creative approaches to providing elder care in remote communities.
• Provide more resources for falls prevention and increase resources so people to stay at home.
• Encourage Healthy eating and exercising.
• Establish Community kitchens.
• Increase the number of home care nurses and train volunteers to perform home assessments.
• Create program where local pharmacists and doctors come into communities to review each person’s medications.
• Provide medication subsidies to individuals where needed.
What is Vancouver Coastal Health doing to address outstanding Aboriginal Health Services issues?

VCH’s performance measures for Aboriginal health are long term population health measures requiring concerted effort on many fronts. In the 2007/08 year we plan to:

- focus on child and family health to improve perinatal health and school readiness, the subject of three of the five performance measures.
- implement strategies to increase counseling for pregnant women on substance use during pregnancy.
- examine how to maximize new funding for childhood screening programs to provide child health education to parents in conjunction with the screening.
- focus efforts on chronic disease prevention and community health initiatives to address poor health behaviors.
- focus on improving the cultural competency of our health services to better respond to Aboriginal needs.
- respond to new federal and provincial initiatives and funding and update the Aboriginal Health Plan to better align with Transformative Accord goals and the Transformative Accord First Nations Implementation Plan.
- continue to participate in Provincial projects on Aboriginal Maternal Health and Telehealth to Aboriginal communities.

Furthermore, there is a need to link more strongly to the federal government’s 2005-2006 Aboriginal Health strategy which saw the implementation of the Aboriginal Health Transition Fund.

Federal Government Aboriginal Health Transition Fund: Adaptation Envelope

During 2005-2006, Health Canada proceeded with implementation of the Aboriginal Health Transition Fund (AHTF). The AHTF is designed to improve access to and quality of health services for all Aboriginal people through better adaptation and integration of federal, provincial and territorial programs and services. These include public health, and programs in community-based care such as maternal child services, mental health, and chronic disease management.
To provide linkage to the AHTF, VCH will concentrate on five strategies outlined in the table below.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Main Goals</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td><strong>1</strong> Building the Continuum of Care for Aboriginal People</td>
<td>Build the continuum of care for Aboriginal people, ensuring appropriate adaptation and integration of existing services.</td>
<td>Support specific programs and services to engage with Aboriginal people. Use community input to design and adapt existing services to better meet the needs of the Aboriginal community.</td>
</tr>
<tr>
<td><strong>2</strong> Cultural Competency Training</td>
<td>To increase cultural competency and responsiveness of staff to Aboriginal clients’ health care needs; and to support the inclusion of FN/Aboriginal people and perspectives within the organization</td>
<td>Cultural training of staff across a number of levels in the organization from front line staff to senior management</td>
</tr>
<tr>
<td><strong>3</strong> Aboriginal Health System Navigators Pilot Project</td>
<td>To improve access to and navigation of health care services</td>
<td>Trained liaison staff in place</td>
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<tr>
<td><strong>4</strong> Aboriginal Health and Human Resources Strategy</td>
<td>To increase employment and career opportunities for Aboriginal people at all levels of the organization</td>
<td>Increased recruitment and retention of Aboriginal staff; “upstream” collaborations to increase the number of trained Aboriginal health professionals</td>
</tr>
<tr>
<td><strong>5</strong> Aboriginal Health Systems Management Collaborative</td>
<td>Development of a service delivery system to integrate and coordinate services throughout the VCH area</td>
<td>Development of a clearly articulated policy framework</td>
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Additionally, VCH continues to implement a strengthened relationship with its Aboriginal constituents, to which end we have developed an Aboriginal Health Plan which will guide our efforts.
Vancouver Coastal Health’s Aboriginal Health Plan
Over the past two years VCH has been developing a regional Aboriginal Health Strategic Plan through compiling local and regional Aboriginal health information and community discussions about local health priorities.

Key goals of the Aboriginal Health Strategic Plan include continuing the building of relationships and partnerships with the Aboriginal community throughout the region; increased focus on health promotion activities; increased access to health services, including the development of an urban Aboriginal Healing Centre; and better evaluation of Aboriginal health information and programming.

This is an important step in an on-going Aboriginal health planning process and VCH will continue to collaborate with Aboriginal communities to improve the health, wellness and quality of life of Aboriginal people within the region.

Vancouver Coastal Health’s Strategic Plan is posted online at www.vch.ca/aboriginalhealth/docs/AH_Strategic_2002_2005.pdf

For more information on Vancouver Coastal Health’s Aboriginal health programs go to: www.vch.ca/aboriginalhealth.
# Appendix 1

## Conversation Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
<th>Organization/Location</th>
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<tbody>
<tr>
<td>Teresa Barney, Counsellor</td>
<td></td>
<td>N’Quatqua Health Station</td>
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<tr>
<td>Leonard Bob</td>
<td></td>
<td>ACHAC Tla’amin F/N, ACHAC Tla’amin F/N, ACHAC Powell River</td>
</tr>
<tr>
<td>Kim Brooks, Health Director</td>
<td></td>
<td>Squamish F/N (ACHAC – Co Chair)</td>
</tr>
<tr>
<td>Nicola Campbell, Acting Tenant Relations Manager</td>
<td></td>
<td>Vancouver Native Housing Society Vancouver</td>
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<tr>
<td>Joy Chalmers, Coordinator, Home Support</td>
<td></td>
<td>Pacific Association of First Nations Women, Vancouver</td>
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<tr>
<td>Ken Clement, Executive Director (ACHAC)</td>
<td></td>
<td>Healing Our Spirit BC Aboriginal HIV/AIDS Society Vancouver</td>
</tr>
<tr>
<td>Rain Daniels, Aboriginal Community Developer (ACHAC)</td>
<td></td>
<td>Richmond Youth Services Agency Richmond</td>
</tr>
<tr>
<td>Diana Day, Community Developer</td>
<td></td>
<td>Aboriginal Health Initiative Program, VCH and Smart Fund Vancouver</td>
</tr>
<tr>
<td>Linda Day, Program Coordinator</td>
<td></td>
<td>BC ACADRE</td>
</tr>
<tr>
<td>Lou Demerais, Executive Director</td>
<td></td>
<td>Vancouver Native Health Society Vancouver</td>
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<tr>
<td>Andrea Foster</td>
<td></td>
<td>Aboriginal Patients’ Lodge &amp; Lu’ma Native Housing Society Vancouver</td>
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<tr>
<td>Margaret Gellaty, CHR/Health Programs &amp; Services Mgr</td>
<td></td>
<td>N’Quatqua Health Station D’Arcy</td>
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<tr>
<td>Lynda Gray, Executive Director</td>
<td></td>
<td>Urban Native Youth Association Vancouver</td>
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<tr>
<td>Sandra Greene</td>
<td></td>
<td>Pacific Association of F/N Women Vancouver</td>
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<tr>
<td>Thelma Harvey</td>
<td></td>
<td>Nuxalk Nation Bella Coola</td>
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<tr>
<td>Blair Harvey</td>
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<td>Executive Director</td>
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<td></td>
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<td>Vancouver Aboriginal Council</td>
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*Aboriginal Conversation on Health*

*March 2007*
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
<th>Organization</th>
<th>Location</th>
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<tbody>
<tr>
<td>Linda Lepine</td>
<td>Administrative Support Worker</td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Mount Currie</td>
</tr>
<tr>
<td>Marcy Ptolemy RN</td>
<td></td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Mount Currie</td>
</tr>
<tr>
<td>Rick Linger</td>
<td>ACHAC Health Director</td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Nuxalk Nation</td>
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<tr>
<td>W. R. (Bill) Tallio</td>
<td></td>
<td>Mount Currie</td>
<td>Bella Coola</td>
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<tr>
<td>Vanessa Linger</td>
<td></td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Mission</td>
</tr>
<tr>
<td>Merv Thomas</td>
<td>Executive Director</td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Vancouver</td>
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<tr>
<td>Marilyn Mura</td>
<td>Operations Manager</td>
<td>United Native Nations</td>
<td>Vancouver</td>
</tr>
<tr>
<td>Jean Thompson</td>
<td>Community Developer</td>
<td>United Native Nations</td>
<td>Vancouver</td>
</tr>
<tr>
<td>Lester Ned</td>
<td>Health Director</td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Mount Currie</td>
</tr>
<tr>
<td>Leslie Varley</td>
<td>Ministry of Finance, Internal Audit &amp; Advisory Services</td>
<td>Southern Stl’atil’imx Health Society</td>
<td>Mount Currie</td>
</tr>
<tr>
<td>Jan Oberson</td>
<td>Director, Outreach Services</td>
<td>Sea To Sky Community Services</td>
<td>Squamish</td>
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<tr>
<td>Maureen Weyhe</td>
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<td>Douglas First Nations</td>
<td>Mount Currie</td>
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<tr>
<td>Time</td>
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<tr>
<td>8:00 a.m.</td>
<td>Continental Breakfast</td>
<td>Provided</td>
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<td>9:00 a.m.</td>
<td>Large Group</td>
<td>Nelson</td>
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<td></td>
<td>Opening Prayer</td>
<td>Audrey (Tiyaltelot) Rivers, Squamish Nation</td>
<td></td>
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<tr>
<td></td>
<td>Welcoming Remarks</td>
<td>Kim Brooks, Squamish Nation Health Department</td>
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<td></td>
<td>Lou Demerais, Vancouver Native Health Society</td>
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<td></td>
<td>Opening Remarks</td>
<td>John Sproule, Vice President, Strategic Planning and Community Engagement, Vancouver Coastal Health</td>
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<tr>
<td>9:30 a.m.</td>
<td>Goal for today</td>
<td>Identify key provincial Aboriginal health priority issues and suggestions for informing the BC Ministry of Health’s Conversation on Health.</td>
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<td></td>
<td>Objective for morning</td>
<td>Identification of key priority Aboriginal health issues for Conversations on Health</td>
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<td></td>
<td>Process</td>
<td>1. In order to support this objective, twelve “issue” stations (Conversations on Health topics, and one table for additional priorities) have been positioned around the room, each with background notes and flip chart paper and pens.</td>
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<td></td>
<td></td>
<td>2. Each participant will tour the stations to review possible priorities, make their comments on the flipchart paper if desired, with a view to voting for their priorities later this morning.</td>
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<td>3. Before choosing priorities, participants will come back to the large group to debrief.</td>
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<td></td>
<td>4. Each person will be given three dots and tasked with placing their dots on what they determine to be their three top priority Aboriginal health issues.</td>
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<tr>
<td>10:30 a.m.</td>
<td>Health Break</td>
<td>During the break, the dots will be counted and the key priority health issues will be identified.</td>
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<tr>
<td>11:00 a.m.</td>
<td>Large group discussion</td>
<td>Priority health issues will be presented to the group for further discussion.</td>
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<tr>
<td>12:00 p.m.</td>
<td>Lunch</td>
<td>Provided</td>
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<tr>
<td>1:00 p.m.</td>
<td>Small Groups</td>
<td>Nelson (with dividers)</td>
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<td>Objective for afternoon</td>
<td>Identification of solutions to key priority Aboriginal health issues.</td>
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<td></td>
<td>Process</td>
<td>1. Participants are asked to attend three forty-five minute small group sessions in which facilitators will guide themed discussions.</td>
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<td></td>
<td>2. Outcomes from the small group sessions will be compiled on Thursday evening and presented on Friday morning.</td>
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<tr>
<td>3:45 pm</td>
<td>Large Group</td>
<td>Nelson</td>
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<tr>
<td></td>
<td>Gather as large group, feedback on process and break for the day</td>
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Appendix 3 – Unedited chart notes

Health Education and Human Resources
Small Discussion Groups in Afternoon

- Shared understanding of what role is and supported
- Retention
- 3 grandchildren under 5/35-year-old son with chronic diagnosis
- Timeliness
- Single female/marginal
- Own chronic history/diagnosis “sick cycle”
- Temp banks/volunteers
- Understand, support and plan for this!!!

- **Burnout** especially with home and community care
- Programs and policies that support
- Self care/personal wellness
- Financial planning
- Life planning
- Priority setting
- Budget for this and for management
- Elder/20 staff positions? postings?

Funding formulae for additional training

Allied Health
- X-ray
- Optometrist
- Lab tech
- Pharmacists
- Dieticians
- Audiologists
- Denturist
- Speech therapists
Mental Health and Addictions
Small Group Discussion in Afternoon

- Residential school trauma is a multi-generational concern that affects all of our FN communities, yet little to no resources are available to address this ROOT CAUSE of much of the mental health and addiction concerns in our communities.
- More services, funding for counselling, therapy, treatment required for dealing with the detrimental effects of residential school traumas.
- Establishment of a mental health pathway for FN/Aboriginals at all levels of health care. Too many have fallen through the cracks/holes. There are young people sitting in psych wards waiting for a place to go, removed from family, sitting day after day after day.
- Culturally appropriate care.
- More programs that have a strong cultural and traditional foundation that are fun, inspiring and well-attended alternative to old habits of behaviour.
- Peer-based local counselling and meeting with dance, song and spirit.
- Increased funding federally to provide adequate mental health services to FN. Current funding does not allow on-reserve populations to receive adequate access to mental health or develop mental health (culturally safe, culturally-based) programs given the amount of historical trauma. We cannot begin to promote health until we can support people in mental health crisis, of persons living in depression, oppression, shame, etc. We need to support people where they are geographically, physically, spiritually, etc. Think of the amount of suffering/injustice that has happened to our people. Less than 10,000/year for 3 remote communities doesn’t cut it.

Small Group Discussion in afternoon
Comments on Primary Health

- Have centres that are client-centred and holistic in approach.
- From medical to cultural (medical only one part).
- Community garden, etc.
- Create capacity.
- Include dental care.
- Mental health services.
- Child services.
- Look to the medicine wheel.
This approach has been dif. in rural context – funding issues
The above does not need to be medically-centred
What works in urban situation may be different in rural
Education for range of professionals on how to work together and in partnership with clients – creation of access and follow through.
Connection between traditional and western medicine – needs to have policy and dollars behind it
Continuity over time of service
Include access to mental health professionals
Allow for provision of food (culturally important)
Allow for provision of staff training
Fund an in-house elder
Ensure access to Adult Day care for everyone
Get away from stove piping of services
Don’t force Aboriginal communities into western approach
Invite your “people” into the Primary Care Centre
Traditions, resources, drumming, smudging
Open it up to the community, not barred
Real cultural sensitivity training – create allies and work together
Lay a strong foundation for the future
Need to act!!!

Transportation/Isolation
Ambulance won’t respond
Lack of knowledge of area
2 day trip to get diagnostics, etc. in town
need diagnostics, etc., much closer to area
Both urban and rural
Hard to get bus tickets or taxi to services - Not enough money for this
Need access to appropriate transport
Break is follow up of system, e.g., a prescription that cannot be filled because of transportation, cost
Clinics need to be well resourced
Community partnerships to help address issues, e.g., transportation – helicopter available with IPP
Holistic view of primary care
Whole family
Culture
Leads to education/prevention
Community needs to define own needs
Comments on Seniors and Aging
Small Discussion Group in Afternoon

- Elders should be made a priority
  - Safety issues
  - Elders left alone at home
  - Elder abuse & overcrowding in the home environment
  - Falls at home
  - Provide appropriate equipment
- Currently, there is no weekend or holiday relief
- Federal support programs = 5 days per week
- Provincial support programs = 7 days per week
- Caregiver **burnout** – caregivers get sick, leaving elders on their own
- Increase assisted living beds – Slaimmon & Nuxalk – have had a community engagement process on this already. The problem exists for other communities as well.
- Increase support for elders
- Home support
- Decrease isolation from community
- Resource issue
- Lack of funding and allocation
- Funding is based on number of residents
- No designated home support workers
- Need more resources for falls prevention and promotion of people to stay at home!
- Falls Prevention Programs
  - Keeping and encouraging elders to stay home longer
  - Healthy eating
  - Exercising
  - Community kitchens
- Increase manpower to implement programs in community
- In-home needs assessments
- Trained volunteers to perform assessments
- Increase nurses to do home assessments
- Medication use, abuse and addition to:
  - Local pharmacists and doctors come into the community and review each person’s medications
- Provide medication subsidies to individuals
- NIHB reduced med. dispensing pay fee, therefore people now have to see a doctor/pharmacist **every month** to receive a prescription
Transportation issues of getting to and accessing services every month
Need to increase period (ex: every 3 months) or go to the pharmacy only
Concerns around over-medication

Role of Elders as Mentors to Children and Youth

- E.g., pair elders with suicide prevention programs
- Teaching cultural practices to he youth
- Encourage active involvement and contribution to community
- Assess readiness of both groups to engage with each other instead of top down pushing of the groups together
- Incorporate elders into day care programs, e.g., storytelling and language in the Head Start Program (Health Canada Initiative)
- Using elders to reintroduce and keep alive traditional herbs, foods
- Have elders teach certain topics in schools
- Mentor role of elders will increase empowerment and feelings of being valued in the community
- Provincial elders gathering, Elder Centres
- Personality conflict issues with elders (historical issue)
- E.g., lunch sales
- Were able to bring together the larger community
- Chief Council purchased and supported lunches with other community members being actively involved.

Mental Health Issues

- Depression
- Addiction
  - Alcohol
  - Bingo, lottery addiction
  - Prescription drugs
- Dementia
- As you progress with the Continuum of Care, more resources and services will be required.
Effects of Residential School Care

- Promote and encourage cultural sensitivity and cultural competence
- Increase supports to address this issue
- Currently, there are no resources for addressing this
  - Funding is unavailable for those over 80 years old
  - Increase knowledge and awareness around signing wills
  - Address impacts on the community
  - Loss of First Nations’ people’s identity
- Church still holds a lot of power in Aboriginal community
- Language, culture and traditions are not being practices as a result of Residential School
  - “Not allowed” to speak or practice culture
  - “Will not go to heaven”
  - “Bad” if elders speak the language, etc.

Comments – Canada Health Act – March 8, 2007

- Addressing jurisdiction (federal/provincial) issues related to how Aboriginal people access health care (communication / awareness)
- Coordinate federal-provincial programs e.g. Health Authority programs – how federal initiatives assist provincial / local
- The Act is supposed to ensure equal access to equivalent standards of care – obviously that remains a fallacy
- The Romanow Report “missed the boat” on Aboriginal health issues nationally
- Stop private clinics, put more money into the public system
- Never mind the Health Act, what about federal fiduciary responsibility
- Accessibility to and from health care services for Aboriginal people in B.C.

Comments – Emergency Departments – March 8, 2007

- Potential for overnight 24 hr. stay observation unit for Pemberton Medical Centre
- Ultrasound and other diagnostics available to reduce barriers to access and reduced cost for patient travel
- (Error – this is Primary Health, not ED) diabetes clinic – respiratory clinic for management of chronic disease etc.
- X-ray access (Pemberton Clinic) – 24 hour availability
• Sensitivity training for all emergency workers re Aboriginal People’s needs
• Waits are far too long, not enough beds, doctors or nurses
• Improve access – emotionally, physically, culturally and geographically
• Increase number of Aboriginal emergency health care professionals
• Extended hours for walk in clinics – more education about Nurse Line and shorter waits at doctors’ offices to encourage people to better utilize these services
• Staff must be more sensitive to all patients
• Wait times are far too long
• Perhaps the Swedish idea of having an annex health centre open 8:00 a.m. – 10:00 p.m. to take care of the non-emergency clients would alleviate the ED bottleneck
• Be more sensitive to people’s needs at Pemberton Emergency when clients have 2 ½ hour drive to clinics
• Need to involve youth as much and as soon as possible (education)

Comments – End of Life – March 8, 2007

• This work on palliative care is currently in progress in VCH and input participation is welcomed
• Palliative care within existing systems now costs too much. Time for non-profit sector to take over.
• Palliative care for Aboriginal persons dying of HIV/AIDS are needed, perhaps to start a five to eight bed facility.
• Must be culturally sensitive in palliative care
• Rural Palliative Care programs that are accessible and deliverable in communities or at least in closest town/community that is central to on/off (reserve) communities
• Increase and improve information for Aboriginal families
• Respite care for Aboriginal / rural / remote
• Partnering with an Aboriginal housing non-profit to strengthen a proposal to build with the province could be done. E.g. a project that is part affordable housing units, part palliative care units
• End of Life Care to also include after care / support for those left behind … grief and grieving
• Preparation for death and dying – wills, living wills, power of attorney – info for people so they will be prepared
• Care of Caregiver
• Allowances for culturally-sensitive practices that facilitate the death/dying process
• Families who dress/prepare bodies themselves need hospitals to support them in those decisions.

Comments – Health Care Delivery – March 8, 2007

• Culturally appropriate
• Access to health care services
• Aboriginal control of Aboriginal health
• Public funding needs to be maintained / enhanced
• Whatever happened to recommendations of Seaton Commission re Aboriginal people?
• Cultural competency +++
• Still waiting for Aboriginal healing centre (Healing Ways report)
• Is any of this feedback new?
• Educating interested youth as soon as possible

Comments on Mental Health and Addictions

• Development of life skills (focus on youth, children, especially)
• Multigenerational impacts – residential schools
• Family-based rehab centres
• Grief/loss/trauma support
• Yes, development of life skills (kindergarten – 12 and on and on) – cultural identity
• Burn out – extra support, relief, prevention, offer encouragement by recognition
• Prevention of suicide and drug abuse in our Aboriginal youth population?
• Why is there no crisis line for Aboriginal youth in B.C.?
• No walk-in clinic for Aboriginal youth – pregnancy prevention in B.C. schools?
• Is homelessness really all about people without a safe, warm, dry shelter – or is it mostly about mental health, addictions, diminished capacity of all kinds that manifest itself all to often in individuals being unable to obtain, or to maintain, adequate safe, warm dry and respectful shelter?
Access to services – addictions – healing/support and recovery/detox in a timely manner within or close to community as possible
Increase mental health resources!
Improve resources for all addictions (e.g. gambling)
Mental health programs for supporting men “Caring for Dad’s” program.
Reunification program for children in care – most often system only focusing on the mum – what she needs to do – we need to promote families.
More support for families in remote communities with little dollars for family outreach services – re-gaining families

Comments on Problematic Substance Use

Increase in funding for training and staffing for youth involved with drug and alcohol abuse needed
Healing strategies for prevention required
Culture must be foremost in planning and intervention
VCH needs to look at “treatment centres” closer to “home”
Crystal meth is less a problem these days with our youth
Attach dollars to harm reduction
Develop programs and services to address “causes”
Increase number of Aboriginal people and organizations resourced to do this work
Agriculture camp as opposed to treatment centre to apply cultural ways and eliminate stigma
Perhaps a partnership with the Ministry of Education would be effective in including culturally sensitive programming through schools targeted toward the younger ages included in curriculum in health and science and biology
Lack of treatment, especially for women/pregnant women
FASD awareness (prevention awareness)
NNDAP workers need more education on hard drugs
Offering continuous education and information in the school system staring with the younger grades
Services for problematic substance use need to be timely, accessible, supportive and on a continuum and preferably close to home – detox, treatment, support
Harm reduction strategies are more inclusive and supportive than models using abstinence as an absolute.
- **TAKE ALL THE ABOVE SERIOUSLY**
- Rather than apprehend, work with recovery process, to eliminate oppressive behaviour. Keep families together, build on their strengths as opposed to condemning and isolating individuals.
- Go after the dealer and pushers. The police know who they are on reserves. They just need more help to deal with it.
- Monitoring of prescription behaviours and patterns of physicians to eliminate the misuse and abuse of prescription drugs. To eliminate addictions.

**Comments: Pressures on the Health Care System**

- Aboriginal people in B.C. account for approximately 4% of the population, (yet their health stats are comparable to third world countries). **4% of the overall budget** should be allocated to Aboriginal health. Aboriginal people should direct how those resources are used !!!
- Aging population.
- To reduce misuse/overuse or inappropriate and ineffective medication use, promoting safe use as well consider Clinical Pharmaceutical Reviews annually with clients on numerous medications. Perhaps increased access for health care professional to Pharmacy not to monitor and review and reduce poly use of prescriptions.
- Reduce the pressure on the healthcare system by providing Assisted Living Beds for the elderly in our communities.
- Many isolated communities do not have access to physician services 7 days a week. Allowing pharmacists to renew prescriptions for chronic conditions will decrease demand on emergency room services.
- Covering new drugs – efficacy for individual patient as well as reduce side effects. The idea is to use medications to allow patients to resume normal activities not take other meds to manage unwanted side effects. Cost of drugs needs to consider ability of patient to resume normal life.
- Aboriginals are dispensed generic drugs, with less potency and effectiveness (cheaper?). Why?
- Elders with chronic illnesses should not have doctor’s visits/renewals.
Chronic Disease Prevention and Management:

- Early education to Aboriginal children and families on prevention, high risk behaviour, diabetes, etc.
- More money spent on detection of depression in children in the school system (Aboriginal).
  - Especially FASD support to parents and children affected – primary grades.
  - Spending money in earlier diagnosis of learning disabilities
    - Early pregnancy
    - Incarceration

- Link this with diabetes programs/services.
- Earlier education about chronic disease prevention, in schools, more proactive.
- Educating people about lowering stress/impact on chronic disease.
- Incorporate education in the school system/daycares.
- Allow CDSM $’s to be used in creative ways to engage people to assume responsibility for their own health (e.g. removing fear of judgment for diet and lifestyle that contributes to condition).
- Continued workshops on how to stretch the $ (on more healthier foods) – particularly for those on welfare.
- Comprehensive approach to chronic disease care; most people with chronic disease have multiple issues.

Comments: Other Issues to Address

- How to engage population. Need to go to the people.
- Cultural sensitivity to Aboriginal issues.
- Don’t reinvent information – many reports exist.
- Been studied to death.
- Don’t just talk, implement.
- Lack of recognition by mainstream agencies of F.N. health authorities/Aboriginal organizations. Hospitals, regarding discharge planning.
- Lack of participation by Aboriginal people (why?).
- Lack of housing for Aboriginal people.
- Poverty of Aboriginal people needs to be addressed.
- More services for residential school survivors (especially with the effect of the compensation issues).
- Aboriginal control of Aboriginal community-based health services!
- Respect Aboriginal holistic health.
- Let’s partner with the Ministry of Education to have a course called LIFE. This should start from grade 4 to learn about health, nutrition, addictions, conflict resolution, behaviour, positive thinking. Also, could we have night courses at schools in remote locations where people get together to tackle issues as a team and community.

**Health Human Resources – Notes from Morning Session**

- Resource Aboriginal non-profit societies as adequately as non-Aboriginal services!
- Need more support, funding, education, promotion for more FN in professions in health field.
- Perhaps the College of Physicians and Surgeons should partner with UBC to start a four-year accreditation program for foreign nationals specifically in return for a 10 year commitment to practice in remote communities.
- Health administration development in areas such as evaluation and monitoring
- Earlier introduction to sciences in schools that are focussed on health to stimulate interest. Innovative and creative fun science programs on reserve including science lab equipment, exposure opportunities to various health science professions.
- Discussions early in education to start to stimulate children thinking at what they could to build positive, “you can do it” - empowerment
- Proactive identification of students in Grade 11/12 who may be interested in pursuing career in health care – have shadowing programs, mentoring programs, incentives for pursuing this career
- Consider promotion of RN – registered nurses to work in Aboriginal communities, by possible sponsorship/scholarships offered to non-
Aboriginal nurses willing to come work on reserve – we support them by helping with a portion of the financial cost of their education.
- “Commitment” of funding (combined in Health Transfer Agreements) to encourage FN youth’s interest in pursuing health careers.
- Easier access to dollars for FN students ENTIRE STUDY PERIODS to increase opportunities
- Money to support electronic data elements to keep up with technology and increase FN youth interest in pursuing health careers
- Education – develop health careers in all areas with special recognition to traditional health and midwifery. Give incentives. Allocate a percentage of seats to FN in all medical schools as did UBC.
- Education – create career ladders to make room for advancement
- Attract and attain professionals by assuring the population stats are current as it impacts the calculation of transfer payments
- Work with other FN organizations – on/off reserve – to increase high school completion rates
- Health Authorities need to create opportunities for employment for FN at all levels

Notes from Morning Session
Comments on Primary Health Care
- If primary health care is so important, why do we need such a large bureaucracy in each authority?
- Is it true the provincial Ministry is starting to grow again?
- Increase numbers of Aboriginal health professionals and actively recruit
- Make Aboriginal (or non-Aboriginals in the interim) doctors and nurse practitioners available IN the community!!!!
- We desperately need more doctors (and more female doctors) and nurse practitioners, and community health clinics
- Increase recruitment of ob/gyn (maternal care) physicians and nurses in rural areas
- “Inadequate Transportation” in remote and isolated communities. Needs enhancement to improve access “NOW”!!!
- Monitoring of prescription behaviours and patterns of physicians to eliminate the misuses of prescription drugs to eliminate addictions.
- Increased and improved service delivery in remote communities
- Education – Interested students as soon as possible
- Let’s train local community people to be counsellors in chronic disease management to combine traditional principles with educated methods
- Need to include health promotion education!!!
- Recruit Aboriginal people, support high school students – tutor – mentor – role model – more Aboriginal people to enter these fields/occupations
- Provision of community/region-specific primary health programs/clinics to support/address the primary health issues
- Team development of core professionals, volunteers, etc. – persons with disease, elders and other leaders to build consensus, participation and evolvement to make change – meeting the needs of the community
- Reduce the amount of administrative dollars to open opportunity for more front-line money being spent administratively versus taking care of the needs of people – hands on care, etc., or more dollars that match the realistic needs – streamline
- Need more dollars for case management and follow up for complex care clients with mental health
- Pre-natal programs locally, no comprehensive programs in rural areas. Plus if we send out, then it may not be culturally appropriate. Uncomfortable for client. Different learning levels, different learning needs.
- Equal access or even better services on reserve that currently are offered/available to off reserve general public – i.e., occupational therapy, child mental health, safe clinics, bullying programs, transportation for seniors, support groups, grief/loss, bereavement, etc.

Notes from morning session
Comments on Seniors and Aging

- Our parents/grandparents are our elders and we need to put them higher on the priority “list of deliverables”, i.e., ALB’s
- Why is there no Aboriginal long term care residence in Vancouver when there is Finnish, Scottish, Ukrainian, Icelandic, etc.? Yes! And this would create opportunities for youth to volunteer and be inspired to go into health as a career.
- Why is there no Aboriginal home support agency servicing elders or LTC clients in Vancouver?
- Continue implementing HCC by providing more funding and decreasing the unreasonable reporting requirements imposed that creates administrative burdens with less focus on delivery
- Federal only provides 5 days vs provincial provide 7 day week. Health care should be equal.
● Improve resources and information for Aboriginal families to increase awareness around available services
● Increase number of Aboriginal extended and long term care services – culturally sensitive and accessible and family-oriented.
● Increase number of Aboriginal personal care workers – provide training opportunities
● We need to consult with seniors about what they would like and what their needs are
● Access to transportation to get to appointments and social activities, etc. (rural)
● More interaction between youth and elders – healing for elderly. Growth, learning and culturally grounding for youth – live healthier lifestyles
● Seniors come to Vancouver for medical treatment and often have to move permanently. With affordable housing waitlists of 3000+, to get Aboriginal affordable housing here, they may be forced into substandard housing. A partnership between VCH and an Aboriginal affordable housing provider could be made to strengthen a bid for an Aboriginal Elders Housing Project with a weekly nurse visit component.

Small Group Discussion – March 8, 2007
Recruit, Retain, Educate, HCP's

● Set targets specifically Aboriginal recruitment
● Include Aboriginal people process of recruitment

Retention
● What kinds of support?
● Burn-out too few – 46 people know which jobs/positions have high rates
● No budget for backfill for holidays – ripple effect
● People don’t want to leave, but need to feed families
● Equity (2/3 of white people for same jobs)
● Travel – car, accommodation
● Inequities in budget allocation and for programs
● Status quo can’t continue because it doesn’t work
● Need resources for our own services
● What happened to all recommendations in previous consultation?
● Recap Seton Report/Commission
● Healing Ways
● Governor’s report on health
Attract HCP’s to remote B.C.
- Cultural sensitivity, “Boot Camp”
- Quotas all HCP’s
- Feedback processes
- Shadowing programs for new non-Aboriginal nurses
- Training
- High level people need to visit/?
- Providing supports – cars, expenses
- Current stats – transfer payments
- Transportation costs!!!
- Forgotten children 1-3, living on reserve 46.6%
- Different way to utilize current resources.

ACHAC
- How do we become involved in decision-making process?
- Don’t want to be seen as puppets for HA
- Aboriginal people participated in numerous “conversations on health” without any action taken on recommendations. How is this different?
- Recruit, retain
- Dearth of qualified people
- Support universities/colleges training
- Qualified (equally) professionals from accredited institutions
- Personal care aides – pay and benefits
- Aboriginal Minister of Health

Targets
- Training dollars for committed employees – Adults
- Laddering programs
- People don’t want to go to hospital so using personal care aides as liaisons

HA’s
- Aboriginal leads (15 nations)
- Recruit/Retain – questions, skill set, life experience
- Outward reaching vs reach in
- Why at bottom of organization chart (totem pole)
- Committed, recruitment, engaged
Budget
- 5 year plan
- Good ideas are put forth and people give up on it – “token approach”
- 4% of population = 4% of ______
- 18% of hospital usage = numbers of employees need to reflect that
- Regionalization hasn’t worked so perhaps we need to re-jig structure – i.e., Health Boards!
- Aboriginal Health Authority? – Toronto, Winnipeg, Saskatchewan, Tulalip

Cost/Benefit → HR’s
- Decrease number of need health care resources
- Numbers needing care are much increased
- Factor in use of drugs, crack, meth
  - toll on body systems
  - long term implications, i.e., valve surgery
- Lack of integrated approach to health care
- Reallocation of resources – cost effective and care effective
- Urban Aboriginal strategy
- Homelessness initiatives to harness existing resources
- Why don’t health authorities do this as well? i.e., MCFD
- HCC conference in Winnipeg vs. Richmond – waste of time – white nurses complain at what they have to do in Aboriginal communities – just there for dollars
- Ratios completely different
- Need to promote health careers in communities
- Reorganizational insensitivity of rural/urban issues – different layers

Link high school and post secondary
- decrease “segregation” of our students into “trades streams” early in high school
- Create awareness around options in elementary school
- Need to acknowledge “Aboriginal Expertise”, i.e., in hiring/training, decision-making
- Need some kind of accreditation

Career Ladders
- Skills development for those who come in
- Succession planning – mentoring programs
- Sustainability
OMFE – Succession plans
- Continuous evaluations/monitoring skills for administrators to plan in implement programs
- Priority for health professional funding
- Equal access to funds for education
- Thompson University, bought seats, etc. because no dollars to support

Electronic – e-health
- Committed dollars for training/support these systems

Chronic Disease Prevention and Management / Seniors:
Chronic Disease Prevention:

- Mould in homes (physical environment)
  - Prevention of mould build-up
  - Education
  - Structural processes around designing and building homes
  - On air circulation
  - Heating practices
  - On clothing
  - On areas in the home that are prone to developing mould
  - General house cleaning practices
  - Consequences of mould (health; signs & symptoms)

Diabetes Prevention
- Programs on diabetes that start early in life
  - Earlier education about chronic disease prevention in schools, more proactive.
- Educating kids on diabetes prevention – healthy foods – active living
  - On impact of lifestyle choices
  - Early education to Aboriginal children & families on prevention, high risk behaviour, diabetes, etc.
- Courses in school: teaching kids on healthy eating
  - Ensuring that ActNow BC initiatives are being implemented on reserves
  - Incorporate education in the school system/daycares
Traditional Foods & Cooking Practices
- High sale intake
- Junk foods: too readily available

Key Points on CDM:
- Education
- Subsidies and support
- Self-care management and support
- Engage and find role models in the community

Lack of healthy food alternatives
- On reserve stores/businesses need to reduce junk food available – Policy change
  - Decrease the cost of healthy foods
  - Continued workshops on hot to stretch the $ (on more healthier foods) – particularly for those on welfare.
- Subsidies to allow people to purchase more healthy foods
- Increase education on cooking with and using traditional foods/herbs/plants
- Increase opportunities for people to farm and grow own foods
  - “Community farming” programs
- Changing policies
- Too much emphasis on budgets to hand out honorariums vs. budgets for healthy choices.

Lifestyle Choices
- Encourage physical education and participation in schools.
- Strong leadership from within the community.
- Address the lack of opportunity of exercise in rural areas:
  - Network with FN provincial groups
  - Local leadership and enthusiasm
    - Identify champions in the community and empower them to build their community and increase participation.
  - Community Programs
    - Community to take action – build on strengths
    - Ex: Walking programs
    - Traditional programs/events combined with education and increasing awareness
    - Go to the existing local gathering places and bring in the education components.
Clinic days; blood pressure program
- Encourage weight management
  - Training mothers. Ex: 1 week time period of going into community
  - Go to the existing local gathering places and bring in the education components.

In order to set up a local chronic management program: Have a travelling team that spends 1 week with each community with the following objectives:

1. Meet with the Heads of each Clan in the community to have core interest and dedicated participation. Find out what is important to their community socially.
2. Train 2 local women, 2 local elders female and male and 2 local men in chronic disease management. (Hot to read blood sugar, weighing babies, infant health, heart disease, hypertension, cholesterol).
3. Go to the social gathering where there is music, tradition, and arts. Add the health component for mothers, men, fathers and elders to have vitals checked, talk about health issues, education, prevention, chronic management.
4. Have the Heads of Clans bless the health program and gain nod of approval for participation in fitness program as well.
5. Have 2 local women, 2 local elders and 2 local men trained as leaders in 7 days on putting together social fitness group – walking, soccer, road hockey, basketball.

**Mental Health & Addictions:**

- Cultural safety training.
- Empathy & understanding.
- Awareness training – this will shift practice.
- Staff orientation – workers with Aboriginal communities first and all others second.
- Historical data.
- Name giving ceremony.
- Staff who are connected have relationships with Aboriginal communities.
- Permission to allow ceremonial healing practices in acute care situations.
- Incorporating traditional practices into daily care – focus on respect of ceremonial.
- Wilderness Treatment – referral into this program that allows connection to roots/beliefs – caring community may include detox.
- Create networks of support webs/dream weavers.
- More – comprehensive – multiple treatments.
- Your personal health – identity)
- Your spiritual/mental health-Assessment based on these 4 areas
- Your physical health-treatment connected to this assessment
- Your family health
- Acute supports – ED for MH & A clients
- Promote open minded – person centred care.
- Community centered – people focused care.
- Assessment of Aboriginal children earlier to provide the right supports at the right time to improve outcomes.
- Create connections within Aboriginal communities and with integrated services to build networks.
- Linkages – partnerships
- Restorative Justice
  - Crown
  - Police
  - Aboriginal
  - Probation Officers
  - Nurses
- Focus on solutions for individuals to bypass jail – connect to community services.
- FASD – assessment can be achieved but services for individuals and families are needed to support the successful.
- Outcomes – give hope, have a plan long term for children and families.
- Building capacity within community based services – child care, schools to allow for those services to support children and families.
- Allowing families the opportunity to gain a diagnosis of FASD without the stigmatization and offering real support.
- Federal funding for MH & A issues within Aboriginal communities.
- Province to put pressure on Feds.
- Skills training to support parenting role.
- Positive role modelling to support behaviour that allows youth to make healthy choices.
- Have the Ministry’s work together to find solutions to community based issues.
- Residential Schools – prepay for gravestones for each individual impacted – back date to day last residential school closed.
- MOU’s need to be inclusive have frontline care providers involved in the development of MOU’s.
- MH services for children on reserve.

Flip chart from second group
Mental Health & Addictions

- Look at the underlying reasons for the issues surrounding MH&A
- A dedicated portfolio to focus on Aboriginal needs – Aboriginal person / people to honour that
- Support for parents to provide networks for their children to build resiliency in children
- Broad based education to create, in school or community based, interests connected to heritage – agricultural for example – what can be harvested – how can it be used to feed, clothe, keep up healthy
- Funds for prevention – how do we focus on upstream initiatives to mitigate MH&A issues
- Promotion – to young people on positively depicting Aboriginal community strengths, values, heritage
- Training for elders to support programs to build resiliency in youth and others in community – use local
- Knowledge and talent to build and strengthen community
- Build up leaders in our community
- Re-connect to society / cultures remove the influences of electronics
- Monitoring of prescription drugs – don’t just prescribe – look to root issues
- Monitor prescriptions – doctors need to be accountable – prescriptions are being sold to buy illicit drugs
- Legislation can bind people to a point where decisions made have a detrimental effect
- Addictions – internet, electronics supports for youth and families to mitigate negative impact
- Create a culture of open minded, non-judgemental decision making process
- Respect and honour traditional practices and individual beliefs
- Rejuvenate the socialization of Aboriginal communities
- Holistic healing
Flip chart from second group
Recruit/Retain Educate Aboriginal Health Care Providers

- Equivalency for professional experts in health care setting i.e. RN – requirements, prerequisites
- Targets – number of Aboriginal MD, RN, Allied Health professional by target date – specify targets, benchmarks – with financial disincentives
- Career plans early on for those who are not academically focussed
- Mentoring programs – child / teens / youth
- Recruitment – waiting lists – priority for Aboriginal people
- Training people from rural and remote areas – with financial support
- Creative justification to run cohort – accredited Aboriginal nursing programs in isolated and rural remote areas – cost analysis for twenty nurses – liabilities
- Bridging programs
- Medical school – create college – mentorship – support – financial
- VACFS - only use Aboriginal agencies for home support
- VCH procurement numbers / targets – accredited
- Fed’s – specifically hire Aboriginal contractors for Aboriginal projects
- VCH/Province could mirror – see Aboriginal employment initiative
- Unions do not fit with Aboriginal organization – need to develop alternative solutions
- Employ indigenous people for personal / professional cultural skills not just professional skill set
- Bereavement leave – family issues – conferences – Aboriginal people “work” day / night /weekends because they work with family and community
- Shared understanding of what role is supported

Retention

- Three grandchildren / 35 year old son with chronic disease
- Timelines
- Single woman / marginal income – own chronic detox – “sick cycle” – understand and support plan for kids
- Temporary banks / volunteers
Notes from morning session

R. Linger
- Need to think about a family-based rehab centre

S. Helin
- People coming from outlying places need places to stay

L. Lepine
- Number 1 issue is inadequate medical transportation. Needs enhancement now. Critically important.
- Affecting isolated and remote communities to eliminate isolation barriers.

R. Daniels
- Talking about lack of connection and isolation in general – rural and urban. Thinking about who’s not here. How to have creative process at grassroots level, especially with youth.
- In downtown eastside with nurses just walking around and talking to people. This is a good model for our people. Need more nurses and teams of youth walking around and meeting people “on the street”.
- What we have now is “trickle-down” – what we need is bottom up affect is far more dramatic and will help to change perceptions about system and lack of trust we have.

Andrea Foster
- I was in high school when HIV/AIDS was just coming out, in the 80’s. Most effective thing was to have core group of influential kids to help educate. They were focused on educating and put positive spin on education.
- Very different than authoritative person saying you must do this and that.
- Elders and youth – have training program that could go on the road, grassroots. People within community in different age levels being trained and spreading the word.

Ken Clements
- Lack of inter-connectedness and fragmented approach to health care.
- Need interconnectedness
- We need to bring other social determinants together, like social housing
Encouraging to see Aboriginals in the program, engaging out people in the system. We need to support them and also others that work in the system that support us. You carry messages in support of us, but we need to support them.

Kim Brooks
- The health care system needs to respect and mirror holistic Aboriginal health. Can do this by sharing out stories (storytelling).
- Gave example of suicidal patient. Went to hospital, was assessed, they said he was fine and asked the addictions counselor to pick him up. She did unfortunately. She did not feel comfortable taking him home. He was suicidal, had an addiction and a disability, chronic health and mental health issues. The challenge is how do we work together better. The addictions counselor was frightened to be the last person to talk to this person (because he was suicidal).
- Kim didn’t have enough resources to support the employee. The emergency telephone line was good in that there was someone to contact, but they had nothing for us.
- Even if there was someone to watch the person so they wouldn’t be alone. The hospital would be a good place but they said no.

Gord Edwards
- The biggest challenge is with the kids. They were scary to raise. Their challenges and questions were hard. There is not much help at how to make good decisions. As parents, we want to help our kids, to give them information and guidance so that they can make healthy decisions.
- Need to look at giving kids guidance on making healthy, informed decisions.