



COALITION OF ENGLISH SPEAKING  
FIRST NATIONS COMMUNITIES IN QUEBEC

# **Barriers to access to health and social services for English-speaking First Nations communities in Quebec**

**DOCUMENT FILED TO THE**

**PUBLIC INQUIRY COMMISSION ON RELATIONS BETWEEN INDIGENOUS PEOPLES AND  
CERTAIN PUBLIC SERVICES IN QUÉBEC: LISTENING, RECONCILIATION AND PROGRESS**

**BY THE**

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Quebec  
(CESFNCQ)**

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## **I - Presentation of the CESFNCQ**

The Coalition was established in 2012 by English-speaking First Nations of Quebec. It is made up of First Nations communities and one Indigenous organisation, including Akwesasne, Kebaowek First Nation, Gesgapegiag, Kanesatake, Kahnawake, Kawawachikamach, Kitigan Zibi, Listuguj, Long Point First Nation / Winneway, Timiskaming, and the Native Women's Shelter of Montreal. These communities are located in seven of Quebec's 18 health regions in isolated, rural and urban areas. Six are border communities. The Naskapi community of Kawawachikamach is party to the Northeastern Québec Agreement of 1978.

About 64.5% of the total Indigenous population in Quebec is predominantly English-speaking or has English as the first official language spoken after their own Indigenous language.<sup>1</sup>

The Coalition's goals are to expose challenges in accessing services in federal and provincial systems, share strategies that stakeholders are using to overcome them, further define the members' relationships with federal, provincial and regional partners in addressing access issues, co-create a strategic framework on a preferred future state of access, and align their First Nations health and social services governance and policies to support their partnerships in addressing access issues. The Coalition has worked hard to bring access issues in regards to health and social services for English-speaking First Nations to the attention of the provincial and regional health authorities, and in doing so has developed partnerships with other associations and centres.

## **II - Introduction**

Issues of access to public services for English-speaking First Nations communities in Quebec can be exacerbated by the fact that they reside in a predominantly francophone province. In order to ensure substantive equality in the funding and provision of these services, it is necessary to undertake an intersectional analysis that takes into account the multiple grounds of discrimination a person or a group of persons can face, and the unique situation that results from their intersection. In the case of members of English-speaking First Nations communities in Quebec, the specific needs resulting from being both First Nations and English-speaking in a predominantly francophone province have to be taken into account. Otherwise, serious gaps in access to services may be overlooked. Though funding is an important part of the equation, it is not sufficient alone to solve these issues.

This submission will shed light on some of these issues, basing its analysis on Amy Chamberlin's detailed report titled "Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Québec" ("2013 Report") (Appendix A), which documents the challenges faced by English-speaking First Nations in Quebec and provides

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<sup>1</sup> Pièce P-079 of this Inquiry, Amy Chamberlin, "Portrait of the Situation for English-Speaking First Nations: Accessing Health and Social Services in English in the Province of Québec - Research Report", Presentation, 2014, citing Aboriginal Affairs and Northern Development Canada, 2012 and Ministère de la Santé et des Services sociaux du Québec, 2012.

recommendations; and a second report titled “English-Speaking First Nations in Quebec: A Portrait of the Situation when Accessing Social Services” (“2016 Report”) (Appendix B). Both reports examine social services from provincial and federal systems. The CESFNCQ will file both reports with the Commission.

These issues, identified by health and social services workers and members of English-speaking First nations communities, include access to specialized services in English; documentation and information in English; cultural discrimination and a lack of cultural sensitivity; communication and language barriers; jurisdictional issues; long wait times for services (especially services in English), emergency services; funding; and quality of services in English.<sup>2</sup>

The submission will also address the special status of Indigenous peoples in Canada and recent developments in the recognition of Indigenous rights at the federal level; offer a portrait of the situation of English-speaking First nations communities in Quebec when accessing health and social services; outline the government of Quebec’s obligations and the applicable standards with regards to the provisions and funding of health and social services; and offer a series of recommendations for the government of Quebec (“Quebec”).

### **III - The special status of Indigenous peoples in Canada and recent developments in the recognition of Indigenous rights**

Indigenous peoples have a special historical, legal, and cultural position in this country, and a recognition of that position is essential to the protection of their constitutional rights. Indigenous peoples’ health, dignity and security should not be impeded by intra-provincial administrative arrangements, provincial borders or the lack of cooperation between provinces. Quebec must respect its constitutional obligations towards Indigenous peoples. It must therefore consult and involve them in government decisions and measures affecting their health; respect their language and cultural rights; and respect their right to assume control over their communities’ health through their own institutions.

Recent shifts in the federal legislative landscape point to greater recognition of these rights, which may have repercussions on the role of the provinces in delivering health and social services. It would be to Quebec’s advantage to follow these developments closely, given longstanding countrywide disparities in levels of public services between Indigenous and non-Indigenous people.

In February 2018, the federal government announced that it would be revealing later this year a new legislative framework—the Recognition and Implementation of Indigenous Rights Framework—which among other things would facilitate self-determination for Indigenous peoples, including control over areas including education or child welfare. That same month, Bill C-262, *An Act to ensure that the laws of Canada are in harmony with the United Nations*

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<sup>2</sup> For the key access issues identified by each participating First Nation community, please see Appendices G and H of the 2013 Report.

*Declaration on the Rights of Indigenous Peoples*, passed second reading in the House of Commons.

That being said, it should be noted that (also in February 2018) the Canadian Human Rights Tribunal (CHRT) issued a fourth non-compliance order, having found that Canada's approach to First Nations child welfare is unlawful and discriminatory, because it failed to take into account the specific needs of Indigenous children.<sup>3</sup> These steps towards further recognition, respect and implementation of Indigenous peoples' rights are important, but it is clear that concrete actions must follow.

Quebec has also taken important steps in the right direction with its Action Plan for the Social and Cultural Development of First Nations and Inuit and by recognizing its history of systemic discrimination, as well as with the work of this Commission. Nevertheless, Quebec may find itself in similar waters, where words of recognition will not be enough to end deeply entrenched discrimination in the provision of public services and to protect the rights of Indigenous peoples.

In its calls to action, the Truth and Reconciliation Commission (TRC) made several recommendations pertaining specifically to health, calling "upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties." The TRC added that "in order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples." The TRC also recommended all levels of government increase the number of Aboriginal professionals working in health care and to ensure the retention of Aboriginal health-care providers in Aboriginal communities.<sup>4</sup> It is clear that more action is needed.

Serious gaps exist in the provision of health and social services to English-speaking First Nations communities in Quebec, where a lack of culturally appropriate access to services that meet their actual needs may not only threaten Indigenous rights but also threaten the right to security of the person under s. 7 of the *Canadian Charter* and minority language rights protected by the *Constitution Act, 1867*.

This submission aims to shed some light on issues affecting English-speaking First Nations communities in Quebec and to provide concrete recommendations that aim to improve access to health and social services for their members and to meet their actual needs.

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<sup>3</sup> *First Nations Child and Family Caring Society of Canada et al. v Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*, 2018 CHRT 4.

<sup>4</sup> See recommendations 18-24, Truth and Reconciliation Commission of Canada: Calls to Action (2015), online: <[http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls\\_to\\_Action\\_English2.pdf](http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf)>.

Guiding our analysis is an emphasis on full participation of First Nations in decision-making that is susceptible to affect their rights and interests and First Nations control of the delivery of health services in their communities, as “[i]t is now widely acknowledged that Indigenous communities themselves are better positioned to identify their own health priorities and to manage and deliver healthcare in their communities.”<sup>5</sup>

## **IV - A portrait of the situation for English-Speaking First Nations Communities in Quebec when accessing health and social services**

This section focuses on specific problems identified in Amy Chamberlin’s 2013 Report and explores legal tools and strategies that may be helpful in addressing those problems. The means of resolving issues of access may differ depending on the region in question. This means that a closer collaboration between the Quebec government, its institutions and First Nations communities is essential in order to identify solutions to improve the gaps in health and social services that English-speaking First Nations experience.

### *a) Access to Quebec’s health and social services*

Like all Quebecers, English-speaking First Nations people residing in Quebec are entitled to choose the professional or institution from whom or which they wish to receive health and social services.<sup>6</sup> However, this right is far from absolute. It must be exercised within the framework of the laws and regulations relating to the organizational and operational structure of the institution in question and within the limits of the human, material and financial resources at that institution’s disposal.<sup>7</sup>

### *Corridors of service*

Generally, a person’s right to choose the professional or institution from whom or which they wish to receive health and social services is curtailed by the access rules set by the regional agency.<sup>8</sup> The access rules set by each regional agency are called corridors of service. These corridors can present obstacles for individuals seeking services in English.

### *Access programs*

The right to health services in English is similarly restricted. While the *Act Respecting Health Services and Social Services* recognizes that English-speaking persons are entitled to receive

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<sup>5</sup> National Collaborating Centre for Aboriginal Health, “The Aboriginal Health Legislation and Policy Framework in Canada”, online: < [http://nccah.netedit.info/docs/Health%20Legislation%20and%20Policy\\_English.pdf](http://nccah.netedit.info/docs/Health%20Legislation%20and%20Policy_English.pdf) >.

<sup>6</sup> *An Act Respecting Health Services and Social Services*, s. 6.

<sup>7</sup> *An Act Respecting Health Services and Social Services*, s. 14.

<sup>8</sup> *R.D. c. Garneau*, 2011 QCCS 2963 at paras 18 and 29. The health and social services agencies of each of the province’s administrative regions are empowered to determine the general rules governing access to the various services.

health and social services in English, access to English services is only guaranteed to the extent that:

- 1) it is in keeping with the organizational structure and human, material and financial resources of the institutions providing such services; and
- 2) it is provided for in an Access Program developed by the health and social services agency of the region in question.<sup>9</sup>

As a result, the true extent of the right to access English health services is determined by each regions' Access Program for English health and social services. Each Access Program evaluates the need for English language services in the region and the services required to meet the need. It also determines the providers of those services and the means by which they can be accessed by users.<sup>10</sup> If needed, the plans are developed jointly with agencies of other regions,<sup>11</sup> allowing users from one region to access services from another. The program must be approved by the Government and revised at least every three years.<sup>12</sup>

Access Programs are developed by the regional agency in consultation with a regional committee,<sup>13</sup> and approved by the Minister in consultation with a provincial committee.<sup>14</sup> More specifically, the process by which the Access Programs are developed and approved is detailed in Appendix C.<sup>15</sup>

Despite the existence of regional Access Programs, many of the problems identified in Amy Chamberlin's 2013 report relate to lack of access to health and social services for First Nations in English. This could be the result of the Access Programs' failure to take into account the distinct needs of First Nations.

Many of the problems identified in the report could be addressed and resolved by the regional Access Programs. For example, some participants reported difficulties because of a lack of public transportation available to access English services at institutions within their corridor of service.<sup>16</sup>

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<sup>9</sup> *An Act Respecting Health Services and Social Services*, ss. 15 and 348.

<sup>10</sup> *Frame of reference for the development of programs of access to health and social services in the English language for the English-speaking population*, (Québec: Santé et Services Sociaux Québec, 2007), p. 21. Online: <<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-406-01A.pdf>> [*Frame of reference*].

<sup>11</sup> *Ibid* at 5; *An Act Respecting Health Services and Social Services*, s. 348.

<sup>12</sup> *An Act Respecting Health Services and Social Services*, s. 348.

<sup>13</sup> *An Act Respecting Health Services and Social Services*, s. 510.

<sup>14</sup> *An Act Respecting Health Services and Social Services*, s. 509.

<sup>15</sup> *Frame of reference* at 30.

<sup>16</sup> Amy Chamberlin, "Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Québec" (October 21, 2013) at 36, 41 [2013 Report].

Other problems identified in the Report that could be addressed in regional Access Programs include:

1. Lack of access to health and social services in English
2. Limited access to mental health services in English
3. Limited detoxification services and treatment services in English
4. Corridors of Service – The provincial network (corridors) can present obstacles for individuals seeking services in English
5. Emergency Services – General access issues and obstacles because of language and culture
6. Calling provincial institutions is difficult because of language barriers
7. Documentation from the province is mainly in French
8. Tracking clients' information is difficult because of language barriers
9. Translation services are limited: lack of funding and treatment can be delayed while waiting for translations
10. Lack of client escort services
11. Lack of appropriate transportation and lodging

*b) Proposed approaches*

*Participation of English-speaking First Nations people in the development of Access Programs*

Because access to English health services in each region is determined by an Access Program, the best way to address First Nations' views, concerns, and challenges regarding access to English health services would be to have them addressed in that Access Program. The best way to do this would be for First Nations to meaningfully participate in the development of their region's Access Program.

In addition to the problems listed above, First Nations' participation in the development of Access Programs would help address other problems, such as lack of consultation and engagement with First Nations in planning and lack of communication between First Nations and provincial institutions.<sup>17</sup>

One way to assure meaningful participation would be for First Nations to be represented on the provincial and regional committees. Approximately 7 percent of the English-speaking population in Quebec are Indigenous.<sup>18</sup> In keeping with the UNDRIP's recognition of First Nations' right to be actively involved in developing and determining the health programs affecting them, we

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<sup>17</sup> Amy Chamberlin, 2013 Report at 47.

<sup>18</sup> This is a rough estimate, based on the assumption that there are 885,000 people in Quebec for whom English is the first official language spoken (Jean-Pierre Corbeil, Brigitte Chavez and Daniel Pereira, *Portrait of Official-Language Minorities in Canada - Anglophones in Quebec* (Ottawa: Statistics Canada, 2010) at 13, online: <<http://www.statcan.gc.ca/pub/89-642-x/89-642-x2010002-eng.pdf>>) and that 63 691 of those are Indigenous (64.5% of 98 731). Amy Chamberlin, 2013 Report at 26.

recommend that regulations and bylaws be amended to ensure Indigenous representation on these committees.<sup>19</sup>

We recommend that in the long-term each health region in Quebec develop an independent Access Programs specifically designed for English speaking First Nations' communities and with their active participation, to ensure that all Indigenous peoples in the region have equitable access to health care.

### *Reducing barriers to out-of-province services*

On the topic of the impact of borders on Indigenous peoples, Peter W Hutchins remarked in 2005:

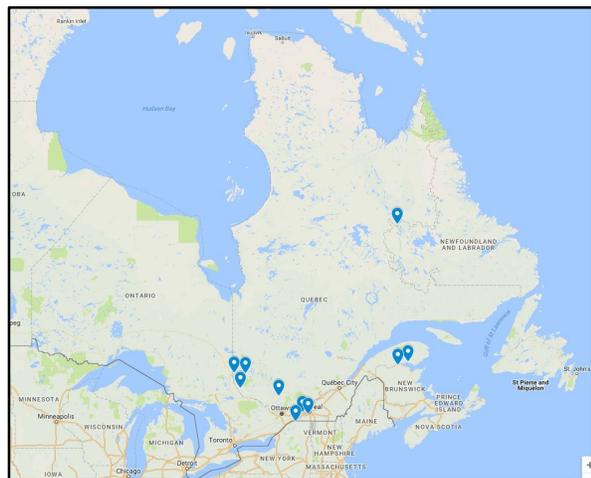
“In the post-colonial state, borders often dissect economic, cultural and social spheres, which, in turn, transcend the imposition of an arbitrary demarcation. Political lines were drawn to divide up territory and groups of people among the competing colonial powers. Peter Nugent argues that the colonialist objective was to classify groups of people into manageable units. In this sense, borders function as instruments for the enforcement of colonial policy.<sup>20</sup>

Provincial borders continue to operate as effective barriers to essential services for English-speaking First Nations communities, and the impacts are significant.

Several English-speaking First Nations communities in Quebec are border communities and could benefit from greater

**“The border complexities are a constant reminder to the Mohawks of their frustration and inability to control the destiny of their own communities.”**

*Mitchell v MNR*, [2001] 1 SCR 911, 2001 SCC 33 per Binnie J at para 80



cooperation between provinces in the provision of health and social services. These include Listuguj and Gesgapegiag, which are situated near the New Brunswick border, and Kebaowek First Nation, Kitigan Zibi, Timiskaming, Long Point First Nation/Winneaway and Akwesasne, which are situated near the Ontario border (see map below).

A possible solution to the dearth of English-language services in Quebec is to cross the border and seek medical services out-of-

<sup>19</sup> *Regulation respecting the provincial Committee on the dispensing of health and social services in the English language*, RRQ, c S-4.2, r 4, s. 11; *An Act Respecting Health Services and Social Services*, s. 510.

<sup>20</sup> Peter W Hutchins, “A State of Exception—The Impact of Borders on Aboriginal Peoples”, Aboriginal Law Conference—2005, Continuing Legal Education Society of British Columbia at 4.1.3.

province. Unfortunately, Quebec's unique position in Canada's health care system complicates matters.

All Canadian provinces and territories, including Quebec, have signed interprovincial agreements to cover in-hospital and emergency care. As such, Canadians may receive urgent care free of charge anywhere in Canada, provided they are carrying a valid provincial health care card. The difficulty rests with non-urgent care. Quebec is the only Canadian province or territory that refuses to sign bilateral reciprocal billing agreements.

Bilateral billing agreements remove point-of-service charges for medically necessary services. They allow physicians to submit their bills to their own jurisdictions for services rendered to out-of-province residents. The province, in turn, is reimbursed by the patient's home province.<sup>21</sup> Without such bilateral agreements, the patient (or sometimes physician) must pay the bill upfront and then apply to the RAMQ. Eventually, the RAMQ will partially reimburse the person who bore the cost of the service, often only covering half of the amount paid.<sup>22</sup> RAMQ recommends purchasing insurance when traveling in the rest of Canada to avoid the problem of the difference in costs.<sup>23</sup> This reality poses significant barriers to access, especially to youth and economically disadvantaged peoples.

Doctors, patients and advocates alike have argued that Quebec's refusal to sign the reciprocal billing agreement violates the *Canada Health Act's* principles of portability and universality.<sup>24</sup> Quebec maintains its position that it need not sign any agreements and that it is under no legal obligation to pay the higher rates demanded by physicians in the rest of Canada.

Despite the lack of bilateral billing agreements, some strategies do exist for accessing out-of-province medical services for border communities. Specific arrangements, for example, may be made with health care providers in Ontario and New Brunswick communities bordering Quebec. Quebec regulations provide for the possibility of out-of-province pharmacists to enter into agreements with RAMQ if there is no pharmacy within a 32-kilometre radius.<sup>25</sup> Similarly, physicians in border communities may register with RAMQ, thus removing the billing difficulties. Quebec should propose and facilitate the process for doctors in border communities to sign up with RAMQ. Note that Quebec requires that these physicians make union contributions of 5 per cent for each service rendered up until the full contribution amount is covered.<sup>26</sup> If these arrangements

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<sup>21</sup> Canadian Institute for Health Information, *Reciprocal Billing Report, Canada, 200-2005, Revised August 2007* (Ottawa: CIHI, 2007) at 1; (Annual Report 2009-2010 at 9).

<sup>22</sup> See Charles S. Shaver, "Shaver: Quebec must join other provinces in health-care parity", *Ottawa Citizen* (December 27, 2017), online: <<http://ottawacitizen.com/opinion/columnists/shaver-quebec-must-join-other-provinces-in-health-care-parity>>.

<sup>23</sup> R.S.Q., c. A-29 at s.10.; <http://www.ramq.gouv.qc.ca/en/citizens/temporary-stays-outside-quebec/health-insurance/Pages/services-covered.aspx>.

<sup>24</sup> *Canada Health Act*, s.11(1).

<sup>25</sup> *An Act Respecting Prescription Drug Insurance*, chapter A-29.01 at s. 8.

<sup>26</sup> Michel Desrosiers, "Traitez-vous des patients venant d'autres provinces?" *Le Médecin du Québec*, vol. 45, no. 4, avril 2010 at p.111. Online : <<http://www.fmoq.org/Lists/FMOQDocumentLibrary/fr/Le%20M%C3%A9decin%20du%20Qu%C3%A9bec/Archives/2010%20-%202019/2010/Septembre%202010/081-084QBE0910.pdf>>.

could provide greater access for First Nations communities, Quebec should provide funding or leniency regarding these requirements in order to help overcome access issues for English-speaking First Nations.

Special inter-provincial arrangements between Ontario and Quebec do exist. According to a special arrangement signed in 1989, Outaouais residents can seek medical care for services not available in their area in Ottawa.<sup>27</sup> A similar agreement was established between Timiskaming and North Bay in 1990.<sup>28</sup> In October 2017, the president of the Centre intégré de santé et de service sociaux (CISSS) of Abitibi-Témiscamingue announced that a new Corridor of Service may be opened soon between that municipality and Ontario.<sup>29</sup> These examples show willingness on the part of provincial government to recognize a shortage of access to health care services and to come up with appropriate solutions. Such arrangements should not be the exception if the result is better health care, dignity and security for Indigenous peoples.

As discussed below, under s. 15 of the *Act Respecting Health Services and Social Services*, English-speaking Quebec residents are entitled to English services, within the available human, material and financial resources. In order to fulfil its obligation, Quebec must reassess whether negotiating agreements with border communities in Ontario and New Brunswick is the most resource-efficient option to provide and support access to health services to some of the English-speaking First Nations.

That we have existing precedents in Outaouais and Témiscaming further bolsters this argument. These two agreements allow for Quebec residents to seek medical services in Ontario when they are not available in their region. If services are not available in a First Nations' region, or are not available in English in their region, then the situation is analogous.

### *Exceptions to the French language requirement for professional licensing*

Provincial governments are responsible for professional licensing requirements. Of the 46 professional orders in Quebec, 26 are related to health care.<sup>30</sup> In accordance with s. 35 of the *Charter of the French Language*,<sup>31</sup> “professional orders shall not issue permits except to persons whose knowledge of the official language is appropriate to the practice of their profession”. The

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<sup>27</sup> Agence de la santé et des services sociaux de l'Outaouais, *Reimbursement of fees for medical services received in Ontario*, Government of Quebec. Online <http://santeoutaouais.qc.ca/en/our-services/remboursement-frais-soins-medicaux-recus-en-ontario/>; Gouvernement du Québec, Décret 1507-89, *Gazette Officielle du Québec*, 4 octobre 1989, 121e année, no. 42.

<sup>28</sup> Programme de remboursement des services médicaux spécialisés consommés à North Bay, Ontario par les résidents de Témiscaming, de Kipawa et de Tee Lake, Mars 1990.

<sup>29</sup> « Un nouveau corridor de services de santé entre le Témiscamingue et l'Ontario pourrait être prochainement ouvert », Radio-Canada (26 October 2017), online: < <http://ici.radio-canada.ca/nouvelle/1063739/sante-le-ci-ss-envisage-un-corridor-de-service-entre-le-temiscamingue-et-lontario>>.

<sup>30</sup> Ordre des infirmières et infirmiers du Québec, *Infirmière formée hors Québec*. Online: <<http://www.oiiq.org/admission-a-la-profession/infirmiere-formee-hors-quebec>>.

<sup>31</sup> RSQ, c C-11. [*Charter of the French Language*].

French language requirement for admittance into Quebec’s professional orders is a significant barrier for Anglophones generally.<sup>32</sup>

The *Charter of the French Language* allows the Government to adopt regulations exempting professionals from the application of the French language requirements “in respect of a person who resides or has resided on a reserve, a settlement in which a native community lives or on Category I and Category I-N lands within the meaning of the *Act respecting the land regime in the James Bay and New Quebec territories*”.<sup>33</sup> The Government has done this through the enactment of the *Regulation to authorize professional orders to make an exception to the application of section 35 of the Charter of the French language*.<sup>34</sup>

Some professional orders, such as nurses, have made an exception to the French language requirement for the licensing of individuals working in and for Indigenous communities. Quebec should ensure that other professional orders that have not made an exception to the French language requirement for the licensing to do so for individuals working in and for English-speaking First Nations communities.

Another issue regarding professional licensing,<sup>35</sup> is the limited access to English training in Quebec. One solution to this problem is to seek training out-of-province. Mobility issues for professionals into and out of Quebec, however, are the most constrained of any Canadian province or territory. According to s. 40 of the *Charter of the French Language*, however, a professional order “may issue a restricted permit to a person already authorized under the laws of another province or another country to practise his profession” if it is in the *public interest* and with the prior authorization of the Office québécois de la langue française. Given the crisis surrounding access to English health services in First Nations’ communities, the Office québécois de la langue française should grant the necessary authorization to allow for restricted permits for persons working in and for First Nations communities.

**[Our communities] understand the importance of language ... We all want to protect our language ... But I’m wondering if it means it’s at the cost of a human’s life.”**

David McLaren, Health Director,  
Kebaowek First Nation

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<sup>32</sup> Conseil permanent de la jeunesse, *Report: Discussion Forum for representatives of young Anglophones of Quebec*, (September 2003). Online: <<https://www.jeunes.gouv.qc.ca/documentation/publications/publications-cpj/documents/diversite-culturelle/jeunes-anglo-ang.pdf>> at 18.

<sup>33</sup> *Charter of the French Language*, s. 97.

<sup>34</sup> Chapter C-11, r.10.

<sup>35</sup> Amy Chamberlin, 2013 Report at 39.

## V - Obligations and standards

Our positions are supported by legal arguments based on provincial, federal and international laws, and by human rights treaties and instruments that include the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) at the international level, the *Canadian Charter* at the federal level and the *Quebec Charter* at the provincial level.

### a) *The United Nations Declaration on the Rights of Indigenous Peoples*

On February 7, 2018, Canada took an important step toward the adoption of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) when Bill C-262, *An Act to ensure that the laws of Canada are in harmony with the United Nations Declaration on the Rights of Indigenous Peoples*, passed second reading in the House of Commons.<sup>36</sup>

UNDRIP provides that Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights,<sup>37</sup> including the right to access social and health services. UNDRIP also provides that Indigenous peoples have the right to participate in decision-making in matters which would affect their rights. This includes the right to be actively involved in developing and determining health and social programs affecting them and to administer such programs through their own institutions. UNDRIP reflects the standard of substantive equality that Quebec is bound to uphold pursuant to the *Quebec* and *Canadian Charters*.<sup>38</sup>

UNDRIP recognizes that Indigenous peoples around the world, including First Nations in Canada, have a number of rights relating to health:

- the right, without discrimination, to the improvement of their economic and social conditions, including in the area of health;<sup>39</sup>
- the right to determine and develop priorities and strategies for exercising their right to development, in particular by being actively involved in developing and determining the health programs affecting them and, as far as possible, administering those programs through their own institutions;<sup>40</sup>
- the right to their traditional medicines and to maintain their health practices;<sup>41</sup>

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<sup>36</sup> Vote no. 446, 42nd Parliament, 1st Session, sitting no. 259, February 7, 2018, online: <<https://www.ourcommons.ca/Parliamentarians/en/votes/42/1/446>>.

<sup>37</sup> UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly, 2 October 2007, A/RES/61/295, art. 2. [UNDRIP]

<sup>38</sup> *Caring Society 2016* at paras 452-453.

<sup>39</sup> United Nations Declaration on the Rights of Indigenous Peoples, GA Res. 61/295, UN Doc. A/RES/61/295 (2007). [UNDRIP], art. 21 (1).

<sup>40</sup> UNDRIP, art. 23.

<sup>41</sup> UNDRIP, art. 24 (1).

- the right to access, without any discrimination, to all social and health services;<sup>42</sup>
- an equal right to the enjoyment of the highest attainable standard of physical and mental health.<sup>43</sup>

In order to ensure that Indigenous peoples' rights with respect to health are respected, UNDRIP recognises that states have the responsibility to:

- take the necessary steps with a view to achieving progressively the full realization of indigenous peoples' right to the enjoyment of the highest attainable standard of physical and mental health;<sup>44</sup>
- take effective measures to ensure, as needed, that programs for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.<sup>45</sup>

While UNDRIP is a Declaration and therefore not binding in the sense of an international treaty, many of the rights contained in UNDRIP are already contained in treaties that Canada has agreed to respect and fulfill.<sup>46</sup> One such treaty is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<sup>47</sup> Canada made a commitment to respect this right when it acceded to the ICESCR in 1976.

Further, experts have argued that many of the rights contained in UNDRIP are already part of international customary law and are therefore binding.<sup>48</sup> In *Baker v Canada (Minister of*

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<sup>42</sup> UNDRIP, art. 24 (1).

<sup>43</sup> UNDRIP, art. 24 (2).

<sup>44</sup> UNDRIP, art. 24 (2).

<sup>45</sup> UNDRIP, art. 29 (3).

<sup>46</sup> While international declarations are never in themselves legally enforceable, the rights and obligations they contain can be binding on States as customary international law. Experts have argued that many of the rights contained in UNDRIP are already part of international customary law. See, e.g., James Anaya & Siegfried Wiessner, "The UN Declaration on the Rights of Indigenous Peoples: Towards Re-empowerment", (2007) *Jurist*, Online <<http://jurist.law.pitt.edu/forumy/2007/10/un-declaration-on-rights-of-indigenous.php>>. It could be possible for a Canadian court to hold Canada responsible for not respecting any of the rights in UNDRIP that had passed into customary law. Canadian courts have already held Canada to its obligations under both customary international law and international treaties ratified by Canada in cases such as *Baker v Canada (Minister of Citizenship & Immigration)*, [1999] 2 SCR 817 and *Suresh v Canada (Minister of Citizenship & Immigration)*, 2002 SCC1, [2002] 1 S.C.R. 3. See also Louis LeBel & Gloria Chao, "The Rise of International Law in Canadian Constitutional Litigation: Fugue or Fusion? Recent Developments and Challenges in Internalizing International Law" (2002) 16 *Supreme Court Law Review* (2d) 23.

<sup>47</sup> 16 December 1966, G.A. Res. 2200 (XXI), 993 U.N.T.S. 3 (entered into force Jan. 3, 1976; accession by Canada on 19 May 1976), art. 12.

<sup>48</sup> James Anaya & Siegfried Wiessner, "The UN Declaration on the Rights of Indigenous Peoples: Towards Re-empowerment", (2007) *Jurist*, online, <<http://jurist.law.pitt.edu/forumy/2007/10/un-declaration-on-rights-of-indigenous.php>>

*Citizenship and Immigration*),<sup>49</sup> the Supreme Court held that even when an international treaty has not been implemented as statute, “the values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review.”<sup>50</sup> International law not only illuminates the positive law on human rights in Canada, but helps to understand the appropriate limits on state power.

#### *b) The Act respecting health services and social services*

The *Act Respecting Health Services and Social Services (ARHSSS)* is the principal piece of legislation that governs agencies and private and public institutions who provide health and social services in Quebec. The *ARHSSS* aims, *inter alia*, “to ensure that services are accessible on a continuous basis to respond to the physical, mental and social needs of individuals, families and groups”<sup>51</sup> and “to take account of the distinctive geographical, linguistic, sociocultural, ethnocultural and socioeconomic characteristics of each region.”<sup>52</sup>

The *ARHSSS* sets out the roles and responsibilities of the Quebec government and various stakeholders including agencies, institutions and intermediate resources (e.g., group homes) and family-type resources (e.g., foster homes). The following guidelines guide the management of health and social services:

- 1) the person requiring services is the reason for the very existence of those services;
- 2) respect for the user and recognition of his rights and freedoms must inspire every act performed in his regard;
- 3) the user must be treated, in every intervention, with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety;
- 4) the user must, as far as possible, play an active role in the care and services which concern him;
- 5) the user must be encouraged, through the provision of adequate information, to use services in a judicious manner.<sup>53</sup>

Furthermore, under s. 15 of the *ARHSSS*, English-speaking persons are entitled to receive health and social services in English, in keeping with the resources of the institutions providing these services and to the extent provided by Access Programs described under s. 348 of the *ARHSSS*.

For excerpts of other relevant articles in the *ARHSSS*, see appendix B of Amy Chamberlin’s 2013 Report (Appendix A).

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<sup>49</sup> [1999] 2 SCR 817, 1999 CanLII 699 (SCC).

<sup>50</sup> *Ibid* at para 70. [Baker]

<sup>51</sup> c S-4.2, s. 2(4).

<sup>52</sup> c S-4.2, s. 2(5).

<sup>53</sup> c S-4.2, s. 3.

The obligations of the government of Quebec under the *ARHSSS* must be interpreted in light of the *Canadian Charter* and the *Quebec Charter*. For example, the Quebec Court of Appeal in *Lachine General Hospital Corporation c Québec (Procureur général)*<sup>54</sup> confirmed that the prohibitions on discrimination pursuant to s. 15 of the *Canadian Charter* and s. 10 of the *Quebec Charter* both apply as limits to the Quebec government's decisions with respect to access to health services in English in Quebec.<sup>55</sup>

### c) Quebec's obligations under the Canadian Charter

#### Section 15: substantive equality

In providing or funding health or social services to First Nations, Quebec must respect the standard of substantive equality. Substantive equality is different from formal equality. While formal equality merely consists of providing exactly the same treatment to everyone, ensuring substantive equality requires being attentive to the social and political context and to the needs, circumstances, and historical disadvantages suffered by a particular group of people.

The standard of substantive equality was addressed in *Caring Society 2016*, where the CHRT ruled that inequitable federal funding for First Nations child welfare amounted to discrimination. To examine the question, the CHRT adopted the substantive equality analysis used in the equality jurisprudence developed under s. 15 of the *Canadian Charter*.<sup>56</sup> As the CHRT noted in *Caring Society 2016*, “[f]or Aboriginal peoples in Canada this context includes a legacy of stereotyping and prejudice through colonialism, displacement and residential schools.”<sup>57</sup> The substantive equality analysis obliges the courts to consider these circumstances<sup>58</sup> and may require differential treatment tailored to the specific needs of individuals and communities.<sup>59</sup>

It is clear that the *Canadian Charter* applies “to the legislature and government of each province in respect of all matters within the authority of the legislature of each province”<sup>60</sup> and so does the jurisprudence developed under s. 15, which affirms the application of the substantive equality standard to the provinces.

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<sup>54</sup> 1996 CanLII 5944 (QC CA) [*Lachine General Hospital*]. The Court of Appeal, following its discrimination analysis, rejected the discrimination claim because of a failure by the plaintiff to demonstrate in a preponderant manner the alleged discriminatory effects. The uncontradicted evidence given by the defendant thwarted the allegation of reduced access to health services, due to closings, by the English-speaking population of Lachine and Dorval.

<sup>55</sup> *Lachine General Hospital* at 54-55.

<sup>56</sup> *Caring Society 2016* at para 399.

<sup>57</sup> *Caring Society 2016* at para 402.

<sup>58</sup> *Lovelace v Ontario*, [2000] 1 SCR 950, 2000 SCC 37 (CanLII) at para 4.

<sup>59</sup> Emmanuelle Bernheim, « Repenser la vulnérabilité sociale en termes d'égalité réelle : une contribution des droits de la personne », *Développements récents : La protection des personnes vulnérables* (2011), vol. 330 (Cowansville : Yvon Blais, 2011) at 193-194.

<sup>60</sup> *Constitution Act, 1982*, Schedule B to the Canada Act 1982 (UK), 1982, c 11, s. 32(1)(b).

Quebec is bound to uphold the principle of substantive equality when providing or funding health and social services to First Nations, as required by s. 15. As the CHRT explained in the *Caring Society* 2016, services provided to First Nations must respond to their specific needs, taking into account geographical, linguistic, cultural and historical considerations.

### *Section 15: protection of minorities*

The protection of minorities is one of the fundamental underlying principles of the Canadian Constitution.<sup>61</sup> Though Indigenous peoples are not “minorities” in the sense that the term is generally used, this principle serves in particular to protect minority official language communities<sup>62</sup> and Indigenous peoples.<sup>63</sup> English-speaking First Nations in Quebec are both.

Changes in Corridors of Service or Access Programs that restrict English speaking First Nations’ members access to English services or to culturally appropriate services that they formerly had access to are vulnerable to a constitutional challenge under s. 15 of the *Canadian Charter*. Amy Chamberlin’s 2013 Report suggests that these types of changes have been made in recent years:

The corridors of service have been changed for people living on the South Shore. Access to hospitals in Montreal is restricted, clients being referred back to South Shore. More and more we are being delegated to the South Shore for services, which are almost all French. The “State of the Art” medical services are on the island and we are being shut out because of our postal code address. (Kahnawá:ke)<sup>64</sup>

### *Section 7: the right to life, liberty and security of the person*

Every individual has a constitutionally protected right to life and the security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice, which is enshrined in s. 7 of the *Canadian Charter* and s. 1 of the provincial *Charter*. Legislation respecting the provision of health services is limited by every individual’s constitutional right to life and the security of the person.

For example, the delineation of corridors of service or an Access Program makes access to mental health services in English significantly more difficult in a way that endangers individuals’ lives or that could result in serious psychological or physical suffering may violate the right to life, liberty and security as guaranteed by the *Canadian Charter*.

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<sup>61</sup> *Reference re Secession of Quebec*, [1998] 2 SCR 217 at para 79-82 [*re Secession of Quebec*].

<sup>62</sup> *Lalonde v Ontario (Commission de restructuration des services de santé)*, 1999 CanLII 19910 (ON SC) [*Lalonde*].

<sup>63</sup> *re Secession of Quebec* at para 82.

<sup>64</sup> Amy Chamberlin, 2013 Report at 41.

#### *d) Quebec's obligations under the Quebec Charter*

Quebec laws must also respect the fundamental, political and judicial rights enumerated under sections 1 to 38 of the *Quebec Charter*. Quebec statutes can only derogate from these rights if the legislation in question expressly states that it applies despite the *Quebec Charter*.<sup>65</sup>

#### *Section 10: substantive equality*

As is the case of the non-discrimination right provided in the *Canadian Human Rights Act* and defined in *Caring Society*, the right to equality provided in s. 10 of the *Quebec Charter* protects the right to substantive equality. Canadian courts have interpreted the equality right in s. 10 of the *Quebec Charter* to require substantive equality and not merely formal equality.<sup>66</sup>

Thus, the norm of equality protected under s. 10 of the *Quebec Charter* is not about delivering the exact same treatment but requires taking into account the context and making distinction to understand how a certain measure can indirectly affect a person or a group of persons. Furthermore, the Supreme Court of Canada also recognized that “although the [*Quebec*] Charter’s provisions need not necessarily mirror those of the *Canadian Charter of Rights and Freedoms*, they must be interpreted in light of the latter.”<sup>67</sup> As shown in the previous section, s. 15 of the *Canadian Charter* protects the right to substantive equality.

#### *Section 4: the right to the safeguard of one's dignity*

English-speaking First Nations peoples have the right to the safeguard of their dignity under s. 4 of the *Quebec Charter*, and the Quebec government must uphold the substantive equality standard accordingly when providing or funding health and social services to English-speaking First Nations communities in Quebec, pursuant to both the *Quebec* and *Canadian Charters*. Corridors or service determined based on administrative limitations that prevent or substantively delay access to appropriate care may infringe on a person's right to dignity.

#### *Beyond Quebec's obligations*

During his testimony before this Inquiry in September 2017, Professor Sebastien Grammond highlighted the importance of analyzing beyond provincial public services and of looking at the interaction between services for Indigenous peoples provided and funded by both the federal and provincial governments:

« Il me semble impossible d'analyser la portée de ses services [publiques], d'analyser les bénéfices que les peuples Autochtones en retirent sans se poser la question de leur interaction

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<sup>65</sup> *Charter of Human Rights and Freedoms*, s. 52.

<sup>66</sup> *Bombardier; Commission scolaire régionale de Chambly v Bergevin* [1994] 2 SCR 525; *Fraternité des policiers et policières de la Ville de Québec v Gagnon* [2017] JQ no 17851.

<sup>67</sup> *Ibid* at para 31.

avec les services offerts et financés par le fédéral et sans se poser la question du principe de Jordan, et sans se demander s'il y a par la combinaison de tous ses facteurs une discrimination envers les peuples autochtones. »<sup>68</sup>

A complete understanding of the situation of English-speaking First Nations communities will certainly require an analysis of federal-provincial dynamics, without which the true scope of issues cannot be fully captured.

## **VI - Recommendations**

There are many tools available to reduce barriers to access to health and social services for English-speaking First Nations communities. What is needed is the will to act.

### **1) Quebec must respect its constitutional obligations towards Indigenous peoples**

Quebec must respect its constitutional obligations towards Indigenous peoples, which underlie all the recommendations put forward in this section. Quebec must consult and involve First Nations in government decisions and measures affecting their health; it must respect First Nations' language and cultural rights; and it must respect First Nations right to assume control over their communities' health through their own institutions. We urge Quebec to enact the TRC's calls to action, namely recommendations 18 to 24, pertaining to health.

### **2) First Nations participation in Access Programs development**

Ensuring that First Nations meaningfully participate in the development of their regional Access Programs:

- Making information about Access Programs publicly available so that First Nations can develop suggested changes to respond to English-speaking First Nations' needs;
- Ensuring and facilitating English-speaking First Nations' participation in the development of Access Programs;
- Establishing effective mechanisms to track access issues and challenges for English-speaking First Nations;
- Ensuring that English-speaking First Nations communities participate in the determination of corridors of services and adapting corridors to remove barriers to seeking services in English;

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<sup>68</sup> Sebastien Grammond, testimony before this Inquiry, September 22, 2017, online: <<https://www.cerp.gouv.qc.ca/>>

- Amending regulations and bylaws to ensure First Nations' representation on the provincial and regional committees;
- Appointing English-speaking First Nations' representatives to the provincial and regional committees;
- Developing independent Access Programs specifically designed for English speaking First Nations' communities and with their active participation.

### **3) Removing barriers to access Ontario and New Brunswick health services**

Facilitating access to health services in English for English-speaking First Nations living in border communities by:

- Complying with the portability and universality criteria under s. 11 of the *Canada Health Act*;
- Concluding bilateral reciprocal billing agreements with Ontario and New Brunswick;
- Making special arrangements with institutions in neighbouring provinces to facilitate First Nations' access to health and social services;

### **4) Cultural sensitivity trainings and campaigns**

Developing training and awareness-raising campaigns to address discrimination and improve cultural sensitivity towards Indigenous peoples:

- For health and social work professionals working at First Nations and provincial institutions;
- To learn about colonial legacy and to enhance respect for culture, traditional ways, and First Nations' languages in the delivery of health and social services;
- To increase visibility of Indigenous culture/practices and languages at provincial institutions.

Providing support for Indigenous peoples receiving services from provincial health and social services institutions (e.g., Indigenous liaison person)

## **5) Improve access to information in English for health and social services**

Improving access to information concerning health and social services such as government documents, which are often only in French by:

- Identifying and prioritizing which documents are a priority to translate into English and make available for First Nations communities;
- Ensuring funding required for translation;
- Ensuring language support for Indigenous clientele (especially for crisis/critical situations or for specialized care);
- Promoting bilingualism in provincial institutions (i.e., through training opportunities for staff);

## **6) Professional licensing, training and employment**

Allowing for exceptions to the French language requirement for health professionals' licensing working primarily with English-speaking First Nations.

Ensuring that more training opportunities (health and social services related) are available in English.

Recruiting and providing incentives for Aboriginal professionals to work in the communities in the areas of health and social services (including in related areas such as lodging, vehicles rental, outing allowance, especially in remote communities).

## **7) Agreements and protocols**

Developing formal engagements and protocols between provincial and First Nations' health and social institutions:

- To establish partnerships and strengthen continuity of care;
- To enhance access to English services in remote areas, especially emergency and intensive care services;
- To enhance access to English services in crisis situations (e.g., violence, sexual abuse);

- To enhance access to English services in priority areas for First Nations (i.e., detoxification, mental health services, developmental needs for youth, care for Elders).
- To enhance escort/liaison and language services for the elderly.

Ensuring that all agreements between the provincial government and First Nations respect the provision and funding of health and social services, self-government agreements respect the constitutional principles and the substantive equality criteria established in *Caring Society 2016*. Support First Nations in assuming control over the health of their communities:

- Concluding tripartite agreements;
- Facilitating the exchange of expertise between provincial institutions and First Nations institutions;
- Bringing health and social services' resources (e.g., specialized services, assessments, clinics, training) into First Nations communities/organizations

# Appendix C

## Appendix C - Additional information on Access Programs

1. The agencies initiate the development of Access Programs in their regions;
2. The agencies prepare an inventory of accessible English language services at the local, regional and interregional levels. The inventory of services already accessible in the English language in the region concerned is drawn up with the help of existing Access Programs and in consideration of the clinical and organizational projects being developed by the health and social services centres of that region;
3. The agencies prepare their Access Programs, request the opinion of their regional committees in this regard, and have their programs adopted by resolution of their board of directors;
4. The agencies submit their Access Program proposals to the Minister for government approval. Each proposal contains the following information:
  - a. data on the English-speaking population;
  - b. a profile of health and well-being needs of the English-speaking population, including demographic, socio-economic and socio-sanitary profiles, as well as an outline of the patterns of service-use;
  - c. an outline of the English language services being offered, namely the resources and services currently available to meet the needs of the English-speaking population, and an analysis of same;
  - d. the identification of gaps, and of projected measures to offset them;
  - e. the opinion of the regional committee on the Access Program;
  - f. the resolutions (adopting the Access Program) of the boards of directors of the agency and of the institutions involved in the Access Program.

The different modalities are set out in detail, and the range of services required to meet the needs of English speaking persons is defined. The contents of service agreements, as well as the roles and responsibilities of the partners are also described;

5. The Minister receives Access Program proposals accompanied with the information requested;
6. The provincial Committee for the delivery of health and social services in the English language receives a copy of each Access Program:
  - a. It consults, if need be, the appropriate regional bodies;
  - b. It submits to the Minister its advice on each proposal for tabling with the government.
7. The Ministry analyses, according to the assessment criteria in place, the Access Program adopted by the board of directors of each agency and submits its assessment to the Minister, taking into consideration the opinion of the provincial Committee;
8. The Minister tables with the Cabinet a brief on the Access Program of each region including his or her recommendations, accompanied by the written opinion of the provincial Committee;
9. The government approves the Access Program of each region;
10. Each agency can revise its Program at any time but must do so at least every three years.

# APPENDIX A

**Portrait of the Situation for English-speaking First Nations:  
Accessing Health and Social Services in English in the Province of Québec**

By:

Amy Chamberlin, M.A.

Submitted to:

Onkwata'karitáhtshera

and

Coalition of English-speaking First Nations Communities in Québec (CESFNCQ)

October 21, 2013

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## **1. INTRODUCTION**

### **1.1 Foreword**

The project “Expanding and Building our Partnerships to Improve Access” is a three-year project that started in 2012 with funding from Health Canada’s Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera; an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal).

The goal of the project was to establish a coalition among English-speaking First Nations Communities in Québec (CESFNCQ) in order to expose and improve access to health and social services in federal and provincial systems. The Coalition is comprised of four nations – Naskapi, Mi’gmaq, Mohawk, and Algonquin, from eight First Nations communities: Kawawachikamach, Gesgapegiag, Listuguj, Kanesatake, Kahnawake Eagle Village First Nation / Kipawa, Kitigan Zibi, and Timiskaming. The communities are located in different geographical areas (remote, rural and urban).

In April of 2012, the English-speaking First Nations communities began working together to address access issues. The Coalition, made up of directors and key individuals from First Nations health and social services’ organizations, identified that there is a lack of existing health, social and related services accessible for First Nations in the English language: as such, English-speaking First Nations do not have the same level of access to services as that of the mainstream Québec population.

In Québec, English-speaking First Nations communities face many challenges when attempting to access services from the federal and provincial systems. There are obstacles because of language, and for First Nations there are access issues resulting from historical and social injustices. Generally speaking, underlying issues such as poverty, coupled with the intergenerational effects of colonization and residential schools, continues to

affect the health and wellness of Aboriginal peoples.<sup>1</sup> Furthermore, numerous studies and reports have raised concerns about the health concerns facing Aboriginal People. For example, John O’Neil et al. assert that: “Aboriginal Peoples bear a disproportionate burden of illness in Canada”; the authors argue that community well-being is fundamentally linked with ‘self-governance’ in terms of both the administration of services and the health and well-being of Aboriginal population.<sup>2</sup> As such, access to, and making decisions about, health and social services is critical in order to begin addressing the many pressing health and social concerns prevalent in First Nations communities.

In working towards solutions to mitigate the ‘disproportionate burden of illness’ carried by Aboriginal Peoples, the Coalition of English-Speaking First Nations of Québec oversaw a one-year research project. The overarching objectives of the project were to: i) Create a portrait of the specific issues and challenges facing First Nations when accessing health and social services in English; and ii) Identify strategies that English-speaking First Nations communities have in place, or would recommend, on how to improve access to those services. While each First Nation community has its own distinct needs, the Coalition enables First Nations to work together, and to come before the government with one strong voice.<sup>3</sup> The research is part of an ongoing effort to improve English-speaking First Nations access to health and social services from provincial and federal systems. Participants’ comments are included throughout the report to capture their perspectives – challenges, positive experiences, and proposed solutions – with respect to accessing health and social services.

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<sup>1</sup> Health Council of Canada. *Empathy, dignity and respect: Creating cultural safety for Aboriginal people in urban health care*. Toronto: Health Council of Canada, 2012 : 4. PDF file.

<sup>2</sup> O’Neil, John, et al. “Community Healing and Aboriginal Self-Government.” *Aboriginal Self-Government in Canada*. 2<sup>nd</sup> ed. Ed. John Hylton. Saskatoon: Purich, 1999 : 139 -142. Print.

<sup>3</sup> Coalition of English-speaking First Nations Communities in Québec (CESFNCQ). “HSIF Project Launch.” Québec City, 28 Jan. 2013. Research Meeting.

## 1.2 Mandate and purpose of the research

The mandate for the research was to document a portrait of the situation for English-speaking First Nations people when accessing health and social services in English from federal and provincial systems. The Coalition oversaw the direction of the research, and the Organizational Development Services (ODS) provided management support for the project.<sup>4</sup>

The purpose of the research was to expose and identify:

- Access issues and challenges facing English-speaking First Nations
- Strategies and solutions to mitigate access issues and challenges

## 1.3 Health Canada: mitigating gaps in health

In recent years, Health Canada has taken steps to mitigate access issues for First Nations. For example, in 2004, Health Canada launched the Aboriginal Health Transition Fund (AHTF), which supported projects that addressed “the gap in health status between Aboriginal and non-Aboriginal Canadians by improving access to existing health services.”<sup>5</sup> In the province of Québec, Aboriginal communities engaged in AHTF projects, helping to raise awareness and understanding about the barriers and constraints that Aboriginal Peoples face when accessing health and social services.<sup>6</sup>

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<sup>4</sup> The Organizational Development Services (ODS) is a First Nation consulting/training business within the Kahnawake Shakotiiia'takehnhas Community Services (KSCS).

<sup>5</sup> Canada. Health Canada. First Nations and Inuit Health Branch. “Improving Access to Health Services - First Nations and Inuit Health Canada.” Health Canada. 2 Oct. 2013. Web. Oct. 2013.

<sup>6</sup> First Nations of Québec and Labrador Health and Social Services Commission. *Compendium of Projects: Aboriginal Health Transition Fund*. FNQLHSSC, 2011: 9. Print.

Then, in 2010, Health Canada announced another similar initiative: the Aboriginal Health Transition Fund (HSIF). This initiative also addresses the challenges that Aboriginal Peoples face when accessing health care services. Specifically, the HSIF is a multi-year initiative geared to support collaborative planning involving multi communities and projects in order to meet the health care needs of First Nations, Inuit and Métis.<sup>7</sup> This research initiative was funded under the HSIF initiative; the research builds upon previous work and projects addressing access issues and gaps, including, but not limited to, the AHTF projects.

#### **1.4 Scope and limitations**

In November of 2012, the Coalition engaged a research consultant to design and to conduct the research. The intent of the research was to seek out the perspectives of English-speaking First Nations community resources (key informants working in First Nations Health and Social Services community organizations) and First Nations community members (i.e., Elders (or their caretakers), parents with young children, and individuals with chronic health conditions).

This research also included the perspectives of key informants who had been involved in previous Aboriginal Health Transition Fund (AHTF) projects to uncover best practices that could foster lasting and sustainable strategies to improve access.<sup>8</sup> The communities of Eagle Village, Listuguj, Gesgapegiag, Kanesatake and Kahnawake conducted AHTF projects to address various barriers when accessing services.<sup>9</sup> (Appendix A: AHTF Projects of Coalition communities).

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<sup>7</sup> Canada. Health Canada. First Nations and Inuit Health Branch. “Health Services Integration Fund.” Health Canada. 4 Feb. 2013. Web. Feb. 2013.

<sup>8</sup> The AHTF projects (2004 -2010) addressed barriers when accessing services (for example, English language services, cultural appropriateness, and jurisdictional issues), and also identified *strategies to improve access* (i.e., fostering formal and informal linkages between Aboriginal health care service providers and provincial service providers) *Compendium of Projects*.

<sup>9</sup> Interviews were conducted with key informants engaged in projects in Gesgapegiag, Listuguj, Kahnawake, and Kanesatake. It was not possible to access data related to Eagle Village’s AHTF project.

Following the review of the draft research report, the Coalition requested that ‘additional preliminary research’ on a specific access issue facing English-speaking First Nations.

Focus groups, interviews, and questionnaires were conducted to seek out the perspectives of First Nations, and to document a portrait of the situation. Participants were asked about their experiences when accessing health and social services from the provincial and federal systems. The research questions focused on the following areas: general access issues, issues related to language and culture, as well as positive experiences when accessing services. Furthermore, participants were asked about solutions they have in place, or would recommend, towards improving access.

The answers to the questions varied; nevertheless, the research demonstrates that English-speaking First Nations – in remote, rural and urban areas – face obstacles because of language when attempting to access health and social services.

Some of the limitations of this research:

- Time Constraints – Availability of the project partners to contribute to the various aspects of the research;
- Accessing Information – Working through the various protocols (written and unwritten) about how best to conduct research with and for First Nations communities. Most of the research conducted ‘at a distance’ (video or teleconferencing), thus, the researcher worked closely with communities to ensure that data collection was consistent; and,
- Data Collection – Ensuring that data (perspectives) was gathered equally (breadth and depth) from each of the participating communities.

## 1.5 Data collection

- All data was collected by the researcher, or by research liaison assistants, from the eight participating communities over a five-month period from March 12 – July 24, 2013.
- Additional Research was conducted from Oct. 4 – Oct. 11, 2013. This research was preliminary only, and was conducted in a short time frame. It is likely that more communities would have participated given more time to conduct the research.
- In all, a total of 130 participants took part (the majority of participants were First Nations, and a small number of non-Native individuals who either work(ed) or live in the First Nations' communities took part in the research).
  - *Focus groups*: A total of 14 focus groups (semi-structured) were conducted (ten with community resources and four with community members);
  - *Interviews*: A total of 19 individual interviews (semi-structured) were conducted (six with key informants involved with Aboriginal Health Transition Fund (AHTF) projects; nine key informants (health and social services), and four with First Nation community members);
  - *Follow up research (questionnaires)*: Three (3) key informants completed 'Follow Up Questionnaires' as part of this research.

## **Research findings**

Generally, First Nations spoke about long wait times at hospitals, difficulties travelling because of poor road conditions or lack of public transportation. Some participants described access issues resulting from jurisdictional issues – corridors of services, provincial boundaries, and a lack of clarity between federal and provincial authorities. As articulated by a First Nations community member: “People are bounced back and forth between the hospitals ... [The boundary] divides the population and influences when they are willing to go to the hospital”. Participants expressed their frustration when attempting to access English-language services, while others spoke about challenges because of a lack of understanding and awareness about their culture, history and health needs as First Nations. There were also positive stories about “compassionate” and “culturally sensitive” nurses, doctors, and social workers – those who went above and beyond to make certain that individuals received the services that they needed.

Participants described the strategies they use to overcome obstacles when accessing services. For example, some organizations have worked in partnership with provincial institutions and have successfully drafted agreements and protocols for the delivery of English-language services. While other First Nations stated that: “[we] rely on bilingual colleagues” to translate documents or place phone calls to mitigate language issues.

Finally, throughout the research process there were questions raised. For instance: How does the provincial health system work? Can First Nations access services from the network? Are individuals able to choose where they access services? What are the responsibilities of the federal and provincial government when delivering health care to First Nations? And, can we request health and social services in English?

## 2. METHODOLOGY

### 2.1 Goal and objectives

The goal of the research was to seek out the perspectives of English-speaking First Nations people when accessing health services and social services from the federal and provincial systems in English.

The research objectives:

- *Expose challenges* – Identify the specific issues and challenges that the First Nations communities face when accessing health services and social services in English from federal and provincial systems.
- *Explore strategies* – Share and explore strategies (best practices) utilized by First Nations to address the challenges of accessing English-language health services and social services from the province. Explore how these (and other) strategies may work in First Nation communities when accessing health and social services. Finally, determine how these strategies can be sustained in the long term.

### 2.2 Research approach

This project used an action-research approach to document the perspectives of English-speaking First Nations. Action research (or participatory research) is a way of conducting research that allows participants to be directly involved in the research process – determining questions, gathering data, reflection, and deciding on a course of action.<sup>10</sup>

The researcher worked with the members of the Coalition to identify questions, and decide on the best ways to gather information from the communities. Community support was critical to the research, and key individuals from each community assisted in bringing people together to participate in the focus groups and interviews.

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<sup>10</sup>Chilisa, Bagele. *Indigenous Research Methodologies*. California: Sage, 2012 : 226-227. Print.

### **2.3 Activities**

The activities involved in the research project included:

- Review the Access Project proposal prepared by the HSIF Coalition
- Scan reports and relevant materials regarding accessing health services and social services for English-speaking population of Québec
- Scan reports from Aboriginal Health Transition Projects (AHTF) undertaken by the First Nations partners.
- Attend project meetings as required
- Develop and test research tools (i.e., consent forms and research questions)
- Work with First Nations communities to set up a list of potential participants from the participating First Nations communities (community resource people and community members)
- Conduct focus groups and interviews
- Transcribe focus group and interviews
- Analyze information received
- Draft research report
- Review draft research report, and conduct any additional research
- Submit final Research Report

### **2.4 Methods**

The research methods were as follows:

- Research Design – Develop an appropriate research methodology; develop research questions/tools; test research tools to ensure that methods are relevant and appropriate for the First Nations communities;
- Literature Scan – Gather documents and reports related to accessing English-language health services and social services from provincial institutions; review Aboriginal Health Transition Fund (AHTF) reports from the participating communities;
- Data Collection – Work with Coalition and Project Managers to prepare a schedule for the data collection. Work with local HSIF Research Liaisons to gather information from First Nations communities (focus groups and interviews);
- Analysis – Compile, organize, transcribe, and review the data collected through the focus groups and interview processes; and,
- Share Findings – Finalize research report.

### 3. BACKGROUND

#### 3.1 Aboriginal health legislation and policy environment

In Canada, health and social services for Aboriginal Peoples fall under the responsibility of both federal and provincial governments. Over the years, what has emerged for Aboriginal Peoples is described in *The Aboriginal Health Legislation and Policy Framework in Canada* as a ‘complex patchwork of policies, legislation and relationships’ among the federal, provincial and Aboriginal governments. Generally speaking, the lack of clarity over jurisdictional responsibilities has negatively impacted Aboriginal Peoples access to “appropriate and responsive” health care.<sup>11</sup> Also, when federal and provincial governments have met and negotiated without First Nations at the table, the resulting decisions did not favorably impact First Nation communities. Throughout this research, in various ways, members of the English-speaking First Nations Communities in Québec (CESFNCQ) asserted that: there is a lack of understanding about their capacity and competency; there are assumptions about First Nations’ abilities to manage; and as a result some English-speaking First Nations fear the 2014 negotiations with their federal and provincial partners.<sup>12</sup>

To understand the present situation, the lack of clarity over jurisdictional responsibilities as well as the ‘fear of negotiations’, there is a need to critically examine how the policies and legislation have evolved over the years. In 1979, the federal government brought forward the Three Pillars / Indian Health Policy. According to Health Canada, this policy stems from the unique relationship between Aboriginal Peoples and the federal government. In their analysis, O’Neil et al., reiterate the three pillars for health identified within this policy in this way: (1) restore Aboriginal health through community development, (2) reaffirm the traditional relationship of Aboriginal peoples with the

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<sup>11</sup> National Collaborating Centre for Aboriginal Health (NCCA). *The Aboriginal Health Legislation and Policy Framework in Canada*. British Columbia: U Northern British Columbia, 2011 : 1-3. PDF file. [Synopsis of *Looking for Aboriginal Health in Legislation and Policies: 1970 to 2008*, by Josee Lavoie et al].

<sup>12</sup> CESFNCQ. Steering Committee Meeting. September 2013. Review of Research Report.

federal government, and (3) strengthen the relationships among the components of the health care system (including provincial and private medical services). This health policy for Aboriginal Peoples required a shift; that is, the Three Pillars policy provided a foundation upon which First Nations and Inuit could deliver their own community health services.<sup>13</sup> (Although some communities had already assumed control over health and social services, as well as community health nursing.)

From the early 1980s, Aboriginal communities have gained more control over health and social services in their communities through the devolution of programs from the federal government. Over the last few decades, First Nations communities have taken over the delivery of programs and services such as: National Native Alcohol and Drug Abuse Program (NNADAP) and the Community Health Representative Programs (CHRs). As well, the federal government established the Non-Insured Health Benefits Program (NIHB) to provide funding for some health services that were not covered by either provincial or third party resources.<sup>14</sup>

The various community-control initiatives have promoted the self-government of health services for Aboriginal people.<sup>15</sup> For example, the Kateri Memorial Hospital Centre (KMHC) in Kahnawake, established in 1955, today provides curative and preventative services as a result of a “nation-to-nation” arrangement between Kahnawake and the Government of Québec.<sup>16</sup> Today, many communities are actively engaged in identifying health and social needs of their communities and developing their plans accordingly.<sup>17</sup>

While it is true that communities are administering and delivering more services through federal transfers and agreements; nevertheless, there remain questions, and frustration,

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<sup>13</sup> O’Neil, John, et al. : 137.

<sup>14</sup> Ibid. : 139 -142.

<sup>15</sup> Ibid; 139.

<sup>16</sup> Hospital services have existed in Kahnawake since the early 1900s. In 1955, the Mohawk Council of Kahnawake took over the hospital services. In 1970, the Kateri Memorial Hospital Centre (“the clinic”) opened its doors. In 1973, the Ministère des Affaires Sociales du Québec designated the community clinic as a “hospital centre”. Since that time the Kateri has received funding “on the same basis as other hospitals in the Province of Québec”. (Macaulay, Ann C. “The History of Successful Community Operated Health Services in Kahnawake, Québec.” *Can Fam Physician* 34 (1988). PDF file.)

<sup>17</sup> CESFNCQ. Steering Committee Meeting. Montreal, May 29, 2013. Preliminary Research Presentation.

about whether or not the programs “are truly responsive to Aboriginal community needs”.<sup>18</sup> The criticism to gaining administrative control is that Aboriginal communities are not fully in control of the planning, implementing and evaluation of health and social services intended for their communities.

Despite the changes to legislation, and subsequent transfer agreements, the access issues remain. To this point, the First Nations Regional Health Survey (2008/10), reveals that just under 40% (38.6%) of First Nations adults felt that they had less access to health services than that of the general Canadian population.<sup>19</sup> For English-speaking First Nations people in Québec the obstacle of language magnifies access issues.

**Kitigan Zibi, Algonquin | Anishinabeg**

*There is a lack of access to specialized services in English. Speech therapy for children is another place the language barrier creates obstacles. ... I think if you're accessing any provincial service, I don't know too many that are in English. For those who are disabled trying to access services, there's nobody in English.*

Finally, as stated within *The Aboriginal Health Legislation and Policy Framework in Canada* there is a growing awareness that Aboriginal communities are “better positioned to identify their own health priorities and to manage delivery in their own communities.”<sup>20</sup> With this in mind, to improve access to health and social services – and to adequately address the ‘complex patchwork of policies, legislation and relationships’ that has emerged– Aboriginal communities and organizations need to have an active role in responding to, developing, and shaping policies and relationships with the federal and provincial governments. As the Coalition put it, Aboriginal communities and organizations want the opportunity to meaningfully respond, through a clear consultation

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<sup>18</sup> O’Neil, et al. : 140.

<sup>19</sup> First Nations Information Governance Centre. First Nations Regional Health Survey (RHS) *Phase 2 (2008/10) National Report on Adults, Youth and Children Living in First Nations Communities*. Ottawa: First Nations Governance Centre, 2012 : 69. PDF file.

<sup>20</sup> *The Aboriginal Health Legislation and Policy Framework in Canada* : 5.

process, to policies, which may impact their access to health and social services from federal and provincial institutions.<sup>21</sup>

### **3.2 Government responsibilities**

First Nations may access health services and social services from both the federal and provincial governments. Yet, depending on whether or not the First Nation community has entered into agreements with the province of Québec, there are different conditions for the delivery and funding of health and social services. The following section summarizes information from the *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit) – Frame of Reference*. This reference document was put forward by the Ministère de la Santé et des Services sociaux (MSSS) for communities that are ‘not under agreement’, as well as those ‘under agreement’.<sup>22</sup>

- The Coalition communities that are ‘not under agreement’ include: Gesgapegiag, Listuguj, Kahnawake, Kanasatake, Kitigan Zibi, Eagle Village/Kipawa, and Timiskaming.
- The Coalition community that is ‘under agreement’ includes: The Naskapi Nation of Kawawachikamach (Northeastern Québec Agreement signed in 1978).

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<sup>21</sup> CESFNCQ. Steering Committee Meeting. Montreal, May 29, 2013. Preliminary Research Presentation.

<sup>22</sup> Québec. Ministère de la Santé et des Services sociaux (MSSS). *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit) – Frame of Reference*. Québec, 2007. PDF file.

**a.) Health and social services provided in communities ‘not under agreement’**

- Program development and the organization of health services and social services are the responsibility of Aboriginal authorities or federal government, depending on whether or not the community has taken charge of service delivery.<sup>23</sup>
- Funding of health services and social services provided in the communities is the responsibility of the federal government, except for the medical care covered by the Régie de l’assurance maladie du Québec. (Note: The Kateri Memorial Hospital of Kahnawake is funded by Québec).
- Community Health and Environmental Health Services.
- Generally, the health services provided in Aboriginal communities focus on “promoting health and preventing disease” (front-line services).
- Addictions and Mental Health.
- Health Canada funds a program of non-insured health services.<sup>24</sup>
- Health Canada funds six alcohol and drug treatment centres for Aboriginal people, five of which are for adults while one is for youth.<sup>25</sup>
- Social Services – A series of programs are funded by Indian Affairs and Northern Affairs Canada. Services are provided in the following areas: child, family and adult services, child and adult placement, home assistance, family violence prevention and the integration of people with disabilities.
- Indian Affairs funds a certain number of safe homes for women and children who are victims of family violence, residential centres for people with decreasing

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<sup>23</sup> With respect to the Coalition communities, the following have not yet taken charge of health service delivery: Kanesatake, Eagle Village/Kipawa, and Temiscaming. With respect to social services, Kanesatake and Temiscaming have not taken charge of the delivery (*Delivery and Funding of Health Services and Social Services for Aboriginal People : 9-10.*)

<sup>24</sup> The NIHB program provides services such as: prescription drugs, vision care, dental care, medical supplies and equipment, medical transportation, and crisis intervention. (Canada and First Nations. Health Canada and Assembly of First Nations’ (AFN). *Your Health Benefits: A Guide for First Nations to Access Non-Insured Health Benefits*. Ottawa, 2011. PDF file.). Therefore, because First Nations people and Inuit are covered under the NIHB, they are “not covered by Québec’s basic prescription drug insurance plan under the Regulation respecting the basic prescription insurance plan (c.A-29.01,r.2)”. (*Delivery and Funding of Health Services and Social Services for Aboriginal People : 11.*)

<sup>25</sup> There are six alcohol and drug treatment centres, four of which are located in Coalition communities: the Wanaki Center in Kitigan Zibi; the Mawiomi Treatment Services in Gesgapegiag; the Onen’To:Kon Treatment Services in Kanesatake; and the Walgwan Centre in Gesgapegiag (for youth). The other two centres are located in La Tuque and Sept-Îles, respectively (*Delivery and Funding of Health Services and Social Services for Aboriginal People : 8.*)

- independence who require less than two and half hours of care per day, group homes for people in difficulty, and foster care.
- The facilities that provide health and social services in Aboriginal communities ‘not under agreement’ are not regarded as institutions of the Québec network.

**b. Health and social services provided in the communities ‘under agreement’:**

- Québec assumes responsibility for the funding of the health and social services provided in the Aboriginal communities under Agreement with the province (Cree, Inuit and Naskapi).
- Québec is responsible for funding non-insured health services for communities under agreement.
- The Naskapi community of Kawawachikamach has its own CLSC, which is under the authority of the Côte-Nord (Region 09) health and social services agency.

### **3.3 Québec’s Network**

In Québec health services and social services fall under one administrative authority, the Ministère de la Santé et des Services sociaux (MSSS), which is regulated by An Act Respecting Health Services and Social Services (Chapter S-4.2). Generally, according to the MSSS, its objective is to: “maintain, improve and restore the health and well-being of the population by making a set of health services and social services accessible ...”<sup>26</sup>

In early 2000, the Government of Québec set about changing its delivery of health and social services for its population. At that time, the government established a commission with a mandate to hold public consultations to discuss issues facing the health and social services system and to propose solutions for the future.<sup>27</sup> Although these consultations were held across Québec, there are questions as to the extent that English-speaking Quebecers engaged in discussions. For instance, in “What Future for English-language health and social services in Quebec?” James Carter argues that from 1994 - 2003, two

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<sup>26</sup> Québec. MSSS. *The Québec Health and Social Services System – in brief*. Québec, 2008 : 3. PDF file.

<sup>27</sup> Québec. MSSS. *Report and Recommendations: Emerging Solution*. Québec, 2001. Commission of study on health and social services. PDF file.

major events changed the "political and administrative" context for the implementation of right to services i) "Radical transformation of the health and social services system; and – ii.) Government sanctioning of the introduction of language politics into the delivery of services in English."<sup>28</sup> Both the transformation of the health services (i.e., networks) and the 'sanctioning of language politics' affected access to service for English-language speakers, including First Nations people seeking services in the English language.

In their discussions about the restructuring of the health and social services network, members of the Coalition spoke about the Government of Québec's lack of consultation with First Nations during the restructuring of the health and social services system – and more specifically, the detrimental impact that the restructuring had on community members ability to access to services in English.<sup>29</sup>

By 2004, the Government of Québec had reformed its health care system by introducing local service networks. According to the MSSS, the corridors of service were intended to ensure that all members of the population would be able to easily access services. In setting up the networks, the goal of the Ministry was to make certain that those who are most vulnerable: "people suffering from mental illnesses, health problems or chronic illness, those nearing the end of the life, frail seniors and troubled youth" would be able to easily access services.<sup>30</sup> Furthermore, according to the Québec Ministry, the system is intended to "welcome the user", determine the individual's needs and "guide him toward an effective service."<sup>31</sup> In his analysis of the network system, Carter asserts that each of the local services networks has assigned designated corridors – "in order to facilitate access of the population of each of the territories to ultra-specialized services."<sup>32</sup> In sum,

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<sup>28</sup> Carter, James. "What Future for English-language health and social services in Quebec?" [Community Health and Social Services Network (CHSSN)] *The Vitality of English-speaking Communities of Quebec: From Decline to Revival*. Ed. R.Y. Bourhis. Montreal: CEETUM, U de Montréal, 2008 : 4. PDF file.

<sup>29</sup> CEFNCQ. Steering Committee Meeting. Research Meetings. Nov. 2012 – Sept. 2013.

<sup>30</sup> Québec. MSSS. "Local Services Networks and Health and Social Services Centres." Santé et des Services sociaux, Québec. 2013. Web. Feb. 2013.

<sup>31</sup> Québec. MSSS. "Local Services Networks and Health and Social Services Centres." Santé et des Services sociaux, Québec 2013. Web. Feb.. 2013.

<sup>32</sup> Carter. 97.

the corridors were intended to make certain that all members of the population could easily access to both general and specialized health services and social services.

Generally speaking, however, the corridors have impacted English-speakers access to English-language services in part because individuals' 'freedom to choose' the institution for services is restricted. The restructuring changed the manner by which organizations deliver their services, and consequently how individuals access services was impacted. As stated by Carter, "institutions within a network must concentrate on meeting the needs of the populations within their assigned zones (population responsibilities)."<sup>33</sup>

For the English-speaking population, and in particular for English-speaking First Nations, the new 'corridors of service' are presenting challenges when seeking out services (specialized and general) in English. This research exposed some of the challenges for English-speaking users when navigating the system if the services they need fall outside of their designated zone or corridor of service. "*We are being refused and redirected to a corridor that does not have or offer the service in English,*" stated one participant.

**Kanesatake, Mohawk | Kanien'kehá:ka**

*Now they say that if you are not from that region you cannot access those services. I have had children caught waiting months [to receive services at a hospital in a different region] only to hear, 'No, we will not give you English services here. .... Sometimes having to go through a committee first ... I have seen delays of a year-and-a-half to two-years trying to get speech language pathology assessments done. Really challenging*

As well, the needs of the population are supposed to be considered in the planning and delivery of programs and services. The Québec Ministry, as stated by Carter, "encourages the participation of English-speaking communities at the institutional level to ensure that their needs are taken into account in the planning and delivery of services."<sup>34</sup> However,

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<sup>33</sup> Carter : 98.

<sup>34</sup> Ibid. : 99.

there are challenges for English-speaking First Nations communities to participate in the planning not only because of language obstacles, but also because there is a lack of awareness of First Nations communities by mainstream society. In sum, although all members are supposed to navigate the system from general to specialized services; the ease by they are able to navigate is questionable.

For English-speaking First Nations, navigating the system would require involvement at all levels of management – at the local, regional and central level; and in all areas – policy direction, coordination and organization of services.

**Table 1. List of the governance structure of the health and social network**

<b>Governance Management Level</b>	<b>Function</b>
Central	Ministère de la Santé et des Services sociaux (MSSS) <u>establishes policy direction</u> (health and social services) and assesses the services of the network ( <i>planning, funding, allocating financial resources, follow up and evaluation</i> ). <sup>35</sup> * Fourteen (14) organizations (Advisory Boards) report to the Minister of Health and Social Services (Note: <i>Among these organizations is the Provincial Committee on the provision of health services and social services in English.</i> )
Regional	Health and social services agencies <u>coordinate and organize the services</u> in their respective territories. *There are a total of eighteen (18) regional administrative authorities
Local	Local health and social services <u>networks deliver services</u> to the population of a territory. *Corridors of Service: There are ninety-five (95) local service networks, known as health and social service centres (CSSS). <sup>36</sup>

<sup>35</sup> Information in this table from: Québec. MSSS. “Local Services Networks and Health and Social Services Centres.” Santé et des Services sociaux, Québec 2013. Web. Feb. 2013.

<sup>36</sup> The CSSSs were established in 2004 by merging local community centres (CLSCS), residential and long-term care centres (CHSLDs), and generalized and specialized centres (CHSGSs). (Ibid.)

### 3.4 Access Programs

In Québec, there are programs in place to make certain that the English-speaking population can access services in English. Notably, in 1999, the Québec Government adopted English-language service plans (these Access Programs are described in section 3.6).<sup>37</sup> Although the Access programs were in place, there continued to be issues and challenges for the English-speaking population to access health and social services. In 2005, the Community Health and Social Services Network (CHSSN) commissioned a polling firm to survey English-speaking persons across Québec on a range of issues related to community vitality.<sup>38</sup>

A few years later, in 2008, the Government of Canada launched the Road Map for Canada's Linguistic Duality. Through the Road Map, Health Canada funded initiatives to improve access to health and social services in English.<sup>39</sup> At that time, the CHSSN was requested by Health Canada to produce a report outlining the health and social services' priorities for English-speaking communities for the years 2013-2018. Subsequently, the Québec Community Groups Network (QCGN) was commissioned to conduct research. Their research report, *The Health and Social Service Priorities of Québec's English-speaking Population 2013-2018*, draws on the findings from the 2005 survey, and also from the researchers' consultations with English-speaking communities across Québec.<sup>40</sup> Some First Nations communities were included in the consultation process, and in fact the report confirms that:

First Nations communities and their members experience many of the same obstacles to access as do other English-speaking citizens, but some

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<sup>37</sup> Carter. : 94.

<sup>38</sup> Ibid. :94.

<sup>39</sup> Community Health And Social Services Network. 2012. *CHSSN*. Web. Feb. 2013

<sup>40</sup> Quebec Community Groups Network. *The Health and Social Service Priorities of Québec's English-speaking Population 2013-2018 – A Document Based on a consultation of member's of Québec's English-speaking population*. [Québec], May 2012. PDF file.

obstacles are experienced more intensely as a result of language and cultural differences, socio-economic disadvantages, and racism.<sup>41</sup>

As indicated in the passage above, First Nations and Québec -citizens face similar obstacles when accessing services because of language; however, as affirmed by Québec Community Groups Network, First Nations' experiences of obstacles resulting from language are "more intense" because of "cultural differences, socio-economic disadvantages, and racism."

Although the QCGN's consultations intentionally sought to include English-speaking First Nations' perspectives, nevertheless, the findings do not fully capture the issues and challenges facing First Nations. For instance, the demographics in the report refer to English-speaking Quebecers as a whole, and do not specifically refer to the First Nations population. Consequently, it would be difficult to draw out Québec's 'population responsibilities' for English-speaking First Nations without an understanding of their specific demographics and community profiles.

In addition, the questions used in the consultations focused on the programs and services delivered by the MSSS: First Nations participants would have had limited opportunity to fully voice the access challenges and issues they face outside of those jurisdictional areas. Given that First Nations fall under the authority of both federal and provincial governments, therefore when it comes to determining priorities for health services and social services, any consultation process would need to take into account issues and challenges that First Nations faces when accessing services from both federal and provincial systems.

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<sup>41</sup>*The Health and Social Service Priorities of Quebec's English-speaking Population 2013-2018* : 52

### 3.5 Québec’s Health Services and Social Services Act

#### Listuguj, Mi’gmaq

*When my son went in for surgery on his lungs. Everybody spoke French, when he went for his operation no one came and talked to me in English. I was sitting there, getting angry and nervous. Finally, a nurse came over and explained everything to me in English. She stayed with me, and I said ‘My God, I love you!’*

In Québec the health and social services system is regulated by An Act Respecting Health Services and Social Services (Chapter S-4.2).<sup>42</sup> The Act provides guidelines for the delivery of health services and social services, recognizing the right of English-speaking persons to receive health and social services in the English language. (Appendix B: Excerpts – Health and Social Services Act.) In addition, the Act stipulates the need to consider the distinct characteristics of the population it is intending to service. Throughout the research, participants (both community members and community resources workers) raised the issue and asked questions about their cultural and linguistics rights when accessing health and social services from the province.

The following section summarizes information from the *Frame of reference for the implementation of programs of access to health and social services in the English language for the English-speaking population*, a reference document produced by the Ministère de la Québec Santé et des Services sociaux (MSSS).<sup>43</sup> The *Frame of reference* specifies information about language legislation and Access programs for English-speaking persons in Québec.

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<sup>42</sup> An Act Respecting Health Services and Social Services (chapter S-4.2). Éditeur officiel du Québec 2013 Québec. Web. Feb. 2013 The language legislation that forms the backdrop to the delivery of programs and services in English includes: the federal government’s Official Languages Act (passed in 1969), which “recognizes French and English as the official languages of Canada” (bilingualism); and Québec’s language policy, Official Language Act, S.Q. 1974 (known as Bill 22) and the Charter of the French Language, 1977 (known as Bill 101). For a legal and political legislative context of the legislative guarantees for English language health services. (Silver, Richard. “The Right to English Health and Social Services in Québec: A Legal and Political Analysis.” *McGill L.J.* 45 (2000) : 681 -755. PDF file.)

<sup>43</sup> Québec. MSSS.. Quebec, 2006. PDF file; Québec. MSSS. “Access Programs for services in the English language.” Santé et des Services sociaux, Québec. 11 Oct. 2013. Web. 11 Oct. 2013.

## Right to Access Health and Social Services in English in Québec

- English-speaking persons in Québec have a right to receive health and social services in English at **designated institutions**.
  - In Québec, there are a total of 42 institutions (of approximately 200 public institutions in Québec), which are designated to make health services and social services accessible in the English language. (*As per Article 29.1 of the Charter of the French Language and under Québec's health and social services Act (Article 508).*)
  - The majority (29 of 42) of the designated institutions are located in the administrative region of Montreal (06).
- English-speaking persons may access programs and services in English, which are listed in a region's Access Program (**Indicated Services**) (*Québec's health and social services Act, Article 15*)
- Agencies are responsible to develop an **Access Program** outlining the services and programs that are available in English at various institutions.
  - These programs are to be revised every three years. The Access Programs are intended to reflect the diverse needs and characteristics of the population for whom the program is intended.
  - The Access Programs are developed by the agencies, in collaboration with institutions and English-speaking representatives of their respective regions.
  - Once developed, the Access Program is tabled with the Minister of Health and Social Services and approved by the Government (*Québec's health and social services Act, Article 348*)
- At the **regional level**, there is a committee responsible for the regional access programs. The agencies must seek the opinions of the regional committee when developing their access program (*Québec's health and social services Act, Article 510*)
- At the **central level** (provincial) the *Comité provincial pour la prestation des services de santé et des services sociaux en langue anglaise* advises the Government with respect to the approval of the access programs of each region. (*Québec's health and social services Act, Article 509*)

### 3.6 First Nations Rights

As well, participants asked about their rights, as Aboriginal People, to access health and social services from provincial institutions. The following information is from the MSSS' *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit) – Frame of Reference*;

- Aboriginal people are covered by the Health Insurance Act (c. A-29) and the Hospital Insurance Act (c.A-28);
- Aboriginal people, “regardless of where they live in Québec, are entitled to equal access to the health services and social services of the Québec network, like all Quebecers.
  - Although entitled to ‘equal access’ like ‘all Quebecers’, there are access issues resulting from language for English-speaking clientele.
- First Nations members may access health services and social services that are available in their own communities.
- Thus, First Nations may access services from either First Nations’ health and social services organizations or from provincial institutions of Québec’s network (*such as CLSCs (local community service centres), hospitals, etc*).

#### **Kawawachikamach, ᓇᓴᓐ | Naskapi**

*People need to be informed about what are their rights. Here [in the North] they think it's a privilege, not a right, to have health care. [We need] to be more informed. It's also a communication thing [First Nations] don't have enough information forwarded to them.*

## 4. COMMUNITY PROFILES

*At many of the focus group sessions, participants spoke about the importance of respect: Respect for ‘who we are as First Nations’; as well as respect and awareness about First Nations’ history, culture and languages.*

### 4.1 First Nations communities in Québec

- In the province of Québec, there are eleven Aboriginal nations (including First Nations and Inuit); there is a total of forty-one First Nations communities in the province, and fifteen Inuit communities.<sup>44</sup>
- The total Aboriginal population (First Nations and Inuit) in the province of Québec is 98 731 (with 69 900 residents and 26 667 non-residents).
- Approximately 64.5 % of the total Aboriginal population (*and an estimated (71% of the community/resident population)*) either speaks English, or English is the first official language spoken after their own Traditional language.<sup>45</sup>

First Nations who took part in this research spoke about the need for more awareness and understanding of the distinct and diverse histories, culture, languages and demographics of their respective Nations developing policies for health services and social services.

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<sup>44</sup> Québec. Secrétariat aux affaires autochtones. “Aboriginal Population in Quebec.” [Aboriginal Affairs and Northern Development Canada, Indian Register, December 31, 2012.] Québec. 27 May 2012. Web. March 2013.

<sup>45</sup> Approximate figure based upon information about First Nations and Inuit communities (languages spoken): Canada. Aboriginal Affairs and Northern Development Canada. “Welcome to the First Nations Profiles.” Aboriginal Affairs and Northern Development Canada. 16 Jan. 2013. Web. Oct. 2013.; and with data from Statistics Canada, 2012 “Aboriginal Population in Quebec.” *Author’s note: Further research is needed about to obtain an accurate figure for the languages spoken by Aboriginal Peoples of Québec.*

## 4.2 Coalition communities

The English-speaking Coalition of First Nations' Communities of Québec is comprised of four nations: Naskapi, Mi'gmaq, Mohawk and Algonquin; from eight First Nations communities: Kawawachikamach Naskapi Nation, Gesgapegiag, Listuguj, Kanesatake, Kahnawake, Eagle Village First Nation / Kipawa, Kitigan Zibi, and Timiscaming. The communities are located throughout the province of Québec in urban, rural and remote geographic areas. The First Nations that currently comprise the Coalition are situated within six of Québec's eighteen public health regions, including: Outaouais, Abitibi-Témiscamingue, Côte-Nord, Gaspésie-Îles-de-la-Madeleine, Laurentides, Montérégie.

### a.) Languages

For the majority of the Coalition communities, English has either become the predominant language spoken, or it is the main language in which business is conducted. (For instance, in Kawawachikamach the majority of community members speak their Traditional language of Naskapi; for some this is their *only* language, while others also speak English and a small percentage speak French).<sup>46</sup> Although in many Aboriginal communities (First Nations and Inuit), English has become the predominate language spoken, still there are many speakers, and learners, of the respective nations' Traditional languages. Furthermore, for many Aboriginal communities, as indicated by participants, the priority is to retain the Traditional language first, and French after. Indeed, studies confirm that the “protection” and “enhancement” of Aboriginal heritage and language is vital to processes of decolonization and empowerment.<sup>47</sup> In comparison, for the mainstream English population whose mother tongue is English, there is a high rate of

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<sup>46</sup> Des Roches, Michel. *Portrait démographique et sociosanitaire de la population*. CLSC Naskapi. Janvier 2005 : 1. PDF file.

<sup>47</sup> Taylor, Donald et al., “Aboriginal Languages in Quebec Fighting Linguicide with Bilingual Education.” *Diversité urbaine* (2008) : 69-89. PDF file.

bilingualism (English and French), which has increased steadily since 1991.<sup>48</sup>

## **b.) Age Structure**

Aboriginal communities across Canada have a fast growing and younger population than that of the overall Canadian population. Aboriginal communities have a far greater younger population because of the high birth rate and a lower overall life expectancy.<sup>49</sup> Likewise, in Québec, the median age for the First Nations population is 31 years of age, while the median age for the non-Aboriginal population is 41 years of age.<sup>50</sup> With regards to the mainstream English-speaking population in Québec, the population is ageing; the number of people under the age of 35 has decreased significantly over the past 35 years.<sup>51</sup>

## **c.) Nations**

ᑭᑦᑲᑦᑲ | *Naskapi*

The Naskapi of Kawawachikamach live within the northern region of Québec on the Québec-Labrador border. Surrounded by “rocks, trees, and water,” the community is situated just fifty kilometers south of the tundra line. The name Kawawachikamach means “the winding river.”<sup>52</sup> Today, many Naskapi continue aspects of their traditional way of life and culture. The main language spoken is Naskapi, and similar to other northern communities many Naskapi People rely on subsistence hunting, fishing, and

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<sup>48</sup> Canada. Parliament. House of Commons. Standing Senate Committee on Official Languages. *The Vitality of Québec's English-Speaking Communities: From Myth to Reality*. Ottawa: Senate of Canada, 2011 : 7. PDF file.

<sup>49</sup> Adelson, Naomi. “The Embodiment of Inequity, Health Disparities in Aboriginal Canada.” *Canadian Journal of Public Health* 96 (2005) : 49. PDF file.

<sup>50</sup> Canada. Statistics Canada. National Household Survey, 2011. “Median age for First Nations and non-Aboriginal population, provinces and territories, 2011.” Statistics Canada. 2 May 2013. Web. March 2013.

<sup>51</sup> *The Vitality of Québec's English-Speaking Communities: From Myth to Reality* : 7

<sup>52</sup> McGill University, Culture & Mental Health Research Unit. “Naskapi Nation of Kawawachikamach (Quebec) | ICIHRP Roots of Resilience Project - McGill University.” *McGill*. 13 May 2011. Web. Dec. 2012.

trapping for a large part of their food supply, and for many raw materials. Harvesting is at the heart of Naskapi spirituality.<sup>53</sup> Kawawachikamach is the most northern community that is part of the Coalition of English-speaking First Nations Communities in Québec.

### *Mi'gmaq*

The homeland of the Mi'gmaq nation is called Mi'gma'gi. The territory is made up of seven districts, which encompass what we know today as the Atlantic Provinces, the Gaspé Peninsula and parts of Québec, parts of Newfoundland and Labrador, and the northern part of Maine.<sup>54</sup> There are three Mi'gmaq communities in Québec of which two are members of the Coalition: Listuguj and Gesgapegiag.

### *Mohawk | Kanien'kehá:ka*

The Mohawk (Kanien'kehá:ka) have a rich, vibrant, and unique heritage. Kanien'kehá:ka is one of six Indigenous nations that make up the Six Nations (Iroquois) Confederacy (also called the Haudenosaunee). The traditional homelands of the Haudenosaunee extended over a vast territory, encompassing much of present-day northeastern North America. As a confederacy of six nations, the Haudenosaunee were joined together under an alliance and form of governance known as the Great Law of Peace. The Kanien'kehá:ka Nation is comprised of eight communities, located in Québec, Ontario, and New York State.<sup>55</sup> The Mohawk communities of Kanesatake and Kahnawake are part of the Coalition.

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<sup>53</sup> Naskapi Nation of Kawawachikamach. "Overview [The Nation and the People]." *Our Community*. n.d. Web. Dec. 2012.

<sup>54</sup> Mi'gmawei Mawiomi Secretariat. *Nm'tginen, Memnaq Ejiglignmuetueg gis na Naqtmueg*. Listuguj: Mi'gmawei Mawiomi Secretariat, 2007. Print.

<sup>55</sup> Mohawk Council of Kahnawá:ke. "Tsi Nitiohtón:ne Oká:ra (History of Kahnawá:ke)." Mohawk Council of Kahnawá:ke. 3 Seskehkó:wa 2013. Web. Oct. 2013.

Algonquin, or Anishinabeg, which means ‘the people’ or ‘first people’, have lived on Turtle Island for thousands of years. A strong element of the Anishinabeg belief system is respect; every animal, every plant, every stone, is part of the circle of life.<sup>56</sup> There are nine Algonquin communities in province of Québec of which three are members of the Coalition: Eagle Village/Kipawa, Kitigan Zibi, and Timiskaming.

**d.) First Nations Communities**

**Table 2. Community Profiles – Location, Population, and Administrative Regions**

<b>Community</b>	<b>Location</b>	<b>Population</b>	<b>Administrative Region</b>
<b>Kawawachikamach</b>	Kawawachikamach is situated at the south end of Lake Matemace, about 16 kilometers northeast of the Town of Schefferville on the Québec-Labrador border	Total population of 1,170 persons (with 857 living in the community and 313 living outside of the community <sup>57</sup> )	La Côte-Nord (09), Remote
<b>Gesgapegiag</b>	Gesgapegiag is located on the southern Gaspé coast, on the north shore of the Cascapedia Bay (about 45 kilometers west of Bonaventure)	Total population 1,412 (with 672 living within and 740 living outside of the community)	La Gaspésie-Iles-de-la-Madeleine (11), Rural
<b>Listuguj</b>	Listuguj is located in the southwestern part of the Gaspé Peninsula. Surrounded by the Appalachian Mountains, the community is situated on the northern banks of the Restigouche River,	Total population 3,672 (with 2,086 living within and 1,586 living outside of the community)	La Gaspésie-Iles-de-la-Madeleine (11), Rural

<sup>56</sup> Doerfler, Jill, Niigaanwewidam James Sinclair, and Heidi Kiiwetinepinesik Sark. *Centering Anishinaabeg Studies – Understanding the World Through Stories*. Winnipeg: U of Manitoba, 2013. Print.

<sup>57</sup> Information for this table from: Quebec. Secretariat aux affaires autochtones. “Aboriginal Population in Quebec.” [Aboriginal Affairs and Northern Development Canada, Indian Register, December 31, 2012.] Quebec. 27 May 2012. Web. March 2013.

	across from the province of New Brunswick ( <i>Border community with New Brunswick</i> ).		
<b>Kahnawake</b>	Kahnawake is located on the South Shore of the St. Lawrence River, 10 kilometers southwest of the city of Montreal	Total population 10,336 (with 7,745 living within and 2,591 living outside of the community)	Montérégie (16), Urban
<b>Kanesatake</b>	Kanesatake is situated approximately 60 kilometers North West of Montreal, on the banks of the Rivière des Outaouais (Ottawa River)	Total population 2,321 (with 1,383 living within and 938 living outside of the community)	Laurentides (15), Rural
<b>Kitigan Zibi</b>	The Kitigan Zibi Anishinabeg community is situated just outside the municipality of Maniwaki. The community is 130 kilometers north of Gatineau/Ottawa. It is bound on the north by Riviere de l'Aigle and Riviere Desert ( <i>Border community with Ontario</i> )	Total population 3,021 (with 1,593 living within and 1,428 living outside of the community)	L'outaouais (07), Rural
<b>Eagle Village   Kipawa</b>	Eagle Village First Nation is located 10 kilometers west of Temiscaming, on the bank of Lake Kipawa ( <i>Border community with Ontario</i> )	Total population 951 (with 276 living within and 675 living outside of the community)	L'Abitibi-Témiscamingue (08), Rural
<b>Timiskaming First Nation</b>	Timiskaming First Nation is located at the head of Lake Temiskaming, approximately 600 km from Ottawa ( <i>Border community with Ontario</i> )	Total population 1,923 (with 641 living within and 1,285 living outside of the community)	L'Abitibi-Témiscamingue (08), Rural

## 5. FINDINGS

### 5.1 Overview

The goal of this research was to document a portrait of English-speaking First Nations when accessing English-language services from provincial and federal systems. In addition, the research sought to document solutions to these challenges. To seek out the perspectives of English-speaking First Nations, focus groups and interviews were conducted with two main groups: First Nations community resources (front line workers from both health and social services) and First Nations community members (Elders, caregivers, parents with young children, and individuals with chronic conditions). (Appendix C: Table. Focus Groups, Interviews Held, and Questionnaires.)

In the winter of 2012, research tools (research questions and consent forms) were developed, reviewed by the Coalition, and then tested with First Nations' front line workers.<sup>58</sup> (Appendix D: 'Interview Guide for Aboriginal Health Transition Fund (AHTF)'; Appendix E: HSIF Focus Group and Interview Guide). Coalition members identified a research liaison from their respective communities who assisted with the data gathering. In some communities, the research liaison set up the focus groups or interviews, while in other communities the liaison facilitated the sessions and gathered the data.

The researcher (or research liaison) conducted the focus groups and interviews on site or with video conferencing/telephone. The focus group sessions and interviews were recorded; the audio was transcribed, or there was a note taker present. Participants who were unable to attend the focus group session or interview had the option to reply to the research questions in written format. The sessions were held in English, with the exception of the community of Kawawachikamach, which held its focus group in Naskapi and English. The research was explained to participants, and consent was

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<sup>58</sup> Research methodology and tools were reviewed by the Coalition at the Project Launch. Québec City, January 28, 2013. Research tools were tested by the researcher with front line workers of health services and social services agencies in Listuguj on February 6, 2013.

obtained either by group consensus or by having the participants sign consent forms at the beginning of each session. Each focus group session lasted from two to three hours, while interviews were generally thirty minutes in length. The names of provincial institutions were not included in the report; however, the locations of the institution are included, if mentioned by the participants. The names of the communities are included; however, individuals are not mentioned by name to ensure confidentiality. Finally, following the review of the draft research report, a questionnaire was developed to gather additional information (preliminary research) about a specific access issue that was identified by the Coalition (Appendix F: Questionnaire – Transportation and Lodging).

## 5.2 Exposing issues and challenges

### a.) Key access issues and challenges

The following is a compilation of the **key access issues and challenges** identified by participants. The access issues are listed in order of priority, and any issues common to both groups (health and social services' workers and community members) are marked with an asterisk\*.

#### *First Nations Community Resources*

- Access to specialized services in English
- Documentation and Information in English\*
  - Key areas: patient records/medical charts, training information, assessment tools, websites, government sites, updates for immunization protocols, ambulance forms, information to understand provincial legislation or new policies in the areas of health and social services
- Training in English (including supporting documents)
- Cultural Discrimination / Lack of Cultural Sensitivity\*
- Communication – language barriers\*
- Jurisdictional Issues: Provincial Borders, Corridors of Service, and Federal/Provincial responsibilities for First Nations
- Access to general services, in either French or English

#### *First Nations Community Members*

- Long wait times for services, and even longer wait for services in English
- Emergency Services (Emergency Room and Dispatch)
- Documentation and Information in English\*
- Communication – language barriers\*
- Cultural Discrimination / Lack of Cultural Sensitivity\*
- Attitudes and Perceptions (fear, anxiety, and not being understood because of language and culture)
- Funding (lack of clarity about who is responsible for First Nations, provincial or federal authorities)
- Quality of Services in English (i.e., assessments, discharge from provincial institutions)

The key access issues identified by each participating First Nation community are included in Appendix G of this report.

**b.) Compilation of data**

The data collected from the focus groups and interviews was compiled and organized into four broad areas:

- i.) General Access Issues and Challenges;
- ii.) Issues Resulting from Language;
- iii.) Issues Related to Culture; and
- iv.) Positive Experiences.

The research data was analyzed to determine which issues and challenges are common among all the communities, as well those issues that are shared by some members of the Coalition because of their geographic location – remote, rural or urban.

The findings for each individual First Nation community are included in Appendix H of this report.

## i.) General access issues and challenges

### *Common issues identified by all First Nations Communities*

- **First Nations lack information and knowledge about where and how to access services from the provincial network.** The responses varied among participants. In rural areas, some participants were unaware that they could access services from provincial institutions (i.e., CLSCs), while others (rural and urban) reported not knowing where to access services (in particular English-language services) in Québec.
- **Concerns about quality of care.** In remote areas, participants reported that ‘errors are being made’ with medication and clients’ appointment; in urban and rural areas, participants reported that quality of care was a matter of ‘*luck of the draw*’, depending on the individual staff and/or institution.
  - *There was a case where there was an error in medication. The names [of clients] were the same, but the medication was sent to the wrong house. (Kawachakimachach)*
  - *When you call you get bounced around and end up in a department you don’t even want. One member tried to get his address corrected and couldn’t manage to do it. He also had a problem in that his file was confused with his son’s, which could have resulted in a significant accident. I don’t trust those guys, I have to be pretty damn sick to go there [hospital] (Gesgapegiag).*
- **Perceptions and Beliefs when accessing services from provincial institutions.** Participants were reluctant to access services from provincial institutions (hospitals, CLSCs, etc.) because of negative perceptions about the quality of care. Community members spoke about their ‘fears’ and ‘anxiety’ around accessing services from the province.
- **Long wait times to access services (specialists, testing).**
- **Ageing population.** Participants described the difficulties that elderly people have communicating with specialists and asking questions about their health needs. Others described the difficulty that elderly clients have to navigate and find services at hospitals because of age-related issues.
- **Travel.** Mixed responses from participants. For those in remote and rural areas there are challenges because of distance (lack of good roads), while participants from urban areas reported difficulties because of a lack of public transportation available to access services at institutions within their corridor of service. Participants reported issues associated with funding for travel through Health Canada’s Non-Insured Health Benefits (NIHB).

- **Government cutbacks in funding to health services.** Participants reported that government cutbacks (provincial & federal), generally speaking, are impacting health and social services: fewer services, and First Nations community organizations need to make up the gap in services.
- **Two-tiered health care.** Participants reported that clients there is an ‘emerging ‘two tiered health care system’ and that “for a fee” individuals can ‘buy their way to quicker services’ (Public Health vs. Private Care).

*Remote & Rural Areas (general access issues)*

- **Distance to access services (travel).**
- **Lack of general and specialized health and social services in either English or French.**
- **Difficult to find a family doctor in Québec.**
- **Lack of access to medical equipment in the area** (i.e., dialysis equipment, wheelchair, walkers, etc.).
- **Transportation and lodging.** Challenges for those from rural and remote areas when traveling to urban areas for medical reasons (general access issue and language).
  - Based on preliminary research (questionnaires), participants are ‘somewhat satisfied’ with the transportation and lodging services;
  - Some participants noted that language is an issue with the transportation; Clients are frustrated in that the drivers do not speak enough English for comprehension purposes;
  - Participants expressed concerns with the lodging; specifically: lack of choice with respect to lodging; there are “mix-ups” with the accommodations; the accommodation process (making reservations with the third party service provider) is “complicated”; and participants expressed concern about the safety of boarding homes;
  - Key informants indicated that First Nations organizations are subsidizing the cost for alternative accommodations. Recommended that communities should be able to run the program (transportation and lodging) based on their own needs, and with adequate funding to support the services required.
  - *Lodging is the big problem. People don’t feel comfortable in someone else’s home where they speak a different language. They should have a choice of where they would like to stay.*

## ii.) English language access issues

### *Common Issues among all First Nations Communities*

- **Language barriers (communicating) – Doctors and specialists more likely to be bilingual, less so for nurses, front line workers, and reception.**
  - *Sometimes nurses yell if people can't understand French, as if speaking louder would help! (Gesgapegiag)*
  - *Mental Health Services: If the person walks into a place and they're getting the impression that this person doesn't really understand them, they'll ask 'why am I going there?'; It's hard enough to get them to go to counseling. They won't go back; They won't open up, they won't talk; You have to have someone who is fluent ... you want to be comfortable that what you are saying is being interpreted in the way and meaning of what you are saying. (Listuguj)*
  - *Some of the doctors speak English. For my son, his doctor speaks English, but it's the receptionists who are difficult. They only speak French. I get my mother to call because I cannot speak French, and whenever we go to the hospitals, I get my mother to come along for the same reasons. (Eagle Village | Kipawa)*
  - *If I am sick, it is already scary enough and if I have a nurse/doctor telling me what is wrong and I don't understand what they are saying, it further affects me – I may not understand the diagnosis and service plan. (Kahnawake)*
- **Calling provincial institutions is difficult because of language barriers.**
  - *If you have to call CLSCs after 4 p.m. or on weekends, it's French. They want to know why you are calling, and I myself am not totally bilingual, but I try to give them the information, it's hard because of the language. (Kitigan Zibi)*
- **Documentation from the province is mainly in French. Participants highlighted:** Information from Professional Orders (Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec (OTSTCFQ); signage; information from the province; reports, assessments and discharge papers; invitation letters from the province (including invites to meetings about 'English Access' programs); Medical Alerts, Protocols and Medical Information; and Training Information – lack of access to English materials.
  - *A lot of information that we get is always in French, and to try to get it in English it's hard; Difficult to obtain information in English, even from*

*organizations that deems themselves bilingual; Lack funding to translate documents, materials or forms: If you want to translate it yourself you can, but do you realize how expensive that is?! Long wait period when requesting province to translate documents. (Listuguj)*

- *Some templates (i.e., for 'Home and Community Care') are sent to First Nations' community organizations in English, however, the instructions may be 100% in French; Ambulance Forms – The forms are all in French, but all of the first responders have adapted and learned to use them. They might not specifically be able to translate what things mean, but they could tell you what box they need to tick of for something like respiratory problems. They get the sense of what it all means, and make due. (Kahnawake)*
- *We do have basic little hand-outs for [clients] that [the province] provides for us in English. But say a mother requires some information about the PIQ [Protocole d'immunisation du Québec] and the only information I can draw from is outdated from the older translation, I don't know how old the information is---maybe five years old. It's not right and downright dangerous. (Kitigan Zibi)*
- **Tracking clients' information is difficult because of language barriers.**  
Participants described obstacles because clients' information may be charted in French, which then requires translation for English-speaking community resource workers. However, in some communities nurses (community health centres) track community members' information in English (homecare stats, vaccines, reports).
- **Translation services are limited: lack of funding and treatment can be delayed while waiting for translations.**
  - *The Agence de la sante has provided a translator on site at the hospital, and I believe it's four days a week within office hours. So, unless you time your sickness within those office hours, there's going to be some issues. (Eagle Village | Kipawa)*
- **Limited access to training in English in Québec.**
  - *Courses are mainly offered in French. We need to go to Ontario for training in English. If we get our training from out-of-province, it may not be accepted by Québec and the information (guidelines, recommendations, procedures) may be different between provinces. (Timiskaming)*
  - *It can be difficult to receive training from a worker who is not fully bilingual; It's frustrating when you're trying to learn something while struggling to understand what the instructor is saying. (Timiskaming)*

- **Lack of access to health and social services in English.** In remote and rural areas, participants reported difficulty accessing both general and specialized services, while in urban areas there were obstacles accessing specialized services. Many participants from across the regions spoke about difficulties accessing: speech language therapy, mental health services, audiologists, and services for individuals (in particular youth) with physical and developmental challenges (ie., autism, learning disabilities).
  - *Access to services for families with special needs is very difficult. First Nation Health Centre brought in services from New Brunswick for autistic child because [there is] none in the area. Services in English for children with Down's syndrome are very limited, even off reserve. (Gesgapegiag)*
  - *The services provided to the students by the CSSS in the school are lacking. Because our students aren't capable of receiving services in French, then a lot of services are pulled back. ... It's not uncommon for parents to just up and leave the province altogether because the services they get for their special needs child in English is not acceptable – long delays and quality of service is not there. (Eagle Village | Kipawa)*
  - *With Ontario doctors refusing our patients, we need to find a place to send them, calling one hospital, another, a third hospital, a four, to get names of doctors, and because they are not locals and can only be here once a month, you send referrals and they get lost. Sometimes I find it very difficult to know where to refer a patient because they change – I have names of psychologists, psychiatrists, and they are not there anymore and you need to do this research all over again. (Timiskaming)*
  
- **Limited access to mental health services in English.**
  - *The mental health issues are more impacted by the language barrier. Clients need assistance with translating personal information for them to obtain services. (Kanesatake)*
  - *Waiting lists everywhere: patients are leaving hospitals, yet no psychiatrists available for these mental health patients. Discharge from hospitals is an issue (strain on family/community); Limited options for psychologists in English. Assessments – limited pool for conducting assessments (non-insured, psychiatrist services). Report provided in French and organization needs to pay to have assessment translated, increases the cost of doing an assessment. (Kahnawake)*

- **Limited detoxification services and treatment services in English.** (Jurisdictional issues, provincial boundaries, funding, and long waiting lists.)
  - *First Nations organizations are sending clients to New Brunswick and Nova Scotia for detoxification services. However, despite having service agreements, some provincial institutions are only accepting referrals from Québec after their own clientele has been served. (Gesgapegiag)*
  - *[Our] Community has paid out considerably to send a few members to private clinics in Québec for English services (approximately 75,000\$ invested one year by the community to send three people from the community to long-term private clinics for English services in the province of Québec). (Kitigan Zibi)*
  
- **Corridors of Service. The provincial network (corridors) can present obstacles for individuals seeking services in English.** Participants reported delays in assessments and treatment (i.e., for speech language pathology). Others reported challenges for any type of mental health services in English if sent to closest hospital (by ambulance). In urban areas, participants commented that travel is also an issue because of provincial corridors: clients must travel farther, and with less public transportation available to them, in order to access services in their own corridor. In border and remote communities, participants reported that they are being encouraged to “stay in the province of Québec,” even if they need to travel farther –but within the province – to access services.
  - *The corridors of service have been changed for people living on the South Shore. Access to hospitals in Montreal is restricted, clients being referred back to South Shore. More and more we are being delegated to the South Shore for services, which are almost all French. The “State of the Art” medical services are on the island and we are being shut out because of our postal code address. (Kahnawake)*
  - *There’s a constant stress in that the provincial government wants to keep everything in the region ... We wouldn’t have any problem staying in Québec, if they could provide those services in English. There’s pressure on us to stay within Québec [rather than going out-of-province]. However, because of the language issue we end up further and further away from our communities. It’s a big circle. (Eagle Village | Kipawa)*
  
- **Emergency Services. General access issues and obstacles because of language and culture.** In remote areas, there are challenges for community members to access emergency services. In rural and remote areas, participants reported that in addition to access issues and language obstacles, the emergency response time is ‘even slower’ in First Nations’ communities. In urban areas, participants reported issues with emergency services, for example documentation of ambulance forms

available in French only, and reported that there is a lack of employment opportunities and training opportunities for English-speaking individuals (paramedics).

- *If you live in the city and you dial 911, that ambulance will be there at your doorstep. Why isn't it the same here in the northern region? (Kawachakimachach)*
- *I've gone on emergency calls in an ambulance, and the ambulance driver and the one working on the patient, they speak French ... That's been a big barrier. (Kanesatake)*
- *I think we've lost lives because of it. Because of waiting, and longer delays: the ambulance driver spending 10 or 15 minutes just trying to find the road in the community. (Kitigan Zibi)*
- **Ageing population.** General concern expressed among all communities that elderly First Nations' community members are not seeking services from the province. There are obstacles associated with ageing, language, and cultural issues.
  - *A lot of Elders don't go to the doctors if they have pain. In the end they may have something very serious. And, they are not comfortable going to CLSC because of the language ... If you trust where you are going you will go and get help, but if you don't trust where you are going you won't go to get help. (Kawachakimachach)*
- **Judicial.** Issues with language where social services interfaces with the Department of Youth Protection and the provincial court system. There are limited services available in English in remote and rural areas. In urban areas, the main issue for judicial services is with the translation of documents (quality of translation, cost).
  - *It's confusing in the courts because there is so much back and forth, the facts get lost in translation ... Using an interpreter also raises the problem of confidentiality and privacy for the client. (Gesgapegiag)*
- **Long wait times for services in English.** Participants report having to wait longer to get services because of language barriers (speech language therapy, rehabilitation services, mental health services, for example).
- **Critical Care.** Participants spoke about issues because of language while at provincial hospitals with family members who were in 'critical care'. In remote and rural areas, the issue of having an escort was identified as a challenge, while in urban areas participants said that institutions cannot always ensure that a

bilingual worker will be available for those in critical care.

- *Once surgery and diagnosis is finished and the person is in critical care, then you need to be able to communicate with people who are assessing you to determine if you are passing benchmarks or deteriorating. It's that lack of confidence that community members feel that people will not understand them and communicate their needs in very vulnerable situations. The hospital is not always able to ensure that bilingual people will be available. (Kahnawake)*
- **Perceptions and beliefs influence whether or not individuals will seek out services from provincial institutions.** Participants reported that they felt they were being discriminated because they are English-speaking. Some participants reported that individuals avoid using hospital services because of language barriers: language is interfering with quality of care when seeking services from provincial institutions.
- **Employment and hiring.** Participants from all regions reported that there is a lack of opportunity for First Nations who cannot speak French, even within organizations of English-speaking First Nations' communities

#### ***Remote & Rural Areas (language barriers)***

- **Medication and Prescriptions.** In remote areas, participants reported obstacles receiving information, in writing, in English (e.g., how to take medication, possible side effects).
- **Crisis Situations.** Participants reported a lack of services in English for women/children/families in crisis situations (e.g., violence, sexual abuse).

#### ***Rural & Urban Areas (language barriers)***

- **Provincial boundaries** are presenting barriers to individuals seeking English language services out of province (e.g., denial of services such as treatment services and mental health), and issues with funding when seeking services from out of province.
  - *People are bounced back and forth between the hospitals in New Brunswick and Québec depending on the issues; [The boundary] divides the population and influences when they are willing to go to the hospital. (Listuguj)*
- **Provincial databases and software are mainly available in French.** In both rural and urban areas participants reported that the 'French only' databases available in health services and social services are presenting obstacles in the workplace for First Nations' community organizations.

- *They've tried to make [the database] available to First Nations communities in Québec, but it is still not available in English. To keep up with the standard of delivery and tracking of data, in comparison with the rest of the province, we have to wait until that database is available to us. (Kitigan Zibi)*
- **Liaising and networking with provincial institutions.** Participants spoke about the difficulty liaising and networking because of language barriers.
- **Negotiating English-language services and placements for adults and children with severe special needs is difficult.** There are challenges because of limited services, and transferring to a different region is difficult (corridors of service and issues with funding). Although there are agencies that serve the Anglophone communities, participants from urban areas reported that English-speaking First Nations are not the top priority.
- **Provincial Help Lines.** Participants reported obstacles when accessing services from provincial help line numbers because of language. Community workers reported that they rely on out of province lines or US lines. Participants from urban areas were more familiar with Info Santé in comparison to those from rural or remote areas.
  - *The Elder abuse, the hotline number is very difficult to access for a lot of community members. We've always come back to that same question 'When an Elder is being abused, who do they call?' Where do they go? Because when they try to access that 1-800 number, it's all French. (Listuguj)*

#### ***Urban Areas (language barriers)***

- **Youth seeking services in English.** Teens may require additional support (i.e., transportation, information). Participants reported that youth (generally speaking) do not seek out services.
- **Medical vehicles (ambulances).** In urban areas, participants reported obstacles because of language. *English-speaking communities need to make certain that the writing inside of the ambulance is in English and not solely in French*
- **Support Services/ Resources.** Participants reported difficulty accessing programming, support services and resources for health and social issues, in English.

### iii.) Access issues related to culture (Aboriginal)

#### *Common Issues among all First Nations Communities*

- **Provincial legislation creating barriers for English-speaking First Nations' communities.**
  - Language Legislation (Proposed Bill 14). Participants spoke about the difficulty of striking a balance between the workers' rights to speak French in workplace and clients' rights to receive services in English. For First Nations, there are additional issues because many felt that their rights as First Nations (cultural and linguistic) are not being respected.
  - *Many community members believe that nurses can speak English but many simply do not want to, "they want you to speak French." Québec's new language policy [Bill 14] is creating even more problems. (Gesgapegiag)*
  - Bill 21: Obstacles to recruit and retain English-speaking professionals to work in English-speaking communities; professionals (nurses and social workers) may work in communities on 'conditional basis' only. Required to be part of the Professional Order, however, documents, meetings, and training are available in French only.
  - Bill 49, Act for Family Resources (language issues and governance). In addition to issues with language, there are also issues because First Nations were not consulted about the proposed changes.
  - *The new system for Foster Care placements does not take into account First Nations culture, spirituality, sense of identity of the child and community. (Kahnawake)*
  - *Lack of understanding of First Nations communities service delivery capacity, the province and even in some case the feds don't know what we are doing. (Kahnawake)*
- **First Nations' health needs and priorities are not being met. Community organizations reported that they are 'going beyond their mandates' to make up for the gaps in services.**
  - Participants reported that it is difficult for First Nations to access to services despite being included in the population count for the region (Note: In remote area, a priority issue identified was ambulance/emergency services).
  - Case management / Translation Services – Participants (First Nations health care workers) reported that they are spending a lot of time and energy on case management, primarily because of language issues

(referrals, booking appointments, and follow up.) Funding is not available for translation this service (translating documents, placing phone calls). Thus, staff members at First Nations organizations who are bilingual, and willing to go above and beyond their own responsibilities, fill this need for their clientele.

- **Funding. Reported a lack of adequate funding for First Nations' health and social services, and obstacles accessing funds because of language.**
  - First Nations' organizations are expected to provide more services, with the same level of funding (i.e., lack of funding for translation services)
  - Proposals – The perception is that language is an issue when submitting proposals to government to access funding for projects (funding/project proposals need to be submitted in French).
  - *First Nations' Health and Social Issues are well-known, there is a lack of funding to implement lasting solutions. (Kitigan Zibi)*
  
- **Non-Aboriginal Health Benefits (NIHB). Obstacles when accessing services.**
  - Lack of clarity and information about what is covered and what is not covered through NIHB. Participants reported that community members are 'caught paying bills' for health services due to the lack of clarity.
  - Obstacles accessing payment for services (i.e., medication) under the NIHB (non-Native Health Benefits) program. Participants may need to pay out of pocket, and then wait for reimbursement from Health Canada.
  - Not all medications are covered under NIHB, in particular for palliative care patients.
  - Participants reported that there is a lot of paper work involved for clients, and not all service providers will accept NIBH.
  - Participants reported inequities in what is covered under the NIHB in comparison to provincial programs geared for individuals who are receiving social assistance.
  - Limited Coverage for Mental Health Services through Non-Insured Health Benefits (NIHB).
  - *For an elder that goes in and wants to get their eyes done, there's a little bit of a barrier, wondering, 'Do they pay for the drops at the optometrist?' Is it reimbursable? They don't tell them enough about that information; They go to pharmacies, and the pharmacists say, 'it's not covered.' If a person doesn't have money to pay, they may not receive their medication. (Kanesatake)*
  - *There is a growing issue of "delay of care" due to the decision to centralize the bureaucratic program approval process in Ottawa it is worsening the situation. (Kahnawake)*

- **Jurisdictional overlap between federal and provincial governments creating barriers when accessing services.**
  - First Nations have access to health and social services from both federal and provincial governments, however participants reported that there is a lack information and clarity about who is responsible for what services (delivery of services and funding), which affects access to services.
  - Participants reported that there is a lack of services for physically handicapped persons due to disputes over fiduciary responsibilities.
- **Consultation and engagement health planning is insufficient.**
  - Participants reported that the province is not conducting meaningful consultation with English-speaking population, including First Nations, about changes to health policies. (i.e., Québec’s changes to computerized system for health records).
  - Participants reported that there are difficulties for English-speaking First Nations communities to fully participate in health planning and decision-making with the province: linguistic obstacles and lack of accommodation of First Nations health priorities.
- **Communication between First Nations’ and provincial organizations/institutions – gaps in discharge.**
  - First Nations community members reported that patient’s confidentiality is not being maintained in the communications between the hospital and the community health services (not satisfied with quality of services).
  - Lack of communication between institutions (First Nations and provincial) when clients are discharged.
  - Language is an obstacle because the discharge summaries are all in French.
- **First Nations Rights are not being respected.**
  - Participants commented that community members are “being taken advantage of” if they don’t speak French. Client’s rights are being violated because “*workers [at provincial institutions] talk about you, but you don’t know what they are saying.*” (*Kawachakimachach*)
  - Some First Nations are not aware that they have a right to access services from provincial institutions: participants reported a lack of information

about how and where First Nations can access services from the province.

- First Nations reported that it was difficult to make formal complaints to provincial institutions – some participants stated that they were ‘afraid to rock the boat’, and others were not familiar with complaint processes. Bilingual participants reported assisting English-speaking First Nations to lodge their complaint in writing.
- *Not only the Naskapi, but all Native people are facing racism. There is an attitude of colonization ... We have to be fighting all the time for rights that are already given to everyone else. But we have to fight for them every day. We don't have the right to be informed. We don't any respect given to us for who we are and what we are. (Kawachakimachach)*

- **Discrimination and lack of cultural sensitivity.**

- Participants spoke about their frustration with the lack of cultural understanding and awareness about Aboriginal history, culture and social context. In remote and rural areas, many participants spoke about a lack of respect for their culture and ‘feeling judged’ by provincial workers. Some reported that, or their clients, have experienced “discrimination and cultural stereotyping” when seeking services from provincial institutions.
- Double discrimination – as English speaking persons, and as Native people.
- *There are still some people out there who look at you and treat you differently because of the colour of your skin. (Eagle Village | Kipawa)*

- **Language and culture**

- Participants from all communities (rural, remote and urban) spoke about issues with language and culture. Some said it was ‘unjust’ to expect First Nations community members to have to learn/speak French, given that some First Nations have already lost their language once, learning English.
- *There was a loss of language once, and [Aboriginal languages] were replaced with English, they cannot expect you to change your language again. (Kahnawake)*
- *Provincial institutions and specialists lack knowledge and awareness about First Nations culture and history. There is a lack of understanding ... there is a lack of understanding about ceremony. (Listuguj)*

- **Ageing Population**

- There are challenges for Elders because of linguistic issues and challenges related to health issues associated with ageing. Reported that many Elders are ‘falling through the cracks’.
- Elders who need nursing home care face obstacles because of language, which may trigger ‘reliving residential school experiences’.
- *They fall through the cracks a lot, because when you talk about elders ... first of all their first language is Mohawk. They always have someone with them to help. Okay, this is the first time they are going alone, so you ask them what they need to do and they say, ‘I don’t know. They just gave me this paper,’ so if nobody is going to help them, how are they ever going to be diagnosed with cancer? Because they didn’t know what to do with that paper.” (Kanesatake).*

- **Detoxification and treatment services.** Participants spoke about the lack of culturally and linguistically appropriate care for First Nations when seeking services for detoxification and treatment (rehabilitation) from the province. Participants spoke about the gap between detoxification and treatment services.

- **Escort/liaison services.** Participants reported that clients who need assistance because of language are not able to access ‘escort/liaison’ services (primarily available for elderly population).

- **Medical Transportation**

Lack of funding for medical transportation (generally speaking). Funding for transportation is not always available when accessing services ‘out of province’ or in a different corridor of service (which clients need if seeking out English-language or culturally appropriate services).

- Some reported that the transportation services are not always available in English. When traveling from rural to urban areas, participants described being unable to communicate with drivers resulting in ‘missed appointments’.
- *[Elder’s experience, translated from Naskapi into English]: Our Elder spoke about the escort that was needed. His son had a small surgery, a small bypass. He was going to have an escort, but at that time he was not provided with one because there were no funds for an escort (Kawachakimachach).*

### *Remote areas*

- Training in the community for students in health field can be problematic (i.e., intern doctors, social work programs). Participants reported obstacles because of language barriers and a lack of respect for cultural protocols.
- Language and Culture (Naskapi, English and French) – lack of respect, awareness and understanding about First Nations history and culture.

### **iv.) Positive Experiences**

At the focus group sessions and in the interviews, participants spoke about positive experiences when accessing services from the province. The following is a compilation of comments from the First Nations communities in remote, rural, and urban areas:

- **Projects that bring together the federal, provincial and First Nations – positive outcomes.**
  - First Nations are building connections and relationships with local provincial institutions through joint projects
  - There is an increased awareness among community members that First Nations may access services from the provincial CLSCs.
- **Agreements between First Nations organizations and provincial institutions are improving access to services.**
  - Agreements have resulted in increased access for First Nations in some areas (i.e., mental health).
  - Agreements between First Nations organizations and provincial institutions have allowed for the inclusion of cultural practices
  - Mental Health Services (Suicide Prevention): Hospitals are making efforts to accommodate English-speaking workers from First Nations' community organizations
  - Building relations – Hospital is reaching out to First Nations community during crisis situations
- **Quality of care. Some participants reported being satisfied with the quality of care received while at provincial institutions.**
  - Participants described compassionate nurses, willing to speak English with patients when undergoing surgery.
  - Some participants reported that they are satisfied with the quality of care and services at provincial institutions: some hospitals described as “excellent” and “culturally sensitive”.
  - Staff at provincial institutions described as “understanding”, and “willing” to provide services in English. Other participants reported that emergency service providers spoke English and were “attentive” and “caring”.
  - One participant spoke positively about a CLSC social worker assisted the mother to access rehabilitation services in English, from out of province, for a youth who is severely autistic.

- Staff at CLSC are helpful – assisting individuals (knowing where, how, what is required)
- Efficient services from local CLSC: when making an appointment, the CLSC provided the client with a date and time when they would call, all communication was in English.
- RAMQ services: Very helpful and efficient
- **Some participants reported that wait times for services have not been too long.**
- **Services are available in English at some provincial institutions, including hospitals and CLSCs.**
  - When able to access services in English, participants spoke positively about the quality of services available to them. In the larger urban centres, there were “usually no problems” finding someone who speaks English.
  - There are hospitals in Québec (in larger urban areas such as Montreal) where the services in English are good. Sometimes, clients may be afraid about getting around, because it’s all French, and when they come back, they always say, ‘You know, it’s not too bad. There was always someone around to help us out.’
  - Some staff people try to speak English or provide English documents.
  - Participants commented on the need for a positive attitude and a willingness to work together.
  - If they know that you speak English, some of the support staff [at hospitals] will speak to you in English. Another participant at the session commented on the importance of “cooperation and both parties being willing to communicate using each other’s language.” (Listuguj)
  - Doctors at provincial hospitals are encouraging English-speaking clients to access services from the province.
- **Availability of English language documents.**
  - Participants reported that the documentation and information is available from pharmacists in English (rural and urban areas)
  - Participants described positive results when provincial institution sent invitation letters in English to community members about breast cancer screening; observed an increase in the number of community members who went for screening.
- **Resources and Networking**
  - Participants reported that the Health Canada representative (regional office) is very helpful in giving direction for finding English regional services.
  - Support services for certain chronic conditions are available in English from community organizations (urban areas)

## 5.3 Strategies and solutions

### a. Strategies in place

Participants were asked about the **strategies that they have in place** to address obstacles when accessing services; the following is a compilation of their responses:

- Relationship building
  - First Nations are networking and researching to find out what services are available in English;
  - Building on relationship with the Agency and working with their openness to help (key contacts persons) and showcase best practices, including cultural teachings; and
  - Professionals are visiting First Nations' community (information sessions), and in turn “gain understanding of the communities needs’ and priorities”).
- Agreements and policies
  - First Nations are entering into agreements with provincial institutions; for example, liaison positions to assist clients overcome barriers because of language and culture;
  - Policies have been established between First Nations and provincial institutions, which protect cultural practices (for example, there are policies in place at some provincial hospitals for birth practices following Mohawk cultural practices, established through the Aboriginal Health Transition Fund (Kanesatake)); and
  - Urban Areas: First Nations have entered into special agreements to receive services from other administrative regions; however, participants report that such agreements are becoming more difficult to enter.
- Protocols between institutions
  - Rural Area: Protocols between agencies (provincial hospital and First Nation organizations) about the delivery of services for First Nations clients (for example, Mental Health Protocol and Speech Language Therapy protocol were developed in rural area to provide services to Anglophone and First Nations clientele);
  - Referral Tool established between First Nation organization and some provincial institutions (in English); and
  - Letters sent to provincial hospitals with procedures when discharging clients.
- Accessing services in English from other jurisdictions
  - Participants reported seeking services (primary care, family doctors, and specialized services) from other corridors of service in Québec and also from out-of-province (primarily, New Brunswick, Ontario and also Nova Scotia); also, some clients are seeking services in the US.

- Accessing services in English from private institutions
  - Participants reported that First Nations organizations and/or individuals are paying for private services in English in Québec (i.e., mental health services, detoxification/rehabilitation, and also developmental needs for youth).
- Complaints' process
  - Clients are encouraged to make formal complaints about discrimination (language or cultural) (“squeaky wheel”);
  - First Nations organizations are sometimes asked to write up formal complaints for clients (translator services required); and
  - First Nations' organizations set up meetings with provincial institutions to address issues/complaints.
- Training in English
  - First Nations request simultaneous translation at training;
  - Seek training in English from out of province; and
  - First Nations of Québec and Labrador Health and Social Services Commission (FNQLHSSC) has offered English training for health and social services.
- Translation services
  - Bilingual staff translate documents or place phone calls for co-workers;
  - Staff translate for clients (assist clients to fill out forms that are in French);
  - First Nations need to cover the cost to translate documents; some translation services are provided by FNQLHSSC;
  - Family members who are bilingual will take patients to their appointments and help with translation (i.e., grandchildren will accompany grandparents);
  - Bilingual family members place calls for patients (general inquiries or to book appointments); and
  - Organizations report promoting the use of French: “You do get better reception if you go in with a good attitude”; “Using my ability to speak in both languages has opened doors” (Kahnawake).
- Advocate and escorts
  - First Nations organizations report that they spend a lot of time being an advocate and support for clients to help them get the treatment and services they need;
  - Elders (55+) can have an escort included with transport; and
  - Community members are volunteering at hospitals – visiting patients, and to help people to get around.
- Discrimination and cultural sensitivity
  - First Nations offer awareness training and workshops for service providers, both First Nations and provincial; with a changeover of staff, need to check if the training plan is being implemented;
  - Work with universities to develop ‘Cultural Awareness and Sensitivity’ training for those studying health and social services; and

- To enhance cultural awareness, participants spoke “being assertive and knowing your rights”; “Perseverance”; and “Being creative and culture-based”.
- Emergency services / crisis situations
  - Participants reported taking a bilingual family member with them when accessing emergency services;
  - Urban area: Paramedics reported that “try to put someone on each shift who is bilingual”; and
  - Rural Areas, some border communities: During crisis situations, community organizations seek English-language services from shelters out of province.
- Transportation
  - First Nations are providing transportation services for clients who need to travel to access services (because the service is not available locally or to obtain the service in English).
- Information and awareness
  - Search on various websites to find information to print out materials;
  - Request materials in English from the province (in writing and calling);
  - Documentation (i.e., pamphlets with information about health conditions) are obtained from out-of-province;
  - Information about medication is available in English from pharmacies;
  - Doctors and specialists, some of who are from out of province, deliver workshops and presentations in the community in English; and
  - Rural Areas: Specialists are delivering presentations in English in communities through videoconferencing and webinars (networking with local organizations in the delivery of online presentations).

## b. Proposed solutions

Participants were asked about any **solutions**, which could improve access and expand partnerships; the following is a compilation of their responses:

- Leadership and vision
  - Develop a concrete strategic plan outlining how English-speaking First Nations can gain access to services in English;
  - Establish a ‘Health and Social Services’ forum or body to share information about accessing services from the province; and
  - Political leadership is needed. *“Chief and Council need to address the health sector at the Table with the province”*.
- Relationship building
  - Collaboration between First Nations service providers and provincial agencies is needed (share information for contacts, work together, ‘think tank’);
  - Form partnerships with provincial and local institutions;
  - First Nations need to have a seat on Advisory Boards;
  - Cooperate with local not-for-profit organizations in place for Anglophone communities to overcome access barriers (networking & collaboration); and
  - Establish partnerships with universities: internship opportunities in First Nations communities.
- Agreements and policies
  - Periodically review agreements and policies between First Nations and provincial institutions to ensure proper implementation;
  - Suggested that First Nations establish a code at provincial institutions if clients require services in English;
  - Improve relationship at the local level with CLSCs, hospitals (need consistent policies for services, such as: occupational therapy, specialized nursing, IVs/VAC, Dressings/Support); and
  - Need to have tripartite agreements with First nations, provincial and federal governments (political will required) – address jurisdictional responsibilities and gaps in services.
- Access to services in English – priority areas
  - Ensure that First Nations can access services geared for their own health care needs and priorities (i.e., detoxification, mental health services, developmental needs for youth, care for Elders) First Nations population is young and English services are needed to meet their health care needs;
  - Crisis situations: When services are needed immediately, funding needs to be made available to access services in English from private institutions;
  - Private Clinics: Long-term funding for services at private clinics;

- Corridors of Service: English-speaking clients need access to services at English speaking hospitals and from English-speaking health care providers, rather than accept the Corridor of Service;
  - Provincial Boundaries: Need to ensure that English-speaking residents of Québec can continue to access services in English from other provinces (if unavailable in Québec);
  - Referral and follow up: Address how doctors/ hospitals work with clients, directly and/or through First Nations health centre (privacy issues and quality of care);
  - Telephone reception services – Option to speak with an English-speaking agent; and
  - Ageing Population: Support for Elders is needed .
- Rights and Responsibilities – English language and Aboriginal Rights
    - Information about language policies and legislation is needed (i.e., Health and Social Services Act) to access services in English;
    - Bilingual staff at provincial institutions: *Provincial agencies receive per-capita funding to provide services to First Nations communities, therefore they should ensure that there's at least one person on staff who is bilingual;* and
    - Advocate for English-speaking services for First Nations communities.
- Aboriginal culture and Traditional languages
    - Health field needs to recognize Aboriginal Peoples cultural practices and languages. For First Nations who are speakers, services need to be made available in the language. *"We need to work in our language. We could provide services to our Elders. Because our Elders are not in the picture. They need to be put in the picture for the health services even if it's from the provincial government," Naskapi Nation;*
    - Visibility of First Nations: Provincial institutions need to have First Nations' designs and pictures visible in the buildings to encourage Aboriginal Peoples to access services from the province; and
    - Respect: When outsiders work in the community, they need to respect the people – respect their language, culture, and health needs.
- Training and employment
    - Training for trainers (increase the number of English-speaking trainers);
    - More training opportunities (health and social services) in English;
    - Recruit Aboriginal professionals to work in the communities in the areas of health and social services. *It is very important to have Native people with university degrees working in the community;*
    - Promote bilingualism (i.e., through training opportunities for staff); and
    - Remote Areas: Incentives for (local) Aboriginal workers to work in the community (i.e., lodging, rented vehicles, outing allowance).

- Address discrimination and improve cultural sensitivity
  - Cultural Awareness workshops and updates for staff at First Nations and provincial institutions;
  - Orientation sessions with various health professionals/organizations about First Nations culture and services available in the communities; and
  - There needs to be respect for culture, traditional ways, and First Nations languages in the delivery of health and social services.
  
- Complaints' process
  - Establish a process to gather and address complaints from clients (related to language and culture);
  - Track access issues; and
  - Identify possible long-term effects if change does not happen and services are not accessible.
  
- Translation services
  - Funding required for translation;
  - Identify and prioritize which documents to translate into English;
  - Referral Forms – Need to indicate the client's primary language.
  
- Liaison and support services
  - Liaison person for English-speaking clientele (phone calls, fill out forms, and help to navigate through the provincial network);
  - Escort/Support Person (translation and to navigate provincial institutions);
  - *There's this big building, and we're at the building, and there's no door. At least with an Aboriginal liaison there would be a door, and they could say, 'Go see this person... To have someone on hand to understand and translate like that would fix a lot of the problems that we are facing.'* (Kitigan Zibi)
  
- Information and awareness
  - Share information about where and how to access English-language services from provincial institutions in Québec (i.e., create a list of bilingual service providers (issue: high turnover rate);
  - Share information using different methods (i.e., newsletters, radio, websites, posters, presentations, and workshops);
  - Telemedicine: Access to video conferencing for specialized services; and
  - Address First Nations perceptions and beliefs about accessing services from provincial institutions.

## 6. CONCLUSION

This research was conducted to expose issues and challenges that English-speaking First Nations face when accessing services from provincial and federal systems. The conversation began in the East, in the Mi'gmaq communities of Gesgapegiag and Listuguj; then information was gathered from Mohawk territory in the communities of Kahnawake and Kanasatake; then west, in the Algonquin communities of Timiskaming First Nation, Kitigan Zibi, and Eagle Village | Kipawa; the research concluded in the North, in the Naskapi Nation of Kawachakimachach.

The data collection took place over a period of five months, from March 12 until July 24, 2013. Additional Research was conducted from October 4 – October 11, 2013. (The follow up research was preliminary only, and was conducted in a short time frame. It is anticipated that more communities would have participated had there been sufficient time to conduct the research.)

A total of one hundred and thirty participants took part in this research (key informants from health and social services, as well as community members); fourteen focus group sessions were held, involving all eight of the participating communities; and a total of nineteen interviews were conducted. Finally, at the conclusion of the research, each community had the opportunity to complete a questionnaire in order to gather additional research; a total of three communities completed questionnaires, involving an equal number of key informants.

A common theme among the many focus group sessions and interviews was the recognition and awareness about “the difficulty and the need” to strike a balance between workers’ rights to speak French in the workplace, and clients’ rights to receive services in English. As well, First Nations participants spoke about the pressing need for more information about where and how to access services in English. *“We have the right to access services in a language that we can understand, and in the province in which we live,”* said one participant.

Many of the participants spoke about the ‘double discrimination’ that they face: as English-speaking individuals, and also as First Nations. Language and culture are closely connected; participants spoke about the need to break down barriers between provincial, federal, and First Nations organizations, and to build relationships based on respect. In the words of an individual who took part in this research, *First Nations need to consider how important it is for their partners to properly understand their history and culture, and to be able to perform in a culturally competent way when providing services.*

In rural, urban and remote areas from six of the province’s administrative regions, the issues and challenges were discussed, exposing common issues.

**The following are the key priority areas with respect to accessing services for English-speaking First Nations:**

- Communication – language barriers when communicating with workers;
- Jurisdictional issues: Provincial borders, Corridors of Service, and Federal/Provincial responsibilities for First Nations;
- Access to documentation and information in English;
- Cultural discrimination and lack of cultural sensitivity;
- Attitudes and Perceptions (fear, anxiety that there will be a lack of understanding because of language and culture);
- Access to specialized services in English (\*rural and remote areas: lack of access to general services and services in English);
- Long wait times for services, and even longer wait for services in English;
- Lack of availability of training in English in Québec;
- Emergency / Crisis Services (Emergency Room and Dispatch);
- Funding (Lack of funding for services such as translation and liaison workers).
- Dissatisfied with the quality of services in English.

This research was conducted to create a portrait of access challenges when accessing services. The research exposed the challenges facing English-speaking First Nations when accessing health and social services from provincial and federal systems; the research also identified solutions to those challenges.

Over the course of this research, participants from the various First Nations communities spoke about the challenges that they face, as well as the strategies either in place or recommended to improve access to English-language services. In general, common among all the communities, was the perspective that: English speaking First Nations need to be actively involved and engaged in the assessing, planning, and delivery of services at all levels with non-governmental organizations and networks; with the province (local, regional, and central); and with the federal government. Similarly, as expressed by the Coalition of English-speaking First Nations of Québec, *“If First Nations are not being adequately consulted, and if communities are not represented at the Tables, then decisions should not be made on behalf of First Nations.”* Simply put, *“First Nations need to be at the Table.”*

The research is intended to contribute to English-Speaking First Nations’ long-term vision of expanding and building partnerships to improve their access to health and social services from provincial and federal systems. Because of First Nations unique relationship with both governments – federal and provincial, there is a need for a tripartite initiative to be used to address the challenges noted in this report. Reflecting back to the principles of the Three Pillar Policy: that is, restoring health through community development; reaffirming the traditional relationship of Aboriginal Peoples with the federal government; and strengthening the relationships among the components of the health care system, change will be possible. Those who participated in this research recognize that English-speaking First Nations face difficulties, in particular stemming from language issues, when accessing services from provincial and federal systems. Despite the challenges, many English-speaking First Nations voiced their commitment to seek lasting solutions that will lead to community health and wellness.

## **7. RECOMMENDATIONS**

### **1) Expand and build partnerships with federal and provincial partners**

- Develop protocols when working with both levels of government (federal and provincial) to mitigate jurisdictional gaps for First Nations when accessing services;
- Establish and foster relationships with provincial institutions (local, regional and central levels). English-speaking First Nations need to be meaningfully involved in the planning and delivery of services to ensure that the needs of English-speaking First Nations are being responded to appropriately and effectively; and
- Meet regularly with partners to discuss concerns and challenges.

### **2) Develop a strategic plan that reflects the linguistic and cultural needs and priorities of English-speaking First Nations to improve access to services**

- Identify the legislation and policies (e.g., Québec's Act for Health and Social Services, Three Pillars / Indian Health Policy), which could contribute to developing lasting strategies that meet the linguistic and cultural needs of First Nations;
- Address the 'issues, challenges and strategies' facing English-speaking First Nations; and
- Establish formal mechanisms to track access issues and challenges in First Nations' communities (that is, continue to identify the emerging issues, challenges, and solutions by and for English-speaking First Nations).

### **3) Establish protocols and agreements with provincial institutions based on the needs and priorities of English-speaking First Nations**

- Formal mechanisms are needed to ensure a continuity of understanding and communication between First Nations and provincial organizations – at the program delivery level (i.e., regular meetings, committees, roundtable discussions, etc.);
- Evaluate protocols and agreements between First Nations and the province to ensure proper implementation (identify other gaps or challenges in the implementation strategy).

### **4) Collaborate and network with non-governmental organizations and networks to improve access to services for English-speaking people in Québec**

- 5) Integrate First Nations history and culture into the planning and delivery of services – foster cultural sensitivity**
  - Cultural Awareness workshops help to bridge gaps of understanding;
  - Identify any misconceptions that may create obstacles for First Nations when accessing services from provincial institutions.
  
- 6) Share information and raise awareness about services (including English-language services), which are available for First Nations from provincial and federal systems**
  - First Nations’ organizations and provincial institutions need accurate information about the programs and services available at their partners’ institutions;
  - Provide information about how and where First Nations can access services from the province.
  
- 7) Long-term funding is required to build and expand partnerships to effectively address access issues and challenges**
  - Transfer Payments: The federal and provincial governments need to be able to meet the cultural and linguist needs of First Nations to improve access to health and social services from provincial and federal systems.
  
- 8) Formalize the Coalition to enable English-speaking First Nations to address their unique linguistic and cultural needs in order to improve access to services from provincial and federal systems.**
  - Representative of the Coalition to sit on the Provincial Committee for the delivery of health and social services in the English language to ensure that English-speaking First Nations’ access issues are addressed appropriately.

APPENDIXES

Appendix A: Table. Coalition’s Aboriginal Health Transition Fund (AHTF) Projects

First Nation Community	Organization	Project Title(s)
Gesgapegiag	Gesgapegiag Health and Community Services	1.) Improved access to detoxification services adapted to the needs of the Gesgapegiag and Listuguj communities  2.) Development of a plan for continuity of services between the Centre de Santé et des services sociaux de la Baie-des-Chaleurs and the Gesgapegiag Health and Community Services
Listuguj	Listuguj Community Health Services	1.) Improving Access to Health Care Services: Listuguj, Québec and New Brunswick Collaborative Development
Kahnawake	Kahnawake Shakotiiia’takenhas Community Services	1.) Exploring Partnerships– AHTF Integration Project– Onkwata’karitashera
Kanesatake	Kanesatake Health Center Inc.	1.) Assessing, Enhancing and Integrating Health Services for Kanesatake 2.) Cultural Adaptation of Pre-Hospital, in-Hospital and Post-Hospital Services and Liaison for Kanesatake
Eagle Village ~ Kipawa	Eagle Village Health Center	1.) Miwijiwa Minomatsiwin: project focusing on improving the health care and follow-up among the members of the Eagle Village First Nation community (MM)

**Appendix B: Excerpts – Health and Social Services Act**

**Table. Excerpts from ‘An Act Respecting Health and Social Services’ Chapter S-4.1, which refer to both language and culture:**

OBJECTIVE OF THE ACT	<p>Article 1: Services are to “maintain and improve” an individual’s physical, mental and social capacity to carry out their roles in their community.</p> <p>Article 2: Services are to be provided on continuous basis to meet the physical, mental and social needs of individuals, families <b>and groups</b>. Each region’s distinctive characteristics must be taken into account (geographical, <b>linguistic</b>, sociocultural, <b>ethnocultural</b> and socioeconomic);</p> <p>Article 3: The user must be treated with “courtesy, fairness, and understanding” and in a way that respects his “dignity, autonomy, needs and safety”; the user is to be encouraged to play “an active role” in the care and services that concern him; the user is to be provided with information to use services appropriately</p>
RIGHTS OF USERS	<p>Article 4: To be informed about health and social services available in his community;</p> <p>Article 5: To receive continuous care in a personalized and safe manner</p> <p>Article 6: To choose the professional or institutions from whom or which he wishes to receive health services or social services.</p> <p>Article 9: When receiving care of any nature, his consent must be given</p> <p>Article 10: Every user is entitled to participate in any decision making affecting his state of health or welfare.</p> <p>Article 15: <b>English-speaking persons have the right to receive health and social services in English</b>, keeping in mind the resources (human and financial) that are available and the regional ‘Access program’.</p>
USER’S RECORDS	<p>Article 19: When an institution transfers a user to another institution, a summary of their information must be provided to the institution taking charge within 72 hours after the transfer.</p> <p>Article 24: At the request of the a user, an institution must send a copy, summary or extract of the user’s record as soon as possible to another institution or professional.</p>
EXAMINATION OF COMPLAINTS	<p>Article 29: The board of directors of every institution must make a by-law to establish a complaint examination procedure.</p> <p>Article 30: A local service quality and complaints commissioner must be appointed by the board of directors of every institution.</p> <p>Article 33: The complaint commissioner shall .. distribute information to increase understanding of the <b>rights and obligations of users and the code of ethics</b>.</p>

ASSISTANCE BY COMMUNITY ORGANIZATIONS	Article 76.6: When a user wishes to address a complaint ... community organizations involved must collaborate in providing any assistance and support requested by a user.
GENERAL PROVISIONS	Article 80: The mission of a local community service centre is to offer “health and social services of a preventative or curative nature and rehabilitation or reintegration services <b>to the population of the territory served by it.</b> ”
LOCAL HEALTH AND SOCIAL SERVICES NETWORK AND LOCAL AUTHORITY	<p>Article 99.3: The purpose of establishing the network is to foster “greater sense of responsibility” among providers of the network and to ensure that the people in the territory have “continuous access to a broad range of general, specialized and superspecialized health services and social services.”</p> <p>Article 99.5: The local authority is responsible to identify: “the social and health needs and the <b>distinctive characteristics of the population</b>” ... “Supply services required given the <b>needs and the particular characteristics of the population.</b>”</p> <p>Article 99.8: The local authority must use different methods of informing and consulting the public in order to involve people in the organization of services and determine their level of satisfaction.</p>
FUNCTIONS	<p>Article 100: The function of the institution is to ensure provision of safe, continuous and accessible health or social services which <b>respects the rights and spiritual needs of individuals</b> ... respond to the needs of the various population groups ....<b>elicit and facilitate the cooperation with other key players (including community organizations)</b></p> <p>Article 101: Every institution must: i.) receive any person who needs services and assess his needs; ii.) <b>provide the require health and social service directly or from another institution</b> with whom it has entered a service agreement; iii) ensure that services are “continuous and complementary” with those provided by other institutions and resources of the region, and <b>that services are organized a way that reflects the needs of the population it serves</b>; iv) refer persons to whom it cannot provide certain services to another institution or body that provides them.</p> <p>108: An institution may enter into an agreement with another institution: for the provision of certain health services required by the a user of the institution.</p>
BOARDS OF DIRECTORS OF PUBLIC INSTITUTIONS	<p>Article 129: The board of directors is composed of persons who are elected, designated, appointed or co-opted (<b>including two independent persons</b> elected by the public in an election).</p> <p>Article 130: The board of directors must be made up of an equal number of men and women.</p> <p>Article 138: Selection of board members must ensure a “better representation of the territory and <b>better sociocultural, enthocultural, linguistic and demographic representation</b> of the population served by the institutions.</p> <p>Article 171: Board of directors shall establish strategies focusing on the</p>

	<p>populations to be served ...and taking into account the <b>distinctive geographical, linguistic, sociocultural and socioeconomic</b> characteristics of the users and of the human and financial recourse of the institution.</p>
<p>HEALTH AND SOCIAL SERVICE AGENCIES (Regional Institutions)</p>	<p>Article 339: The Government shall establish an agency for each region.</p> <p>Article 340: Each agency shall: prepare a multi-year strategic plan; ensure mechanisms for referral and coordination between institutions; develop information and management tools adapted to the <b>distinctive characteristics</b> of those institutions; develop a mechanism to <b>protect the users and for user rights advocacy</b>.</p> <p>Article 343: Agency shall ensure implementation of a mechanism for public participation (i.e., users' committees).</p> <p>Article 346: Agency shall: i.) ensure that information on health of the population is up to date and accessible and ii.) identify the needs of the population (for its multi-year strategic plan).</p> <p>Article 348: Agency shall collaborate with institutions to <b>develop a program of access to health and social services in the English language for the English-speaking population of its area</b> ... or develop jointly with other agencies of another region (taking into account the human, financial and material resources of the region). Program must be approved by the Government and revised at least every three years.</p> <p>Article 349: Each agency must, with bodies representing cultural communities and the institutions of the region, facilitate accessibility to health and social services in a manner, which is <b>respectful of the characteristics of those cultural communities</b>.</p>
<p>BOARD OF DIRECTORS (Regional Agencies)</p>	<p>Article 397.3: When appointing board members, the Minister must take into account representation of various parts of the territory of the agency, the sectors of activity and the <b>sociocultural, linguistic and demographic groups</b>, as well as the different age groups.</p>
<p>ADMINISTRATION OF THIS ACT</p>	<p>Article 508: The Government shall designate (from among the institutions recognized under section 29.1 of the Charter of the French language (chapter C-11)) <b>those institutions, which are required to make health services and social services accessible in the English language to English-speaking persons</b>.</p> <p>Article 509: the Government shall provide for the formation of a <b>provincial committee</b> advising the Government on: i.) dispensing of health and social services in the English language; ii.) approval, evaluation and modification of each access program developed by an agency.</p> <p>Article 510: the Government shall provide for the formation of a <b>regional committee</b> that shall: advise the agency about the access programs developed by the agency; ii.) evaluate and suggest modifications to access programs.</p>

## Appendix C: Table. Focus Groups, Interviews & Questionnaires

<b>Data Collection –</b>						
<ul style="list-style-type: none"> <li>The data collection for this research took place over a period of five months, from March 12 until July 24, 2013. Additional Research was conducted in a short time frame, from Oct. 4 – Oct. 11, 2013. This research was preliminary only, and was conducted in a short time frame. It is anticipated that more communities would have participated had there been sufficient time to conduct the research.</li> <li>A total of 130 participants took part in this research. Total participants: 130 individuals (100 community resources (health and social services and AHTF key informants) and 30 community members)</li> <li>Target Groups – Community Resources in Health and Social Services; Community Members (Elders and/or their caregivers; parents with young children; and individuals with people with chronic health conditions, both men and women); Key Informants (Aboriginal Health Transition Fund project –AHTF), community resources and community members.</li> <li>Focus group sessions: Fourteen (14) focus groups: ten with community resources and four with community members)</li> <li>Interviews: Nineteen (19) interviews – six with key informants involved with AHTF projects; nine key informants (health and social services); and four with First Nation community members)</li> <li>Questionnaires: Three key informants completed ‘Follow Up Questionnaires’ as part of this research.</li> </ul>						
<b>First Nation Community</b>	<b>Region and Administrative Zone</b>	<b>Data Collection</b>	<b>Target Groups</b>	<b>Number of Sessions</b>	<b>Number of Participants</b>	<b>Total</b>
Gesgapegiag	Rural	Focus Groups	Health and Social Services	1	6	2 focus groups
			Community Members	1	8	1 interview
	La Gaspésie-Iles-de-la-Madeleine (11)	Interviews	Key Informant (AHTF)	1	1	1 <i>Questionnaire</i>
		Questionnaire	Health and Social Service	1	1	16 <i>Individuals</i>
Listuguj	Rural	Focus Groups	Health Services	1	8	3 focus groups
	Border		Social Services	1	5	2 interviews
	La Gaspésie-Iles-de-la-Madeleine (11)		Community Members	1	8	1 <i>Questionnaire</i>
		Interviews	Key Informant (AHTF) & Key Informant (Health Services)	1	1	24 <i>Individuals</i>
			Questionnaire	Key Informant	1	

Kahnawake	Urban Montérégie (16)	Focus Groups	Health Services and Social Services	1	5	2 focus groups
		Interviews	Key Informants (AHTF) Key Informants (Community Resources)	3 8	7 10	11 interviews 25 individuals
Kanesatake	Rural Laurentides (15)	Focus Groups	Health and Social Services	1	10	1 focus group 5 interviews
		Interviews	Key Informant (AHTF) Key Informants (community members)	1 4	1 4	15 individuals
Kitigan Zibi	Rural Border L'outaouais (07)	Focus Groups	Health and Social Services	1	13	2 focus groups
		Questionnaire	Community Members Key Informant	1 1	4 1	1 Questionnaire 18 individuals
Eagle Village ~ Kipawa	Rural Border L'Abitibi-Témiscamingue (08)	Focus Groups	Health and Social Services Community Members	1 1	8 6	2 focus groups 14 individuals
Timiskaming	Rural Border L'Abitibi-Témiscamingue (08)	Focus Group	Health Services	1	9	1 focus group 9 individuals
Kawawachikamach	Isolated La Côte-Nord (09)	Focus Group	Health and Social Services and community members	1	9	1 focus group 9 individuals
<b>TOTAL</b>					<b>130 participants</b>	<b>14 focus groups 19 interviews 3 questionnaires (follow up research)</b>

## Appendix D: Interview Guide for Aboriginal Health Transition Fund (AHTF)

### ABOUT THE RESEARCH

The project “Expanding and Building our Partnerships to Improve Access,” is a multi-year project that will operate from 2012-2015, with funding from Health Canada’s Health Services Integration Fund (HSIF). The project is sponsored by Onkwata’karitáhtshera, which is an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal).

The goal of the project is to formally establish a Coalition. Currently, there are eight First Nations communities involved. The Coalition of English Speaking First Nation Communities in Québec (CESFNCQ) is comprised of the following communities: Eagle Village First Nation, Listuguj, Gesgapegiag, Kitigan Zibi, Kawawachikamach, Kanesatake, Timiskaming and Kahnawake.

One of the Coalition’s objectives is to address the challenges faced by First Nation communities in the province of Québec with respect to accessing health and social services in English.

As part of this work, the Coalition is overseeing a one-year research project. The goals of the research are to create a portrait of the situation by documenting:

- ❖ The challenges and issues that First Nations face when accessing health and social services in English in the province of Québec.
- ❖ The strategies and solutions needed to address the challenges of accessing services in English.

The results of the research will be shared at a forum with the First Nation communities, and their federal and provincial partners.

An Independent Research Consultant has been mandated to conduct research for the HSIF Access Project. **As part of the research, interviews are being conducted to seek out information about the successful strategies that English-speaking First Nations communities developed through previous Aboriginal Health Transition Fund (AHTF) initiative.**

You will be contacting you to make arrangements to conduct a telephone interview using the following questions. If you are interested, please read through the questions, and complete the consent form at the end of the questionnaire. Thank you.

Should you have any questions about the HSIF Access Research contact:

Project Management Team:

Dale Jacobs & Winnifred Taylor  
Organizational Development Services (ODS)  
Kahnawake, Québec

Project Researcher:

Amy Chamberlin, M.A.  
Listuguj, Québec

AHTF – Interview Questions

**Part 1 Questions on Challenges, Issues and Goals**

To start, I would like to learn more about the project that your community developed through the Aboriginal Health Transition Fund (AHTF) initiative:

- 1) Generally, can you describe your community’s AHTF project?

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- 2) What gaps were you trying to address? (In particular any access issues related to language)

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- 3) What were the main activities that your organization undertook through this project to accomplish your end goal? Please provide examples

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- 4) What were you hoping to accomplish or realize through the project?

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**Part 2 Questions on Outcomes**

We would like to hear more about what resulted from the project.

- 1.) Can you tell me about any changes or outcomes that may have resulted because of this project?

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2.) Did you identify other gaps or needs, particularly related to language, from this project. Please provide examples.

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**Part 3 Questions on Long Term Impact**

The following questions address the long-term impact of the project and what happened after the project initiative came to a close.

1.) After the AHTF project came to a close, did the initiative continue in any way? Please describe what has been happening.

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2.) From your perspective, how can the solutions developed through the AHTF projects be sustained over the long term? What is needed to make sure the strategy has a lasting impact.

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3.) In your view, how might other First Nations communities benefit from the strategies or solutions that your community developed to address access issues? Describe the lessons learned.

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**Part 4 Closing**

1.) Are there any other comments that you would like to make?

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Thank you for your time.

**CONSENT FORM**

**Community:** \_\_\_\_\_

TITLE OF AHTF PROJECT(S): \_\_\_\_\_

\_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

PLEASE CHOOSE:

We accept to have a telephone interview based on the ‘Interview Questions’ \_\_\_\_

We do not accept to have a telephone interview based on the preceding questions \_\_

We will prepare answers to the questions and e-mail our responses \_\_\_\_

LIST OF PARTICIPANTS FOR TELEPHONE INTERVIEW:

NAME	ORGANIZATION	CONTACT INFORMATION	AHTF PROJECT (IF MORE THAN ONE PROJECT IS LISTED ABOVE)
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1.			
2.			
3.			
4.			

**Thank you**

## **Appendix E: HSIF Focus Group and Interview Guide**

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### **EXPANDING AND BUILDING OUR PARTNERSHIPS TO IMPROVE ACCESS Health Services Integration Fund (HSIF) Project**

#### **FIRST NATIONS – FOCUS GROUP**

1. Welcome and Opening Prayer
2. Roundtable Introductions
3. Introduce HSIF Research & Purpose of the Focus Group (Consent Forms)
4. Group Discussion – Sharing Experiences

#### **HEALTH BREAK**

5. Group Activity – Challenges and Issues (Group List and Top Access Issues)
6. Roundtable Discussion – Where do we go from here?
7. Closing

**CONSENT FORM**

I, \_\_\_\_\_, (your name) voluntarily agree to participate in the research for the project “Expanding and Building our Partnerships to Improve Access.” This project is funded under Health Canada’s Health Services Integration Fund (HSIF) and sponsored by Onkwata'karitáhtshera, a health and social services agency of Kahnawake.

I understand that the research is being conducted by Amy Chamberlin (Researcher), with assistance from a community Research Liaison. The goal of the research is to **document a portrait of the situation for English-speaking First Nations when accessing health and social services in English in the province of Québec.**

For the research:

- ❖ I agree to participate in a focus group and/or interview.
- ❖ I agree that the focus group and/or interview may be recorded.
- ❖ I agree that pictures / video may be taken, which may be used for the report.
- ❖ I understand that my participation is voluntary, and I only need to answer those questions that I am comfortable answering. If at any point during the process I wish to withdraw for any reason, I may do so without explanation.

The results of the research will be shared at a forum with the First Nation communities, and their federal and provincial partners. Thank you for taking the time to participate in this research project. Your assistance is appreciated.

<p><b>Please Indicate:</b></p> <p>Community Name: _____ Organization: _____</p> <p><b>Signatures:</b></p> <p>_____ Participant (Focus Group or Interviewee)</p> <p>_____ Facilitator</p> <p>_____ Date</p>
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**THE FOLLOWING QUESTIONS WILL BE USED TO GUIDE THE FOCUS GROUP:**

**IDENTIFYING CHALLENGES & BARRIERS, AND WHAT IS WORKING**

1. What were some of the general obstacles that you faced when accessing health and social services?
2. Did you experience any challenges because of language and culture? (Who, what, where?)
3. Tell us about your positive experiences when accessing services from the province (highlight what is working)

**PRIORITY AREAS**

4. (Group Exercise- *Optional*): List out in point form the challenges, issues and obstacles when accessing services (*general access issues, related to language and culture*)
5. As a group, what are the five (5) most pressing challenges, issues or concerns that need to be addressed with respect to accessing health and social services from the province?

**SOLUTIONS**

6. Describe ways that you (or your organization) have overcome the barriers that you face when accessing health and social services in English from the province?
7. In your view, what is needed to make sure that you and your clientele can access health and social services in English from the province? i.e. What are the best ways to share information? Can culture play a role? Describe ways to overcome barriers.

**CLOSING COMENTS**

Any other comments or questions?

**Appendix F: Questionnaire – Transportation and Lodging**

**Health Services Integration Fund (HSIF)**

**Access Issues and Challenges: Transportation / Lodging**

The following questionnaire was developed to gain insight into any challenges or issues that your organization (or clientele) may have encountered when travelling to larger urban centres for medical reasons. As well, the purpose of the questionnaire is to identify solutions (either in place or recommended) to overcome those challenges.

*If you wish to participate in this HSIF follow-up research, you may respond to the questions in writing; or, if you prefer, you may arrange for a short telephone interview (15-30 minutes). The interviews will be held October 8-11, 2013. All questionnaires must be returned no later than October 11, 2013.*

- 1.) Your name and position within organization: \_\_\_\_\_
- 2.) Organization’s Name: \_\_\_\_\_
- 3.) Contact Information (email or telephone number): \_\_\_\_\_
- 4.) Are you satisfied with the Transportation/Lodging services that your organization (or clientele) accesses when travelling, for medical reasons, to larger urban centres? (*check one*)  
Yes (satisfied) \_\_\_\_\_ No (not at all satisfied) \_\_\_\_\_ Somewhat satisfied \_\_\_\_\_
- 5.) Explain the reasons (why or why not) that you are satisfied with the Transportation / Lodging Services;
  - a) Transportation (comments):
  
  - b.) Lodging (comments):
- 6.) Describe strategies that your organization has used to address any challenges or issues with either transportation or lodging services:
  
- 7.) Do you have any recommendations to improve transportation or lodging services?
  
- 8.) Any additional comments?

## Appendix G: Key Access Issues and Challenge for English Speaking First Nations

### Kawawachikamach

#### Community Resources & Community Members

- **Respect** – for culture and among people.
- **Language barriers (communicating)**: between First Nation and provincial institutions and lack of information about where and how to access services are available in English from the province
- **Accessing English language services** – in the community and from the province is challenging in the North.
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French
- **Training**: limited training available in English in Québec
- **Emergency (Ambulance) services are inadequate**

### Gesgapegiag

#### Community Resources

- **Lack access to health and social services both general and specialized** (English or French)
- **Language barriers (communicating)**: between First Nation and provincial institutions and lack of information about where and how to access services are available in English from the province
- **Training**: limited training available in English in Québec
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French
- **Double Discrimination**: English speaking persons and as First Nations

#### Community Members

- **Emergency services** at provincial hospitals are not always available in English
- **Quality of services in English**: Communication issues when seeking services, lack of documentation in English, privacy issues when translation is needed.
- **Cultural discrimination**
- **Long wait times** (at emergency hospital and for specialized services)
- **Lack information** about what where and how to access services from the province

## Listuguj

### Community Resources

- **Rights and responsibilities:** Information lacking about services available to First Nations from either federal or provincial systems
- **Access to specialized health and social services in English** (*specifically for mental health services and addictions*)
- **Language barriers (communicating):** between First Nation and provincial institutions and lack of information about where and how to access services are available in English from the province
- **Cultural discrimination / Lack of cultural sensitivity**
- **Jurisdictional issues** (local, regional, provincial and federal). Difficult to access services in English from out of province
- **Lack of funding:** First Nations services expected to provide more services with same level of funding
- **Lack access to judicial services in English** for clients under Youth Protection

### Community Members

- **Attitudes and Perceptions:** Fear, anxiety, frustration, being alone, not being understood because of language and culture
- **Long wait lists for services:** longer wait for services in English
- **Lack of funding** (provincial & federal governments) for health and social services
- **Need liaison and escorts services** (translation and support for Native people)

## Kanesatake

### Community Resources

- **Attitudes and Perceptions:** province's general unwillingness to provide services in English
- **Legislation:** Québec's language laws creating when seeking services in English
- **Long wait times for services in English**
- **Documentation:** Forms, documentation, resources and correspondence from the province are primarily in French
- **Jurisdictional – Corridors of Service** – difficult to access services in English
- **Cultural discrimination:** Lack of cultural knowledge outside of the community
- **Lack of access to provincial services (specialized)** (*despite previous AHTF work*)

### Community Members

- **Access to local general and specialized services in English** (psychologists, family doctors)
- **Emergency Phone services (dispatch)** – French only
- **Cultural Discrimination:** ignorance (cultural insensitivity)
- **Attitudes and Perceptions:** Staff at provincial institutions not willing to speak in English

## **Kahnawake**

### **Community Resources**

- **Documentation:** Forms, documentation, resources and correspondence from the province are primarily in French
- **Jurisdictional Issues / Accessibility of services** for clients closer to home in English – Corridors of Service is a challenge to obtain services in English in the Monteregie.
- **Communication:** Need a basic understanding of information from doctor/nurse, or institution.
- **Time-frames for accessing services (long wait) due to language barriers** and at same time dealing with day to day life. Impact for individual gets compounded.
- **Training:** limited training available in English in Québec. *If legislature is from the province and they expect us to do things in a certain manner, they should be providing us the ability to take the training. “They obligate” us but “do not accommodate”.*

## **Eagle Village – Kipawa**

### **Community Resources**

- **Accessing specialized services in English** from the province (extra distance to access those services, added cost and stress to individual and family members)
- **Training** (limited training available in English in Québec)
- **Documentation** – follow up reports, feedback, and treatment plan
- **Funding** (Funding for English language services at private clinics, when unable to access services from provincial institutions in Québec; Translation services; Point of service charges for ‘out of province’ medically required care)
- **Quality of services in English** – evaluations and assessments

### **Community Members**

- **Communication** – Verbal communication with staff at provincial institutions (reception, doctors, nurses) (*lack of translators*)
- **Documentation** – Forms, letters, information
- **Jurisdiction –Provincial boundaries / Travel:** Being “forced” to stay in Québec, rather than being able to access closer services in English outside of the province. *“It’s difficult to deal with the long travels ... My father has to travel two days to travel to Montreal for a one-hour appointment, whereas Sudbury is only two hours away.”*
- **Funding** – NIHB and difference in pay rates between provinces.
- **Long wait times** for specialized services, and longer wait times for services in English-language.

## **Kitigan Zibi**

### **Community Resources**

- **Accessing specialized and general services in English from the province**
- **Language barriers (communications)** with provincial institutions
- **Documentation:** Forms, documentation, resources, and correspondence from the province are primarily in French
- **Cultural Discrimination:** Racism, need to be more culturally sensitive
- **Training:** limited training available in English in Québec
- **Jurisdictional Issues** (provincial boundaries, and with different levels of government, both federal and provincial) – difficult to access services in English out of province

### **Community Members**

- **Emergency Services** – Need to address the ‘Emergency Response Time’ (ambulance services)
- **Care for Elders** – Linguistic and culturally appropriate care for ageing population (long term residential care) is needed
- **Attitudes and Perceptions:** Respect for basic human rights. Community members have a right to receive health and social services in the language they can understand
- **Documentation** –Receive documentation in English (forms and information)
- **Communication** – with specialists is difficult because of language.

## **Timiskaming**

### **Community Resources**

- **Accessing specialized services in the language of your choice** (i.e., speech and language pathologist, audiologist, treatment centres)
- **Training:** limited training available in English in Québec
- **Documentation:** Forms, documentation, resources and correspondence from the province are primarily in French
- **Quality of Services - Gaps in discharge:** Lack communication between institutions when clients are discharged; discharge summaries are all in French
- **Jurisdictional Issues:** Lack of freedom of choice to access services because of corridors of service, provincial jurisdictions, and transportation

## Appendix H: Community Findings

### English-speaking First Nations Communities – Community Findings

The Community Findings section is a compilation of the findings from all fourteen (14) of the focus groups, as well as the interviews held with each of the eight participating First Nations' communities; namely:

1. Kawachakimachach
2. Gesgapegiag
3. Listuguj
4. Kanesatake
5. Kahnawake
6. Kitigan Zibi
7. Eagle Village | Kipawa
8. Timiskaming First Nation

Specifically, data was collected from two groups – First Nations Community Resources and Community Members. For the majority of the communities (5 of 8), focus groups or interviews were held separately with the two groups; two (2) communities held focus groups or interviews with Community Resources only (note that most of the participants are community members); and one (1) community held its focus group with representation from both groups (Community Members and Community Resources).

Thus, the data is presented to reflect the manner in which it was collected, and the composition of the groups; as such: a.) Community Resources; and b.) Community Members. (Note: For the community of Kawachakimachach the findings are presented together 'Community Resources and Community Members' because one (1) focus group was conducted with deliberate representation from both groups.)

The findings were grouped into four broad areas:

- i. General access issues and challenges;
- ii. English language access issues;
- iii. Access issues related to culture (Aboriginal); and
- iv. Positive experiences.

These findings are included in the report to enable each First Nation community to develop action plans for their respective communities based on their individual needs and priorities.

## ᓇᓂᓂ, NASKAPI

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### 1. Kawachakimachach

#### a.) Community Resources (Health Services and Social Services) and Community Members:

##### i. General Access Issues and Challenges

#### **Lack of general and specialized health and social services in the region (in either English or French)**

- We don't have any specialists. For all kinds of specialists we have to go down south. To get a scan or all kinds of tests.

#### **Distance to access services (Travel)**

- Distance to access specialized services: We don't have any roads here. We only travel by plane or by train.
- Costly to travel (lack funding)

#### **Quality of care – ‘errors are being made’, mixing up clients’ names due to communication issues**

- My sister was sent to Montreal for something, and the doctor told her there's nothing wrong with you. It was another person who was supposed to go.
- They sent the wrong patient to Sept-Îles.
- There was a case where there was an error in medication. The names [of clients] were the same, but the medication was sent to the wrong house.
- *Elder's experience (translated from Naskapi into English):* Our Elder was explaining to us, his daughter has a medical problem, epilepsy. She received medication and the medication that she received was expired.

##### ii. English Language Access Issues

**Language Barriers (Communicating) – Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses and reception (front line workers). Participants spoke about being unable to fully participate in meetings with provincial workers because of language barriers.**

- The first language [at the CLSC] is all in French, it's very hard for a community where that is their second language, to go and see the professionals where they can't speak English.
- It's very dangerous [if professionals and clients are having difficulty communicating].
- Just because it's a CLSC run by the provincial government, that doesn't mean that every one of us speaks French.
- Community workers are not attending meetings with the province because of language barriers.

**Calling Provincial Institutions is difficult because of language barriers. Participants described the long delays waiting for an English speaking professional when calling provincial institutions (hospitals, CLSCs). Some stated that they were being hung up, while waiting for an English-speaking worker. Community resource workers may persist and call back; however, concern that, 'some people will not phone back'.**

- I phoned the [hospital] to ask for information and they asked me to speak in French, and I said I don't know how to speak in French. They said they would send me to someone else, but they hung up. So, I phoned right back, and found someone who can speak in English.

**Medication/Prescriptions: Information (in writing) about medication and prescriptions is not readily available in English.**

- All the instructions are in French, and they won't give you them in English [in writing].
- Doctor prescribes medication and writes prescription in French. And they will translate and tell the patient how to take them. If they give them 3 or 4 different medications, how do you know how to take them? Easily mix up the medication.
- Sometimes the doctors don't talk about what are the side effects with these medications (relaxation, depression pills, sleeping pills), when they are prescribed.
- When they order medications to come in, all their instructions for use are in French. The nurses will rephrase in English. Then, they give you instructions [in writing], but they are all in French. I am tired of fighting, but I keep doing it.

**Lack of Mental Health Services in English – Participants spoke about the lack of English-speaking mental health professionals. A psychologist visits the community on a monthly basis, and frequently only speaks French.**

- We also need an English psychologist. Frequently the psychologist we have here comes once a month. We have huge problems regarding mental health and it's only once a month he comes here and he frequently speaks French.
- All the instructions for the medications are in French. Our community's second language is English [third language is French].

**Translation services are insufficient – There is a translator at the provincial hospital; however, participants noted that the translator is unable to keep up with the demand for English language services.**

- Regarding health issues. When I went to see the elder this morning, when he went down south for a medical examination they sent him a written letter, and it was written in French and he had to run around and look for a translator regarding that letter. He found one outside of the community.
- In Sept-Îles we have a translator, but we only have one translator in a big hospital like Sept-Îles. Sometimes there are two or three clients there at the same time. That translator isn't going to go from room to room to translate for the Elders. The hospital in Sept-Îles is French. Why can't they send them to an English hospital with a translator? With an Escort?

**Documentation from the province is primarily in French (forms, posters, clients' records). Community resources spoke about being impeded in their work because of the lack of availability of English-language documentation.**

- All the information, all the posters everything is all sent in French. I threw it all in the garbage and phoned them back and said 'Please send it in English, this an English-speaking community.'
- Just because we work for the provincial government doesn't mean we have to speak French. Kawa their second language is English.
- I'm a social worker and I have access to peoples' files, records. I can't read them because they are only in French. I can't help the clients because I don't know their backgrounds. It impedes me.

**Ageing population – Community resources reported that Elders are not seeking services from provincial institutions. 'Elders don't go to the doctors if they have pain.' Participants stated that the elderly are not comfortable going to the CLSCs because of language and there is a 'lack of trust in the system'.**

- A lot of Elders don't go to the doctors if they have pain. In the end they may have something very serious. They are not comfortable going to CLSC because of the language.
- Elders won't tell. They won't say anything. I just know that with cancer, they are dead within a few months. A lot of people outside of the community down south, who have access to all the services if something is wrong they go to see a doctor their cancer is caught in time. If you trust where you are going you will go and get help, but if you don't trust where you are going you won't go to get help.

**Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. Language presents an obstacle when accessing client's reports/assessments. Confidentiality must be maintained, which makes translation of the documents more difficult.**

- Youth Protection – access issues resulting from language

- The Justice Department sends everything in French to parents - they [parents] don't understand anything.
  - Every document that is processed through the Department of Youth Protection is written in French.
  - Requests for translation of Youth Protection documents (assessments) are rejected by the province.
  - The challenges that people here in Kawawachikamach face regarding Youth Protection is translation. They need to have someone translating the interviews to English.
  - They say that the Youth Protection here is like the residential school system.
- Court system (divorce, custody, child protection).
    - When the papers arrive here in Kawawa they are in French. I can't translate, I can't take these documents and give to anyone to translate because they are confidential.
    - Even in the court, we had to complain a lot of times in order to go to court and have proceedings done in English. They were given in French and you have to complain and write letters before individual cases are heard in English.
    - Your lawyer won't translate everything said by the prosecution.

**Emergency Services: There are challenges accessing ambulance services because of language – there is a lack of bilingual emergency workers. Participants described their frustration with the system, for example it was stated that an ambulance will only go to individuals' homes if a nurse or provincial health care professional places the call. There is a lack of information about funding (who is responsible to pay for the ambulance). The response time is very slow, generally speaking, which is only exacerbated by poor roads. [General Access Issue and obstacles because of language].**

- We also have bad experience with ambulance services. They are all in French. Ambulance services. They speak only in French, they're not too good when they speak in English.
- They are not equipped, they don't have the certificate equipment that Québec City, Montreal, or Sept-Îles have in the ambulance. I don't know if they are trained.. It takes a long time to get ambulance from town to here, from Schefferville to here. Sometimes the cases here are severe. We had one that took over one hour and half, for the ambulance to come in. And the elder died at the CLSC.
- [Elder's experience, translated from Naskapi into English]: Even when the ambulance arrives and it goes back to Schefferville with a patient in there, our road is really bad. It's not paved, if a person is having a minor heart attack in the ambulance it's bumping around all over the place.
- I had to take an Elder to the CLSC that night and to me she died in my truck. She was already fading away. We kept talking to the nurse, he was speaking in French. He refused to get that ambulance in ... I think that the services here in our community are not too stable. We know we live in an isolated area, but more and

- more services have to improve. We have to get more improved services for our people here in our community. It's not there right now.
- At the CLSC when there is an emergency, and when you call the CLSC the first thing you get is a recording. The nurse will accept your call and they have to go out and evaluate the problem, assess the problem and they are the people who will decide if the ambulance will come into our land. They will decide that ... If you live in the city and you dial 911, that ambulance will be there at your doorstep. Why isn't it the same here in the northern region?

### **Limited access to training in English in Québec**

- [Social Workers/Nurses]: All the education that I am supposed to be getting every year, all the workshops are all in French. I can't go because I don't speak French.

### **Language legislation causing barriers for clients seeking services in English: Participants spoke about the difficulty of striking a balance between the workers' rights to speak French in workplace and clients' rights to receive services in English.**

- [Elder's experience, translated from Naskapi into English]: Our Elder went down south for a medical check up, when he got to the hospital he had a face-to-face confrontation, but when he was speaking English he was told 'You have to speak French you are in Québec.'
- At the CLSC, the nurses talk to each other in French, and you don't understand anything. That happened to me a couple of times at the CLSC I experienced that with my mother died. I didn't get much information about what was happening with my mother. They were talking in French.
- Nurse will talk to the doctor, explain the case right in front of them to explain the case in French. Patient is sitting there listening to this conversation and doesn't know what is happening. Getting more stressed. Happening everywhere in Québec, and here at the CLSC.

### iii. Access Issues related to Culture (Aboriginal)

### **Recruiting and Retaining English-speaking Professionals in the First Nations community is a challenge. English-speaking professionals may be limited to working only in the First Nations' community because of language barriers. Further, nurses, social workers and other professionals in health and social services are required to be part of the Professional Order; however, the documents and correspondence are all in French.**

- Native nurses [English-speaking] aren't coming back because of the language problem.
- The Professional Order of Social Workers – everything is sent to me in French. ... Because I don't speak French I am a reserve only social worker, but I pay the same dues as everyone else. 600\$ Yet, no access to documents, I can't even ask questions.

**First Nations' Rights are not being respected. Participants stated that community members are "being taken advantage of" if they don't speak French. Client's rights are being violated because "workers [at provincial institutions] talk about you, but you don't know what they are saying." Elders, in particular, are vulnerable: many Elderly only speak Naskapi, and they may not be aware of what is happening with their health.**

- [As a nurse], I feel that they are taking advantage of people who don't speak French in this community. They are really taking advantage of you. They talk about you, but you don't know what they are saying about you. They know you don't understand.
- [Community members] can't talk back. You can't tell anyone what they said because you don't know what they said. You can't complain.
- Talking about you, but you don't know what they are saying, your rights are violated.
- Elders over here only speak Naskapi. Their Escorts may talk French, but the Elders themselves don't know what is going on. And that is part of the patients' rights! You need to get all the information in English.
- If they don't want to see a certain nurse, they are told they have to. People need to be informed about what are their rights. Here they think it's a privilege, not a right, to have health care. To be more informed. It's also a communication thing they don't have enough information forwarded to them.
- Not only the Naskapi, but all Native people are facing racism. There is an attitude of colonization. The White values, the French values are more important than the Naskapi values. That all of us are just children, we all drink too much. We are not very smart. Our work is not good enough. ... We have to be fighting all the time for rights that are already given to everyone else. But we have to fight for them every day. We don't have the right to be informed. We don't any respect given to us for who we are and what we are.

**Discrimination and lack of cultural sensitivity – Participants stated that First Nations are facing discrimination at provincial institutions. Community Resource workers spoke about their frustration with the lack of cultural understanding and awareness about Aboriginal history, culture and social context. Many spoke about the lack of respect and 'feeling judged' by provincial workers.**

- One time, there was a conversation that was in French. [The provincial worker said], 'this money comes from our pockets. It's my money, I pay taxes.' ... Someone like that should not be working in the Health Centre or in the Native community. It's very discriminatory.
- At the CLSC, they sometimes are judging – they think everyone drinks in the community. That mentality.
- It's a constant battle – one youth protection worker told me, 'Naskapi people are not fit to be foster parents.' This is the attitude, there is a complete lack of respect to say something like that.

**Provincial training provided to health professionals in the community: Obstacles because of language and a lack of respect for cultural protocols.**

- Education institutions that send students to the North for training need to respect community protocols, culture, and language.
- The doctors they come in here to practice, but they can't practice alone. They treat us like guinea pigs. Imagine how high risk we are!

**Funding issues – in particular for travel and escort services**

- Travel is according to how much money we get every year. We have to stay within that budget, or we won't get another CLSC. In the meantime, we don't always get the money for travel. In order to save money we can't send Elders on the train. Still it's very hard on people when they don't have what they need.
- [Elder's experience, translated from Naskapi into English]: Our Elder spoke about the escort that was needed. His son had a small surgery, a small bypass. He was going to have an escort, but at that time he was not provided with one because there were no funds for an escort.

## 2. Gesgapegiag

### a.) Community Resources (Health Services and Social Services):

#### i. General Access Issues and Challenges

#### **Lack of general and specialized health and social services in the region (in either English or French)**

- It is a challenge to access services in either English or French in this region.

#### **Long wait time for services (specialized)**

#### **Distance to access services (travel)**

- Challenges accessing specialized services because of distance and the travel involved.

#### **Perceptions and beliefs about the quality of services at provincial institutions**

- Clients sometimes don't go to get services they really need because they believe it's going to be frustrating.

#### **Gaps in discharge from provincial hospitals**

- A client suffering from PTSD who went to the hospital for help. He didn't want the medication they offered, and became frustrated. Security threw him out at 3 AM and he had to walk home.

#### **Quality of care**

- When you call you get bounced around and end up in a department you don't even want. One member tried to get his address corrected and couldn't manage to do it. He also had a problem in that his file was confused with his son's, which could have resulted in a significant accident. "I don't trust those guys, I have to be pretty damn sick to go there."

ii. English language access issues

**Lack of access to specialized services in English – Participants spoke about the lack of services for detoxification and treatment services, special needs, speech language therapy, and mental health. Clients need to go out of province to receive services in English. Further, the funding for services is inadequate, in particular for mental health services.**

- Lack services in English for detoxification and treatment services
- Access to services for families with special needs is very difficult. First Nation Health Centre brought in services from NB for autistic child because none in the area. Services in English for Downs Syndrome children are very limited, even off reserve.
- Lack services for English language speech therapy.
- Mental health services are very limited in English.
- Clients are being referred to institutions out of province for individual counselling, etc.,
- Funding Issues – Under RAMQ 10 hours of counseling is covered, and then Gesgapegiag Health & Community Services must pay.

**Lack of access to services in English at local hospital: maternity services hospitals and emergency room services**

- Labour and birth are not ensured in English, even though the Gesgapegiag birthrate is so high.
- At [local hospital], the emergency room nurses are not bilingual, except at Triage

**Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. Participants commented that ‘Facts get lost in the translation; confidentiality is difficult to maintain if interpreters are used; issues with fairness when going through the court system; lack of local services in English for young offenders.**

- Young Offenders – First Nations’ social workers seek assistance with translation from co-workers to deal with the Justice Department about young offenders, “that’s confusing as there is so much back and forth, the facts get lost in translation.” Using an interpreter also raises the problem of confidentiality and privacy for the client.
- Clients have a right to legal proceedings in English but it is the client who has to ask. Often the judge and lawyers are trying to speed things up by proceeding in French. Workers reported that ‘sometimes clients are pleading guilty when they should not, just to speed things up.’
- Long-term young offenders must serve their time in Montreal, as there are no English services locally.

**Language Barriers (Communicating) – Nurses and reception are less likely to speak English.**

- Sometimes nurses yell if people can't understand French, as if speaking louder would help!

**Calling provincial institutions is difficult because of language barriers – clients and workers face obstacles when attempting to speak with someone in English by phone.**

- Even bilingual service providers leave French-only telephone messages so [community workers] cannot understand what they are saying and doesn't leave a message for them. Once someone at the hospital actually hung up on a worker [community resource] when she was dealing with an emergency situation.

**Issues accessing services from provincial help line numbers because of language. Community workers rely on out of province lines or US lines.**

- Service providers need to check telephone help lines before giving them out to clients, and many are not capable of serving people in English (rely on out of province lines or US lines)

**Documentation from the province is primarily in French. Participants described the difficulty in their work because documentation from the province is mainly available in French. Examples provided include: information provided to patients about their respective conditions; client assessments/records; documentation from the province about English Access Plan; Forms from the province; Directives from Centre de jeunesse)**

- For follow-up care, for example documentation in English, is inadequate – People need reassurance when hearing diagnosis, etc. they come back from the hospital not sure of the information and so it's scary. They come back from Rimouski (for specialized services) with nothing but French documentation.
- Social Services: All documentation on young offenders is received in French only and often the court proceedings are in French only: "If I am struggling I can only imagine what our clients are going through."
- Documentation is in French only about English Access Plan
- Invitation to meeting about access to services in English came only in French
- Forms are in French only
- Centre de jeunesse directives come only in French

**Tracking Information – Participants described obstacles because clients' information may be charted in French, which then requires translation for English-speaking home care nurses and clients themselves.**

- Nurses have the option to chart in French or English. If nurses are French speaking, they may choose to chart in French even if they work in a First Nation English speaking community. These summaries (in French) then go to a home

care nurse who only speaks English, they have to have them translated.

**Provincial Boundaries – Obstacles for clients seeking English services for detoxification ‘out of province’.** Participants stated that clients are seeking services out of province, primarily from New Brunswick and Nova Scotia. Although there are service agreements in place between provinces, nevertheless some clients are being turned away from centres because they are ‘from out-of-province.’ Participants stated that the distance to obtain detoxification services is ‘somewhat of a problem’, however it also ensures that people may complete treatment because ‘return transport’ is only provided to those who complete their treatment.

- First Nations organizations are sending clients to New Brunswick and Nova Scotia for detoxification services.
- Campbellton [detoxification centre] will not accept referrals, except after all New Brunswick patients first. Miramichi does not follow that same rule.
- Québec and NB have a service agreement, so there should be no difference in access to services for clients.
- While the distance is somewhat of a problem, it also ensures that more people stay to the end of their treatment cycle because return transport is only provided for people who complete their treatment.
- Being forced into corridors of services rather than where we feel comfortable (out of province).

**Limited access to training in English in Québec – Health workers are required by law to have training, yet there is limited opportunity to access training in English in Québec. Funding for training can also be an issue.**

- Training opportunities in English are limited in Québec
  - We are taking the mental health training in NB instead of here because it was not available in Québec.
  - Workers seek training in the Maritimes
- Issues with the quality of training, when translated.
  - I don’t get the full impact if it’s translated
  - The Commission should arrange for some of its training in English with French translation because sometimes the translation is not a great quality and it’s tiring having the head-phones on all day.
- Under Law 21 Health Services needs to keep up regular training, but access in English is often a problem.
- Funding for training can be an issue

### iii. Access Issues related to Culture (Aboriginal)

**Jurisdictional issues between federal and provincial governments: in the community, there is a lack of services for physically handicapped persons (disputes over fiduciary responsibilities)**

- Health Services is having a hard time with a physically handicapped person who is living on the reserve: the federal government does not provide services and the province argues they should not have to provide services either.

**Difficult for First Nations to access to services despite being included in the population count for the region**

- Why are natives not given equal access to services when we know they are counted in the population figures for Québec health care?

**Discrimination and lack of cultural sensitivity. First Nations community resources need to ‘go beyond their mandates’ to make up for the gaps in services resulting from language obstacles and discrimination.**

- [Hospital] nurses have told First Nation’ workers that FN clients should get health care in their own community: imagine what they say to the clients.
- Lack of services in English and discrimination against First Nation members means First Nations’ resources often go beyond their own mandates to make up for gaps.
- Feeling of being doubly-discriminated (English-speaking and First Nations)
- If I learn anything I will learn Mi’gmaq, not French

### iv. Positive Experiences

- **Joint projects between the Province and First Nations** (i.e., through Aboriginal Health Transition Fund (AHTF)) – Projects have helped to foster relationships at the management level between First Nations community organizations and provincial institutions. Participants commented that, “as a result we have some protocols in place and some things have improved. At the managerial level, there is a good rapport with the CSSS managers; however, it does not necessarily trickle down to the front-line workers.”
- **Agreements with the province** – Health Services has an agreement with the CSSS to hire our nurses to give home care services (soutien à domicile) in the community

## **b.) Gesgapegiag Community Members:**

### **i. General Access Issues and Challenges**

#### **Quality of care – Participants described their general lack of trust in the provincial institutions responsible for providing health and social services**

- Too many residents practicing at the hospital, impacts the quality of the services.
- Those who go often [to the hospital emergency walk-in] see consistently poor services.
- Another time, a participant had gone in for mental health services, but all they wanted to do was put her on medication. “I felt they were trying to kill me. My body is not used to that.”
- The yelling by the hospital staff makes people feel afraid and defensive. “And they never say they are sorry.”
- An elder who would like to be at home is being kept in the hospital because he might fall – but he has fallen in the hospital and also in a rehab centre, so he might as well be at home where he is more comfortable. “He is being held against his will.”
- The emergency ward is the worse department, and generally it’s always the same staff members there.
- Those who go often at the Emergency in the hospital see consistently poor services.

#### **Perceptions and beliefs when seeking services from provincial institutions – Participants described their fear and anxiety**

- Elders are afraid to go to the hospital by themselves. They do not want to ask questions and so do not usually understand what is going on.
- Clients sometimes don’t go to get services they really need because they believe it’s going to be frustrating
- There was general agreement that many community members avoid going to the hospital out of fear, and therefore they are deprived of prevention medical treatment.

#### **Long wait times, in particular to access specialized services and at emergency rooms in hospitals**

- At least one participant waited three years to see a specialist
- One participant took a child with a fever to the waiting room and had to wait for hours, but nobody ever came to check on the child.

#### **Distance to access services (travel) is an issue**

ii. English language access issues

**Language legislation causing barriers for clients seeking services in English**

- Many community members believe that nurses can speak English but many simply do not want to, “they want you to speak French.” Québec’s new language policy [Bill 14] is creating even more problems, according to one community member. He said he has picked up most of his French from extensive time spent at the hospital.

**Language Barriers (Communicating): Doctors may be bilingual, however less so for nurses or front line workers (reception)**

- Participants often have to call the hospital for family members whose English or French is not as good. One community member lost 40 pounds as she did not understand fully the impact of the cancer treatment she was receiving.

**Perceptions and Beliefs – Community members stated that language is interfering with quality of care when seeking services from provincial institutions**

- They are rude if you can’t explain in French and don’t take the time to get to know you.

iii. Access Issues related to Culture (Aboriginal)

**Discrimination and lack of cultural sensitivity**

- There was a general feeling that local hospital is not a very good place for native people.
- There was general agreement that First Nations are twice discriminated against: first as natives, and then as English-speaking clients. “The first thing they ask you as a native person is if you drink or smoke.” One participant, who was 17 at the time, was not believed when she said she was not pregnant. They dismissed her pain and sent her home. In about one month it was discovered she had ovarian cancer. She also believes they did not give her strong enough painkillers after her surgery because she was native.
- “Pain is pain; First Nations people should be treated like French or English patients and not denied painkillers when they are needed.”
- [Staff at provincial institutions] look down at you for being native. There seem to be stereotypical attitudes towards natives. One person was told during the recent road blockade, ‘You should let the doctors and nurses through,’ although they had nothing to do with the blockade.
- One participant had to go for a surgery at a hospital [further away] and says she was treated much better there. When she had to use [local provincial] services due to an infection and other complications, she was told “Why aren’t you getting

services at your own [First Nations'] clinic?" She was made to feel very bad about going to the local provincial institution.

**Jurisdictional Issues – Lack of clarity about who is responsible to fund services for First Nations (federal and provincial governments).**

- They start passing you around, who is going to pay; the province or the federal government? You just about need a psychiatrist by the time you come out.
- They don't care about you, they only care about the money they are getting.

**Some First Nations are not aware that they have a right to access services from provincial institutions (such as CLSCs) – lack information about where and how to access services.**

- During the meeting, a number of First Nations' community members realized for the first time that they have a right to go to the CLSC for services. They suggested we make sure people know their health care rights.

**Quality of Services – Community members felt that patient's confidentiality was not being maintained in the communications between the hospital and the community health services.**

- It would appear hospital personnel are dealing with Gesgapegiag Health Center Services about personal medical situations, rather than calling community members directly to set up appointments, etc.

### 3. Listuguj

#### a) Community Resources (Health Services and Social Services):

##### i. General Access Issues and Challenges

#### **Lack of general and specialized health and social services in the region (in either English or French)**

- Difficult to access specialized services from the province (in either French or English)
- Difficult to find family doctor – long waiting lists in the region

#### **Lack Information and knowledge about where and how to access services from the province**

- Do not have enough information about where and how to find services, or specialists, in the province
- It is difficult to understand the medical terminology for health conditions, even if the explanation is in English

#### **Distance to access services (travel)**

- Distance to access specialized services is an issue
- Costly to travel (lack funding)
- Difficult for caregivers to accompany clients/family members to urban areas for medical reasons (costly).

##### ii. English Language Access Issues

**Language Barriers (Communicating): Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses, reception (front line workers), and support staff. Participants described the need to have English services for mental health. Participants described the difficulty of participating fully at meeting with provincial workers because of language obstacles. There is a general feeling of frustration because of language barriers when communicating.**

- The doctors all speak English, but it's the support staff who can't, or don't want to, speak English. That's the difficulty.
- Mental Health Services: If the person walks into a place and they're getting the impression that this person doesn't really understand them, they'll ask 'why am I going there?'; It's hard enough to get them to go to counseling. They won't go back; They won't open up, they won't talk; You have to have someone who is

fluent ... you want to be comfortable that what you are saying is being interpreted in the way and meaning of what you are saying.

- Long term care at hospitals: “If you send them to the hospital in Québec, they’re grumpy about it because most of the patients are French-speaking so they can’t communicate with other people, or even their roommate.”
- Obstacles because of language at meetings: When at meetings, and because we’re English, it’s like we’re punished. We’re the one’s that having to wear translative devices all through meetings for days on end, we’re listening and we’re watching lips, we’re trying to take notes, and you’re exhausted by the end of the day.
- People are frustrated so they don’t want to go [seek services].

**Calling Provincial Institutions is difficult because of language barriers – Participants described their frustration when trying to call institutions and the lack of English services at reception.**

- When you call an institution, the person answering will say ‘Can you hold on a moment, we’re going to find someone who speaks English! Ten minutes later, they might come back.

**Participants described the difficulty of accessing English language services from provincial help line numbers**

- Elders abuse hotline, sexual assault hotline: no options or limited options for English services
- The Elder abuse, the hotline number is very difficult to access for a lot of community members. We’ve always come back to that same question ‘When an Elder is being abused, who do they call?’ Where do they go? Because when they try to access that 1-800 number, it’s all French, all French.

**Documentation from the province is primarily in French. Examples include: Forms, information, and materials. Lack funding to translate documents, and waiting for translation means delays in services.**

- A lot of information that we get is in French, even from organizations that deems themselves bilingual
- Lack funding to translate documents, materials or forms: If you want to translate it yourself you can, but do you realize how expensive that is?!
- Long wait period when requesting province to translate documents
- Reports [for Youth Protection] come back [from the Province] in French, need to ask for reports in English or our liaison will translate for us. That causes delays.
- [Social Services]: Especially with Centre Jeunesse, all of their forms, and all of their information is in French and we have wait a year if not longer to get it in English. Sometimes we don’t even get them, they just say ‘Oh, we never got that translated yet!’

### **Provincial Databases are mainly available in French**

- *Social Services*: We're still waiting for the Information Management System from the province for the foster care to be translated – it's been over one year.
- *Health Services*: Data Base system for vaccine immunization and updates are available in French only

**Provincial boundaries – Participants described a range of barriers when seeking services in English from 'out of province': jurisdictional issues, being 'bounced back and forth', being denied services, in particular for detoxification, because clients are from 'out of province'; issues with funding and clients need to pay out of pocket for services, and full reimbursement from the province is not guaranteed. Participants are being encouraged to stay in the province of Québec rather than go out-of-province to obtain services in English (even if the service is closer in another province).**

- People are bounced back and forth between the hospitals in New Brunswick and Québec depending on the issues
- [The boundary] divides the population and influences when they are willing to go to the hospital
- Psycho Social care is not accessible in New Brunswick for Québec residents (at the NB regional hospital): If you are struggling with mental health issues, end up in an ambulance all the way to Maria [rather than nearby bilingual hospital in New Brunswick], then I will have a French speaking person, and not deal with what I am really struggling with, language barrier and of course the cultural components.
- Funding: For some services, you have pay up front, and then get reimbursed [from the province]; Patient isn't reimbursed for the full amount (i.e., Methadone clinics)
- There's not that many border towns in Québec, I can't see why an agreement can't be made between the provinces!
- Detoxification Services and Treatment Services: Patients seeking services from some institutions in New Brunswick are put on waiting lists because they are from Québec (NB clients first) – “a pregnant lady inquired about detox services in NB. Because she is from Québec it was indicated that she was put on a waiting list, despite the urgency of this request.”

**Lack of access to specialized services in English – Participants noted that there is a need for English speaking specialists in areas such as mental health services, speech and language specialists, and physiotherapists; there is a lack of support group services in English for special needs and chronic conditions; and patients are 'left on their own' to find English speaking specialists.**

- We don't have many English speaking specialists (for instance, for mental health services, speech and language specialists, physiotherapists)
- People have problems accessing services for addictions in English in Québec.

- You can always find a psychologist or psychiatrist to do an assessment, but you can't find someone to do the therapy in English.
- Lack support group services in English for families (mental illnesses, physical disabilities, or different disorders, such as autism)

### **Long wait times for services in English**

- The waiting list is long if we need a psychological assessment done because we are limited to the number of psychologists or psychiatrists who actually speak English. It tends to delay services, it's a longer waiting list, sometimes up to a year.

### **Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English (legal and follow up care)**

- [In our region] there are no English-speaking lawyers accepting legal aid for Youth Protection files. Going to court and a lot of our clients don't have representation. Difficult for family, difficult for us as workers. Difficult process for everyone involved, tends to be lengthy.
- Under Youth Protection and adult care – many barriers that we see for services in the province of Québec, almost 90% of services are from the province of NB. Montreal is where we would access English speaking services [follow up care]

### **Rehabilitation centres (addictions, elders, youth) – Limited services in English in Québec (Distance, long waiting lists, jurisdictional issues)**

- In my area [social services], we are seeing higher numbers of mental illness coming forth, we're doing more placements for young adults who suffer from mental illnesses and cannot live independently on their own, we don't have any services in Québec that we can have access to.
- Another barrier with cliental is rehabilitation centres for addictions – centres are far away, and we can't always access services in New Brunswick.

### **Crisis Situations (trauma, crisis, and emergency) – Difficult to access services from the province because of language barriers [General access and obstacles because of language]**

- There are people that are in trauma or crisis, they will not access the services in the area because of the language. If they want to go to the [nearby English speaking hospital, out of province], they are interrogated, assessed, then sent to [hospital on the Québec side], so you have to go through the process twice. ... And, if you are kept there, they only have French speaking staff – you could be waiting a long time before you see anyone who speaks English.
- Recently, while I was on call [social services] I received a call from [Québec hospital in the area] at 4 a.m., for a sexual assault victim. They were looking for someone at 4 a.m., and there was no one who spoke English.

### **Limited access to training in English in Québec**

- Social services – We haven't had any training in English
- Health services – Training is limited, we usually have to go out of province.

**Lack of information and knowledge about which services clients may access in English from the province**

- What are the rights of clients to access services in English? We're lacking information.
- Trial by error, experience. [A person] may go to a few places before they arrive at where they need to start treatment, and then they're confronted with a language barrier.

iii. Access Issues Related to Culture (Aboriginal)

**Lack of communication between First Nations' and provincial organizations**

- The CLSC, CSSS, and Listuguj Health Centres all have decisional trees – but, do they look at it? Do the people who work there now, do they know about what services are being provided?

**Funding issues: First Nations' organizations are expected to provide more services, with the same level of funding**

- You are expected to do more reports, and provide services, but they are not providing you with additional funding, they want you to do x, y, and z with the same amount of funding and always with the threat that funding can be cut and it's the same with all sources of funding.

**Jurisdictional Issues: First Nations have access to health and social services from both federal and provincial governments, but there is a lack information and clarity about who is responsible for what services (delivery and funding)**

- Non-Insured Health Benefits (NIHB) is a real issue for us.
- It's awareness – people don't understand what is the [Non-Insured Health Benefits] NIHB, what is provincial. It's all one to them.
- There's no collaboration between federal and provincial systems about the issues.
- Lack of clarity about which medications are covered by Federal government:
- Lack of services for people with disabilities
- Difficult to access dental care (in particular for orthodontic services) from the federal government (paper work, delays in services while waiting for approval from Ottawa, lack of clarity about which services are covered)

**Rights as First Nations are not being respected – lack of consultation and ability to participate fully in decisions that impact communities.**

- We're the last to be consulted, there's no consultation about changes to legislation (i.e., Law 21, First Nation communities not consulted about impact on communities);
- Under Article 21, and having people who are registered with the province ... we'll be scrambling around to find qualified social workers to replace our workers
- When it comes to laws and legislation, we don't have a voice and this impacts our communities
- As English speaking Mi'gmaq people our language rights are not being met. People are asking for [services] in Mi'gmaq.

**Discrimination and lack of cultural sensitivity. There is a lack of cultural understanding and awareness about First Nations history, culture and social context.**

- Provincial institutions and specialists lack knowledge and awareness about First Nations culture and history. You feel as though you are hitting a brick wall because of language and cultural sensitivity. You hear that more and more. There is a lack of understanding ... there is a lack of understanding about ceremony, it's all hocus pocus to them.
- Not being acknowledged as Aboriginal, our background, population's needs. [As First Nations] we're not a priority
- There's a litany of issues – from a cultural context, most of the people [who need social services] are marginalized already. There's intergenerational issues, historical losses regarding residential school and so on and so forth. Most of the referrals that are done outside of the community are done so with people who have no interest or knowledge of our history and that speaks volumes. This is all relevant, but there is a definite lack of understanding and I don't think it's a priority.
- The view from outside resources is that Aboriginal resources are fragmented, lack faith in community work. Institutions don't trust each other.

**Services from the province are not meeting First Nations' health priorities and needs**

- The needs are always changing. We're not seeing the same issues that we saw five years ago.
- There are specialized needs for children with autism, or babies coming of methadone, or their mom's coming of methadone
- That's the reality of our world today. We are seeing more children diagnosed with different disabilities, we're seeing more mental health issues with young adults, and we're seeing deep rooted issues.
- We need to address historical trauma. How do you deal with people from a human place? Dealing with sexual abuse? Dealing with having had alcohol during pregnancy? All that stuff and how we [as First Nations] approach it is unique.

- It can start here, plant the seed but this not where it ends. It has to be taken to our leadership, that where someone will be advocating on our behalf and someone at the top level, at those tables where they can make those changes happen to increase the funding, deal with the jurisdictional issues so that we don't have difficulty accessing professional services.
- Medical Transportation services – If there are cuts to the funding for medical transportation, the patients who really need the service will suffer

iv. Positive Experiences

- Today, there is increased awareness among community members that First Nations may access services from the provincial CLSCs. For a long time, when our office [social services] would call the CLSC they would say, 'You have your own people,' that [attitude] has changed since then, but there are still limitations.
- Hospital is reaching out to First Nations community during crisis situations – Victims of sexual assault are asking for community members to support them, and the hospital is calling us.
- Mental Health Services (Suicide Prevention): Hospitals are making efforts to accommodate English-speaking workers from community organizations. When I'm speaking with someone and we can't understand each other [because of language] the hospital has me fax over the information in English, then they will find someone to read my assessment of a client.
- First Nations are building connections and relationships with local provincial institutions through joint projects

**b.) Listuguj Community Members:**

i. General Access Issues and Challenges

- **It is difficult to get a family doctor**
- **Long wait times to access services (specialists)**

ii. English Language Access Issues

**Language Barriers (Communicating): Communicating with specialists and support staff can be difficult across language barriers. Participants described their frustration and fear when requesting services in English.**

- Even if [the specialist] speaks English we're not always able to communicate. I had a hard time with the translation. It's frustrating.
- Try to communicate in French, but you're brushed off

- Some participants described “confrontations” between themselves and workers at hospitals over language
- Other participants said they did not want to “rock the boat” or ask for services in English, for fear of repercussions to themselves or their loved one’s: *I always get scared that they’re going to lose my paper work, and it will be put on the back burner, and I’ll have to wait another month to see that specialist.*

**Calling Provincial Institutions is difficult because of language barriers – Frustrating experience, long delays waiting for English services, and being ‘hung up on’ while waiting for an English-speaking person.**

- Calling hospitals and waiting for a person who speaks English frustrating for patients: “When I called the hospitals and they come on, and I ask them, “Do you speak English? They say ‘no’, well then put someone on who does! They said well you have to wait. I said, ‘No I don’t want to wait. Put someone on.’”
- Difficulty with automated telephone services: reception not always available in English, delays to speak with someone, resulting in increased frustration. “You know the services that they have on the phone, that number for English, that number for French – dial 9, what comes on? French. They tell me, ‘Someone will call you back who speaks English.’ No! I tell them, I dialed 9. I’m not hanging up. I’m waiting. Sometimes, they hang up and then I have to call them back.”

**Ageing population – Language barriers at long-term care facilities for the elderly; there is a lack support services in English for caregivers.**

- I had a family member who had a problem at [long term care facility in the region]. They were speaking to him in French, so he doesn’t understand and I don’t understand. He couldn’t say what was wrong with him.
- Participants described patients’ difficulties at the long-term care facilities when unable to communicate with one another because of language barriers.

**Language legislation causing barriers for clients seeking services in English: Striking a balance between workers’ right to speak French in workplace balanced with clients’ right to receive services in English; attitudes and perceptions about bilingualism**

- They [staff] understand [English] they just don’t want to speak it.
- At first we had problems with the nurses, but after a little while we kept on pushing them to speak English. A lot of them do speak English, but they don’t want to speak English. There was one nurse that came to us, and started talking in English and then she gasped. We’re not supposed to speak English, that’s what she said.
- The nurse talked to us in English, but she kept on looking around to see if there were any nurses around. They’re not allowed. Language barrier there, it’s not right.

**Documentation from the province is primarily in French. Examples include: Forms, reports from specialists, and communications/information from the province (notices).**

- Forms, questionnaires and documents
  - The forms are all in French! They tell you to write it out, but I can't.
  - Filling out questionnaires is challenging: I had to have someone fill out the questionnaire for me, it was about five-pages long and all in French
  - Why are they sending me a French form when they know I speak English? I bring my stuff [to the Health Centre]
  - I throw the information in French in the garbage, I don't care
- Reports from specialists
  - My doctor in New Brunswick gets reports from [Québec hospitals], and he can't read in French, he doesn't understand ...

#### **Provincial boundaries – Barriers for clients who are seeking services in English**

- Need more information about how to access services from another province
- Depends on the doctor, some don't want the paper work [for out of province clients]
- I had a choice for my daughters when they needed to see a heart specialists – either Montreal or Halifax, but that was twenty years ago! They won't let you choose now.

**Lack of information and knowledge about which services clients may access in English from the province – participants stated that there is misinformation and communication breakdown. With respect to accessing medical services, participants asked, 'What are our rights? What are our responsibilities?' Some asked whether or not increased health services could be offered at a clinic in the First Nation community.**

- As a client of the medical services what are our rights? What are our responsibilities?
- As a resident of the province of Québec, do I have the right to access, for instance a physiotherapist, on Québec's dime? I don't know. In the meantime, we're going out of province, seeking private care. Could we have our own clinic here?
- Lack information about what services are available at the local CLSCs: I only take my medical care card there, for renewal, that's it.

**Emergency Services: community members described their frustration when calling for an ambulance as well as the difficulty seeking emergency or walk-in services in English at provincial hospitals in Québec. [General access and obstacles because of language]**

- I tried calling the ambulance and they spoke French. I just threw the phone, I was so upset. And, I didn't get any English speaking person.

- I'll go the emergency [walk-in services] in [New Brunswick], rather than on the Québec side. I'll go there because I know that someone will speak to me in English.
- When my aunt was brought to the hospital, they told her 'We have to take you to Maria, My son said, if you are going to take her there, get her off this stretcher this instant and I will take her to the hospital myself!

### iii. Access Issues related to Culture (Aboriginal)

**Medical Transportation services are not always available in English for clients travelling to urban centres for medical reasons.** Participant unable to communicate with drivers went to the wrong hospital and missed appointment.

**Double discrimination** –as English speaking persons, and as Native people. I've noticed something at the CLSCs, they get your file, they put it right there, then they get another file and [gestures, puts on top]. And, I've seen them do that. If the person's English or Native, they put them down, then two or three people, you're supposed to pass, but they go ahead of you.

**Ageing population – For some Elders who are at long-term care facilities there are challenges because many Elders speak Mi'gmaq and they are not able to communicate with staff or with other patients**

- A lot of Elders are at these institutions [long term care] and they do speak Micmac and nobody understands what the devil they are talking about. [The staff doesn't know] if something is sore.
- They [elderly] forget English. They start speaking Micmac, and they'll talk to anyone in Micmac they don't understand that this person is not fluent. My aunt was always talking to them in Micmac. She used to tell them she felt pain here or there, but they didn't understand nothing. ... We would have to let the nurses know what is going on. The nurse said, 'We don't understand her.'

### iv. Positive Experiences

- CLSC social worker assisted a client to access rehabilitation services from out of province for a youth who is severely autistic. The participants stated that she had been waiting for ten years to access services, and although it took a crisis for the intervention to happen the mother describe her experience: "I was able to access services (rehabilitation) from the province of New Brunswick for my son who is autistic. It took a crisis to be able to access the services, but that's my happy story."
- Quality of care – Some participants described the compassionate nurses, willing to speak English with patients when undergoing surgery. "When my son went in for surgery on his lungs. Everybody spoke French, when he went for his operation no one came and talked to me in English. I was sitting there, getting

angry and nervous. Finally, a nurse came over and explained everything to me in English. She stayed with me, and I said ‘My God, I love you!’”

- Services are available in English at some provincial institutions, including hospitals and CLSCs.
- Doctors and specialists are bilingual, “I see a lot of specialists, but I’ve never had any problems with the doctors they all speak English. French and English. I’ve spoken to nine different doctors all together, and they all spoke English.”
- Some reported that support staff are bilingual and willing to speak in English, “If they know that you speak English, some of the support staff [at hospitals] will speak to you. Some of them do. And we speak to them in English, they understand.” Another participant commented on the importance of cooperation and both parties being willing to communicate using each other’s language. “You have to cooperate. If I have something that I don’t understand, I’ll ask. Some of them have broken English, but at least they’re trying. And, we’re trying to speak French, because I understand just a little bit.”

#### 4. Kanesatake

##### a.) Community Resources (Health Services and Social Services):

###### i. General Access Issues and Challenges

**Ageing population – Participants described the difficulties that elderly people have communicating with specialists and asking questions about their health issues. Others described the difficulty that elderly clients have to navigate and find services at hospitals.**

- You'll get that with a lot of elders, not asking the proper questions that they need to ask ... because a lot of times clients are too scared to even ask or know what the situation is when it comes to a health issue or problem. [Elderly taking an escort with them when going to appointments]
- Some elderly patients, and their caregivers, having a difficult time navigating their way at hospitals: "they were French speaking and they still didn't understand, and [elderly man in his eighties] needed to get help from a stranger."

**Lack Information and knowledge about where and how to access services from the provincial network**

- This is part of the problem, because people don't understand ... what hospital that you need to go to. First of all, you'd need to go to the regular hospital, and then they would send you to the big hospitals, the teaching hospitals, the more complex, depending on your condition and what's wrong.

**Long wait times (accessing appointments to see doctors and specialists)**

###### ii. English Language Access Issues

**Language Barriers (Communicating): Participants described the difficulty because of language barriers when communicating with specialists and support staff**

- When I escort patients, there's times when I'm trying to explain to them and it's like pulling teeth trying to have doctors speak English. Thank God I understand a little French.
- [Support staff unable or unwilling to speak English]: It took three people before they found somebody [who could speak English], just for [her to ask for] a glass of water with ice at the hospital.

**Emergency Services: Participants described the obstacles to obtain services in English. Clients require escorts during emergency situations to make certain that they can access the correct services (for example, drug rehabilitation services)**

- I've gone on emergency calls in an ambulance, and the ambulance driver and the one working on the patient, they speak French ... That's been a big barrier.
- I went to emergency about a month and a half ago, and even at the emergency desk they didn't understand English.
- I know from the rehab centre, in an emergency situation, should we have to send someone out, very often we will have to send someone French along with them in order to access the right services.

**Calling Provincial Institutions is difficult because of language barriers – Elders are reporting difficulties when placing phone calls.**

- Some Elders have a hard time calling the hospitals to ask questions or make changes to their accounts
- Difficult to understand phone directions/instructions, which are in French

**Lack of access to specialized services in English – Participants reported difficulties accessing services in English for mental health. Confidentiality is an issue when clients need assistance with translation.**

- The mental health issues are more impacted by the language barrier
- Clients need assistance with translating personal information relevant for them to obtain services

**Long waiting times for services in English. Participants report** having to wait longer to get services because of language barriers (speech language therapy, rehabilitation services, mental health services, for example).

**Documentation from the province is primarily in French. Participants report that they are trying to translation information/documentation for clients. Lack of access to translated documents (legal aid.)**

**Language legislation causing barriers for clients seeking services in English. Participants described the obstacles they face because of attitudes and perceptions around language. Participants reported feeling 'pushed aside' at provincial institutions because they are English-speaking.**

- It's the attitude as well. I think that's the big thing---their attitude. It's frustrating.
- Now because of legislation it's harder to access English services.
- There's a privacy issue; it goes against Health and Social Services act because you are entitled to receive services in your language preference.
- Double standards – If you go to a francophone speaking hospital and you know only English, there's a double standard because they know you don't understand. But I understand enough to know that we are being pushed aside, but not enough to converse with them to let them know exactly how I feel.

**Corridors of Service – Participants reported delays in assessments and treatment, for services such as speech language pathology because of the corridors to access services from the provincial network. Others reported challenges for any type of mental health services in English if sent to closest hospital (by ambulance)**

- Now they say that if you are not from that region you cannot access those services. I have had children caught waiting months to receive services at a hospital in a different region only to hear, ‘No, we will not give you English services here. Having to go through a committee first. I have seen delays of a year-and-a-half to two-years trying to get speech language pathology assessments done.
- In our community, when it comes to people who have any type of mental health issues, or anxiety ... if they are going by ambulance, then they have to go to the local hospital, which poses problems. The person must go through assessments again, when all they needed was a 72-hour watch or an adjustment to their medication, by the doctor who is following them.
- We can’t get services in English if you follow the Corridors of Services.

**Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. Participants stated that clients accessing services, under Youth Protection, are experiencing delays because of language. There are challenges with translation when going through the legal system. However, clients can have their court proceedings in English, if requested.**

- It may take a little bit longer, because the lawyers are searching a little bit more for their words. They will do it.
- Their language does not always match their translation, either.
- They’ll ask you ‘French or English,’ and if you say English, then they have to.

iii. Access Issues related to Culture (Aboriginal)

**Submitting proposals for funding – perception that language is an issue when submitting proposals to government to access funding for projects.**

- There are strong perceptions of language being an issue when submitting funding proposals. For example, a proposal submitted to Québec government for elderly services and three years in a row not accepted. This past year proposal was submitted in French and it was accepted.

**Jurisdictional Issues – Lack of clarity about provincial and federal responsibilities for health services. Clients are ‘caught paying bills’ for health services. Reports about obstacles accessing services (medication) under the NIHB (non-Native Health Benefits) program. Participants reported inequities in what is covered under the**

**NIHB in comparison to provincial programs geared for individuals who are receiving social assistance.**

- There are a lot of different issues I'm faced with when trying to access the services that Health Canada has to offer.
- People need to find out ahead of time if the institution deals with Health Canada, if not they can be stuck paying for bills.
- Lack of knowledge about what services are covered by the province, and what services are not covered
- For an elder that goes in and wants to get their eyes done, there's a little bit of a barrier, wondering, 'Do they pay for the drops at the optometrist?' They go to pharmacies, and the pharmacists say, 'it's not covered.' If a person doesn't have money to pay, they may not receive their medication.

**Discrimination and lack of cultural sensitivity**

- I often find that there's no knowledge that they have on how we are as a nation, versus our realities, how our version family, it is not exactly, 'your mother, your father, your aunts, your uncles,' it's the whole family.
- I find they don't know about how we are as a nation, as natives, our medicines
- There's a second barrier, when they know you're native. There's another barrier there, so culture plays a role.

**Ageing Population – There are challenges for Elders because of linguistic issues and challenges related to health issues associated with ageing. Reported that many Elders are 'falling through the cracks'.**

- They fall through the cracks a lot, because when you talk about elders ... first of all their first language is Mohawk. They always have someone with them to help.
- Elders face additional challenges because of language, and issues associated with ageing.
- It's happened to Elders who speak Mohawk first, where the staff [at the hospital] thought they were crazy because they've never heard that language before.

iv. Positive Experiences

- Agreements between First Nations organizations and provincial institutions have allowed for the inclusion of cultural practices. Policies in place for birth practices following Mohawk cultural practices (i.e., Aboriginal Health Transition Fund established a policy to allow parents to obtain placenta after birth, protecting rights to practice culture)
- Some participants reported that they are satisfied with the quality of care and services at provincial institutions: some hospitals described as "excellent" and "culturally sensitive". Some staff people try to speak English or provide English documents
- Staff at CLSC are helpful – assisting individuals (knowing where, how, what is required)
- RAMQ services: Very helpful and efficient

## **b.) Kanesatake Community Members:**

### **i. English Language Access Issues**

**Emergency Services: Participants reported difficulties because of language when calling for an ambulance: long wait time and needed to re-explain emergency to different dispatchers. There are delays in services when unable to communicate.**

- When my 76 year-old father required an ambulance for medical emergency and needed to be hospitalized, upon calling 911 I was transferred four times to different emergency responders and was told by one dispatcher, “I will forward you to the department that manages the reserve emergencies.”

**Lack of access to services in English;** It’s not right that we have to go to another province for health care in English.

**Language Barriers (Communicating) – Communicating with specialists about health issues is difficult because of language. Participants reported that they felt that some specialists are unwilling to speak in English, despite being able to.**

- For myself, I can get along fine in French, but when it comes to my own needs or my own services, I would much prefer it in English so that I can understand precisely what a doctor, a nurse, is actually saying.
- Specialist to whom I was referred for physiotherapy could not speak English.

**Perceptions and beliefs when seeking services from provincial institutions – Participants reported that they felt they were being discriminated because they are English-speaking.**

- I remember being laughed at because I didn’t speak French very well
- I had an appointment for physiotherapy and was getting laughed at because I was Anglophone. I was treated unfairly due to language barrier.

**Corridors of service – presenting obstacles to obtain services in English.**

- Ambulance is required to go to closest facility in your region. Issue for patients requiring services for mental health issues and they cannot go to hospitals where they are already receiving services.
- You may want to go somewhere else, to receive English services, but the ambulance has to go to institution in their Corridor of Service.

ii. Access Issues Related to Culture (Aboriginal)

**Discrimination and lack of cultural sensitivity**

- The hospital nurses were unable to pronounce my name in Mohawk, so they started calling me moccasin.

iii. Positive Experiences

**Quality of care – Staff at provincial institutions described as “understanding”, and “willing” to provide services in English. Other participants reported that emergency service providers spoke English and were “attentive” and “caring”.**

- Some staff are very understanding and willing to try to communicate
- The ambulance team that responded to my emergency was fantastic. The paramedic who immediately took charge was attentive, caring and he spoke English. He is from our community to that helped with the transition.

## 5. Kahnawake

### a.) Community Resources (Health Services and Social Services):

#### i. General Access Issues and Challenges

**Provincial rate of pay (fee schedule) varies among the provinces. Participants report that for some provincial services they are paying the difference out of pocket.**

#### **Lack of access to doctors and specialists**

- Health crisis due to fewer doctors and specialists (i.e., paediatrician)
- Huge issue is access to a general practitioner (GP) in the Province of Québec and being able to remain in long term care with that GP.
- Quality of care – Need a doctor who knows family histories
- Lack of clarity about how Montreal’s ‘super-hospitals’ will impact health care

#### **Long wait times for services**

- Length of time that patients wait for a referral to specialists is too long
- Long waiting lists to see doctors (specialists)
- Rescheduling of surgery is a problem

**Two Tiered Health Care: Participants reported that clients there is an emerging two tiered health care system, and that “for a fee” individuals can buy their way to quicker services (Public Health vs. Private Care).**

- For a fee, you could buy your way to quicker services (private)
- Doctors are being capped for hours (public)
- How many people get bumped by private paying patients when they are waiting for surgery or appointments? Doctors are getting capped on hours they can work, for fee you can move up the line.
- If you pay for private services you can get your results in English. We are told we don’t have a 2 tiered system, but we can get results if we are willing to pay.

**Quality of care – Some participants spoke about their dissatisfaction (generally) with the quality of care at provincial hospitals: good service was a matter of ‘luck of the draw’, depending on individuals staff and/or institution.**

- Roulette: Shifts at hospitals determining caliber of service
- Navigating the Social and Medical system isn’t user friendly, it can be very complicated.
- ‘Luck of the Draw’ – Everyone has had different experiences depending on who is working and where in the hospital you are going.

**Government cutbacks to health services** – Participants reported that government cutbacks (provincial & federal) are impacting health and social services.

## ii. English Language Access Issues

### **Participants reported difficulty accessing programming, support services and resources in English**

- Lot of programming out there for clients, but everything is in French.
- Finding resources in English is another story. There are not a lot of resources.

**Language Barriers (Communicating):** Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses, reception (front line workers), and support staff. Participants spoke about the difficulty of participating in meetings with the province and networking with provincial workers because of language barriers.

- The doctors are mostly bilingual, but the nurses are mostly French. The initial intake for clients is in French, which can be troublesome.
- Communicating with physicians and nurses – impacts quality of care
  - Sometimes at triage, nurses aren't bilingual. Sometimes they will only speak French.
  - Sometimes, with nurses, you get the feeling that you are talking for nothing due to the language barrier.
  - People who aren't bilingual have a hard time because most of the hospitals, clinics and doctors offices are French only.
  - If I am sick, it is already scary enough and if I have a nurse/doctor telling me what is wrong and I don't understand what they are saying, it further affects me – I may not understand the diagnosis and service plan.
  - Sickness is scary. Lack of understanding because of the language barrier makes it a more anxiety-ridden situation.
  - Understanding is hard if you don't speak the language
  - Even hospitals themselves aren't user friendly. Everything is fast, vast and not personal and not always bilingual. It is very intimidating.
- Meetings
  - During meetings it is hard sometimes because I can't keep up with the French.
  - Conversations get complicated because of language sometimes. I don't get everything they are saying.
- Trend now is conference calling. Can be difficult because of language.

### **Lack of English-language services (general and specialized). Difficulties accessing diagnostic testing, respite, and general support services in English.**

- General Services: Difficult to access to diagnostic testing, respite, and general support in English. If outside the Montreal area and you require health services you will experience difficulty accessing English services.
- Auditory services

- Clients turned away from auditory testing services when seeking access to services from Montreal (different corridor of service).
- Long wait times for English services (auditory testing) and the whole process is very confusing.
- Lack of services for deaf clients, there are no translators (sign language) at the Kateri Memorial Hospital Centre (KMHC), it is harder to get services because there is not one to help. This is specific to our hospital, because other hospitals have these kinds of accommodations.
- Speech language therapy
  - Lack of English services for speech therapy within a good time frame.
  - We can't get English/Anglophone specialists and time is of the essence in many cases so parents/clients get very frustrated. The hospital in Montreal region only sees a child up until age of two.
  - A mother was turned away for her child's speech therapy [in Montreal region].
  - Clients went to the hospital [Montérégie region] to obtain speech therapy services for their pre-school child and were told that services were provided in French only.

**Critical Care – Participants reported issues with language at provincial hospitals for family members who are in ‘critical care’.**

- Once surgery and diagnosis is finished and the person is in critical care, then you need to be able to communicate with people who are assessing you to determine if you are passing benchmarks or deteriorating. It's that lack of confidence that community members feel that people will understand them and communicate their needs in very vulnerable situations. The hospital is not always able to ensure that bilingual people will be available.

**Long wait time for services in English**

- The waiting lists for a client to be seen by English speaking doctors is long and specialists are mostly French.
- Hospital out-patient or other English programs – long waiting lists.
- Difficult to see a specialist – not enough health care providers and those that are available only speak French. When trying to get to another hospital the waiting list for a specialist was six months.

**Detoxification Services and Treatment Services – Participants spoke about the limited availability of services in English for detoxification and treatment. There are long waiting lists to access English services in other administrative regions in Québec. Clients are seeking services either out of province or in the US, which presents obstacles for funding (for the services and travel). There are very few treatment centres for families in Québec. Quality of English language services is problematic, participants stated some centres claim to offer bilingual services, but “in reality the services are predominately offered in French.”**

- Not many detox services/support for adults/youth/adolescent in Québec in English. We have experienced detox restrictions for a number of years now.
- Long waiting lists for detox services (i.e., in Montreal region)
- Not able to access beds in other administrative regions (i.e., in Montreal region)
- Psychological ward in the corridor is predominately French. They will do medical intakes for detox, but will turn away clients who are intoxicated.
- We are having difficulty finding places that will accommodate us and offer services in English. Most of the services [for detox] in our catchment area are predominately in French.
- There are also American facilities for Detox, but those need to be paid for.
- Centres in the area (i.e., for long term chemical dependency) claim to offer English/bilingual services, but in reality services are mostly available in French.
- We have had some clients do their treatments in French, but it doesn't work for everyone (communication issues, coupled with the need for treatment).
- Continuity of care: If [clients] are sent to the hospital [in Québec], they will release them, and we don't have a facility that will accept them for 5- 10 days. Some of them need the longer period of time for a medical detox (wash out). They need that before going into a treatment centre.
- One of the biggest client demographic is single homeless men, and the homes for them are limited. There is a recovery home in Ontario that offers a place to stay after detox; we might have them here [in Québec], but they are probably in French.
- For women using drugs with children there is no treatment program in Province in English that will work with the mother and children at same time. Have to send family to southwestern Ontario.

### **Provincial boundaries - barriers for clients who are seeking services in English**

- We had access to the Cornwall Detox [in Ontario], however, they are changing to outpatient services, which is not accessible to us. This centre is one of the only English ones we have available.
- Funding issues (detoxification services)

### **Lack of Mental health services in English**

- It is hard to get a diagnosis in English for mental health clients, and this is needed in order to access services for the client.
- Waiting lists everywhere: patients are leaving hospitals, yet no psychiatrists available for these mental health patients. Discharge from hospitals is an issue (strain on family/community).
- We have limited options for psychologists in English.
- Assessments – limited pool for conducting assessments (non-insured, psychiatrist services). Report provided in French and organization needs to pay to have assessment translated, increases the cost of doing an assessment.

**Medical Vehicles (ambulances) – Participants reported obstacles because of language. English-speaking communities need to make certain that the writing inside of the ambulance is in English and not solely in French (because of Québec’s language requirements).**

- Issues ordering ambulances. We get them from Saskatoon and if we don’t watch, the writing inside will be in French because they are meeting Québec requirements.

**Translation Services – Participants report that there is a lack of liaison (escort) and translation services, which are needed by English-speaking clients. Further, community organizations do not receive additional resources for translation services. Participants questioned the quality of translations, noting that there can be “serious delays” because of the “extra step” of translation (reports, assessments).**

- Provincial services – There are no translation services within the Order of Nurses of Québec (re training/teaching/documents)
- Cost of translation – lack of funding
- Quality of translation – Attitude/beliefs, time consuming, meaning ‘lost’ in translation
  - [Home Care Nursing]: When doctors write in French, they use abbreviations that don’t make any sense for translation. This is dangerous because we need to help the patients and our lack of understanding requires an extra step of trying to find someone to help.
  - Waiting for translation creates delays because can’t have a full understanding of documents. May miss a serious deadline.. When we finally get documents in English, delay in waiting to get response to our English questions. This is all very time consuming getting response in French or poor English translation.
  - When community workers asked for clarification about translated documents (reporting for data collection purposes), community workers were provided with “new” translations, along with a statement that the “translator may have been too literal with some of the wording”. Concern that such translations may lead to misinterpretation, thus inaccurate data or statistics for certain programs.
  - Dealing with the Montérégie (asking questions) sometimes can take up to two weeks because of the translation, or transferring of people. We have a liaison, but when she was on leave, it posed some problems.
  - Delay [for translations]: impacts decision-making and deadlines.
  - Verbally, orally have to find someone who is able to speak English when contacting someone at a provincial institution.
  - [Paramedics]: We can’t just send a document to just anyone for translation because of the medical terminology. Someone needs to have a medical background in order to translate.

### **Calling Provincial Institutions is difficult because of language barriers**

- Calling hospitals is a challenge because messages are recorded in French. If you don't wait through it, you miss the opportunity to access services.
- Problem calling hospitals for appointments, they are not mindful of Anglophones and the older population who need to speak to someone.
- Recorded messages are not always easy for the older population ( 50+), and if [the message] is in French, it becomes a two pronged challenge.
- French telephone-trees are a problem (at hospitals).

**Provincial Databases are mainly available in French – Participants commented that databases for prevention programs are not yet available in English. Working with French databases ‘requires time’ to get used to the French menus and titles. Some participants noted that if First Nations wanted to use data from CLSCs using the programs, the data would only be available in French.**

- Enhanced Prevention Programs – access to I-CLSC program has yet to be translated completely from French to English.
- I-CLSC program (English version) is for use by First Nations communities, thus if First Nations wanted to access any data from the CLSCs using this program, the data would only be available in French.
- Centre Jeunesse of Québec – Programme Intégration Jeunesse (PIJ) program: ‘We liked what the program can do, but it is only available in French.’
- For English-speaking users, it requires time to get used to French menus and titles when using a database that is in French only.

**Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English.** “There are problems with the translation of court orders – everything comes in French and then we have to have them translated.”

**Documentation from the province is primarily in French – For example, information from Professional Orders (which professionals such as nurses and social workers are required, by law, to be members); Clients’ assessments; reports, invitation letters (for example, prevention programs such as ‘breast cancer screening clinics’); signage at provincial institutions; medical alerts and protocol procedures; and training information.**

- Professional Orders
  - Information from Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec (OTSTCFQ): All of their information on their web site and other sources of documentation (including any letters or information mailed) is provided only in the French language.
- Signage
  - French signs make hospital navigation difficult

- Information
  - Provincially run institutions providing documents only in French.
  - Government literature is always in French except laws (in both)
  - Documentation given at hospital in French; nurse spoke in English but this did not help as she could not explain why client had to take medication.
  - Discharging patients only have medicine info documentation in French.
  - A lot of literature is sent to us is in French, this is a challenge for nurses.
  - Documents are only available in French on government sites. Should be an obligation to provide information in the two official languages. We need information, written documentation in English to be able to make informed decisions
  
- Reports, assessments, forms, discharge papers
  - Hospital reports are in French. Specific information/details can be lost in translation.
  - Difficult to obtain information from your own hospital file: documentation / charts are in French.
  - Requests for English reports have been denied.
  - Receiving client assessments and reports in French. When translated there are things lost in the translation. Even when requested in English never receive it. Delays relay of information because things need to be translated first.
  - Information forms can be answered in English, but the questions are French. For medial/social, you need to be sure about the information.
  - Some templates (i.e., Home and Community Care) are sent to community organizations in English, however, the instructions may be 100% in French.
  - Ambulance Forms – The forms are all in French, but all of the first responders have adapted and learned to use them. They might not specifically be able to translate what things mean, but they could tell you what box they need to tick of for something like respiratory problems. They get the sense of what it all means, and make due.
  - Discharge papers are usually in French. Montreal has more access to English documents, but other places in Québec, not so much.
  - The discharge papers are usually in French. I have some French, but it can be hard. [At hospitals that are supposed to be bilingual, participants reported difficulty obtaining discharge paper in English].
  
- Letters from province– French only
  - Breast cancer screening invitation letter from provincial hospital is in French – it is not uncommon for clients to ask what it says. Contact can be challenging because it is all in French.
  - Québec Health Records: all the documentation came in French to everyone. If they don't understand they just toss it. There is a small box that tells you where to get it in English.

- Medical Alerts, Protocols and Medical Information
  - *Paramedics*: We get special alerts and immediate protocol changes that are always sent to us in French, constantly trying to play catch up to everyone else, because we have an extra step of translation.
  - *Nurses*: Working documents (immunization policies & procedures) – French only
  - Need important working documents in English i.e. Immunization Protocol
- Training Information – lack of access to English materials
  - Networking/teaching/client information limited – all in French.
  - There is a process to translate training information. There is often a delay in getting translated, English documents to use. Some don't know that they need to translate it or, they just don't want to do it in English.
  - For example, a manager spoke about attending a training session for Continuing Care Program where a document provided at the training was only made available in French.

**Ageing population – obstacles for Elders to access services in English. There is a lack of English-speaking, long term care providers (and facilities) for Elders. Discharge from hospital is an issue (English reports), with additional strain falling on homecare nursing and family members. Participants noted that the Elderly may miss appointments because they are too “shy and scared” to go provincial institutions.**

- Lack of English-speaking, long-term care providers/facilities for Elders
- We have a lot of clients that are sent home from hospitals and their care falls to homecare nursing and family members. This is true in the area of special needs as well. There is no place for clients to go.
- Discharge from hospitals is an issue – places strain on homecare / family / community.
- For the elders, the majority of the services come from Kahnawake, which is always in English.
- Elderly won't go to appointments because they are shy and scared to go there. This happens with others also, but mostly with the elderly.

**Accessing English services and placements for adults and children with severe special needs is difficult. There are challenges because of limited services in the area, and transferring to a different region is difficult (corridors of service and issues with funding). Although there are organizations mandated to serve the Anglophone communities, participants stated that English-speaking First Nations are not the ‘top priority’.**

- Child/Adult Placements: Severe special needs – trying to negotiate English services is difficult
- Placements in our language of choice is difficult. Province has been very difficult in transferring the funding for placements to facilities on the Island – there is a

lack of English facilities in Montérégie area – we have to use [facility in Montreal], but there is a difficulty getting payments made.

- Group Home and Institutional Care: problem to find ones that speak English. Partnership with [an agency that serves the Anglophone community]: assist in finding facility for placement, our organization is not on their priority list. Their clients come first, and we are under them. Can happen that a client is put in a French placement for one night till can find an English facility. Told by the agency that Kahnawake is not a top priority – issue for English speaking children from communities under the agency’s mandate.
- Finding funding to send adults/children to English Montreal services: Province is responsible for it, but are not paying.

**Access issues for youth seeking services in English. Transportation is an issue.**

**Corridors of Service – The corridors of service have been changed in the province. For individuals on the South Shore, access to institutions and services in Montreal is restricted. The services available in the South Shore are almost all in French. Participants stated that travel is also an issue: clients must travel farther, and with less public transportation available to them, in order to access services in their own corridor.**

- The corridors of service have been changed for people living on the South Shore. Access to hospitals in Montreal is restricted, clients being referred back to South Shore.
- More and more we are being delegated to the South Shore for services, which are almost all French. The “State of the Art” medical services are on the island and we are being shut out because of our postal code address.
- It was stated that someone was turned away from [hospital in Montreal] and sent to hospitals on the South Shore
- Lack information about where to obtain services, in particular if outside of the administrative region
- When you try to call on the island they try to sector us off back to south shore.
- Mental health sector – Confined to corridors if trying to get on Island.
- Hospitals in our corridors of service are far away (difficult to access services or to visit family)
- We ignore sectorization and take our patients where they should be going. Service providers are not in bureaucrat mind frame. We have built up a network with certain key people who are still willing to help our community.
- English services are available in the city. It does not make sense to be using south shore hospitals because hospitals in Montreal are only 10 – 15 minutes away.

### **Limited access to training in English in Québec**

- Nursing: Education sessions for nurses' order isn't always offered in English for those not comfortable wholly in French. Language, educational opportunities are offered only in French.
- Paramedics: We can't get paramedics trained unless they go through a program recognized by the Québec government. Not able to send anyone to New York anymore for training.
- Training offered by hospitals, but it is all in French.
- Social Work order has English speaking training being offered, but it is in French so if you don't understand French you won't know there is training. Initial documents come in French. Web sites or mail.
- Staff required to take training every two years, but the list of training is in French.

### **Liaising / Networking with provincial institutions – Participants spoke about the difficulty liaising and networking because of language barriers.**

- My experience liaising with hospitals is that there is a lot of bilingualism, but it is hit or miss sometimes. There isn't always someone who speaks English.
- I don't really network with services outside of the community.
- When trying to network –consistently asked if I speak French.
- Given the run around often because primary language in English. It's frustrating.

### iii. Access Issues related to Culture (Aboriginal)

#### **Jurisdictional Issues – Lack of clarity about provincial and federal responsibilities towards First Nations health and social services. Participants stated that they are 'caught in the vortex': 'we are federal responsibility and they pass us to the province.' There are gaps in terms of who is responsible to fund certain services and equipment for First Nations. For services that are covered by the federal government, there is additional waiting time while waiting for approval for funding.**

- Caught in the vortex – we are Federal responsibility and they pass us to the province.
- We fall under Medicare for certain things and federal government is supposed to cover other things, but there is a gap in what First Nations receive in care.
- The "Jordon Principle" has to be in place now because there is nothing being done. Federal vs. Provincial: who pays?
- No one catching discrepancies – no tracking what we had in the past or present.
- Funding for Detox Services from provincial and federal government is complex:
- Financial cut backs – impacting special needs and Medical Transportation
- There is inequity when it comes to health care and equipment. Simple devices that we should be getting, like the rest of Québec, are being denied to us because of funding sources.

## **Provincial legislation is impacting English-speaking First Nations access to health and social services.**

- Bill 14: Participants expressed concerns about the impact of language legislation for individuals who want to receive health and social services in English. Bill 14 entitles workers to work in their language of choice, yet what will be the impact for those who want to receive health and social services in English?
- *Bill 21*: There were concerns about the Professional Order, which because of language requirements makes it difficult to recruit and retain professional workers (nurses and social workers) who are English-speaking.
- Bill 49: Impact of the Act for Family Resources, which would impact the foster care services. Information about the new criteria for accreditation is only available in French. *Note: The Health Commission is working on translating the form to English.* Database System (STRIF SYSTEM)– The data (from the ‘accreditation’ and ‘Grid’ (criteria)) will need to be inputted into a database called the ‘STRIF system’; however, database is only available in French. In addition to language, there are also issues because First Nations were not consulted about the proposed changes. The new system for Foster Care placements “does not take into account First Nations culture, spirituality, sense of identity of the child and community.”

## **Limited availability of culturally appropriate services from provincial institutions**

- We approach things differently on Reserve vs. the outside community. Family and homecare nursing mostly take care of their family members living on reserve.
- Urban First Nations call for culturally appropriate services but [Kahnawake] can’t always accommodate them because we don’t have the amount of staff.
- Detoxification Services – We don’t have any cultural/language service in English in our province for detoxification. There are cultural services in Ontario.

## **Medical Transportation – Participants spoke about obstacles accessing funding to pay for travel in order to access services in English. Clients need to pay out of pocket for transportation to access detoxification services that are ‘out of province.’**

- Funding cutbacks are impacting access to medical transportation services (generally).
- Medical transport doesn’t transport to some services that are past a certain distance, travel may be required in order to access services in English.
- We need to pay for our own transportation (i.e., train, bus) when accessing detoxification services out of province.

### **Discrimination and lack of cultural sensitivity**

- Services in Montreal are not always culturally appropriate.
- Some [clients] experience challenges because they're Native. They feel that maybe they don't get the whole service (or best) because they are Native or from Kahnawake.
- Elders have a hard time to understand papers or procedures; Pamphlets are usually in French. They express often that they are unable to understand what's going on with them and also what's going on in their environment.
- Sometimes, there is also a taboo in the way people feel about Native people. They think sometimes, maybe that there are special needs that they don't know about. I have to explain to them that they can help us.
- Culturally, we often have lots of people in the hospital. We don't fit into the mainstream way of things because we always go to the hospital for visiting in numbers. Culturally, accommodations should be made for severe illness and more traumatic instances when it comes to someone staying over night, or family visiting. One participant commented, "When my husband was at [hospital], We were having problems with them letting me stay the night because it was against their policy. They tried to take me out but I wouldn't leave, especially since he didn't speak French."

### **Respecting the Rights of First Nations – Participants spoke about the loss of language that First Nations have already experienced, which cannot be repeated. "There was a loss of language once, and [Aboriginal languages] were replaced with English, they cannot expect you to change your language again."**

- There needs to be advocating for information for First Nations. People need to begin standing up for their rights ... Making the need known is important. They cannot force you to know French. There was a loss of language once, and it was replaced with English, they cannot expect you to change your language again.
- We want the option to receive English services at provincial hospitals in our corridor, because it is our money going there, and we are entitled to it.
- Some people in Kahnawake have this mentality that they don't have to speak French, so there is negativity when going outside and everything is French.
- I believe French should be preserved because it has a similar title like all other languages and cultures. However, you cannot cram it down the throats of First Nations People. They should be offered services in their language of choice.
- It's not acceptable when people say Québec has to be French. They forget that we were here first, so we don't have to speak French.

### **Employment and hiring – There is a lack of opportunity for First Nations who cannot speak French, even within First Nations organizations of English-speaking communities.**

- [Paramedics]: We need to bring in non-Natives to hire or to train. There are questions about why we always have non-Natives, but it's because we don't have French speakers.
- Bilingualism wasn't necessary for the position I work, but I think it helped ... If someone else were in my position, they would have a really hard time. Everything that I get from hospitals is all in French. They don't have it in English unless you ask for it. I have to take the time to translate it and then relay the information.

#### iv. Positive Experiences

- Participants reported that the documentation and information that is available from pharmacists in English. As well, some of the hospital do provided information in English, however, clients' files are mainly available in French.
- When able to access services in English, participants spoke positively about the quality of services available to them. In the larger urban centres, there were usually no problems finding someone who speaks English.
- Participants commented on the need for a positive attitude and a willingness to work together. "A lot depends on attitude".
  - There are people who do the best to help everyone and help understand.
  - Attitude of person seeking service also impacts experience. Expecting English in French environment can be difficult.
  - One-on-one calling has been positive experience.
  - There are people who are helpful and who give information you need.
  - Many of the psychologists and psychiatrists can be supportive and helpful, in particular for 'addictions and detoxification services' – however, the process can be difficult and the wait to see specialists can be long.
- Support services for certain chronic conditions are available in English from community organizations (for example, the Alzheimer's Society).
- Resources and Networking – Participants reported that the Health Canada Representative (regional office) is very helpful in giving direction for finding English regional services. As well, the Health Commission is also helpful getting information and direction.
- Info Santé – There were mixed responses about access to services in English from Info Santé. Some participants found the service helpful and able to provide services in English, others stated that there was a lack of English-language services available.

## 6. Kitigan Zibi

### a.) Community Resources (Health Services and Social Services):

#### i. General Access Issues and Challenges

**Lack of general and specialized health and social services in the region** (in either English or French). Because health and social services are limited in the area clients need to travel to access most services.

#### ii. English Language Access Issues

**Detoxification Services and Treatment Services – Participants reported that there is a lack English treatment service centres (detoxification, specialized rehabilitation treatment for addictions, and a lack of ‘after care’ addictions’ treatment services in the area).**

- There’s hardly any English speaking treatment centres, and we have to choose from a list provided by Health Canada
- A lot of the English speaking treatment centres are far away
- If community members do access specialized treatment for their problems in Québec, in English, it’s private treatment centres, which have an added cost, because Health Canada won’t subsidize the cost, the additional cost, of those private treatment centres.
- Community has paid out considerably to send a few members to private clinics in Québec for English services (approximately 75,000\$ invested one year by the community to send three people from the community to long-term private clinics for English services in the province of Québec)
- There are issues with centres in Québec, which are supposed to offer English services: counsellors do not speak enough English to be able to deliver their programs to the English-speaking clientele.
- Our First Nations clients need to learn to speak French really quickly, or other clients at the treatment centre are translating for [the counsellors].
- For after care services (i.e., methadone maintenance plan) clients need to travel about one hour and a half to continue with their plan, distance is another challenge.
- Limited in our area, we need to go to Ontario to access services.
- We’ve been lucky, the detox services in Cornwall accepts our clients, although they don’t usually accept anyone from Québec. If we tell them we are First Nations, they do accept our clientele.

**Ageing population – Participants reported that elderly people face obstacles accessing long-term care facilities in English. There is a language barrier and are fears of ‘being neglected’. In addition, some First Nations elders face additional challenges when needing institutional care because of the traumatic history of residential schooling.**

- The nursing homes in the province are all French. I’m not aware of any English-speaking nursing home.
- It’s the language barrier. And the fear, for the elder themselves, when they’re getting transferred that they are scared they are not going to be understand once they get there. That they’ll be neglected.

**Lack of Mental health services in English – Participants commented on the lack of English-services available for programming, communicating information to clients, and information from the province (reports/assessments).**

- We have, as far as mental health services go, we have a real issue with [mental health hospital] because a lot of their programming is done for the French community, and it’s going to be a very big barrier for our clients, especially the English speaking clients.
- Everything is in French. If we get reports, they’re in French.
- Our clients will not understand what’s being said about them, or why this stuff is being given to them.

**Language Barriers (Communicating) – Participants reported difficulties because of language when communicating with doctors and nurses, in particular there are difficulties for mental health services and understanding diagnosis for chronic illnesses. Communication can be a challenge for the elderly at nursing homes. Participants noted that they find themselves acting as ‘translators’ between elderly clients and staff at provincial nursing homes.**

- Being able to understand what the staff (doctors, nurses) are telling you, especially critical for mental health services and when receiving diagnosis for chronic illnesses.
- At the seniors’ home, First Nations community workers often find themselves acting in the position as ‘translator’ (yet not funding provided for this service).

**Calling Provincial Institutions is difficult because of language barriers – bilingual staff not always available to answer calls.**

- If you have to call CLSCs after 4 p.m. or on weekends, it’s French. They want to know why you are calling, and I myself am not totally bilingual, but I try to give them the information, it’s hard because of the language.

**Documentation from the province is primarily in French. Examples include: Information from the province, correspondence, Protocols (immunization).**

**Participants reported that community organizations do not receive any funding from government for translation services.**

- As a health care professional, it's hard because I only speak English, to access health care here, whether it's correspondence between me and a hospital, everything is done in French. Yes, we have to decipher this, but the patient has to understand the instructions given to them, and it's always in French, and since it's really hard for my clients to follow those orders, it puts their lives at risk.
- Discharge reports are all in French
- Community Health Services translates documents obtained from the province, no funding provided for this.
- One of our nurses went to Sante Publique to get the new protocol for immunization, and [we were told] it's not going to be made available to us in English.
- Health Canada provided a translation [of the immunization protocol] years ago, but they do not do it annually. If there are any changes, there's an outdated English version. It's not regularly updated. We'll have to make a case to have Health Canada translate it into English. And that's just recent---the new protocol came out.
- We do have basic little hand-outs for [clients] that [the province] provides for us in English. But say a mother requires some information about the PIQ [Protocole d'immunisation du Québec] and the only information I can draw from is outdated from the older translation, I don't know how old the information is---maybe five years old. It's not right and downright dangerous.
- Community Resource workers confirmed that they do not receive information from the province (for example, pamphlets) about services in English. Any information that they do receive in English is from Ontario.

**Provincial Databases and software programs are mainly available in French. Participants reported that it is difficult to enter and manage information in the French databases (both health and social services). The databases are not yet available in English.**

- There's an immunization protocol program on our computers and it's only in French. It's a little bit hard to maneuver around that when you only speak English.
- It's hard to work with French databases, if you have it, it's really hard just to do something basic, figuring out how it works. We had to check the references all the time.
- They've tried to make [the database] available to First Nations communities in Québec, but it is still not available in English. So for us to keep up with the standard of delivery and tracking of data, in comparison with the rest of the province, we have to wait until that database is available to us.
- Panorama (database to track immunization across Canada): But as an English service health centre in a French region, are we going to be able to access the Panorama tool in English and will we be able to input our data in English, and will it be conducive to the French version?

**Provincial boundaries causing barriers for clients who are seeking services in English – Clients are being denied access to some services (treatment centres and mental health services) that are out of province.** *(Additional paper work for First Nations, and reports that refusal from outside of the province are because of the length of time it took for the Province (Régis) to pay for services and because letters sent by the province are in French only.)*

- Most English treatment centres are in Ontario, and they do not grant access without an Ontario health card (OHIP)
- We are required to fill in a lot more paperwork if we send clients to receive treatment services from Ontario's provincial institutions.
- When they ran into mental health problems, we tried to network with local mental health hospitals, but they did not have the English mental health services we needed, so we tried to move to Ottawa to access the [mental health hospital], but they were turned away. We were told, "You cannot access treatments here, you cannot access mental health treatments here. 'Go away. Go back to Québec.'" We were left with our clients who cannot speak French really well and needed communication with a mental health worker at a level they could not get. What can we do with them? We're pretty much it. [Community Health Services] is the extent of the mental health services that this community is going to get.
- I was doing a follow up on one of the programs at [hospital centre] in Gatineau to get an access form, a referral form, and the worker said, 'Oh, we'll put you in touch with the [mental health hospital],' in Ottawa! But, we're not even accepted at the [hospital] in Ottawa.
- There's a lot of concern about some community members. We don't know how long they're going to live in their [mental] state if we cannot access proper mental health services.
- There's a lot of refusals [from the hospitals in Ontario] because of the length of time it took for them to be paid by the Régis, and also the letters [in French] they got from the Régis.

**Provincial legislation is impacting English-speaking First Nations access to health and social services. 'Bill 21' Professional Order will 'create barriers' for English-speaking professionals.**

- If we do not belong to an order, there will be licensing issues because of the language.
- Barriers for us as English-speaking professionals in the community and performing assessments on our clients.
- That's a big issue for all First Nations in Québec, but more so for English ones who do not have the French training background that the other professionals have in Québec.

**Lack of access to specialized services in English – in particular for speech language therapy and services for individuals with physical challenges (disabilities).**

- Speech therapy for children is another place the language barrier creates obstacles.
- I think if you're accessing any provincial service, I don't know too many that are in English. For those who are disabled trying to access services, there's nobody in English.

**Limited access to training in English in Québec** – Cannot attain the same level of training as French-speaking counterparts (for example, for nurses and social workers). For nurses, although there is a requirement by law to receive yearly training to maintain their licenses in Québec, the training is not provided in English. Therefore, to gain clinical skills nurses are seeking training out of province.

- Kitigan Zibi English speaking nurses cannot get the same level of training that the French nurses of Québec are attaining ... They are trying to gain clinical skills in Québec, but we for now we send them to Ontario. However, the training needs to be compatible and comply with the laws in Québec: we need to know what are nurses able to do and not able to do as far as delegation of responsibilities and what new skills needed.
- There is a requirement--- a 20 hour training requirement—that the nurses supposed to obtain to maintain their licences in Québec, but if that training is not available in English how are they going to be able to do that? If they go to another province, is it going to be considered valid (by the Professional Order)?
- Social Services: For training, I did try to call [someone from the province] to come down for training, but every time I made a request, it got lost somehow. I did try, and follow up, and then all of a sudden it stops. It's not that we don't try.
- Required to go out of province to Ontario in order to receive training in English “it's sad because we have to go about six hours away, when it's offered [in French] one hour away.”

**Participants reported that they lack information about where and how to access services in English from the province**

- It's up to the [Community Health Organization] to find services in English (for example, getting a speech therapist)

### iii. Access Issues related to Culture (Aboriginal)

**First Nations are included in the provincial per-capita funding, however services are do not meet community's needs.** “Even though the province receives per-capita funding, they are not able to offer the services up to the level that we require.”

**Discrimination and lack of cultural sensitivity**

- Professionals and other service providers interacting with our communities who do not understand and judge quickly.

### **Lack of communication from the Province with First Nations because of language**

- There's a lack of communication between [First Nations Health Centre] and the provincial system. They don't have anybody in English to update us, and we don't find out about these changes until we go to access the services when in actuality we should have been updated with the rest of the province.
- They do publicize [information] in the paper, the local paper, but the paper is in French, so if you don't read French you will miss out on services.

### **Ageing population – Elders who need nursing home care face issues because of language, which may trigger 'reliving residential school experiences'**

- For some of [the Elders] who have lived in a residential school or a shared environment experience, for them it's like reliving that experience again being institutionalized ... For those who cannot speak French, they feel they are reliving that situation where they are taken from a home environment and put somewhere they are not understood. For some of them it's trauma.
- Language is a big factor there. If you're an English speaker going into a primarily French environment, it's a basic communication challenge, and it triggers all other kinds of feelings.

### **Lacking of funding for escort/liaison services when clients need assistance because of language**

- An obstacle we face in accessing assistance, escort, or the translation services--- Health Canada does not cover that cost. They took it out of our medical transportation program. At an administrative level, there's a problem from the beginning, so we need to find a way to bring this much needed services to a person who cannot speak French.

### **Jurisdictional Issues – Lack of clarity about provincial and federal responsibilities**

- [The clients] are played like a yo-yo. If you live in Québec, [the federal government] thinks you should be the province's responsibility, but it's a challenge because we're on reserve. The province says, 'they are the responsibility of the federal'.

## **b.) Kitigan Zibi Community Members:**

### **i. General Access Issues and Challenges**

#### **Lack of general and specialized health and social services in the region (in either English or French).**

- Lack of general and specialized services
- We have to travel two hours to the city to get rehabilitation
- Dentists. There's only one dentist and they're full all the time.
- There's no pediatrician or anything like that, and all the doctors are general practitioners. There's no specialists.
- Lack of obstetric care –You can't have a baby in the area. Any appointment you have when you're pregnant, you need to travel to the city.
- Distance to access services (travel)

#### **Travel – Distance to obtain specialized services. The “realities of living in a small rural town.”**

- We only have physicians who specialize in certain areas come in maybe once a month. That's the way it is. These are the realities of living in a small, rural town.
- Distance to obtain specialized services: we travel hour and a half minimum, it's generally about two hours to access services in the city.

#### **Lack of access to Medical Equipment in the area (i.e., dialysis equipment, wheelchair, walkers, etc.)**

- Medical equipment not always available (i.e., dialysis)
- Another thing is equipment. We'll have to wait two or three weeks for certain pieces. And I guess that comes with living in a rural area, too.
- If you need a wheelchair, you need to go two hours

#### **Long wait times for testing**

- It took me a year to get my son testing for his allergies.
- I've waited, for certain tests, for six months or a year. I was on the waiting list here and they told me to keep waiting. It took a year.

#### **Emergency Services – Emergency response time is slow generally speaking in the rural area. Participants reported additional delays because emergency workers are not familiar with the First Nations' community: they rely on GPS; however, the community 'has not yet been mapped'.**

- For ambulance services, for most cases, it's a 30 to 40 minute wait. There are only two ambulances that cover the jurisdiction. For many of the emergency workers it's the first time they've stepped into the community of Kitigan Zibi, so they mostly rely on GPS, but a lot of our reserve hasn't been mapped yet. If they

would hire somebody from the community it might make a difference. It might save lives.

## ii. English Language Access Issues

**Perceptions and beliefs about the services at provincial institutions: Participants reported that English-speaking avoid using hospital services because of language barriers.**

- Even for community members staying at the hospital. I know there's a general feeling, '*Don't go to the hospital unless you absolutely have to*' because people don't want to deal with the language barrier.

**Language Barriers (Communicating): Communicating with specialists and support staff can be difficult because of language. Participants reported that there is 'additional stress' on family members who are bilingual. Participants expressed the view that, 'It's a 'basic human right' to be able to receive information about your health in the language that you can understand.**

- At the CLSCs not all the nurses speak English, some do – but most of them only speak French.
- I myself, I can speak French to get by, but once I happened to answer in French, they will speak really quickly. It's a big barrier.
- I had a family member in the hospital for a heart attack, and I'm the only one in the family who can speak French, so I was constantly asked to stay here and come wait to speak with the doctors. It's hard for family members.
- For older people, it's also hard understanding all these medical terms.
- No liaison services at the hospital to help clients
- It's very important to have service providers be able to speak in the language that their patients can understand because a lack of communication when you're dealing with your health could turn out to be something fatal.
- I think it's a basic right of an individual to receive that kind of information [about their health] in a language that they understand. It's a basic right, a human right.
- You need to know exactly what you're being diagnosed with. Like with my kid, my child – I'm not exactly sure what they're trying to say. So, I ask them to write it out so I can go home and Google it.

### **Lack of Mental health services in English**

- It's difficult to obtain an English worker for mental health services. They already have limited facilities, but if you're trying to get services in English it's almost impossible.
- First Nation community workers asked to translate: "If the worker doesn't speak French, we have to be called in just to translate and make sure the information gets through."
- A child therapist and psychologist comes to the community half-a-day a week,, and their schedule is full all the time.

- We lack mental health services here. There's no services in Maniwaki.
- There's one psychologist here and they're always booked up.
- People are worried about seeing a therapist here in the community. They are embarrassed and don't want people to see them go into there. But if it's in the hospital, they will be less afraid. But, you need to prove you're really a threat to get a referral down to the city [to access English language services]

**Lack of access to specialized services (in either French or English) – for services such as, physiotherapy, speech therapy, rehabilitation services)**

- I myself am doing physical therapy at the hospital here, and that's where I did run into problems. The first therapist assigned to me was French-speaking, and so they assigned me a bilingual one, and it seems like there's only one, because every member of the reserve is assigned this same physical therapist.
- If they need speech therapy, mental health issues, physical rehabilitation, they all have to go to the city for that.

**Documentation from the province is primarily in French. For example: Forms, information, signage. Reported that some staff unable to explain English (written) documentation to clients.**

- At the hospitals, the emergency consent form is in French. And when you're admitted into the hospital, that's all in French.
- When my son was getting his allergy testing, they gave me a pamphlet in English, thankfully, because I'm not sure I really would have understood what he was allergic to.
- When I went for surgery, they will give you information on how to take that medication, and post-operation, how to take care of your bandages. But other than that, I can't recall ever bringing home any form of written explanation.
- Any poster or any little thing you see around the hospital, it's all in French and I don't know how they expect us to understand this. You never see anything written in English there.

**Provincial boundaries – Barriers for clients who are seeking services in English**

- We use a lot of services in Ontario, because of the English language. But now we're being told they aren't accepting the medical cards.

iii. Access Issues related to Culture (Aboriginal)

**Discrimination and lack of cultural sensitivity**

- In our community, they will avoid the hospital at all costs. Number one, they don't understand when they do go in there. It's not only a language thing, it's prejudice---it's racist. They feel they don't get the quality of care that they should.
- I've heard talk of the racism ... in the hospital. I've witnessed it myself.
- There was a nurse I knew who used to insist that you spoke French whenever you walked into the hospital, because you're in the province of Québec. She would

insist, saying, 'You live in the province of Québec. You should speak French'. She would do that do most community members if she were on shift. You're not there for that. You're there for an illness, not a lesson. And it is racism.

- There needs to be understanding about our community. Why alcoholism and drug addiction is so prevalent in our community. There's a reason. We're not a whole bunch of drunks who live off welfare. Because that's what they think, I've heard it from my own ears. And that's something we could try, to provide cultural awareness to the health service providers.

**Ageing Population – Language and cultural barriers at long term care facilities for the elderly; lack of assisted living and long term care facilities for First Nations' community members; lack of support services for elders who speak their Aboriginal language**

- When elderly community members require more care than what is currently offered in the First Nation community [those who require Level 3 and 4, 'Long term care'] they are transferred to provincial institutions. It's the language, the culture. It's all French in the province, and the neighboring town everything is French. So that's a big issue for community members.
- When Elders have to be transferred to a provincial system, there's not an English one by here whatsoever. And a lot of the seniors are residential school survivors, who were taken out of their community as children, and now we're doing the same when they're elders, and we're placing them where they can't speak their language, where it's not culturally adaptable at all.
- There are only seven residential care facilities in First nations' communities in the province (offering Level 1 and 2 care, home care/ residential care).
- I was visiting a hospital and one of the doctors asked, 'Do you speak Algonquin?' I found someone to translate. The doctor said, 'We've been trying to communicate with this man for two weeks.' That's unacceptable.

**Jurisdictional Issues: Lack of clarity between Federal and Provincial authorities**

- Another issue is jurisdiction—Who do we belong to? Say we try to get stuff from the province, we're told, 'No, you're under the federal.' And the federal will say, 'No, you're under the provincial, or you're a First Nations community.' You're running in a circle trying to get some assistance.

**First Nations' Health and Social Issues are well-known, yet there is a lack of funding to implement lasting solutions**

- That's another issue—Health Canada, Aboriginal affairs—there's always studies, studies, studies, but what's next? When are they going to implement this stuff? Big money's spent but we don't get results.
- It's frustrating because we all mention the same things—funding, jurisdiction, etc...—and I really hope that this time we will see some results.

### **Lack of clarity about Non-insured Health Benefits (NIHB)**

- Times I went to the drug store, the medication wasn't covered. I paid for it myself. 'Not all Medications are covered'

#### iv. Positive Experiences

- Wait times for services have not been long
- Bilingual staff at provincial institutions: A participant described her sister's experiences with provincial institutions. Her sister has been receiving kidney dialysis on a weekly basis – they have “lucked out” with respect to the services they have received in that ambulance attendants, nurses, doctors, physiotherapist, pharmacists have all been English speaking

## 7.) Eagle Village | Kipawa

### a.) Community Resources (Health Services and Social Services):

#### i. General Access Issues and Challenges

- Difficult to access to specialized services
- Distance to access services (travel)

#### ii. English Language Access Issues

**Lack of access to specialized services in English – Participants reported difficulties accessing English-language services for the following: nutritionist, speech language therapy, special needs, occupational therapy. In the school system, participants commented that support services in these areas for English-speaking students are lacking (“long delays and quality of services is not there”)**

- When you got to see a primary physician, there are no issues as far as receiving services in English, it’s just from then on. Once you get to the more specialized care, then language becomes an issue.
- Nutritionist
  - For the diabetes program [at the Health Centre], we would often require the help of a nutritionist, we had problem accessing those services in English.
- Speech language therapy
  - We do have speech pathologist with the school board, she travels twice a year to meet with the students and set up programs for them, but we don’t have someone to support that on a weekly basis.
- Support services for children with autism spectrum disorder
  - There were two other students in our system, around the autism spectrum, they were supposed to be receiving support through the Centre Readaption, but it hadn’t been happening because they couldn’t hire anyone. There is a huge lag in actually being able to provide services. [The worker] coming in now speaks very little English. I appreciate that she is putting a lot of effort to work with these kids, but it’s certainly not the standard of care that a child would be getting in Ontario.

- Occupational Therapy
  - You know, I have an occupational therapist working with my students, but they can barely string two words in English together. They might be fabulous in French, but what good is that to my students?
- Support Services in School (elementary)
  - The services provided by the CSSS to the students in the school is lacking. Because our students aren't capable of receiving services in French, then a lot of services are pulled back. They'll say, 'we can't offer it because we don't speak French.'
  - It's not uncommon for parents to just up and leave the province altogether because the services they get for their special needs child in English is not acceptable – long delays and quality of service is not there.

### **Detoxification Services – Difficult to access local services for detoxification in English**

- Detoxification services, it's hard for clients. The treatment centres are in English, but for detox the closest one that we have is in North Bay, and that's in Ontario. I was speaking with a client about detox in Montreal; she said, 'I don't speak French.'
- If the person goes to Montreal it's about 6 or 7 hours away, rather than being able to go 45 minutes away [out of province]. You need support from your family when you are going through something like that [detoxification], and to be far away, it's difficult.

### **Lack of services for primary eye care in English**

- *Optometrists*: Specialists don't speak English – just to get glasses, it's covered through [Non-Insured Health Benefits] NIHB, but it's not available in English.
- I had to take my children outside of the province to see an optometrist.

### **Lack of mental health services in English**

- With regards to psychological assessments, the individual downtown [at a provincial institution] is French and so we have no access to that service.
- *Mental Health [in the school system]*: Psychological counselling for our students is almost impossible.
- *Psychological assessment for students [in the school system]* – If a parent requests a psychological assessment to find out if their child has special needs, then it's up to them to seek out these services. They are being directed [out of province]. They are paying for it themselves.
- It's when we get to mental health that we run into some issues with language.

## **Shelters for Women – lack of services in English**

- The shelters for women that are close by, don't have any services in English.

**Language Barriers (Communicating): Participants reported that doctors are more likely to be bilingual, less so for support staff. Participants, however, reported difficulties communicating with specialists at meetings (i.e., for support services (developmental and occupational) required by English-speaking youth). Participants stated that 'more time was spent trying to address the language issue as opposed to dealing with the issue at hand'.**

- Doctors are bilingual, less support staff:
  - We had a client hospitalized in Amos, Québec, for surgery, and he had a lot of trouble communicating to the nurses' aids. They'd come into a very, very difficult situation and it was frustrating on both sides, and they ran into some issues ... It's not the physicians themselves—they were all A1, bilingual—it was the support staff coming into the rooms to help out with the client, the baths. Very, very limited in that area.
- Meetings:
  - Centre de Readaption provides services for some students. Meetings [coordination and participating] with their team, when they speak almost zero English, is difficult. If there are any students who should be communicated in their language it's them: these kids can't handle someone trying to speak in French to them. It's a huge challenge.
  - I can get through a meeting, but it's difficult. Two hour meeting with specialists [Centre de Readaption], we're sitting there trying to figure out the language issue, as opposed to how best to work with this child. It's very frustrating.
- Quality of Services
  - How can the specialist help when they can't even understand the child? How true can their assessment possible be when they can't even communicate with the child?

**Translation Services – There is a lack of funding for translation services. Participants reported that First Nation community organizations are providing translations services for clients seeking services from provincial institutions. However, this service is provided 'on their own' – there is no funding and it is only because a particular worker may be able to speak French.**

- Sometimes it's things they get in the mail [from the province], which clients need translated because it's all in French.
- The Agence de la sante has provided a translator on site at the hospital, and I believe it's four days a week within office hours. So, unless you time your sickness with those office hours, there's going to be some issues.

### **Calling Provincial Institutions is difficult because of language barriers**

- When it comes to booking appointments, often the secretaries in hospitals or doctor's offices are only French-speaking.

**Documentation from the province is primarily in French – For example, Information (public health), reports, assessments, correspondence, training information, and protocols (immunization). There is no funding for translation of written documents.**

- Problems with forms and reports.
- All reports from the Centre Readaption are coming in French – that's what's going to the parents and teachers who are English-speaking.
- With les agents de la sante, public health information, more often than not, it's only in French. However, since a few individuals understand that there are a lot of English workers in the area, they are making an effort. They put on workshops, got people from Montreal to do it in English.
- Information about training is sent to us in French. I get it all the time. The invitation letters, the invitations to the particular training sessions, all comes in French.
- *Protocole d'immunisation du Québec (PIQ)*: Information for vaccines, even the notations and all of that is only available in French. You have to be able to read it and administer it, because they won't translate it. They are not required by law to translate it—that's what we've been told.
- For a while, we were having all our documents translated directly through Health Canada, which was a nice gift. We get the Québec manual [PIQ], because our communities are in Québec we worked underneath Québec protocols, the PIQ would be translated by Health Canada, and myself as a nurse, I would use that manual daily. But now they have stopped translating it.
- For health services, the forms are all in French. I believe there are a few translated forms we receive from time to time, but Health Canada took on the translation of those as well. It was not translated through the province.
- The news bulletins coming out of our provincial headquarters is all in French, the bulletin board is all in French. The news flash we get from the hospital (CSSS) is all in French. All the communication is in French.

**Participants reported that there are difficulties for individuals from English-speaking agencies to fully participate in health planning and decision-making at meetings. Further, the participants felt that the province is not conducting meaningful consultation with English-speaking population about changes to health policies. (i.e., Québec's changes to computerized system for health records).**

- Health Planning and Decision-Making (Meetings): The board of directors meeting for one of our hospitals is all in French. Basically it limits the amount of people who can participate, because it's all going to be done in French. And they'll view

it as you being consulted, but we have a different definition of what consultation is.

- True, meaningful consultation is not happening. Decision-making and planning boards are predominately in French.
- If you are providing health care and best care practices and you have three large communities with a large portion of English-speaking people in your population, you think it would be important to reach them, too.
- ‘Informed Consent’ is not being obtained from English-speaking population about changes to health policies (computerized health records).

**Provincial boundaries – Barriers for clients who are seeking services in English Assessment reports from ‘out of province’ not always accepted in Québec (from both public and private clinics). Participants reported that clients who receive services in another province may need ‘to pay up front’ for insured services that are supposed to be covered by the province. ‘Border communities’ in Ontario offer bilingual services; however, it’s not reciprocated: Québec institutions on the provincial border don’t offer bilingual services. Participants reported that the ‘link with hospital in Ontario is vital’ – most specialized services (childbirth, testing, assessments) are obtained at the hospital in Ontario.**

- Assessment reports from ‘out of province’ not always accepted in Québec. Québec has certain ways that they want things coded, for example for psychological reports for students.
- The Québec government is getting more and more picky about accepting reports. One student was turned down for a handicapped vehicle, they had to reapply, parents had to be involved in calling the government.
- Often there will be additional charges, depending on the specialist, if it’s not in a hospital setting, and even sometimes in a hospital setting. And this is to have services in English. I remember going to a hospital where I had to give my credit card number for a patient to receive their surgery, because the anesthesiologist wanted the cash up front. And this is surgery—this is not a private clinic—this is insured services no matter where you are, but because of the price differences, it puts us in a predicament where we have to dish out dollars and wait for reimbursement.
- In a border community, you can access bilingual services from the other province [i.e., Ontario]. However, it’s not reciprocated: Québec institutions that are on the provincial border don’t offer bilingual services.
- The link with hospital in Ontario is vital – it’s where we go for most services other than what a general practitioner can give. We’re having our babies in North Bay, the OBGYNs are there, and the more serious testing. There may be a time when North Bay hospital [in Ontario] says, ‘We are full with Ontario folks now, and we are limiting the patients we take from Québec.’
- Family support available to a client traveling only 45 minutes away [to a hospital in Ontario] is huge. It’s huge as far as all health services are concerned.

**Corridors of Service – ‘greater pressure to stay within the region’. Participants reported that because they are required to stay in Québec they are required to travel further away in order to obtain services in English. The travel presents a challenge: sometimes clients will continue the service for a short while, and then just stop altogether because of the distance (i.e., parents who need to travel two hours for speech language pathology for their child on a regular basis)**

- There’s a constant stress in that the provincial government wants to keep everything in the region.
- [Emergency services (ambulance)]: The ambulance has no choice but to go to the hospital in Québec. You used to have a choice. We’re told, ‘Stay in the system, we’re not in the business of paying Ontario physicians when we should pay Québec physicians.’
- We wouldn’t have any problem staying in Québec, if they could provide those services in English.
- Merger of institutions has led to less emphasis on recruitment of bilingual workers at provincial institutions
- We have to fight to get a referral that’s closer (in Ontario), rather than a referral several hours away (in Québec). Clients are being referred to whatever their corridor of service allows.
- Even if you stay in Québec, sometimes those services are far away.
- There’s pressure on us to stay within Québec [rather than going out-of-province]. However, because of the language issue we end up further and further away from our communities. It’s a big circle.
- Parents were driving them two hours to meet with a speech pathologist .... It’s a huge commitment from parents to be traveling every week with their child. Especially in the winter-time, these aren’t good roads.

**Limited access to training in English in Québec – Participants report that they need to go out of province in order to access required training in English. There are additional challenges to ensure that training taken out of province is accepted in Québec. Health Canada does provide limited training in English (for example, for diabetes).**

- Often all our professional staff needs to be part of orders—psychologists orders, nursing orders, and that type of thing—and often the training for these orders is only in French.
- Anything for nursing training in Québec is only in French. I have been trying to get continuing education courses because you need them for your licence, and I need to go out of province for all that. It’s not available in Québec.
- The challenge is that even if you find something in Ontario, a training course, it’s not always accepted [in Québec].

- The training for diabetes is through Health Canada and it's in English, but you really need to work to get it.

iii. Access Issues Related to Culture (Aboriginal)

**Limited Coverage for Mental Health Services through Non-Insured Health Benefits (NIHB)**

- There's still a corridor of service at the hospital that opens up for us – and there's an agreement with hospital [in Ontario] for psychological support. This service is not available from the province of Québec in English, and so we go to North Bay. They submit the treatment plan to Health Canada and it has to follow the ten sessions of therapy ... it's like fast food therapy. Those are some of the challenges.

**First Nations' clients are required to pay up front for some services and seek reimbursement from Health Canada, under NIBH. Participants reported that there is a lot of paper work involved for clients, and not all service providers will accept NIBH.**

- Clients need to pay up front for services and then seek reimbursement from Health Canada. Providers are starting to say 'Why should I manage it, when I can get the client to pay up front and have Health Canada reimburse them later.'
- The clients are the ones who have to run around trying to get an appointment, just to get the paperwork for funding.
- I have called providers and I've been told, 'Yes, we deal with NIHB,' but when the client gets there, they make them pay up front, so that they will need to be the ones to deal with the process of reimbursement.
- Few and fewer specialists are accepting NIHB.

**Detoxification services geared for First Nations (in the community, culturally appropriate care). Participants commented that there are gaps between the existing 'detoxification' services and treatment centres.**

- It would be nice to have our own detox centre in a First Nations community. We have treatment centres, but it would be nice to have our own detox. That would make a difference, being with First Nations people, the culture.
- For detoxification services, we need to have a transition. There are gaps between detox and treatment centres. It's the continuity of care for First Nations

**Medical Transportation – There are some issues accessing funding for travel when services are obtained from out of province, from a private clinic (required by clients to obtain services in English).**

- All the forms [for medical transportation] are Health Canada driven, so they are in English. It's not a problem.

- The issue with the travel funding is mostly that we'd need to go against the grain of the framework to do so. At times, the nearest 'point of service' is in another province – which leads to issues accessing funding for travel when we go out of province.
- The problem is that with Health Canada if you go to a private clinic [for English language services such as speech therapy] they won't cover medical transportation costs to those clinics.

**Provincial legislation is impacting English-speaking First Nations access to health and social services. Legislation (Bill 21) is creating obstacles for English-speaking professionals. Participants reported that professionals (for example, nurses) are experiencing difficulties working in the communities and it has “nothing to do with competence”, but rather “it has to do with language”. Some professionals who do not speak French may work in Québec on a conditional basis only. Further, the province is not required by law to translate documents needed for prevention services (i.e. Protocole d'immunisation du Québec (PIQ) from French into English).**

- **Bill 21 (Professional Order):**
  - Licensing issues because of language (Law 21) – required to belong to a professional order, yet training in English is limited in Québec
  - From a management perspective, I look for [professional workers] best language to be English. But, when they get to Québec, they have to register to these [professional] orders, and there's some issues, and it has nothing to do with competence, it has to do with language.
- **Translation of documents:** Province is not required by law to translate documents from French into English. (For example, the Protocole d'immunisation du Québec (PIQ) – the vaccination protocols and guidelines is only available in French.)

#### iv. Positive Experiences

- There are hospitals in Québec (in larger urban areas) where the services in English are good. Sometimes, clients may be afraid about getting around, because it's all French, and when they come back, they always say, 'You know, it's not too bad. There was always someone around to help us out.'

**b.) Eagle Village | Kipawa Community Members:**

i. General Access Issues and Challenges

**Distance to access services (travel), roads are not always good, especially in winter**

**Long wait times for services**

- I think the long waits are right across Canada.
- My son was supposed to see a doctor within six months and it took a year. His doctor was really upset about that, and she made sure he would get to see her earlier, every six months.

ii. English Language Access Issues

**Lack of access to general and specialized services in English. Participants reported that they need to go ‘out of province’ to access services in English. Others reported delays waiting for services in English.**

- [Lack of support and services for children who have special needs]: If my mom didn’t speak French, I would have moved to Ontario, because my child needs a lot of help and this is a permanent thing. It’s not going away.
- We go to Ontario right now to get services in English, and they’re closer –one hour away.
- All my appointments are in Ontario, so right now so I have no problems, but I’m worried because I know eventually I will have to go through Québec.
- You need to get referred to see a specialist in Ontario, and if the doctors here don’t want to refer you, then you’re stuck.
- For general physicians and specialists, too, like dentists. We are referred to Ontario.
- I wouldn’t know where to go in Québec for services in English.
- Some things you have no choice, but to go to Ontario, for example speech therapy. You’re not going to find an English speech therapist around here.
- You know, if you go to a hospital, in Québec, and if you walk in there and there’s nobody who speaks English, they should be able to bring someone in there right away, no matter what time of day it is or when it is. We’re in Canada, not some other country! That’s the way it should be. ‘We have somebody,’ not, ‘We will get someone in five days or something.’ And, ‘If you need these documents in English, here they are. You don’t need to wait three months.’

**Language Barriers (Communicating) – Participants reported mixed experiences communicating in English with doctors, nurses, and support staff. Overall, less likely that nurses or support staff are bilingual.**

- We have a French-speaking doctor in our little community who doesn’t speak English – she understands more than she speaks.

- The doctor in town doesn't speak English. Most of the time you can ask for a nurse who speaks English. The doctor knows she has this problem and she tries.
- Some of the doctors speak English, but it's the receptionists who are difficult. They only speak French. I get my mother to call because I cannot speak French, and when we go to the hospitals, my mother comes along for the same reasons.
- At the hospital, the nurses on the night shift were French speaking and I didn't understand anything they were saying, but if they needed to take blood at four o'clock in the morning, go for it. I told them I don't understand French, and they don't understand English, so that's the end of that.
- In our case, it's been the receptionists. You arrive to a hospital, you've got to try to go back to your French to get your information across because they don't understand English. Just your medicare number, little things, phoning for appointments. We have a little problem where we can't seem to get through to the doctor we need to speak to ... and we'll call the receptionists and it's hard because it's all in French.
- For English language, there were problems with the nurses and the receptionists.

**Perceptions and beliefs – Participants reported that they are 'worried' about going to provincial institutions because of language barriers**

- I haven't found these problems yet [with language], but I'm worried about it for later. Having to go to [the hospital] and not knowing what's going on, that would be pretty scary.

**Calling provincial Institutions is difficult because of language barriers. Participants reported that they miss appointments because voicemails are left in French only.**

- They tell me, 'You missed an appointment,' but I get the phone calls in French and I don't understand it. This is for treatments, appointments, and it's all in French. . . I get by through sign language. Pretty much sign language, or find someone in another department to come talk to you, who knows both languages.

**Translation Services – Participants report that there is a lack of liaison at provincial institutions, which are needed by English-speaking clients.**

- [The liaison worker] at the hospital is only available on work hours, and if she's not there, there's nobody there. There's no one there 24 hours.
- I called and they said [liaison person] was only available on Thursdays. So I guess I can only be sick on Thursday.

**Documentation from the province is primarily in French. For example, assessments, forms, and letters received from provincial institutions.**

- [Assessments and reports for children with special needs]: They gave me the doctor's assessment in French first, but they sent me an English translation later. They offered to give it to me, which is good, but it took three months or so.

- [Forms]: When I had my baby, all the forms to get their health cards and everything was all in French. I had to get my mom to translate; The forms were in French, but I wrote [my answers] in English
- [Letters]: We've had a few letters in French, too.

**Provincial boundaries causing barriers for clients who are seeking services in English: 'It's important to keep the link [with Ontario] open'. Provincial 'rate of pay' (fee schedule) varies among the provinces. Participants report that for some provincial services they are paying the difference out of pocket.**

- I had an issue going to Ontario. When I first got sick, she referred me to Montreal, and the reason was, she told me, was because she couldn't send me back to Sudbury because Québec was slow paying their bills.
- There's an optometrist who makes you pay up front, and you bring the receipt to the health offices, because Québec was too late in paying their bills. Later you'll get your money in the mail.
- Lack of consistency between provinces for fees – I got pneumonia last year and I had to pay for my own antibiotics, and I came home, sent the form to Québec, and they only gave me half the price. It's because the government prices for the antibiotics between Québec and Ontario are different.
- I go to Ontario for all my medication and appointments with specialists, but I tell my doctor down here I won't go further into Québec than I am right now. But, I can see that coming to a stop because they want you to stay in Québec.
- If there's a link to Ontario, you want to keep it open. Even for x-rays and ultrasounds, if they can't do it here, they send you to [Ontario]. I don't want to be sent to [hospital in Québec]: the roads are terrible and there's no English up there.

### iii. Access Issues related to Culture (Aboriginal)

#### **Discrimination and lack of cultural sensitivity**

- There are still some people out there who look at you and treat you differently because the colour of your skin.

**Jurisdictional Issues: First Nations have access to health and social services from both federal and provincial governments, but there is a lack of information and clarity about who is responsible for what services (delivery and funding). Issues with funding for services under NIHB.**

- [Dental Health]: My little girl needed her teeth fixed. They made me pay up front because they said that Indian Affairs takes too long to reimburse. I mean, not everybody has that kind of funds, and sometimes you can't wait for something.
- Clients need to pay for prescriptions up front and then wait for reimbursement from Health Canada – They say, 'Oh, you can pay for it now, and when it's authorized, you can come back and we'll reimburse you.'
- Not always clear if the medication will be covered by NIHB.

- Staff at pharmacies are not always aware about the coverage through NIHB – quality of services an issue (long wait times)
- We are being made to pay out of pocket for NIHB, and there are different rates for services between provinces. We're not always reimbursed the full amount for services that are supposed to be provided by the province.

iv. Positive Experiences

**In urban areas, doctors, nurses and specialists were bilingual. Participants reported that bilingual services were available, depending on where you were going.**

- All my doctors spoke English at [urban hospitals].
- A lot of the nurses know English. They're mostly coming from Montreal.
- It depends where you're going. At some hospitals, I was surprised that the hospitals were mostly English. At some hospitals the nurses don't understand English but they'll muddle through and make you understand. Most of the doctors are English.

## 8. Timiskaming First Nation

### a.) Community Resources (Health Services and Social Services):

#### i. General Access Issues and Challenges

##### **Long wait times for services (specialized), longer if waiting for services in English**

- Waiting lists in Québec are long, people wait and wait for their appointments. It can take 3 or 4 years on the waiting list (*longer if waiting for services in English*)

##### **Distance to access services (travel)**

- There is a big distance between our community and specialized assessments

##### **Quality of care can be a challenge**

- Clinics that have rotating doctors on staff can present challenges to clients in terms of continuity of care and understanding their health issues.

#### ii. English Language Access Issues

##### **Lack of access to specialized services in English – Participants mentioned that they lack information about where and how to access services in English from the province (i.e., speech language pathologist, audiologist, treatment centres). Some reported that they are experiencing obstacles accessing services ‘out-of-province’.**

- There’s no English, there’s hardly anything in English strictly, that I know of. Most of the caregivers, or doctors, are French speaking.
- Lack of time to search out specialists that may be available in Québec. The challenge now is to find specialists in Québec, when we’ve always been dealing with Ontario.
- Difficult to access speech and language therapy in English from Québec system. A community worker was told, ‘You better send them to Ontario because I don’t speak English.’ I could not access the services there [institution in Québec].”
- With Ontario doctors refusing our patients, we need to find a place to send them, calling one hospital, another, a third hospital, a four, to get names of doctors, and because they are not locals and can only be here once a month, you send referrals and they get lost.

**Language Barriers (Communicating) – Participants reported that there were issues with communication at hospitals depending on when you were accessing services: in the daytime you are more likely to access services in English.**

- At hospitals, in the daytime, it's easier because there are more people, so we can always find someone English to translate, but at evening and at night the patients struggle, saying, 'I don't understand anything they told me'.

**Calling provincial Institutions is difficult because of language barriers – Frustrating experience, delays waiting for services.**

- Sometimes I had to call them at the hospital and they had to transfer me a few times to find someone who spoke English.
- When I call the pharmacist, the clerk may not speak English and won't answer my phone call. I have to call back, it's really frustrating.
- So when I call for an appointment, you can only call in the afternoon, and when I call back they say, 'Sorry, I do not speak very good English, could you please call back later and we'll make sure this lady's here, ask for her,' and I've already been waiting.

**Crisis situations more challenging because of language barriers**

- In crisis situations, especially, if I had to access a shelter [for a client], I would need to see if there was an English speaking counsellor, which was hard to navigate in the heat of the moment, because the client wants to be safe now, not wait a half an hour for us to make phone calls.

**Documentation from the province is primarily in French: letters, forms, information, and signage.**

- The prevention work we do at the centre here, to get material in English here in Québec is very difficult.
- With the agency of social services, we get a lot of information ... and a lot of our pamphlets and posters come in all French. Sometimes it's about suicides, but most of our material does not come in English, so normally we need to discard them and only keep a few because we cannot use them. The documentation we can have is very limited.
- [Personal experiences reported by community workers]: Even in the hospital, if I read the signs I can't make my way in the hospital, because I couldn't understand the signs. I was frustrated; It was never really clear where I had to be, I would miss my appointments because it was never clear where I had to go because the signs were all in French.

**Provincial boundaries – Because of provincial boundaries, participants reported that they lack freedom of choice to obtain services, in English, from Ontario. Further, Québec residents are now being refused services. Reported that there are**

**issues accessing services because of the provincial ‘rate of pay’ (fee schedule) varies among the provinces.**

- Our village sits on the border of Ontario, but we’re in Québec, and because our patients are mostly English speaking, they have always gone to the Ontario side, and if they needed a specialist they would be sent to an Ontario specialist. But now the problem now is that more and more these specialists are refusing our patients
- Québec patients being refused because of different rates between provinces, and the doctors have to wait a long time to be reimbursed.

**Limited access to training in English in Québec – Training materials are not readily available in English. Participants reported that it is ‘difficult to understand trainers who are not fully bilingual’. Further, some workers whose first language is French stated that they would prefer to receive training in English to better meet the needs of their English-speaking clients.**

- Difficult to obtain training resource material in English
- [Front line workers]: It is difficult to bring people in to train our staff, or to provide workshops, in English.
- [Training for nurses]: When we have courses, often it is offered in French, and they say they will also offer it in English if enough people subscribe. Often they will say they are going to offer it in English but do not because they don’t have the numbers to account. We do go to Ontario for training at the same time. There is some freedom in that training can be obtained from out-of-province and it is still recognized by the province. Others expressed concerns that training out-of-province doesn’t provide you with the accurate information that you need (guidelines, recommendations) for the province of Québec.
- It can be difficult to receive training from a worker who is not fully bilingual
- It’s frustrating when you’re trying to learn something while struggling to understand what the instructor is saying.
- When I go for training, I like to have the training in English, even though I am French. It is easier to learn the material in English, rather than have to translate from French into English for my clients.
- We used to have a lot of training with Health Canada but not so much anymore. We used to go once or twice a year for training, and offered the courses in both French and English through translators, and they don’t offer it anymore. Now we’re struggling to find stuff.

### iii. Access Issues Related to Culture (Aboriginal)

**Discrimination and lack of cultural sensitivity. Participants spoke about the lack of cultural empathy and respect. They stated that they, or their clients, have experiences discrimination and cultural stereotyping when obtaining services from provincial institutions.**

- We are told because this person is coming in the hospital, is maybe intoxicated, is Native, they will sit there for hours until they sober up and can be seen. We've been told that numerous times.
- Sometimes patients that have never touched alcohol before will be treated in the same way. Just because you're native, they expect you to be treated that way.
- [Personal experience reported by community worker]: Generally, any hospital near any reserve, I will be sitting there for hours and hours on end. It's frustrating and you almost don't want to go back, unless you're dying, because you don't want to be treated like that. It's very frustrating. ... Sometimes I should go seek medical advice, but I don't because I wonder, 'What am I in for today?' I think, How am I going to be treated? Will I be sitting there for hours? Will I get the attitude? Or am I actually going to be treated with respect?

**Gaps in discharge – Lack of communication between institutions (First Nations and Provincial) when clients are discharged. Language is an obstacle because the discharge summaries are 'all in French.'**

**Case management – Participants (First Nations health care workers) reported that they are spending a lot of time and energy on case management, primarily because of language issues (referrals, booking appointments, and follow up.)**

- First Nations' health workers are spending a lot of time and energy on case management (referrals, booking appointments, following up with after care) – bilingual staff person is needed for this work: "It is surprising how many hours of case management we do. It is almost unreal the amount. Sometimes, you can be on the phone back and forth for hours, hours on end."

### iv. Positive Experiences

- At the Health Centre, nurses track information in English (homecare stats, vaccines, reports) for the community
- Provincial institutions sent invitation letters in English to community members about breast cancer screening: there was an increase in the number of community members who went for screening. [As reported by one participant]: The letters were all in French and most of the people from the community just chucked it aside because it was in French, and then a lot of people asked me why we were not participating in the screening ... the next year---or maybe it took two years--- their letters are in English, and now that their letters are in English, they get a lot

more people to go to their monograms. The technician explained the procedure in English and documentation was provided to patients in English.

- English training available for provincial workers, reported that there have been ‘big improvements’ over the past few years. “Over the last couple years there’s been a big improvement. There’s still lots to do, in some departments, I guess. And they do give courses for people to learn English at the hospital, to encourage them.”
- Efficient services from local CLSC: when making an appointment, the CLSC provided the client with a date and time when they would call, all communication was in English.
- [Personal experience reported by a community worker]: I had to call to make an appointment for children I look after, and the clinic said they would call me back on a specific date and time. They called me back and the person spoke perfect English, now all I have to do is sign an authorization form. It was pretty fast.
- Doctors at provincial hospitals are encouraging English-speaking clients to access services from the province.
- [Personal experience reported by a community worker]: When I had my baby at the hospital in Québec, they asked me ‘How come you came to Québec? You don’t see many English people from your community coming to Québec?’ And I told her, ‘My doctor’s here now, we moved to Québec.’ And she said, ‘That’s very good. I’m glad to see that. Tell your friends we speak English.’

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Gesgapegiag

## COALITION OF ENGLISH SPEAKING FIRST NATIONS COMMUNITIES IN QUEBEC

Expanding and Building Our Partnerships to Improve Access Project  
Health Services Integration Fund (HSIF) ~ Health Canada

April 2015

Kahnawake

Greetings,

Kanesatake

This letter is to inform and to invite you to participate in community-based research that is being conducted by the Coalition of English-speaking First Nations Communities of Quebec. We are conducting research to investigate the situation of English-speaking First Nations when accessing social services in the province of Quebec.

Kitigan Zibi

Eagle Village  
First Nation-  
Kipawa

In 2012, a Coalition of English-speaking First Nations Communities of Quebec launched a project entitled "Expanding and Building our Partnerships to Improve Access". This project afforded the opportunity for English-speaking First Nations communities to establish a Coalition. This multi-year project is funded under Health Canada's Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera, – an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal).

Listuguj

The Steering Committee Members include:

Timiskaming  
First Nation

Rheena Diabo, Project Chairperson (Kahnawake)  
Donna Metallic, Project Vice-Chairperson (Listuguj)  
Joyce Bonspiel-Nelson, Executive Director (Kanesatake)  
Robin Decontie, Director of Health and Social Services (Kitigan Zibi)  
Jimmy Peter Einish, Addictions Specialist Counsellor (Kawawachikamach)  
Carol McBride, Director of Health and Social Services (Timiskaming)  
David McLaren, Director of Health (Eagle Village First Nation | Kipawa)  
Nakuset, Executive Director (Native Women's Shelter of Montreal)  
Eleanor Pollock, Director of Health (Gesgapegiag)  
Jerry Polson, Director of Health (Long Point First Nation | Winneway)  
April White, Director of Health, (Akwasasne)

Kawawachikamach

Akwasasne

Native Women's  
Shelter of  
Montreal

The Coalition oversaw research to document a portrait of the issues and challenges facing English-speaking First Nations when accessing health and social services from provincial and federal healthcare systems. The final report, "Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec" (2013), is available online at: [www.odsconsulting.ca/project-information](http://www.odsconsulting.ca/project-information).

Long Point First  
Nation/Winneway

In 2015, the Coalition is launching a second phase of community-based research to document the situation of English-speaking First Nations when accessing social services from provincial and federal systems.

The objectives for this research are to:

- i) Investigate the social services' programs available from the federal government (literature review);
- ii) Produce an 'Inventory of Social Services' from the participating communities/organizations; and
- iii) Document First Nations perspectives when accessing social services from provincial and federal systems.

A researcher, Amy Chamberlin (based out of Listuguj, Quebec), will be working with the communities to conduct this research from April - May of 2015. The research activities will include: 1.) Complete a questionnaire 'Inventory of Social Services' and 2.) Conduct interviews with key informants working in social services. (The plan is to conduct 2 to 3 interviews in each of the participating communities. Each interview will last approximately 30 minutes to one hour.)

All the data collected from the communities will be compiled and a report will be produced that will be shared with the participating communities.

Should you have any questions or concerns about this research, you may contact the Project Management Team: Dale Jacobs, Winnifred Taylor and Christine Loft of Organizational Development Services (ODS) - Kahnawake, Quebec at T: 450 632-6880 and email: [dalej@ksckahnawake.ca](mailto:dalej@ksckahnawake.ca) and [winniet@ksckahnawake.ca](mailto:winniet@ksckahnawake.ca)

In Peace and Friendship,

  
 Rheena Diabo,  
HSIF Project Steering Committee Chairperson

APPENDIX 2

Social Service Program Area	Description	Are services or activities provided in your community for this area of social services? Indicate: Yes, No, or Unknown	Agreements (Type of Agreement and between or among Whom) (i.e., Community and AANDC; or Centre Jeunesse and AANDC)	List of services or projects that are available (or a general description of the activities your community provides)
1.) Enhanced Prevention Focus	<p>i.) First Line Prevention Services (Prevention services aimed to reduce the number of children being placed under Youth Protection)</p> <p>ii.) Protection Services (Second Line) – (Intervention, Protection, Foster Care, Group Homes)</p>			
<p>2.) Assisted Living Program</p> <p>[NOTE: There is also a program a different program called 'Home and Community Care' program that is funded by <b>Health Canada</b>, which may be available in your community.]</p>	<p>Assisted Living Program provides assistance <b>(non-medical social support services— such as housekeeping, meal preparation)</b> to the elderly and to individuals living with chronic illnesses or disabilities (mental and physical). The program is available to individuals who are living on Reserve. The objective of the program is to ensure that individuals living with chronic illness or disabilities (mental or physical) “can maintain functional independence and achieve greater self-reliance”.</p>			

3.) Family Violence Prevention Program	The federal government's <b>Family Violence Prevention Program (FVPP)</b> is considered to be the "largest program" devoted to addressing and stopping family violence, in particular violence aimed at Aboriginal women  a.) Women's Shelters b.) Prevention Based Projects			
4.) National Child Benefit Reinvestment Strategy	This program provides child benefits to all low-income families regardless of their source of income (i.e., social/income assistance, low wage employment, Employment Insurance, or other income support program).  a.) Financial benefits b.) Reinvestment Component [Projects]			
5.) Income Assistance (also called 'Social Assistance' or 'Welfare')	Income Assistance: a program of last recourse that provides financial supports to meet basic needs (food, clothing, and shelter) and special needs, and employment-related support for individuals and families.			

6.) National Native Alcohol and Drug Abuse Program) - NNADP	<p>The goal of the NNADAP program is to:</p> <p>“help First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations.”</p> <p><b>NNADAP provides both prevention and treatment services for substance use problems.</b></p>			
7.) OTHER INITIATIVES in the area of social services ( <i>ie., Fight Against Poverty</i> )	Describe goal of program/activity/project			

## APPENDIX 3 – Research Tool ‘Interview Questions’

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### Project Background

- In 2012, a Coalition of English-speaking First Nations Communities of Quebec launched a project entitled “Expanding and Building our Partnerships to Improve Access”.
- This multi-year project is funded under Health Canada’s Health Services Integration Fund (HSIF).
- The Coalition is conducting research to document the situation of English-speaking First Nations of Quebec when accessing ‘social services’.
- A researcher, Amy Chamberlin (based out of Listuguj, Quebec), will be working with the communities to conduct this research from April – May of 2015.
- All data collected from the communities will be compiled and a report will be produced that will be shared with the participating communities.

Should you have any questions or concerns about this research, you may contact the Project Management Team: Dale Jacobs, Winnifred Taylor and Christine Loft of Organizational Development Services (ODS) – Kahnawake, Quebec at T: 450 632-6880 and email: [dalej@ksckahnawake.ca](mailto:dalej@ksckahnawake.ca)

**Thank you in advance for taking the time to participate in this research.**

## INTERVIEW QUESTIONS

As part of this access research, we are conducting individual interviews with key informants from each of the participating First Nations communities/organizations. The purpose of the interviews is to document First Nations 'community perspectives' with respect to accessing social services.

The data from the interviews will be compiled, and presented in a report; however, the names of individuals who take part in this research will not be used in the final report.

Your participation in this research is completely voluntarily. You do not need to answer any questions that you do not feel comfortable answering, and if you wish to end the interview, for any reason, you may do so at any time.

Thank you for taking the time to participate in this research.

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- 1.) Name of the organization for which you work: \_\_\_\_\_
  
- 2.) What is your role or position at the organization: \_\_\_\_\_
  
- 3.) Please list and describe the social services and programs that you are involved with at your organization: \_\_\_\_\_
  
- 4.) With respect to the social services that are available at your organization, what is working well in terms of accessibility of social services? (i.e., Identify which services are easily accessible along with reasons why)
  
- 5.) What are the challenges when accessing social services from either within or outside of the community?
  
- 6.) What are some of the strategies or solutions that your organization has put in place to overcome any challenges that you may face when accessing social services?

**Appendix 4 – Interview Chart\_Social Services** (\*Note: All interviews were conducted by the researcher – Amy Chamberlin, M.A.)

<b>First Nation Community</b>	<b>Individual and/or Group Interview</b>	<b>Social Services* Area of Intervention</b>	<b>Total Number of Interviews</b>	<b>Total Number of Participants</b>	<b>Interview Dates</b>
Gesgapegiag	Individual Interviews	Enhanced Prevention Focus (Prevention and Protection) ( <i>Nepising'o'igam / the Healing Lodge</i> )	2	2	April 28, 2015
Listuguj	Individual Interviews	Enhanced Prevention Focus (Prevention, <i>Families First Support Services</i> and Protection, <i>Child and Family Service</i> ); Assisted Living; Family Violence Prevention ( <i>Haven House</i> ); and Social Assistance.	5	10	May 5, May 19 and May 26 2015
Kitigan Zibi	Group Interview	Enhanced Prevention Focus (Prevention and Protection); Family Violence Prevention ( <i>Maseya House</i> ); Assisted Living ( <i>Kiwedda Group Home</i> )	1	9	April 29, 2015
Eagle Village /Kipawa	Group Interview	Enhanced Prevention Focus (Prevention) and Fight Against Poverty	1	3	May 21, 2015
Long Point First Nation	Group Interview	Enhanced Prevention Focus (Prevention); Health Services (Brighter Futures/Maternal Health, Mental Health/NNADAP (Health Canada program)).	1	5	May 20, 2015
Kanesatake	Group Interview	Enhanced Prevention Focus (Protection) with Centre Jeunesse; Assisted Living with Centre Jeunesse	1	2	May 27, 2015
Akwesasne	Group Interview	Enhanced Prevention Focus (Prevention and Protection); Family Violence Prevention; Social Assistance ( <i>Community Support</i> ); National Child Benefits Reinvestment Strategy; Adolescent Treatment Centre (Addictions), and Community Daycares	1	6	May 28, 2015
Kahnawake	Individual Interviews + Written response	Enhanced Prevention Focus (Prevention and Protection); Assisted Living.	2	3	June 12, June 15 2015
Kawawachikamach	Group Interview	Health Services, Addictions, Mental Health (Health Canada program)	1	3	May 20, 2015
Native Women's Shelter of Montreal	Group Interview	Outreach workers.	1	3	May 14, 2015

Timiskaming	Group Interview	Clinical supervisor (social services) and cultural coordinator; Centre Jeunesse front line manager (Youth Protection and Assisted Living)	2	3	February 2, 2016, February 26, 2016
<b>TOTAL</b>			<b>18</b>	<b>49</b>	

## Appendix 5 \_ COMMUNITY FINDINGS

### NASKAPI

#### Kawawachikamach

##### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

**Note: In the community of Kawawachikamach, this research did not uncover services/programs for social services based on agreements or funding from Aboriginal Affairs, with the exception of some services available for Family Violence Prevention. However, there are Prevention Services delivered in the community with funding from Health Canada (e.g., Wellness programs, NNADAP, Activities for Residential School Survivors, etc.).<sup>1</sup>**

##### a.) Prevention Services (Health Canada – Programs and Services)

- Community Members have access to various addictions (prevention services), mental health and cultural activities, including: One on one counseling, Sobriety Events (Honour individuals living in sobriety), Elders Activities, and Cultural Activities for Youth & Adults (Sewing and Traditional Craft Courses).
- Activities for Residential School Survivors
- Prevention Work – Addictions Awareness Week, Suicide Prevention
- Suicide Training – Staff work together as a team
- Holistic Approaches – Talking circles combined with different activities.
- Focus on physical activity and wellness

##### b.) Social Assistance

- Social Assistance clientele receive vouchers at Christmas time to purchase groceries.
- Thrift Shop available in the community.

##### c.) Family Violence Prevention

- Workshops –Working with women and men (separately and also together)
- Counselors work individually with people
- Developing a traditional parenting program to break the cycle of violence
  - *“Working on creating a parenting program with Elders and Naskapi resources. We’ve had parenting workshops over the years, developed by outsiders, but we think we can reach more people by doing something*

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<sup>1</sup> Conversation with a representative from Provincial Network (CLSC Naskapi) Quebec Region. 25 May 2015. Further research required to identify which ‘social services’ are provided in the community, including any services that may be provided by the Province that would be equivalent to services available to other First Nations from AANDC (e.g Assisted Living program)

*traditional, going back to the roots.”*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Transportation is a challenge when accessing services (health and social) – geographical location of the community (‘remote’ area). Lack of open roads into the community (accessible by train or plane only)**
- **Jurisdictional Issues (Provincial Boundaries)** – Community members are unable to access health and social services (in English and closer) from ‘out of province’ (in Labrador) due to provincial jurisdictional boundaries. Transportation is not provided from the CLSC (province) if services are accessed ‘out of province’.
  - *“Not allowed to send people to Labrador because of provincial rules. They want us to keep people in Quebec. But, [out of province] it’s a lot closer and Anglophone services are available in Labrador.”*
  - *“If people go out of the province, it’s on their own. They’re not able to access funding for transportation. Province made a rule that you can’t send people out of province (to receive services from hospitals, treatment centers)”*
- **Lack of services in the community (health and social services) – both general and specialized. Lack of services in English. Costly to send people out of the community to receive services, therefore not as many people access services (less of an impact).**
  - *“If we had the services here, we could save money and we would be able to serve more people ... Provincial system feels it is easier to send people out. But more people could be impacted if we had the service here.”*
- **Lack of services for mental health in the community. Not satisfied with quality of services for assessments, treatment planning and follow up care. Miscommunication because there is a lack of cross cultural understanding and language barriers. Community members seeking services (English language and culturally based) from out of province.**
  - Psychiatrist in the community two weeks per month. Only works with adults, no services for children
  - *“Lack of treatment plan, follow up plan. It is unclear what kind of assessment the psychologist or psychiatrist do when they are working with our People [at provincial institutions].”*
  - *“You might get a psychiatrist from provincial institution who speaks a little bit of English, or none at all.”*
  - *“Some of our people from the community do not understand English. When they go to get assessments from a psychiatrist, they don’t know what they are doing there ... We do have a translator in Sept Iles, but she cannot help all the clients who are there.”*

- *“Regarding ethics, when people go into hospitals, clients have a right to receive proper services...”*
- **Individuals who are suicidal have limited access to mental health services while in crisis situations to adequately ensure their well being and safety. Increased stress and pressure on prevention workers (health) and also on their families.**
  - *“We are not able to send individuals who are suicidal [out of the community]. We’ve been told ‘you have enough resources to deal with them.’ But we don’t have a hospital so it’s very hard on workers when trying to deal with very suicidal people ... We find that difficult. We need a safe place for those individuals.”*
  - *“It’s a sad reality ... We almost have to wait for someone to try to kill themselves before they can be sent out [by the CLSC]”.*
  - *“There are huge gaps. We need to start talking about those issues [suicide prevention] in the community. We need to strategize solutions. Resource [people] are running around. Families don’t want to accept their relatives who are suicidal. They say, ‘They are afraid, they’re scared. In the morning, they will be hanging in the basement.’ Or, something else might happen. We don’t have any place for them. One client slept outside. The police cannot keep them – they have nowhere to go.”*
- **Documentation from province for health and social services is available primarily in the French language (e.g., health information/awareness, assessments, reports, funding proposal (municipal).)**
  - Youth Protection (documents) available in French language only. Only provided to Health Centre if they have permission to be involved with the file.
  - Cannot take advantage of opportunities for funding from municipal government because information is only available in French.
  - *“Its really sad that people are not provided with documents in English. Even documents for wellness – from the province, we received great poster but they are only available in French ... You need to seek out information or resources from other provinces.”*
- **Experiences of discrimination and racism, lack of cultural sensitivity, at provincial institutions.**
  - *“Often, [provincial] workers do not understand the culture, the history, or the contemporary realities in the communities”*
- **Colonial policies and legacy of residential school era. Participants stated that ‘Echoes from residential schools’ are ‘alive today’ in the programs and services offered through the provincial Youth Protection (Intervention) Services.**

- *“I always go back to residential school, how they wanted to change things, Native People. And they didn’t comply, the Native People. In the olden days, I remember as a child, we didn’t have social services, but our People managed to support one another and to take care of one another. ... The way the department of Youth Protection is processing their program through the community. They are saying, “We will take care of your child.” And, those echoes come from those residential schools. “We will take care of your child. They will become doctors or lawyers when they come home.” But instead every individual that came from the residential school was very destructive. They drank alcohol. Even the parents did not understand why they took their children away from them. They stripped everything from them – the teachings of our culture, traditional ways. The boy that would have become a good hunter. When I came out from the Boarding School, after so many years, I had to start hunting at the age of fifteen. I had to go fishing with my father. But, all the stuff I saw my father doing was a blur to me. Those things are still alive today, when I see the Youth Protection, in regards to intervention. They say, “We will take away your child, they will be living somewhere else, with a bilingual family.” But, when the children come back they are lost. Then, they drink. They do alcohol and drugs. I went to one of the Youth Protection Workers, I said ‘I saw a child who was in an institution, and he is here in the community and he’s not improving. Can you provide a service for him?’ All she said was ‘No, he was discharged already. Why don’t you go to the counselors working there [health centre], and maybe they can provide some services.’ What did they do with him in there? It’s an institution, where they lock them there. When they need to walk, they open the doors, they walk and then go back to the building ... They call it protection services, but for me I say ‘No, they are not protected.’ They come back home, and they slash their hands, their arms. You can see the scars. What kind of protection is that? That is why I say ... the Naskapi need to go forward, they need to do more for the Nation. We need to survive ... I was in a Boarding School and they tried to change me, and they didn’t succeed. ... I cannot live the way the White People live. I am a Naskapi, a Native. I respect what you have, but somehow, sometime they have to respect what we have. If we are to survive with our children, we need to do something [about Youth Protection, about the Boarding School] ... We need to make choices in our Nation.”*

- **Funding from the federal and provincial governments are not provided for translation services from French to English/Naskapi**
  - Community members rely on bilingual (French/English) workers at the Health Centre to translate documents that they receive from the province (health and social services’ related documents).
- **Lack of funding for renovations or construction of facilities (health, daycare, prevention services).**

b.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of social services – Prevention or Protection – in the community.**
  - Lack of cultural sensitivity amongst workers
    - *“One of our weakest allies is Youth Protection. We are trying to make better relations. Trying to make workers more culturally sensitive.”*
  - Language barriers
    - Majority of community members speak Naskapi – lack of translators and services in Naskapi language.
    - Very little material in English, everything is in French.
  - Human Resources – Lack of Youth Protection Workers in the area (worker burnout and long wait times)
    - *“Province doesn’t put enough [youth protection] workers in the area. Workers are overworked, and they get burnt out.”*
    - *“There aren’t any intake workers.”*
    - *“Waited one year for follow up after making a Signalement (Report) to the Centre Jeunesse.”*
  - Prevention (First Line) Services are not available in the community (*other than what is provided by health centre from Health Canada*)
    - *“There are no prevention services available. We don’t have a lot of services from the province.”*
  
- **Foster Care – Homes in the community are not being assessed, resulting in a lack of Native Foster Homes, resulting in children being sent out of the community if they are being placed. Children are being placed with relatives, who are not being accredited as a ‘foster home’, and thus not receiving any financial compensation from the province. Children are being placed in Montreal, because there are English homes. Some families are losing their children once they are placed in the system.**
  - *“There is a lot of removal. Trying to get them to allow us to solicit Foster Families in the community that are Native instead of sending children out.”*
  - *“Need to ask people to be a foster home – but, they’ve never asked. They won’t do it.”*
  - *“When they do recruit family members to take care of kids it’s because they don’t want to pay foster. [Youth Protection] places the child with the aunt, and they don’t make her a foster family, and then they don’t have to pay her. She pays for everything out of her own pocket.”*
  
- **Court System –**
  - Language barriers when families go to Court. They don’t understand the decision or their rights.
  - Procedures they have to go through in Youth Protection are difficult to understand.
  - People have financial barriers – difficult for people to pay their fines.
  - Distance – Hearings take place out of the community at a distance (South)

- Local Court – approximately four times per year for minor infractions. Not as many barriers.
- **Lack of understanding and accommodation of Aboriginal worldview in Social Services and Youth Protection**
  - *“My point of view is that Social Services is not compatible with Native clients. It’s too clinical and the policies are not relative to the person [Native client] ... They do not see what the person needs. Social Services should adapt to our norms, values, ideologies instead of the community adapting to them ... ”*

c.) Family Violence Prevention

***Women’s Shelter – (challenges)***

- Community members use women’s Shelter in neighbouring community on occasion.
- Language barriers – Services are provided in either Innu (Montagnais) or in French (*lack of services in either Naskapi or English languages*).
- Shelter is only accessible for women who have been abused. Cannot send individuals who are suicidal to the shelter to be watched (unless the woman is in an abusive relationship).
- Dry Shelter – not available for women who are intoxicated
- Lack of Transportation – Individuals are responsible for their own transportation while at the shelter.

## MI'GMAQ

### Gesgapegiag

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Protection and prevention social services are readily available in the community – Organization is accredited. Staff are able to conduct evaluations and assessments of Youth Protection files**
  - All Social Services – Protection [under Youth Protection Act] and Regular Services [Prevention] – are provided under one organization and at one location, Nepising'o'goam / the Healing Lodge.
  - Protection – Provide 'protection' services upon notification of a Signalement [or official report] from the Province.
  - Able to provide supervised visits at the Healing Lodge (*hands on activities, such as baking together, crafts*)
  - Preventions Services: the Healing Lodge has an agency car, an office phone, *"the staff can get out of the offices and see people"*.
  
- **Services at the Healing Lodge emphasize Mi'gmaq values, culture and language**
  - *"The vision for the Healing Lodge is to be a place where people come in for help, to get services, to be a real healing lodge and for the lodge to be adapted to the needs of the community ... We are dedicated to the community"*
  - *"Being welcomed in the language [Mi'gmaw] helps out a lot."*
  - *"We are bringing back more spirituality and it's working here [at the Healing Lodge]."*
  - *"It's important for families to take care of their children, their families – the extended family system is important. We are bringing back our values, our beliefs – We made baskets, we took care of our children, we taught them beautiful things."*
  
- **Staff engage and work in a hands on manner with the youth – Serve as 'Role Models'**
  - There are [prevention] activities for the young girls and the young boys (offered separately).
  - *"[The staff] are like role models for them. We offer other avenues, other options to drugs and alcohol. [The Lodge] is a place where [the youth] can come in and vent about what is happening in the home."*
  - Staff encouraged to: *"explore the talent of the children that they deal with. To give them something to dream about."*

- **Team Work Approach and Positive Atmosphere at the Lodge**
  - *“When people arrive at the Lodge they’re made to feel welcome.”*
  - *“Staff work together, in the same direction; we are working to break the cycle of abuse. Working in the best interest of the people.”*
- **Establishing linkages with local hospitals to address health priorities (misuse/abuse of prescription medication) helps to address health priorities of the community**
  - Establishing links with local hospital to address the issue of ‘use and misuse’ of prescription medication
- **Program Informatique Jeunesse (PIJ) system – Tracking information**
  - Implementing an electronic database to document information about Enhanced Prevention Services’ clientele. Linked with the provincial system. *Available in French only.*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Obstacles communicating with staff at provincial institutions because of language (for example, at provincial group homes)**
  - *“Difficult to communicate with provincial institutions if you don’t know French. To work here [First Nations’ social services] you have to be bilingual.”*
- **Obstacles because of language in the Court System – long delays and staff at First Nations organizations are providing translation services ‘in kind’.**
  - Judges and lawyers in the Gaspé region are mainly French speaking.
  - Social Services’ staff from First Nations organizations are translating court proceedings for their clients. There needs to be a lot of trust [between the worker and the client due to the confidential nature of the information being translated]
  - *“There was a case for sexual abuse, it was delayed at least two months to go to court. We were waiting for a judge. There is a shortage of judges, and it is hard to find someone who can speak English.”*
- **Documentation from the province is mainly in French – Courts and Youth Protection**
  - *“The documentation is terrible. Difficult to obtain English documentation.”*
  - *“Constantly running after documentation”*
  - *“Court Orders and Signalement (Official Complaints from Youth Protection) are often times only provided to the First Nation organization in French; the organization has to translate the documents at their own*

*expense.”*

- **Lack English-language services for Mental Health**
  - Lack of services, in particular for individuals in the 18 -25 year old age range: services available at provincial institutions are primarily in French.
  - Services that are available in English are difficult to access due to distance.
  - Although psychologists provide services to clientele, their availability is limited due to the large territory that they serve.
  
- **Language – Many of the family services (from province) are in French.**
  
- **Discrimination – Lack of cross-cultural understanding presents obstacles when accessing social services from provincial institutions (including the local hospital and when going the Court System)**
  - *“Our own people are suffering. There is a stigma with ‘being Native’. We are treated differently at the hospital because we are Native.”*
  - *“Feel like we are being judged because we are Native.”*
  - *“Feel that we are treated in a paternalistic manner in the Court System because we are Native.”*
  - *“Need to address Community Members’ negative perceptions about White [non-Native] people.”*
  
- **Perceptions and fears associated with social services – the view that “children will be taken away”: impedes community members from accessing social services**
  - Challenge is the stigma associated with social services. Because of what happened in the past, people think that social services is there to take their kids away.
  - Healing Lodge is trying to make certain that: *“all children are either adopted or tutored. There needs to be long term commitment. All children need to belong to a family. Try not to place children in Foster Care. As First Nations, we take care of our children.”*
  
- **More ‘out patient treatment services’ are required for people with addictions, in particular for people with children and families**
  - People don’t want to access treatment services [for addictions] if they need leave their families for months.
  - Lack of treatment plans when people finish detoxification
  - *“Need more ‘out patient’ services to work close with the family to help rebuild the home. That is where addictions can be treated. People need everyday help. We need to be there at all levels or the cycle will continue.”*

- **Obstacles establishing linkages with local provincial institutions – addictions referrals**
  - Difficult to obtain services from local CLSCs for clients’ with addictions: *“Called the CLSC, left message but haven’t returned my calls. I was looking for referral services for client with addictions”*
  
- **Services required to address “misuse and abuse” of prescription medication: alternative treatment options are needed, in particular for Aboriginal Youth.**
  - Need to work with physicians to address over-prescription of prescription medication.
  - Youth are being prescribed prescription medication, alternatives needed: *“Sleeping pills were prescribed to a sixteen year old girl living in a group home. I made an official complaint to the hospital. There needs to be more awareness about good nutrition and exercise.”*
  
- **Provincial Laws creating obstacles to the delivery of social services by First Nations Communities – Lack of recognition of Mi’gmaq Vision and Involvement in decision making and delivery of services.**
  - **Bill 125** – [An Act to amend the Youth Protection Act and other legislative provisions]: very short term placements for children and youth *“six months, maximum one year.”*
  - **Bill 24** – Family Type Resources – Establishing ‘employee/employer’ relationships for the provision of foster care.
  
- **Family Violence – More training and awareness required for community resources**
  
- **Lack of a ‘safe house’ for women who are in crisis (psychologically distressed)**
  - There is a need to provide shelter (short term) to women who are ‘psychologically distressed’, but may not be in an abusive situation (local shelter is only available for women and their children experiencing family violence).
  
- **Family Type Resources (Foster Care) – Challenges maintaining family ties and for parents to access parent groups** [Submitted in writing as part of Inventory of Social Services]
  
- **Transportation – distance to access services, particularly difficult for single parents without vehicles.** [Submitted in writing as part of Inventory of Social Services]

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention Services)

- **Community Members access various prevention-based services from ‘Families First Support Services’ in the First Nation community.** Programming – Aboriginal “circle type format” and also non-Aboriginal “mainstream” services. Workers develop individual plans for each client (individual, family or organization) depending on their needs.
  - *Examples of services:* Parenting programming, Grief and Loss, One-on-One Support, Cultural Based ceremonies, circles, mediation, empowerment groups for young girls (GEMS), support clients at Court.
- **Team of community-based prevention workers provides services to community members** (*Intake Worker, Administration, Home Support Workers, Community and Cultural Coordinator*).
  - Staff is well connected with community members, which helps in the delivery of services. Non-hierarchical approach
  - *“We [Prevention Services] are there to support families and individuals.”*
- **Case management approach. Staff will work with other organizations in the community and with provincial organizations to develop plans for clients (Individual Service Plans).**
  - Case management approach allows individuals to access the different services that they need from a team of workers.
  - Meetings are held on a monthly basis among the Case Management Team (includes First Nations and non-First Nations) – review each case.
  - Refer clients to provincial institutions, and the province will refer clients to First Nations’ organizations for prevention services.
- **Safety Plan – First Nations and local provincial institutions have a ‘Safety Plan’ in place to make certain that individuals receive the services that they need during times of crises. Having a plan in place helps to ensure that community members “are not sent home” during times of crises.**
- **Staff provide support services to First Nations’ community organizations during times of loss – (for example, debriefing, medicines in work environment, having circles with and among staff).**
- **Networking with provincial organizations (for example, CLSC, Re-adaption Centre). Good connection with some provincial institutions. Able to access professional/clinical services required by some families; however, services in English are limited (i.e., occupational therapy for children with Autism)**

- Some provincial workers will make a real effort to speak in English. They will ask for help, and they have a good attitude. That makes a difference.
- **Good communication and support with the local elementary community school and the high school in the area. Workers offer prevention services for the youth at local schools (life skills). Also, support other organizations when they deliver programs/workshops in the schools.**
- **Community Action and Mobilization – Share information and build trust so that people use the prevention services. Building a healthy balance in the community by working with Men, Elders, Women and Youth. Create awareness in the community about social issues in a non-hierarchical manner.**
  - *“Trying to mobilize men in the community. Identify activities/services men are seeking, and to determine their role. Need to identify their gifts, what they would like to offer to give back to the community”.*
- **Work in collaboration with Youth Protection [Child and Family Services]**
  - Consent to release information to Youth Protection (Listuguj Child and Family Services), as required by law (i.e., Disclosures of any type of abuse, threats to one self, suicide or harming others)

b.) Enhanced Prevention Focus (Protection Services)

- **Access to services under Youth Protection (Sections 32 and 33 of Youth Protection Act).** Evaluate situation and determine if Protection or Prevention services are required. Follow up services (either voluntary or court imposed measures)
- **Support services for the family (Family Enhancement)** Programming available such as parenting, discipline, and life skills.
- **Adults and Elderly with physical limitations and mental health issues have access to in home support services.** Families are supported if the individual needs to be placed in a nursing home or adult group home.
- **Foster Care (Children and Youth) – ‘Child and Family Services’ is responsible for the recognition of foster homes, follow up with families, and payment.**
  - Staff has good connection with foster families and homes. Able to address issues quickly.
  - *“We think it is really important to keep responsibility for our community – the children and the homes.”*
- **Young Offenders: Staff work with youth who break the law (12 to 17 years old).** Provide a ‘presentencing report’ to the court, which gives the judge a well-rounded view of the youth’s strengths and weaknesses.

- **Access to Restorative Justice:** Individuals can access ‘restorative justice’ rather than going through the penal system for some situations (*i.e.*, non indictable offences).
- **After Care and Follow Up – Addictions:** Individuals with addictions have access to after care services from organizations in the community and from external agencies (out of province). Also, organizations (internal and external) provide information and support to youth in schools.
- **Agreements recently established with nursing home and Adult Group Homes (Mental or Physical limitations) in New Brunswick allowing community members to enter institutions ‘out of province’. Reduces barriers because of distance and language.**

c.) Assisted Living

- **Community members can access ‘Home Management’ services (Meal Preparation, Light Housekeeping) “easily and readily”.**
  - There is a ‘point of entry’ at the Listuguj Health Centre.
  - Home Care nurse conducts assessments (using the provincial Multi-Clientele Assessment Tool (M-CAT)) to determine which services the client needs to live independently.
  - A Committee at the Listuguj Health Centre meets regularly and reviews clients’ files.
- **Assisted Living (*home management services*) and Home and Community Care (*nursing services*) are managed and delivered by staff at the Listuguj Health Centre. Delivering the services in a complementary manner helps to ensure clients have access to all services from both programs (funding from Aboriginal Affairs and Health Canada, respectively).**
- **Personal Care Workers – provide assisted living services to community members.** Listuguj Health Centre manages the team of PCWs who work on a rotational basis in different homes. The schedule helps to maintain a ‘worker’ and ‘client’ relationship (reduces potential risk for abuse of power).
- **Training (Personal Care Workers (PCWs))** – English-speaking trainers brought in to the community to provide training (easily accessible and no barriers because of language). Video Conferencing – information on different health topics made available to PCWs at Health Centre. *Challenge – difficult to find training in English in Quebec.*
- **Discharge Planning** – Nurse Liaison from Listuguj Health Centre assists with discharge planning (from New Brunswick hospital only).

- **Social Worker** – Bilingual social worker available one day per week at the Health Centre. Provides information to families about resources available in the region and assists families who ask for respite care from provincial institutions.
- **Occupation Therapist available on a part time basis (Home assessments, develops plan for each client).** Assesses medical equipment to ensure equipment meets safety requirements (up to code)
- **Clients have good access to Medical Equipment from the Non Insured Health Benefits (NIHB) program.** Health Centre installs medical equipment for clients; however, funding is not provided for installation.
- **Meals on Wheels – One day per week meals are provided to clients.**
- **Life Line** – Clients can be set up with ‘life line’ services (clients with reduced mobility able to access emergency services).
- **Prescription Medication** – Funding available for prescriptions from the NIHB program. Some pharmacies are familiar with the funding process, while others are “less familiar”. Information about medication is readily available in English (orally and written).

d.) Family Violence Prevention

- **Women and children who are experiencing family violence in the home may access to short-term residency at the shelter located in the community. Open to community members and also to First Nation individuals from other First Nations communities in the area (Quebec and out of Province).**
  - Women feel “at home, safe and comfortable” at Haven House.
  - Staff able to communicate in the Mi’gmaq language with clientele. *“This helps especially with the Elders.”*
  - Clients have choice of mainstream or traditional service delivery – services are accessible by “all clients” while at Haven House.
  - Clients have access to outreach services, anger management programs, and assistance with life skills (budgeting, grocery shopping)
- **Public Relations – Information and Awareness campaigns to address family violence**
  - Access to information about family violence through social media
  - Community- based activities to build awareness about family violence prevention (*Wellness Fair, Commemorative Events, Awareness Walks, Workshops*).
- **Community members have access to 24/7 Crisis Line run by the Shelter**

- **Good relationships established with Native organizations (provincially and nationally) geared for Native women and violence prevention.** Access to: Training, Information Sharing, and Networking (no obstacles because of language; Translations are provided if meetings are held in Quebec.)
- **‘Joint Case Management’ (Circle of Care) – Key Resources from within community brought together (i.e., Youth Protection, Health, Prevention, and Police). Discuss in confidence situations for mutual clients deemed high risk.**
  - Share relevant information without breaking confidentiality (*“helps to take down silos built up among the community service providers”*)
  - Reduce duplication of services
  - Improve communication among service providers
- **Good Relationship with Provincial Liaison from Victim’s Services – Liaison is bilingual, and aware of the needs of Aboriginal clientele.**
  - Empowering for women who need to navigate the legal system.
  - *“Staff have developed a good relationship with [Liaison]; it’s not so intimidating over there [at Court] ... She is our link to that system [legal] It’s all French. It has made the whole situation easier.”*

e.) Social Assistance

- **Last Resort’ assistance – last resort assistance to on Reserve Listuguj community members. Agency is located in the community – easily accessible and sensitive to the needs of First Nations clientele.**
  - *“[With having First Nations staff] we are more sensitive to the needs of First Nations people, rather than someone from out of town.”*
  - Refer clientele to resources in the community to assist with life skills – Set up banking, Obtain Medical Cards, Income Tax Returns
  - Provide counseling services and/or referrals to clients who may be experiencing financial difficulties.
- **Refer clientele to resources (training, counseling) located in the community**
  - *“Always all kinds of postings up [training opportunities] at the local training centre that Social Assistance clientele can access.”*
- **Enhanced Services Delivery. Program available for social assistance clients ages ‘18 to 24 years of age’ who have completed high school and/or post-secondary education**
  - Clients are assessed by counselors – Identify any barriers, and determine if client qualifies to go into the ESD program (workshops and Job Placements). Goal is for youth to gain work experience and return back to school. *“Some do come back here. But, some [youth] go back to school. They don’t want to see us [Social Assistance] anymore.”*
  - ESD program is delivered at the local training centre – career counseling available. Encourage Younger Generation to obtain training/education.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- **Communication barriers with provincial workers because of language and lack of cultural sensitivity. Some clients ‘feel intimidated’ by professional workers and have a hard time expressing themselves accurately.**
  - *“One mom almost lost her children because the lawyer did not fully understand the situation. ... “*
- **Limited number of English-speaking social workers available at provincial institutions. Participants noted that there is a high turn over rate among English-speaking staff at provincial institutions.**
  - Obstacles obtaining assessments (Mental Health, Disabilities) because there are a limited number of clinical workers at the province who provide such services in English.
- **Documentation from the province (i.e., correspondence, emails, reports, and meetings) is primarily available in French.**
- **Translation Services – Funding is not available for translation of reports, documents, and written material provided by the province to First Nations organization. Bilingual staff members will provide assistance with translation of documents, e-mails or reports.**
- **Challenges establishing partnerships and working with the province because of language.**
  - *“If we’re going to develop partnerships [with the province], then meet us half way. We’re not French speaking. This is a big issue – it’s about attitude and willingness to try to work together.”*
- **Jurisdictional Issues (Provincial) – Difficult to access services for mental health from provincial institutions in New Brunswick due to provincial boundaries – obstacles to go ‘out of province’ to access services in English.**
  - *“Clients may access ‘emergency’ mental health services from out of province; however, follow up and treatment can only be accessed from hospital in Quebec Region where there are limited English-language services and clients must travel further distance.”*
- **Long waiting list for mental health services from provincial institutions**
- **Lack of Cultural Sensitivity and Awareness – Generally speaking, there is a lack of awareness and understanding among staff at provincial institutions about colonialism and its impact on First Nations’ access to social services.**
  - *“When accessing specialized services (Social Workers, Psychologists, etc.) it is difficult to find someone who understands the situation from an Aboriginal understanding and approach.”*

- **Racism and discrimination among First Nations and non-First Nations in the region. Prevention Services has a role to play in addressing racism, especially among the youth.**
- **Prevention Workers felt that their work and experience is at times devalued by external non-Native organizations/committees (Clinical Approach vs. Life Experiences/Teachings)**
  - “[First Nations Prevention] team members feel that their work is less valued. They will come back from a meeting [with non Native resource people] and say ‘they didn’t really want to hear what I had to say. They want to hear it from a professional’.”
  - Devalues the meaningful work that is being done by prevention workers whose qualifications may differ from workers at the provincial level.
- **Communication and information sharing between First and Second Line Services. Need to balance ‘client confidentiality’ with ‘holistic community approach’.**
- **Follow up with external resources: Need to ensure that once referrals are made to external resources that First Nations continue to stay involved with a file.**

b.) Enhanced Prevention Focus (Protection Services)

- **Barriers communicating because of language**
  - Court – Limited number of English-speaking lawyers. Court proceedings in French. First Nations workers provide some translation to families. Translator is brought in from the province, but not always available.
  - Group Homes – Lack of English services at Group Homes in Quebec Region (i.e., Secure Group Home in Gaspé). To access services in English, youth need to travel farther distance in Quebec or go out of province. Lack of English-language instruction (education) for Youth who attend ‘Secure Group Home’ in Quebec Region (Gaspé Area).
- **Local CLSC – Difficult to access services from local CLSC because of language.**
  - Some staff may be English-speaking, however programs are not readily available in English. Services required: Clinical support for Autism Spectrum Disorder and also Respite Care.
- **Lack of specialized services for Mental Health and Addictions (Detoxification and Treatment) in English from provincial institutions in Quebec. (Barriers accessing services because of language, distance, and lack of cultural sensitivity). Long wait time for services in English.**

- Community members mainly access specialized services for mental health from private agencies out of province.
  - Long wait time for psychological assessments.
  - Lack of residential care for youth with disorders such as autism or who require specialized psychological services.
- **Documentation from provinces is provided in French**
    - Court Orders (Youth Protection and Young Offenders) mainly provided in French. Difficult to find a translator (need to maintain confidentiality)
- **Court – (Young Offenders and Youth Protection) – Obstacles accessing services due to financial barriers and ‘preconceived notions’ about legal process.**
    - Financial barriers – Parents are showing up in court without legal representation.
    - Parents/Children lack of understanding about the legal process (generally speaking)
    - Preconceived notion of court creating obstacles for families. Parents view the courts as a ‘penal system’ as opposed to a support system to get outside agencies to create a better family environment.
    - “[*Child and families*] lose their voice in the [*legal*] system ... The [*legal*] process is too fast. Parents need a stronger voice to speak on their behalf when it comes to court.”
- **Distance – difficult to access some social services because of distance**
    - Court –Funding is not provided for parents to travel to court. Some parents do not have vehicles, difficult to participate in legal proceedings.
    - Youth Treatment Centres (Substance Abuse) – Access to Youth Treatment Centres (English language and cultural programming); however, distance is an issue (located one hour away). Wait time to access treatment services (clients accepted on cycle basis).
- **Provincial Laws creating obstacles to the delivery of social services by First Nations Communities – Lack of recognition of Mi’gmaq Vision and Involvement in decision making and delivery of services.**
    - Provincial Legislation is changing how foster care services may be delivered in communities (*recognition of foster homes and payment for services*). [Bill 125 – An Act to amend the Youth Protection Act and other legislative provisions]
    - Inequities in amounts foster families are receiving – different rates for homes accredited from the province.
- **Jurisdictional Boundaries – Provincial Boundaries**
    - Lack of access to specialized services for Mental Health and Addictions from provincial institutions that are located ‘out of province’ (in New Brunswick). (*Psychological services, Detoxification, and Treatment*).

- Long wait list if individuals are able to access services from out of province.
- **Lack of support services in the area for Sex Offenders (general lack of services, and also because of language).**
- **Discharge – Lack of notification.** Provincial institutions in the Quebec Region are not notifying First Nations organizations when clients being followed by Youth Protection are being discharged even if this requirement is noted in their file (for example, if a client obtains services for Mental Health reasons at the provincial hospital).
- **Lack cultural sensitivity/awareness – Generally, staff at provincial institutions (e.g., Group Homes) are not aware of the history, social and cultural needs of First Nations’ clientele.**
  - *“Staff at provincial institutions may not know anything about our culture. Even something basic like smudging.”*

c.) Assisted Living

- **Good access to medical equipment, but funding is not available to install medical equipment or to build any infrastructure (i.e., wheelchair ramps).** Participants noted that there is a long wait time to receive approval for some medical equipment through NIHB compared to provincial system (“Non Natives access medical equipment faster at the CLSC”).
- **Some obstacles when individuals are discharged from hospitals in Quebec Region – language barriers and lack of communication**
  - Discharge reports from hospitals in Quebec region are written in French,
  - Hospitals may notify the Health Centre that community members are being discharged.
- **Lack of Personal Care Workers.** Workers are mainly hired on a casual basis, which makes it difficult to recruit workers (*staff burn out, lack of benefits for workers, lack of employment security*).
- **Transportation is not provided to assist clients with ‘daily living’ activities (i.e., grocery shopping, run errands, banking, etc.)**
- **Funding is not provided for translation services. Bilingual staff members at the Listuguj Health Centre provide assistance with translation, which “takes up their time from other duties”.**
- **Specialized services – (dietician and physiotherapy). Limited services in English, long wait times at provincial institutions.**

d.) Family Violence Prevention

- **Lack of Detoxification Services / Addictions Services in the area generally, and English-language services specifically.**
  - The shelter is being used as a place for women who are waiting to go into detoxification. Difficult for other clients and the staff if the woman is going through withdrawals.
- **Lack of English-speaking mental health services (such as psychologists) at provincial institutions in Quebec.**
  - *“We have to get services [mental health] for our clientele from out of province at private institutions. Costly for the organization. Funding is not provided to pay for mental health services (e.g., psychologists).”*
- **Obstacles communicating with provincial government agencies because of language.**
- **Minimal networking or communication with provincial mainstream organizations for family violence prevention**
  - Provincial Network (mainstream shelters): *“They meet regularly. We’re never invited to their meetings. We do not receive any information or documentation.”*
  - Organization for women (mainstream) – *“Rarely call us. Difficult to establish partnerships. We have a meeting, and then we never hear from them again.”*
- **Difficult to navigate the provincial network (e.g., local CLSC). Lack of English-language services for health and social services.**
  - *“We rarely go to provincial institutions in Quebec.”*
- **Communication issues when working with shelters in the area (out of province) – misinformation and obstacles because of language**
  - Staff at local shelter (in New Brunswick) was unaware that they could accept ‘out of province’ clientele.
  - Obstacles because of language (staff mainly speak French) – *“clients don’t stay [at the shelter] very long”*
- **Shelter is not able to provide services to individuals referred to shelter for reasons other than family violence (i.e., clients seeking services for addictions, detoxification, mental health, homelessness).**
  - Staff is not trained in these areas, nor is there medical personnel available if required.
  - Compromises the safety of staff and other clientele
- **Working with the local police (First Nations) – Dialogue is needed to ensure that police force is informed about the resource available for victims of family violence at the Shelter. More attention required for victims of sexual assault.**

- **Shelter is not accessible by individuals with limited mobility**
  - Funding is not available to make any renovations or to ensure that the home is accessible by people with physical disabilities.

e.) Social Assistance

- **Stigma associated with relying on ‘income of last resort’**
  - Staff help clientele who face obstacles because of literacy levels, social stigma
  - *“This is the last place some people thought they would end up. They are almost in tears.”*
  - *“Sometimes it’s embarrassing for the client. I ask the questions, and fill out the form. It’s less degrading.”*
- **Rules and Regulations – Organization is required to follow rules and regulations set by Aboriginal Affairs and the First Nations Health and Social Services Commission (Framework). Difficult for community to set their own priorities for social assistance.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Community members have access to range of prevention and protections services** – (programming provided in schools and community). *Including: one-on-one with clients, group settings (support groups), service planning and referrals.*
- **Protection Services are readily available** – Community organization is mandated to provide child protection services in both the Quebec and Ontario districts of Akwesasne.
  - Networking helps with access – Member of Ontario Association of Children's Aid Society (Ontario) – Staff able to access training (front line and management) in English *“We are connected with Ontario association, we can network, share resources, problem solve ... that has helped our Agency out a lot.”*
  - Foster Homes – Training Tools available from Ontario (Ontario Tools are implemented across the board, such as screening foster homes and training for foster parents).
- **Protocol established with Akwesasne Mohawk Police** – Youth Protection workers able to receive support from police, if required. Police will refer individuals to the child and family services' organization.
  - *“We have a good relationship with Akwesasne Mohawk Police. We have a Protocol with them, if we have to go in for situations if they need to go in and accompany workers, for their safety, they will do that.”*
- **Joint Case Management Team** – Community agencies (Health, Social, Police, Justice, Housing) meet to discuss complex and challenging cases. Better able to meet the needs of the client when resources work together.
  - *“Many times, it's mental health and addictions issues, on top of poverty, or criminal charges in there also. To meet the needs of a family or individual, we come together and sit and discuss in case management.”*
  - *“We will brainstorm on how to share resources, and coordinate some type of support [for clients]. We've been able to come together and resolve issues.”*
- **Court System** – All the court hearings are held in English. First Nations organization provides information to families (i.e., legal aid, directions to court). The organization and children in protection have access to legal from Quebec's Centre Jeunesse. Transportation is available for the children.

## b.) Family Violence Prevention

- **Community members have access to a safe house and also to educational programming (men and women).** Curriculum includes: domestic violence, as well as other topics –addictions, (including addictions’ assessment and treatment), employment & education counseling, health, and building healthy relationships. Programming is open to all community members (whether they stay at shelter or not) both men and women have access.
  - *“Work is beyond just being a ‘safe house’. There is prevention work and programming provided to clients.”*
  - *“Requested to start training other First Nations communities about the curriculum provided at the shelter.”*
  - *“Safety Planning and Prevention Services – Reduction in number of women seeking services (fewer people coming in to reside at facility) due to safety planning and education being offered in community.”*
- **Networking with other Shelters – Information sharing, resources, and best practices.**
  - Member of National Aboriginal Circle Against Family Violence (*National network*)
  - Shelter Net (*Provincial network for Aboriginal and non-Aboriginal organizations in Ontario*)
  - Native shelters (in Ontario)

## c.) Social Assistance

- **Social Assistance is delivered in the community under the Ontario Works’ Social Assistance program for all clients (Quebec and Ontario districts). Few barriers because of language (delivered under Ontario’s framework).**
- **Networking** – Strong support mechanism in Ontario. First Nations belong to an association that meets biannually. Discuss any policy changes, training. All available in English.
  - Limited networking with Quebec – lack of information, awareness of services, and there are language barriers.
- **Education and Training opportunities** – Created strong network and partnership with Adult Education Program in the community to deliver programming (training and education) to SA clientele.
  - Clients have access to transportation (to attend training/education)
  - Successfully worked with Economic Develop (internal agency) to identify labour market trends and needs in the community (for training)
  - Moving program to become more education and training focused, rather than continuing the dependency cycle of Social Assistance. *“We recognize that we have generational clients on assistance – parents and*

*grandparents have been on SA. How do we break the cycle? ... We conduct assessments of clients and with our partnerships, we direct them to services they need to break the cycle of dependency (education, mental health, and addictions)."*

d.) National Child Benefits Reinvestment Strategy (Available through Ontario Works (Social Assistance) program)

- **Funding is available for projects to address poverty from National Child Benefits Reinvestment Strategy. Program effectively addresses poverty, managed and controlled by the community.** – *“The people who need help the most, actually get the support.”*
  - Community evaluates proposals (Community Based Committee) for projects that address poverty.
  - Committee reviews applications based on priority areas established for NCBR. Dispersed funding not only for community funding, but also to community groups. Children living in poverty able to access support that they need, so they have a little bit extra available to them.
  - **Challenge** – Funding has been decreased; only available on a year to year basis.
  - Note: **Akwesasne** indicated that services are provided under NCBR strategy. Although the mandate still exists to provide NCBR projects in Quebec, First Nations communities have limited availability to funding through their Social Assistance programs for such projects.<sup>2</sup>

e.) Adolescent Treatment Centre (Addictions)

- **Culturally relevant treatment program offered in the community of Akwesasne.**
  - *“Culture and traditions are built right into the programming.”*
  - Clients have access to other services available in the community (Prevention, Medical)
- **Staff is well experienced** –Life experiences and formally trained.
- **Partnership Agreement established with Northern Cree** – Networked with the communities, agreement established – *“Good partnership with the Cree communities.”*
  - Maintain close communication and relationship with partner.
  - First Nations clients from more remote areas have access to medical, optometry, and dental services available in the community while at the treatment centre
  
- **Recognize the importance of After Care and Relapse Prevention for Youth**

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<sup>2</sup>Conversation with a representative (Marie-Pierre Bessette) from AANDC Quebec Region. 8 June 2015.

- *“Adolescents in facility do well. They grow and improve. But, once they transition back into community the supports aren’t there. We are trying to help communities to build capacity and have the supports necessary for when the youth are back home. Recognize that that is an area that needs to be strengthened for treatment.”*

- **Networking and Information Sharing – Sharing ‘wise practices’ with other Nations at Conferences and other forums.**

- Provide training to other communities
- Provide information and resources to parents.
- Community information sessions in Akwesasne (for all districts, regardless of provincial/national borders)

f.) Community Day Cares (*Daycare included in this research due to the connection that Daycare has with Social Services*)

- **Case management approach (schools, health care, prevention services, and daycare centre) – helps to ensure that children have access to all resources**

- *“Good networking in the community, but still very stand alone and working outside of Quebec (lack of information, awareness, and funding opportunities.)”*

- **Special Needs – Services available for clients with Ontario Medical Cards; however for residents with Medical Cards from Quebec there are obstacles accessing specialized services (OT, and speech therapy) from specialists located in Ontario (Jurisdictional issues – see below)**

- Centre able to complete developmental assessments on children using a developmental tool.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **‘Jurisdictional Issues’ (Provincial and International borders) – General challenge because of jurisdictional issues identified by all social services providers. Also, face discrimination and racism when ‘crossing the border’.**

- *“Akwesasne has always been Akwesasne. The government divided us up into three different jurisdictions. We go through a ‘jurisdictional nightmare’ on a daily basis ...In our community, no matter where you are – in Quebec or Ontario – you have to travel through New York State to get to each ‘district’. We are constantly in and out of New York State. That is why things are so challenging and frustrating in how we work and operate ... The racism is still there. You go through that on a day-to-day basis.”*

b.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of English language services for children and youth in protection related to Special Needs**
- **Lack of Anglophone Foster Homes for adolescents in Quebec. Access services ‘out of province’ (residential placements for Youth); then face obstacles accessing medical services because of provincial jurisdiction for Medicare.**
  - *“Difficult to have residential placements in Quebec. We’ve had occasions where youth have been placed in French-speaking facilities. We place them in Ontario, but then we have a problem because health providers have an issue with Quebec health insurance. There are differences in rates. [In Ontario] they are refusing Quebec medical card.”*
- **Lack of information and notification about Quebec’s Youth Protection legislation (i.e., Changes to legislation, Standards).**
  - Staff need to know the YP legislation for both Ontario and Quebec, yet information is not readily available about legislation in Quebec Region.
  - *“We don’t know if we are meeting standards, or even what standards exist in Quebec.”*
  - *“We’ve heard some talk about social workers needing to be registered, but we haven’t been notified.”*
  - *“We are one community, yet we have portions of our reserve in Qc, Ontario, and NY State. When we are looking at bringing children into care and placing them, there are challenges in terms of licensing regulations for foster homes. There are some things allowed in one province, but not in another ... we need this information.”*
- **Lack of information about any funding available from Quebec Region for Youth Protection.**
  - *“Connected with Aboriginal Affairs out of Ontario, but services are provided to residents who live in Quebec region ... We don’t receive any information or funding from Quebec.”*
- **Not satisfied with the quality of services received from the provincial Liaison Worker (agreement in place with Centre Jeunesse): Lack of communication and follow up is an issue.**
  - *“We work with a Liaison Worker for First Nations’ communities. Relationship has deteriorated over the years. ... Would like a back up person, need more than one person to connect with for support.”*
  - *“We’ve asked the Liaison, but haven’t received any responses. We’ve asked for information, but we don’t receive direction or training.”*
- **Lack of training opportunities in Quebec Region for Youth Protection Workers**

- *“Training has been an issue. Minimal training from Quebec. Repeated requests for training. We do receive annual training, but it is just a refresher of the Youth Protection Act.”*
- *“Mainstream agencies must receive training, but we don’t receive any.”*

c.) Family Violence Prevention

- **Jurisdictional Issues (Provincial) – Issues with funding services (family violence prevention) for clients from ‘out of province’: residents with Quebec Medicare seek services from shelter because services are in English and programming is culturally based.**
  - *“Shelter is on Ontario side. Services are provided, for residents from Quebec region, but organization is not provided with funds from Quebec. We receive referrals from Quebec because we provide English-language services, cultural is a component in all the programming that is offered. Transportation provided to Quebec residents – cost (out of pocket). Quebec not providing any funding for individuals .... It angers me, because it’s not fair.”*
  - **Second Stage Housing** – Funding is not provided for “non-residents” to stay and use the programming from ‘Second Stage Housing’. *“Women may be forced to go back to unsafe situations because they don’t have any other alternatives.”*
- **Detoxification Centers in Quebec– Language Barriers, and long wait period to access English language services.**
  - *“When clients go [to some treatment services in Quebec] they have difficult because it’s all in French. Staff speaks French. They just don’t like to go there. They often won’t stay because it’s too difficult. Long wait period to access English language services.”*
- **Applications for Subsidy Forms**– Clients at the Shelter experience barriers filling in applications because of language. Often the applications (*housing, subsidy forms for Daycare, Schools*) are all in French. Difficult for clients. Clients often relocate to Ontario side.
- **Communication barriers because of language when calling provincial institutions.**
  - Called the information network and it was “really difficult to get an English-speaking person on the phone.”
- **Difficult to access specialized services in English in Quebec** (*services such as: Mental Health, Medical, Counseling, Addictions’ Services*)
  - *“Very frustrating, people tend to use the Ontario services rather than in Quebec because of language”.*

- *“We can get an assessment for a child, or parenting capacity assessment done in Quebec. But beyond that, we don’t know where to go for more services.”*
- **Documentation from the province is mainly available in French – General Information and Official Court Documents**
  - *“When you call the province and request information, they will send it to you in French.”*
  - *“Information from Court System is mainly provided in French. Difficult to read the documents from Court System in Quebec (mix of French and English); long wait period when the province translates the documents, funding is not provided for translation.”*
- **Lack of Information about and disconnected from the Quebec Health Care Network, generally speaking, and specifically with regards to Family Violence Prevention.**
  - Disconnected from Quebec. Not fully aware of what services are available (support, medical). Funding, subsidies – lack of information.
  - Doctors may have license for both provinces (Ontario and Quebec), however, (the professionals) are more familiar with the network in Ontario. We have that disadvantage of not being fully aware of what is available.
  - Family Violence Prevention workers do not currently network with any Family Violence Prevention organizations in the Quebec Region. *“We don’t attend any meetings in Quebec. Not invited. Costs money because translation would be required for meetings. Quebec Shelter Network... not aware or invited to any conferences.”*

d.) Social Assistance

- **Language Obstacles and facing discrimination as First Nations when filling out application forms (i.e., driver’s license)**
  - *“It was a racism issue, and specific to Akwesasne because of the border. [Workers at the province] were adamant that I prove where I live. Passport was inadequate — it was a nightmare. I hate going there.... Because I’m First Nations, and I live in Akwesasne, I had to provide more documents. They said ‘how do I know that I don’t live in New York State?’”*
- **Disconnected from Quebec’s Social Assistance program – lack of support and resources from Quebec, yet there are residents who live in ‘Quebec district’ of Akwesasne.**
  - *“The unfortunate thing is that we are so disconnected from Quebec. Even though we are following Ontario model, we should have support and resources from Quebec. By not being aware of it, are we doing a disservice to the clients?”*

- **Food Security – Community member have access to a food bank in Quebec; however, drawback is the distance (food bank is about one hour away) - not readily accessible. Lack of awareness and limited connections with Quebec networks to address issues resulting from poverty.**

e.) Adolescent Treatment Centre (Addictions)

- **Inability to service sister communities in Quebec because the treatment centre is not recognized as a National Native Alcohol and Drug Abuse Program (funding is not available for clients from Health Canada).**
  - *“The culture and traditions are built right into the programming. It would be really fortunate for the other communities to have access, to provide youth with that type of Treatment. Because of Health Canada and NNADAP, and lack of funding, and not being able to designate another facility as a NNADAP organization. We could in the past (when it was a Group Home), however, once transitioned to a treatment centre they were unable to provide the service.”*

f.) Community Daycares *(Included in this research due to the connection that Daycare has with Social Services)*

- **Jurisdictional Issues (Provincial) – Community has three fully functioning centers (one in Ontario and two in Quebec). Historically, received funding from Ontario. Not recognized in Quebec. Community was told they were not ‘situated in Quebec’, therefore not eligible for funding subsidies (yet two of the centres are physically located in Quebec).**
- **Financial Obstacles– Families pay full rate for places at daycare (unlike daycares in Quebec, which are subsidized). Daycare seats subsidized from various ‘social assistance’ programs in the community. Limited funding available to subsidize seats. Financial barriers for families and children who are ‘at risk’.**
  - Distance is an issue when children need to access services from Quebec health system (i.e., specialists to address developmental delays and special needs)
  - Long wait for services from Quebec Medical System.
  - Difficult to access services from Quebec institutions because of language issues. Some parents are “not comfortable” going to institutions in Quebec due to language barriers –not comfortable explaining their child’s situation to specialists.

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention Services)

- **Collaborative approach among social services’ providers: Reduces duplication of services and ensures that clients are aware and have access to all programs/services that are available in the community.**
  - *“Multidisciplinary work between Prevention and Support workers, i.e. shared cases. (First Line and Second Line)”*
  - *“Networking amongst various services within the community to meet the needs of community members”*
  - *“Prevention Worker and the nurse will go into the school together to deliver programs on healthy sexuality – nurse will cover the topic from a medical perspective, while the prevention worker provides a social perspective – holistic approach.”*
  
- **Prevention programs and services are readily available in the community for families, individuals and groups. Prevention topics (e.g., family violence, addictions, healthy sexuality,) are integrated into activities.** Resource binders (modules and curriculum) have been developed and available for staff to use in their programs. Healthy meals/snacks provided for some programs (healthier food choices and increase awareness about diabetes prevention) from Prevention Services at KSCS
  
- **The Family and Wellness Center offers the following services: Traditional Support, Parenting, Satatenikonrarak, Indian Residential School and smoking cessation**
  
- **The Whitehouse offers youth programming** (ie Our Gang and Mad Group)
  - The team offers *support and guidance, resource information, workshops, groups and activities* designed to meet the needs of Kahnawake families.
  - *Parenting Programs* geared for different age groups (i.e., 0-6 years old, Youth). Curriculum focuses on topics such as: life skills, budgeting, parent child exercises, arts and crafts, healthy sexuality and children, and one-on-one services to assist with the development of skills such as scheduling (with children), discipline, attachment parenting.
  - *Parent- child interactive workshops* that promote parent child interaction through activities that stimulate development and self esteem
  - *Nobody’s Perfect Program* which is a 6-8 week program for parents with children from 0-6 years, offering interactive workshops and experiential learning on a variety of parenting issues such as child development, understanding children’s feelings and behavior, stress amongst parents, etc.

- *Traditional Prenatal Group*- offered for mothers seeking prenatal teachings from a Traditional perspective. The group marries the Traditional teachings with the Medical information available today.
  - *Kids in the Middle* is a parenting program offered to parents who are separating/ divorcing and offers information and skills building to ensure children are not in the center of their issues during family breakdown
  - *Where the Creek Runs Clearer Traditional Youth Group* –prevention programming based on traditional cultural teachings (for example, roles and responsibilities of men and women; traditional skills – hunting and harvesting).
  - *Our Gang (After School Programs and Summer Camp)* for school-aged youth – offers assistance with homework, support and prevention education (healthy sexuality, family violence, life skills, social skills) integrated into all activities.
  - *Making Adult Decisions (Teen Group)* – Mental health, addictions, life skills, social skills, and building on Leadership skills.  
Promotion and Education Services- “*Prevention workers will meet with teens who are experimenting with drinking and drugs to offer education, awareness, and prevention work for teens.*” In addition to this various campaigns such as bullying prevention, Spirit of Wellness month, Safe Grad, Violence Prevention, and Suicide Prevention are offered on a yearly basis.
  - *Support Groups offered based on identified needs*, i.e. Addictions Education, Grieving/ Loss Group, Divorce and Separation, Self Esteem Group, Youth Groups for empowerment.
  - *Traditional Services* - offers one on one sessions, Group teachings, Sweats, roles and responsibilities for men and women, and various ceremonies based on traditional Iroquois teachings.
- **Mental Health –Access to counseling services in the community from Traditional Support Counsellors and Support Counsellors (under the umbrella of Prevention Services).** Workers offer individual therapy/ counseling to work on issues. Clients have an opportunity to receive services from a Traditional Iroquois perspective (using both the natural and spiritual realms of Iroquois Teachings) and/or from the mainstream western perspective.
  - **Addictions Services –Access to services for many kinds of addiction (smoking, gambling, drug and alcohol).**
    - *Challenge (treatment services)* – Clients are referred to treatment centers outside of the community and access is limited in Quebec due to language barrier.
  - **Youth Criminal Justice** – Social workers (Case workers under Support Services) work with courts to ensure that court measures are completed (Second Line)
    - Case workers are assigned to provide the judge with a “pre-decisional report”, and will follow the youth throughout the process.

- Hearings are held in English; however, the “context” of the situation is not always considered or understood by judiciary.
- Some documentation (letters, Court Orders) may be sent in French and require translation.
- Under Section 84 - members of Prevention and Support Services, along with the Director of Justice and members of Corrections Canada, **assist individuals released from federal penitentiaries to transition back to their community**. The committee is in place to assist the individual with support and acts as a means of accountability during their transition
- **Networking** – staff network with external agencies in the community, i.e. Hospital, Peacekeepers, Fire Brigade, Kahnawake Diabetes Prevention, Community Schools, Mohawk Council of Kahnawake etc. Also, in the past, we have been able to bring outside resources in to the community to assist with youth programs (i.e., drama programs)
- **Satatenikonrarak Component** which provides the community with **awareness and prevention information regarding Fetal Alcohol Spectrum Disorder, HIV/AIDS, Healthy Sexuality, Smoking Cessation Initiatives and Suicide prevention**
- **Protocols** – There are protocols in place with police (Kahnawake) for situations involving family violence.
  - Police will send referrals for individuals experiencing family violence to receive prevention services.
  - KSCS and the Kahnawake Schools Partnership is in place to meet the needs of the youth with a spectrum of prevention activities and services to help ensure the children’s educational and social goals are reached. Programs include person and social development, Leadership and Empowerment Group for girls, Health and Sexuality, and Leadership for men Group.

b.) Enhanced Prevention Focus (Protection Services) [Response submitted in writing]

- **Intake Services provided by the Organization: assess and screen each request. Ensure that each request has been properly assigned and followed up.**
  - *“Intake Services is responsible to provide immediate responses to all requests placed to KSCS for any of the service areas (although many of the calls related to elders services and assisted living services may be sent directly to those service areas)”*
- **Youth Protection Services Provided by the Organization through delegated authorities through the Director of Youth Protection of the Centre Jeunesse (Monteregie). Since the 1980s, Kahnawake has entered into specific**

**agreements with the Province to provide services to its own population. Work with provincial partners to implement institutional or Group Home Placements.**

- *“We will continue to assume this responsibility [Youth Protection Services].”*
  - *“We collaborate with the Tsi Ionteksa’tanonhnha Foster Care Program to implement foster care placements”*
  - *“Our family members sometimes require more structured environments to help stabilize their current situation. To support these situations, we rely on the support of our partners at the Child Services of Akwesasne, the CJ Monterege, and the CJ Batshaw”*
  - Roster Services: *“Ensures that someone is available to respond immediately to emergencies and/or new intakes when the demand is necessary.”*
- **Youth Criminal Justice Services are provided by the Organization through delegated authorities (e.g., assessments for extra-judicial sanction and probation follow up).**
    - *“In partnership with the Quebec Justice system, we conduct all necessary functions to support the Quebec Youth Criminal Justice Act, such as conducting assessments for extra-judicial sanctions and probation follow-up. Funding for the Youth Criminal Justice Services is administered through the Province of Quebec.”*
- **Tsi Ionteksa’tanonhnha “Foster Care” Program is provided by the organization. The main responsibility of the Foster Care Program is to provide a safe, stable environment for children who may be at risk in their family environment. Organization recognizes foster homes and provides support and training for foster families.**
    - *“Our intent is to always seek child placement with a child’s own extended family members first; this is in direct alignment with our Kanien’keha:ka tradition of families taking care of each other.”*
    - *“Since before 1982, Kahnawake has recruited, assessed, recognized and approved our own foster homes, using standards equitable to the provincial standards, but also in keeping with our own values and traditions. We believe we are the **only** agency who has the mandate, the right and the knowledge of who should be caring for our children.”*
    - *“All of our foster homes and extended family members are provided with the support, and training if required, maintain children in their care. This support may include financial assistance, counselling, training, support group meetings and any other support determined by the Foster Care Team Leader.”*
    - *“Funding for the foster care program is administered through the AANDC, and is accordance with the rates provided within the province.”*

- **Institutional Care and Group Home placement provided by our partners, (Batshaw, Centre Jeunesse).**
- **Case Aide Program provided by the Organization:** The main responsibility of the Case Aide program is to provide essential services to children who are in foster care, institutions, and group homes such as providing transportation and facilitating supervised visits. Case Aides are frontline workers who directly observe the clients' situation and family environment, and provide valuable input into service and treatment planning.
  - *“Through supervised visits, the case aide, as an extension of KSCS, provides an opportunity for families in crisis to interact, enjoy activities and outings that enable them to maintain their bond and re-establish the family unit in a more familiar environment.”*
  - *“These visits are normally held after school hours and on weekends. Therefore, cases aides must be flexible in their availability to provide this service.”*
  - *“Case aides also provide transport to children and youth when deemed necessary. These may include transports to school, to supervised visits, to special activities, and any other transport that is clinically appropriate.”*
  - *“Transport areas include the surrounding communities, as well as Akwesasne, Kanasatake, Shawbridge, Ottawa and the Eastern Townships.”*
  - *“Case Aides able to provide emergency childcare within KSCS in the event there is an emergency and childcare services are required.”*
- **After Hours Response Services “On-call” provided by services in the community. Staff work collaboratively with other agencies in the community (Kahnawake Peacekeepers, Kahnawake Fire Brigade, Kateri Memorial Hospital Center). Specific emergency services are provided to community members.**
  - Respond to emergencies after hours.
  - Collaborate with the Kahnawake Mohawk Peacekeepers and other emergency services to intervene on clients who require immediate attention
  - Conduct court-ordered or requested “spot checks” with high-risk families to ensure the safety of minor children
  - Conduct “outreach” calls with clients who are in distress or crisis;
  - First access point for engaging the rest of KSCS during a community emergency.

c.) Assisted Living

- **Community members have access to Assisted Living services in two main areas ‘Special Needs’ (Ambulatory and Cognitive Issues) and ‘Mental Health’ (severe and persistent disorders– schizophrenia, bipolar, oppositional disorder).**

- **Individual and Group programs are available for individuals with Special Needs. Programming focuses on Social and Life Skills to bring individuals to their maximum independence.** Provide support and respite services to their families. Each client has a social worker attached to their file to conduct an assessment and to determine needs).
  - **Life Skill Support Workers** – assist with one-on-one focused activities; **Adult Program**, 18 years and over (runs during the week, and occasionally in the evenings and weekends); **Teen Social Club** (runs after school and summer day programs).
  - “[Adult Program] is essentially for individuals who are no longer eligible to attend school, keep up their social and life skills, keep them connected to community around them, mindfully engaged so they don’t lose what they have from school or continue to learn.”
  - “[Teen Social Club] focuses on life skills to bring participants to maximum independence. Respite for families. A lot of the caregivers are aged ... one family is in their 80s. This is support for families and also for individuals.”
  
- **Organization is developing a profile of statistics of individuals with special needs to better prepare for what is coming in the future (chart of needs)**
  
- **Mental Health (Independent Living Centre)** – A 12-Bed ‘Residence’ facility. One-bedroom studio, no kitchen facilities, one-bedroom studio-type setting. Provide 24/7 security. Day staff available (Monday to Friday) – social workers, life skills workers. Activities keep individuals socially connected and integrated in the community. Work with Mental Health Nurses, doctors, psychiatrist, and pharmacy.
  - “Multi-disciplinary approach. Clients typically don’t re-enter hospitals. We have a long history of stability in their health.”
  - “Mental Health side of the services have evolved ... we have access to psychiatrist, mental health nurse, support for medication. Carved out our own resources on Reserve ... We are able to care for our own here, and as a result they do have better services (access and quality).”
  
- **Support for clients with severe and persistent mental health issues** (day programs, and access to multi-disciplinary health team).
  - “Typically, the individuals tend to be isolated, or self-isolating, so we help them to keep connections with the community.”
  
- **Court System** – Organization able to contract English-speaking lawyers. Minimal involvement with Court System. Organization assists families with setting up ‘Plans of Care’ and financial plans. Able to obtain resources in English from province to set up Trust Accounts.
  
- **Partnerships established with some provincial hospitals for Mental Health – good access to English language resources, training opportunities for staff, and continuity of care (relocate clients).**

- *“Partnership with the hospital helps community members who are seeking services for mental health reasons “to stay connected or reconnect with the community ...”*

d.) Addictions Response Services (*Consolidated Health Agreement, established in partnership with Health Canada*) [Response submitted in writing]

- **Addictions Response Services provided by the community – direct support to community members on an “Intensive Outpatient” model, within a continuum of care.**
  - Services that community members have access to include: Addictions screening; In-depth addictions assessments; Individual counseling; Family interventions; Couple and family counseling; Referrals to inpatient treatment short or long term; Referrals to withdrawal management centers; Internal referral to other KSCS services; and in partnership with Corrections Canada, support the re-integration and release of community members in the justice system.

e.) Other Initiatives: Psychological Services (Administrative and Clinical Supervision) [Response submitted in writing]

The Psychological Services Team is integrated with all services at the Organization. The team provides highly specialized guidance, referral and support to staff members and community members.

- Develops and delivers appropriate psychological services for members of the Kahnawake Community, by creating service plans and making referrals to appropriate resources.
- Coordinates and monitors all off-reserve psychological and psychiatric referrals.
- Conducts and coordinates with contracted service providers (Psychologists) psychological assessments, and conducts youth protection court ordered psychological assessments.
- Demonstrates psycho-legal expertise in terms of parental capacity evaluations for the Department of Youth Protection.
- Participates as consultants on various community initiatives, such as: FASD prevention, Mental Health Team, efficacy of service approaches and consultation on cases.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- Lack of access to specialized services (i.e., Clinical Workers, Mental Health) because of language.
  - “[In Quebec] French is the first language. You are expected to function in French. The services provided in Kahnawake are 100% in English. But, if you need to go to the provincial system (CLSC) the services are completely in French.”
- Law 21 has had an effect on the way in which we offer services.
- Some Social Workers experience difficulties when dealing with the Professional Order [Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec] due to language barrier
- Lack of services in English for Addictions (Treatment Centers) in Quebec.
- Provincial Boundaries – difficult to access English language services from out of province (services for addictions and also from Women’s Shelter)
  - Lack of funding to cover services from out of province
- Transportation costs are not covered for services received ‘out of province’.

### b.) Assisted Living

- **Difficult to obtain early diagnosis for children (two or three years of age) with potential cognitive development disorders (such as autism spectrum disorders)**
  - “We are not a position to get optimal early intervention unless it is a disability that is easily visible at birth (such as Down syndrome, Cerebral palsy). Something outside (such as autism), is not getting the early diagnosis and that advantage of early intervention. That’s a problem.”
- **Lack of specialized services (in general), and long waiting lists for English-language specialized services for ‘Special Needs’ clientele (e.g., dentists, Occupational Therapist, Speech Language, psycho-educator for families). Also, lack of English-speaking specialists who are able to treat individuals with Special Needs. Lack of funding for some specialized services (such as Occupational Therapy)**
  - “Clients with a diagnosis, such as autism, there is only one English-speaking dentist who specializes in treating special needs’ patients. Dental care can be a big problem for someone with severe autism ... It’s quite a challenge just for dental care.”
  - “We have good access to general practitioners at the hospital in the community (Kateri Memorial Hospital) – long waiting lists for specialized services (in general) and longer wait for specialized services ‘in English’. It is critical to have English-language services for individuals with Special Needs due to obstacles with communication that are already present because of their diagnosis.”

- *“Huge problem to obtain English-language services, in general on the South Shore, and even more challenging for individuals with Special Needs or Mental Health issues.”*
- **Lack of English-language resources for individuals with Special Needs (even in jurisdictions that provide English-language services to the population)**
  - *“English-language resources are slim at best for Special Needs across [Quebec] the Island of Montreal and South Shore ...”*
- **Corridors of Service – Community is in a ‘unilingual French jurisdiction’; unable to obtain services (in English) from other administrative jurisdictions in Quebec. If resources are accessed from another corridor, funding is not provided.**
  - *“[Kahnawake] is an English island in the middle of a francophone jurisdiction. Our ‘go to resource’ off Reserve, [at the provincial level] for families with individuals with Special Needs is exclusively French ... trying to partner in terms of resources is really difficult.”*
  - *“If we access English-language resources from Re-adaptation Centres located in another administrative region (West Montreal), then there is a cost that we don’t have the budget for.”*
- **Lack of residential resources for individuals with Special Needs on Reserve. Lack of English-speaking resources from the province.**
  - *“It gets to a point where someone needs placement, they no longer have a caregiver ... in our area, there are almost no English-language resources.”*
- **Lack of training opportunities for front line workers working with individuals with Special Needs from the province because of language. Lack of funding to access training opportunities from other administrative jurisdictions in Quebec.**
  - *“In terms of shared training opportunities, what the province has they offer in French. Cannot partner up to access what they provide.”*
  - *“It’s hard for staff to access what they don’t understand. If we access training from other jurisdictions, it comes at a cost ... It’s a struggle.”*
- **Jurisdictional Issues – Lack of clarity between the Federal and Provincial governments about who is responsible to pay for some services (i.e., Group Home placements) for individuals with Special Needs – First Nations are ‘caught in the middle’.**
  - *“Volleyed back and forth between the provincial and federal government. If someone is assessed for a Group Home off Reserve, if they fall within a certain number they are provincial responsibility, but if below that number they are federal responsibility ... For our Special Needs clients, they are in limbo – everyone is saying it’s not my responsibility.”*

- *“Assessment Tools – difficult to get the province and federal government to ‘speak the same language’ with regards to assessments.”*
- **Mental Health and Addictions Services – “Access to English services for Addictions is a nightmare in general, and it’s a disaster for someone with Mental Health Issues.”**
  - Limited treatment options in English in Quebec (adult population) – addictions and mental health.
  - Lack of treatment services for younger population (youth). Not able to go ‘out of province’ for English language treatment services (no funding)
  - Lack of Detoxification Services
- **Transportation – Funding for transportation is available if within ‘corridor of services’; however, if clients obtain services from other jurisdictions (because of language), funding [from Health Canada’s Non Insured Health Benefits Program] is not provided to cover transportation costs.**
- **Provincial Restructuring – Challenge at the present time to work with the Province due to the restructuring of their health network. Uncertainty about what services will be available with the closing of provincial hospitals.**
- **Networking – Difficult to network with provincial institutions because of language barriers (i.e., Services to assist and support families and individuals with Special Needs)**
  - *“It’s very difficult [to network] within our area because it’s all francophone resources. We’re eligible to go to the CLSC [provincial network], to receive services for Special Needs, but all the services are in French.”*
  - *“Nothing available through the structure itself. We’re very isolated in trying to meet the needs of families in the communities ... “*
- **Lack of resources to provide services to Youth/Young Adults (16 to 24 age range) requiring services for Mental Health Issues. Wait lists for Mental Health Services (younger population).**
- **Lack of English language documentation from the province (e.g., Contracts, Placement Agreements, Assessments). Funding is not provided to translate documents (no budget for translation).**
  - *“Trying to get documents from the province in English is impossible (i.e., contracts, placement agreements, assessments for individuals placed at provincial institutions). We have to get documents and information translated. We have no budget for translation. It’s such a labour intensive struggle.”*

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Protection Services)

- **Protection Services are available and provided by Social Workers from the Centre Jeunesse** –Responsible for Evaluation and Application of Measures (Follow Up) – *Court Imposed and Volunteer Measures.*
- **Families can reach social workers from Centre Jeunesse if they need information about Youth Protection.**
  - *“The Youth Protection laws are the same for everyone in Quebec.”*
- **Social Workers refer clients to the Health Centre (First Nations) to receive prevention (First Line) services – helps to reduce the number of children being placed in Youth Protection.**
  - Easy to access due to the proximity of the services (clients do not have to leave the community).
  - Prevention services that are easily accessible include: Anger management counseling, Family Support program, Speech Languages program, and medical support (doctors and nurses).
  - First Line support worker provides “coaching” for parental support, including providing strategies for parenting.
  - *“The proximity of the resources [makes a difference] ... that is why most of the families in my caseload can keep their children – because they have access to [prevention] services, easily.”*
- **Strength of the Community – Everyone is willing to give food and clothes to help support children who are in need.**

b.) Assisted Living

- **Social worker from Centre Jeunesse conducts assessments of individuals (using the provincial Multi-Clientele Assessment Tool (M-CAT) to determine which services the client needs to live independently. Staff from CLSC use a computerized system) to determine the number of hours for which the client is eligible to receive services.**
  - *“[Centre Jeunesse] does not have access to the program [to determine number of hours]. All information is sent to the CLSC and they tell us the number of hours.”*
  - *“Access to completed OEMC by nursing in order to develop therapeutic nursing care plan and/or complete the holistic picture are inconsistent. [Challenge]”*
- **Social Worker from Centre Jeunesse provides assisted living clients with a list of homemakers.**

- Set up initial contract between the ‘Care Worker’ and the ‘Client’.
  - Homemakers are hired on a ‘casual’ basis. Many workers are on Social Assistance, so they are “afraid of losing benefits” if they work too many hours. [Translated]<sup>3</sup>
  - Many of these clients are followed by HCC [Home Community Care] nurses who would encourage a reporting mechanism to be in place so that the observations of these homemakers can be considered and round out the therapeutic nursing plan, if necessary
  - The HCC program is well established in the community and provides all the initial assessments, treatment plans, and clinical evaluations of HCC clientele while incorporating the principles of community health nursing.
- **Services available – Homemaker Services and Respite Care (rarely accessed).**
    - *“Ideally, these services would be coordinated by the Kanestate Health Centre/Home Community Care nurse based on ongoing nursing assessments and available respite services.”*
- **Assisted Living services mainly accessed by Elders, there are no restrictions because of income levels.**
    - *“Services available for short term, younger clientele needs as well; lack of staff has been an issue.”*
- **Clients have access to Medical Equipment “that is all good”; however, there is no funding to provide any modifications to homes (wheel chair ramps etc.) or to install the medical equipment.**
    - *“Equipment requested, usage and evaluation is initially done either by medical, OT, or nursing assessment; requires documentation of needs assessment, equipment loaned and duration of use, etc.”*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Difficult to access English-speaking specialists/resources in the area, in particular for Mental Health Services. Additional obstacles accessing services because of distance (lack of funding for transportation).**
  - *“For psychological care, for Anglophones, they have to go farther. Social worker is available, but for specialists they need to go farther. And, then they will need transportation, [Centre Jeunesse does not provide that] ... many [people] do not have their permit ... they are limited.”*
  - *“Psychology referrals in the public system have long wait times and services in English are limited. Private psychology costs are prohibitive, and few people have private insurance.”*

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<sup>3</sup> Interview conducted in French and English – translation by researcher.

- **[Response submitted in writing as part of Inventory of Social Services] Difficult to access specialized (prevention) services: child psychologists, Art therapy, Legal Aid, Occupational Therapy, Speech Language (evaluation and therapy), Psychosocial evaluations, Psycho-Educator, Psycho-educational assessment, Child Development Assessments, Autism Evaluations, Social Workers, Nutritionist.**
  - *“Challenges because of service area restrictions; clients are not able to access services in their language.”*
  - *“Community [Kanesatake] is included in in the mandate of our local CLSC, services are most often not available in English. E.g. We have had long waits or NO service availability for a nutritionist that speaks English, and in fact, this is true of most of the services listed [above].”*
  - *“A long standing problem for prevention services has been the lack of a Social Worker in the community to do prevention and promotion work with families. Clients are not able to trust a DPJ SW wearing two hats.”*
  - *“The “corridor of service” policy has severely impacted our clientele who do not speak French. E.g. One child, later diagnosed with autism, was bounced back and forth due to the “corridor of service” as English language Child Developmental and Autism Evaluations were not available in our region. It took over two years for this child to be assessed and to receive needed services.”*
  - *“Kanesatake Education has a costly contract with West Island Therapy Centre to provide interdisciplinary services to the Kanesatake schools including: Psycho -Educational Evaluations, OT, Speech Language, Social Work, and Psychologist. Unfortunately these services have not always been timely or consistent.”*
  
- **[Response submitted in writing as part of Inventory of Social Services] Limited Prevention and Protection Services provided by the province**
  - *“Selective clientele from Social Services (Centre Jeunesse) – when it comes to Signalements [Reports] e.g., threatening vs. non-threatening; Native vs. non-Native.”*
  
- **Court System – Court proceedings take place “all in French” and court documentation is provided in French. Lawyers are bilingual, and speak to clients in English. It is “very stressful” to go to court. Parents face further obstacles to attend court hearings due to lack of transportation (distance).**
  - *“Centre Jeunesse will always provide a translator for the families because the hearing is always in French. Lawyers are bilingual and talk to clients in English. But, a translator is required when judge is speaking. No issues finding a translator.”*
  - *“Social Worker will sit with clients to go over court documents “to let them know what is in there.”*
  
- **Social Workers from the Province learn about the culture and community by working with the clients – there is no formal training or orientation provided.**

- There are differences between non-Native and Native peoples, which in turn affects how to proceed with Interventions and Follow Up Measures.
  - *“You cannot go there and do a ‘cop job’ and say you have to do ‘this and this’ ... Parents won’t listen, they won’t be involved in the relationship ... I highly suggest a training – What are the ‘Indians’? What is their history? When I talk to them it’s still fresh in their memory their history and what they have been through.... You cannot do things fast. Need to respect their pace, and you need to know that.”*
  - The FNIHB [First Nations and Inuit Health Branch], in collaboration with Université de Montreal, is developing a community health nursing competency framework, which includes cultural competency and sensitivity awareness.
- **Respite Services (Youth Protection) –Parents are not able to easily access ‘Respite Services’. In the community, there are families with large number of children (up to eight children); there are many single parent families (“famille monoparentale”). Parents are “tired”; yet, there are “no resources to give them respite”. Children at risk for being placed in foster care.**
    - *“Parents are really tired and they cannot give the proper needs to their kids ...kids may have to be entrusted to foster families because parents are not fully there – physically, mentally because they are tired. They are on the limit. ...”*
- **Distance – obstacles accessing services outside of the community because of a lack of transportation.**
    - Accessing specialized services out of the community
    - Youth protection – Parents face challenges visiting their children if placed out of the community and also difficult for some parents to travel if required to appear in Court
- **Foster Families – There are no First Nations’ foster families in the community of Kanasatake; difficult to find Anglophone foster families outside of the community; siblings of large families are “being split up” because it is difficult to find one foster home able to care for all the children.**
    - First Nations families are “not applying”.
    - Ageing population and may not be in good health, therefore not able to become foster families
    - Difficult to recruit foster parents because of issues with housing in the community (*e.g., mold, insulation, water may not be safe*). Lack of funding for renovations.
- **Working with ‘high risk and vulnerable’ youth – Social Workers are not able to properly provide services for Youth who are “running away” from Group Homes.**

- **Social Services’ workers from Youth Protection (Centre Jeunesse) are not able to receive support from the police (provincial), if required due to “community policies”.**
  - *“[In the community] there is a policy that the cops cannot enter the houses if the owner refuses to let them in. In one case, I had a teenager that ran away from resource she was entrusted to. His mother hid him in the home. The cops couldn’t enter the house. I couldn’t do my part as a social worker. ... If we have a report that a person might be dangerous or aggressive usually we ask for the police to accompany us in case it degenerates. But, [the police] are limited because of political issues. They don’t want to go through the ‘crise d’Oka’ what they went through in the 90s. The [police] have an agreement with [Kanesatake]– they are limited in what they can do.”*
- **Addictions – Lack of prevention work to address addictions. Difficult for individuals to break the cycle of dependency.**
  - *“Adults are using drugs, and they have their kids ... It’s not specific to Youth Protection, but there needs to be more prevention work, with the community and environment. It’s a big risk factor.”*

b.) Assisted Living

- **Lack of access to Mental Health services – need to travel farther distance to access specialized services for mental health in English.**
  - *“[To access services in English] they have to go to Montreal, it’s farther than if they had been speaking French. They could go to city just beside us.”*
- **Obstacles because of language when accessing services from provincial hospitals.**
  - *“Clients speak English or Mohawk, and the hospitals in region mainly provide services in French language.”*
- **[Response submitted in writing as part of Inventory of Social Services] Difficult to access the following services – Personal Care (Bathing), Day Program, Respite Care, Assistance with errands and as medical accompaniment.**
- **Lack of communication and collaboration between Provincial and First Nations organizations for ‘Assisted Living’ services**
  - *“Communication among the CLSC, KHC [Kanesatake Health Center] and HCC [Home Community Care] can be improved so as to improve inter-collaborative practice and facilitate multidisciplinary cooperation.”*
  - *“Lack of inter-collaborative approach and reporting/documentation between services and nurses who are responsible for the assessment, monitoring, treatment and evaluation of clients jointly served: question of legal accountability and follow up.”*

- *“Lack of inter-disciplinary communication between service providers to avoid gaps and duplication, and also to maintain standards for professional accountability and legal documentation.”*
- **Challenges when hiring Personal Care Workers because of the policy that stipulate that ‘personal care workers’ cannot be related to the client.**
  - *“Difficult to hire ‘Personal Care Workers’ because of the rule that stipulates that the homemaker cannot be related to the user [client].”*
  - *“It is difficult to find workers in a small community where “almost everyone is related.”*
- **Lack of consistent homecare workers (staff) [Response submitted in writing as part of Inventory of Social Services]**
- **Barriers because of transportation when accessing services that are outside of the community. Difficult for family members to visit.**
  - *“For Elders – all services that are outside of the community are difficult to access. A lot of people don’t drive, or they don’t have money to afford going away from the community to access services (if an individual is hospitalized outside).”*
- **Jurisdictional Issues between federal and provincial governments with declaring an individual ‘incompetent’ and for making a report of Elder Abuse.**
  - *“The CLSC in the region did not want to do the evaluation for the community members ....(translated)’ – When we called the ‘Curateur Public’ (office of the government) they always told us that they can’t help with the community, that we have to deal with Indian Affairs or the Band Office or other services. But in reality they have to offer that same service to them [First Nations community members].”*

c.) Family Violence Prevention [Response submitted in writing as part of Inventory of Social Services]

- **Funding – Lack of funds to cover costs to stay at shelters**
- **Counseling – lack of referrals**
- **Lack of direct client care (Funding mainly used for training/activities for youth and children**
- **Training**
- **Under skilled personnel managing program**

d.) Social Assistance [Response submitted in writing as part of Inventory of Social Services]

- Individuals do receive Social Assistance; however, funding is inadequate. There are people living in impoverished [conditions]. Food banks are being used more frequently (local and outside of community).

## ALGONQUIN

### Eagle Village First Nation – Kipawa

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) Enhanced Prevention Focus (Prevention Services)

- **First Line (Prevention) Services are readily available and accessible in the community.** (Geared for children ages 0-18 years of age and their families. Main objective is to reduce child placements in the community). “We’ve been working with the community, they’re not afraid to call. We’ve built *up trust, and maintained client confidentiality.*”
  - **Counseling services** – meet ‘one-on-one’
  - **Referrals/Corridor of Services** – Compiled list of all resources available in the community and from external agencies. Provided this information to all front line workers (health, police, first line services). “*Important that clients are aware of all the options in the community and from provincial institutions.*”
  - **Guardian Angel Program** – Students hired during summer months to work alongside First Nations’ police. “*More youth are asking questions about other resources that are available, including seeking counseling for issues they are facing themselves.*”
  - **Documents and information is available in English from the First Nations Quebec Labrador Health and Social Services Commission.**
  
- **Prevention-based activities (such as Family movie night, community kitchen) are helping to “support the family unit”. Increased awareness among community members that prevention based social services is “not intervening in a negative way.” Workers are sensitive to the needs of Aboriginal families.**
  - “*[Prevention services] works with families in a comfortable level ... we are getting out in the field and really helping. ... Taking a more sensitive approach, we are all First Nations so we understand the hardships we’ve been through and we’re sensitive to that.*”
  
- **Legal Aid – When contacting legal aid, lawyers speak English (no communication issues were noted with legal because of language)**
  
- **Corridor to other services – refer clients other agencies in the community for prevention services. Good communication with other sectors – health and police in the community.**
  
- **Collaborative Agreement with hospital in Temiscaming (Quebec) – Regular meetings with Addictions and Mental Health teams. Information sharing and good continuity of care between First Line services and external agencies.**

- **First Line staff has established a “good relationship” with ‘English section’ of the local school; however, there are barriers because of language when working with students from the community who attend the ‘French section’ of the school. First Line services is unable to provide any programming or awareness building with the students in the French section because of language barriers.**
- **National Aboriginal Youth Suicide Prevention strategy (funded by Health Canada): Reaching the youth population and community members have access to training (for suicide prevention).**
  - Reaching out to youth. Doing activities throughout summer to work with kids to identify cultural beliefs, get out in the environment and away from technology. Introduce youth teachings such as – smudging, storytelling. *“Work on bringing back the culture to the Youth.”*

b.) Assisted Living

- **Home Support Program – Individuals have access to support services (retain their autonomy and ability to live at home). Issues with how the program is being administered (\*see challenges).**

c.) Family Violence Prevention

- **Family Violence Prevention program – Programming is open to all community members (e.g., Drum fit for family empowerment).**
- **Awareness and Information – Community members have access to information about ‘healthy relationships’ (English language and culturally appropriate).**
  - Regular communications (through newsletter) with community members about family violence to raise awareness and understanding on the topic and also to provide information about resources that are available.
  - Calendar – Wellness tips, healthy recipes, available in Algonquin language.
- **PALS – Parents of Active Little Souls.** Engage families and get them out and provide them with unique experiences. While children (ages 0-5) play, workers can communicate with families – share information and build awareness about ‘family violence’ prevention.
- **Information (in English) about family violence prevention is available from the First Nations of Quebec and Labrador Health and Social Services Commission. Organization actively seeks out information (in English).**
- **Protocols established and networking among service providers for situations involving family violence,**

- Between First Line services and Health Directorate, which outlines steps to follow should staff encounter a situation that involves family violence.
- Work with community police should an individual need assistance
- Shelter in North Bay – willing to take individuals from the community (English language services are available) – Out of Province

d.) Fight Against Poverty Programs – (funded by First Nations Quebec Labrador Health Social Services Commission)

**Food Bank – Community members (at risk/vulnerable) have access to a food bank in the community. Networking with local businesses, and creating awareness about ‘food security’ issues among the community to help break down barriers.**

- *Community members are willing to access the food bank because they know that confidentiality will be maintained.*
- Partnerships – Established a partnership with local grocery store (recently opened in neighboring community) to solicit donations.
- Information and Awareness about ‘food security’ – Presented information about ‘what a food bank is’ at local school.

**Addressing Food Security and Health and wellness through the Community Garden – Community members have access to information and opportunity to ‘grow their own food’ at the community garden.**

Community Garden – Access to food, education/skill, and promotion of healthier eating and lifestyles among community members. Volunteer based. Incorporated workshops into programming (topics such as: nutrition, benefits of community garden, how to start a garden). Would like to implement a green house in the community. Garden is located at the Health Centre (easily accessible).

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- **Perceptions and fears associated with ‘social services’** – Main focus to separate ‘First Line’ (prevention) services from Second Line (protection) services provided by Centre Jeunesse.
  - *“That [lack understanding about first line services] was a big problem. No one wanted to access services. People weren’t sure who we were or what we did. We spent a few years breaking down barriers and getting into peoples homes and providing them with the help and support that they need.”*
  - *“We’ve noticed that people aren’t waiting until there is a crisis; they are coming in before that happens [because of the approach, understanding, and the location of services].”*

- **Lack of communication and information sharing between First Line (prevention) and Second Line (protection) social services. Lack of notification from Youth Protection (Centre Jeunesse) about any YP files involving band members.**
  - *“It’s difficult because there is no sharing of files (with Centre Jeunesse in Quebec). .... when a band member has a file opened by CAS [Children’s Aid Society] in Ontario we get that file. We are aware of what is going on, we can reach out if the person is in close range and we can offer support. Quebec doesn’t do that ...there is no collaboration.”*
- **Lack of training opportunities in English from provincial agencies in Quebec for front line ‘prevention’ workers.**
  - *“Training up north to help kids deal with texting and bullying and it was only in French ... There is training to prevent conjugal violence, family violence, but it was not available in English.”*
- **Difficult to access specialists (health and social services), generally and specifically for English language services – Child psychologist, language and speech therapist, audiologist.**
  - *“We are mainly an English speaking community, but our provincial partner has mainly French-speaking professionals. Although they claim to be bilingual, accessing the services is very difficult. ... If you don’t have someone who is bilingual you are in a tough spot. Because we are so close to the border [with Ontario] our first instinct is to access services in Ontario.”*

b.) Assisted Living

- **Home Support Program –** Centre Jeunesse administers the home support programs for Elders from the community. The difficulty is that an “outside organization” takes care of First Nations’ community members. Personal Care Workers have felt discriminated against because of being Native. Lack of First Nations involvement in management.
  - Limited amount of services (cook, clean, run errands).
  - Policy needs to be updated (determine new threshold)
  - Program is only available to lower income individuals
  - Individuals (clients) are not comfortable having their needs assessed by an outside resource person (lack of cultural sensitivity, communication barriers due to language)
  - Clientele is responsible for hiring their own home support worker – lack of administrative support to hire, oversee, and if necessary, ‘let go’ of the Personal Care Worker.
  - Home care workers are hired on a ‘casual’ basis. Told by agent, “it’s not a job.” Low morale among home support workers. Home care workers do not receive any training. Lack of job security.

- Agents (from the Province) do not receive any sensitivity training to work with Aboriginal communities.
- Lack of First Nations involvement in decision-making and policy adjustments for the Assisted Living Program. *“We don’t have any say. We have an outside organization [from the province] that is coming in making decisions. ... It’s complicated because we don’t control the program.”*

c.) Family Violence Prevention

- **Lack of training opportunities in English on the topic of family violence prevention.**
  - *“There is a lot of training available in the area, but it is all in French.”*
- **Networking with provincial institutions – staff were not aware of any partnerships or networking with provincial shelters (in Quebec)**
- **Distance is a barrier for individuals seeking services from a shelter (local shelters are located one hour away from community). Transportation difficult, and lack of family support system.**
  - *“There are a lot of women who will not leave the community. They just want a place to sleep, but they are not willing to leave.”*

d.) Fight Against Poverty (Food Bank and Community Garden)

- **Food Bank – Difficult to establish partnerships with local food bank (provincial) and community members ‘in need’ may not access services due to stigmatism and negative perceptions associated with accessing services from food bank.**
  - Obstacles establishing partnerships with neighboring food bank.
- **Community Garden – Difficult to get volunteers and community involvement. Working on a campaign to publicize the garden.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Courts (Youth Protection):** Judges and lawyers are generally all bilingual
- **Documentation from the Courts is available in English upon request**
- **Mental Health Services –**
  - Psychologist and psychotherapist are accessible in the community. These services are available through federal government’s Non Insured Health Benefits program (Health Canada).
  - Long wait times for English language mental health services (province).
- **Bilingual staff at CLSCs. Participants noted that certain positions at the CLSCs are designated as being ‘bilingual’; however, programs are not necessarily provided in English.**
- **Community members can easily and readily access the Enhanced Prevention services provided in the community –**
  - *“It is not a perfect system, but we have our own people in these roles to deliver services for our own people. Generally, this keeps our community statistics low (e.g., mortality and morbidity rates are low (youth suicide/suicide).”*
- **Good working relationship with Centre Jeunesse**
  - Work collaboratively with the province when intervening with a family on a situation – works “really well”.
  - The respective roles and responsibilities of the First Nations and Province are “clear” and “transparent” – Intervention and Application of Measures.
  - Provincial Interveners speak English.
- **Youth Protection Social Worker who works in the community is familiar with Algonquin culture, the political process, and how programs work on the reserve –familiarity with community helps ensure good access.**
- **Good communication and working relationship with local schools (on and off Reserve) – “We try to help each other to the best that we can”.**
- **Access to some social services (for example, specific programs for anger management) from the province in adjacent town [Maniwaki] in English**

- **No major barriers with transportation if the services being accessed are in line with the Non Insured Health Benefits (NIHB) program. Some issues with funding for transportation, however, accessing services ‘out of province.’**
  - *“Sometimes, clients will need to access services in Montreal, which is four hours away, rather than the same service in Ottawa, which is one hour away – transportation may not be funded for services that are out of province, despite the fact that the service required is in closer proximity.”*

#### b.) Family Violence Prevention

- **Clients of the Waseya House [Woman’s Shelter] who are members of Kitigan Zibi have access to all the services delivered in the community** (i.e., *Enhanced Prevention, Mental Health, NNADAP*). Prevention services are not easily accessible by non-Kitigan Zibi Members who are staying at the shelter (status individuals from neighbouring First Nations communities).
- **Staff members provide referrals and work with other shelters in the area to meet the needs of clientele, which are beyond family violence** (e.g., *addictions, homelessness, second stage housing*)
- **Networking with other external organizations with a mandate to address violence against women helps to ensure “information sharing” and to maintain lines of communication among service providers.** (Round Table comprised of different services providers for Family Violence)
- **Work well with other front line workers from nearby First Nations communities to address family violence**

#### c.) Assisted Living

- **Kiweda Group Home** – Nine-bed Group Home for semi-autonomous individuals who cannot live on their own (including both younger people and also elderly who need assistance with daily living).
  - Access to all services in the community.
  - Good access to provincial services from the CLSC (e.g. Occupational Therapy and equipment, social worker, and some ‘clinical nursing services’ (i.e., wound care).
  - Pharmacy – communicating, delivery, and changes to medication works well. Pharmacist speaks English, and will go out of the way to communicate to clients. Documentation is provided in English.
  - Entering the Group Home – no major access issues identified: *“To enter the home takes about one week to conduct the assessment and determine if the individual meets the criteria to be eligible to enter the home. No delays to get into the home unless there is a lack of availability or space”*

- **Weekly Lunch for Seniors**– Once a week provides seniors (55+) a lunch. *“It’s their social outing and their time to get together in the community. It’s almost become an institution in the community.”*
- **Nicholas Stevens Centre** – Day program for multi-disabled community members (Adults) – Physical handicaps and mental health conditions/mental development. No major access issues identified.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of English language services for Addictions (Youth and Adults) – Clients need to travel great distances (2 to 4 hours) to obtain services (including assessments). Discouraging for clients when they are “shifted from one municipality to another ...”**
  - *“Clients are being referred to several different agencies in order to get an assessment done in English. The agencies are often time located in different municipalities, and require the client to travel anywhere from two to four hours.”*
  - *“Discouraging [for clients] when they are shifted from one municipality to another, and all the travel in between. Individual may not follow through with assessment or treatment plan.”*
- **Lack of English language services for sexual assault victims (in particular youth) and physical assault victims. Sexual Abuse victims – Interviews by police (mandatory under Youth Protection Act) are delayed because there is a “lack of English speaking officers trained and authorized to conduct the interviews”.**
  - *“There was a situation where the Report [for sexual abuse] came in, and we wouldn’t have an English-speaking officer who was authorized to do this kind of interview. Had to wait two weeks once for a video taped session to be arranged to have it all legally done. You are allowing the child to go home to potentially receive this abuse by a family member. There is a delay because of language.”*
  - *“Wait time at hospital to conduct physical assessment of the child to make certain that the staff can speak English.”*
  - *“It’s difficult to facilitate and ease parents to try to be relaxed and be calm during very sensitive situations when you don’t have workers [because of language] from the provincial system helping you.”*
- **Mental Health Services – Lack of resources at First Nations organizations. Long waiting list for mental health services generally, and in particular for English language services from Provincial Institutions. There are differences in how mental health problems are perceived by staff at First Nations and**

**Provincial organizations. Participants observed that: “Patients are not kept for the duration of the mental health evaluation at Provincial institutions”.**

- First Nations organizations are expected to provide CLSC equivalent services on Reserve funded by Indian Affairs, however First Nations do not have the same resources as the CLSC. Cannot readily and easily access Mental Health Services in Quebec due to language. Difficult to access services from other regions (distance and jurisdictional issues)
- **Lack of English-language training opportunities – i.e., for Mental Health**
  - *“Hospital offers training, but it is only offered in French. [First Nations organizations] receive English language training from out of province.”*
- **Bilingual First Nations staff members are “providing translation services”: Assisting with professional assessments, translating reports verbally for clients and coworkers. Participants noted that the translation work can be “time consuming” and requires “trust”. Translation services are possible depending on the “language proficiency of the staff.” Funding not provided.**
- **Lack of English-language documentation (information, reports and assessments)**
  - *“When reports and assessments are requested from the province (i.e., Mental Health evaluations), they are only provided to the First Nation organization in French. Organization responsible for translation of documents. Funding comes out of program dollars.”*
- **Participants noted at “lack of understanding at the front line CLSC level” about the Ministry’s regulations with regards to the availability and accessibility of front line public health information in English – “the individual seeking services is the one who gets hurt”**
  - With regards to English-language front line public health information at CLSCs on participant noted that: *“I was told at a meeting by the program manager at the CLSC that when the province comes in to evaluate their program, they have to hide all the English language pamphlets. They have to watch the English. They take away the pamphlets, and then put them back out.”*
- **Perceptions and Attitudes about First Nations People – facing discrimination from neighbouring non-Native communities (including the general public and service providers). Participants note that it is more difficult for First Nations’ who only speak English to “connect” with the town of Maniwaki.**
- **Provincial Laws impact access to social services –**
  - **Bill 10** – *“There is a lot of confusion and it is unclear how Law 10 will impact Youth Protection services being delivered in First Nations communities.”*

- *Law 21* – Limits English speaking Social Workers from being licensed professionals under the Social Services’ Association of Quebec. *Impact – Fewer professionals who can conduct assessments. It was noted that First Nations remain “dependent” on the CLSCs to perform assessments.*
- **Challenge to maintain relationships with provincial institutions and committees (such as Mental Health Table at the CLSC) due to the province’s “high staff turnover rate” and “restructuring” of their organizations.**
  - *“Always need to reeducate workers because there is a high turn over rate at provincial institutions. The restructuring at provincial agencies is confusing. Difficult for follow up. Don’t know if the intervention is working because there are new workers [at agencies where we refer our clients].”*
- **Jurisdictional Issues (Provincial boundaries) – Accessing social services (in particular Mental Health Services or for victims of sexual or physical assault) in other provinces (i.e., Ontario) can be difficult.**
  - Community members may prefer to access services from outside of the community for reasons of privacy and confidentiality. However, it is challenging to access services out of province due to jurisdictional issues.
- **Lack of information and updates from the province about health and social services protocols for Mental Health Services (i.e., Suicide Prevention).**
  - *“It’s like we’re aliens to them. ... It has to come from the CLSC to take initiative to say ‘we have a First Nation reserve close to us. We have to work better with them’. We always have to run after them [the CLSC].”*
- **Reintegrating Offenders into the Community – Obstacles accessing services due to lack of transportation**
  - Lack of parole and probation officers in the area generally, and in particular for English-language services. Clients are required to travel outside of the community on a weekly basis to visit with parole officer. Transportation is a major obstacle.

b.) Family Violence Prevention

- **Woman’s Shelter – Clients (battered women and their children) at Wasaya House who are from other English-speaking Algonquin communities cannot access services that are available in Kitigan Zibi (such as, Enhanced Prevention services, Clinics, Doctors, mental health services, addictions services, counseling).**
  - *“On Reserve band memberships are entitled to receive the services. In Kitigan Zibi, if you are not a band member, but you are in our community, you cannot access our services even if you are First Nations. That is the political stance of our leadership. We have limited resources to provide*

*services to our band memberships. That is an issue with Indian Affairs.”*

- **Lack of services for mental health crises/psychiatric services**
  - *“There is a gap in services for individuals who are experiencing mental health issues. Wasaya House cannot offer psycho/social services and assessments.”*
- **Lack of security available at the hospital for mental health patients**
- **Lack of Access to low income housing – difficult to access low income housing in neighboring non-Native community.**
  - *“As First Nations, there are barriers accessing low-income housing in local community. You need to be a resident of Maniwaki for one year before you qualify for low-income housing.”*
  - *“Clients become discouraged and give up ... They often go back to their home communities and the cycle continues.”*
- **Negative perceptions about First Nations People presenting obstacles for individuals who are seeking low income housing**
  - *“Reality is landlords are not quick to rent their apartments to First Nations Indian People. There is a stigma. Overcrowding, too much drinking, lower standard of living. Not quick to readily house clients of ours who are trying to find apartments and are trying to start over.”*

c.) Assisted Living

- **Difficulties due to language to obtain professional assessments for Elderly people who may be showing signs of Dementia or Alzheimer’s. Long wait for an English Speaking social worker. First Nations staff providing translation services due to language barriers, which requires high degree of “trust” on the client’s part. Assessment reports are prepared in French, funding is not provided for translation.**
  - *“Clients are very trusting. If I wasn’t there, there would be serious trust issues. The client would be hesitant to be evaluated. Clients have asked me “What is she saying?” Why is she here?” The client had not idea why [social worker conducting evaluation] was there.”*
- **Communication barriers when escorting clients to hospitals due to language barriers – “There are challenges with how well the escort can relay information to the client. If they don’t speak French, then there will be communication breakdown.”**
- **Lack of bilingual staff at the local CLSCs Home Care Services. First Nations providing translation services – “time consuming”**
  - *“When you access services from the local CLSC Home Care Services, they all speak French. Some of the nurses servicing the clients will be able to*

*get by in English. But, when it comes to details and providing information they have difficulty to do so. [First Nations' workers] will step in and do the translation, so that is a barrier. It takes away from other work that I could be doing because I have to work as a translator. Time consuming."*

- **Challenges because of language when accessing services from the pharmacy – pharmacists are usually bilingual, less likely that the technicians will be able to speak English – delays for the clients and First Nations' staff need to verify information.**

- *"Bilingual pharmacist is not always available, and the technicians don't always speak English. When they call the Group Home and give information to my workers, who primarily speak English. I will need to call back to verify or obtain information."*
- *"The pharmacy will sometimes send information about a client's medication in French. Workers cannot read the dosages, so we need to call back and request instructions in English."*

- **Jurisdictional Issues – The Long Term Care Facility is federally funded; however, regulations for Medicare System (clinical services) are provincially regulated. First Nations are caught "in between" jurisdictions. It was noted that: "Nurses are practicing illegally (under Law 90, which outlines responsibilities that a nurse can undertake) to provide the care that the clients need with the threat that they may have their licenses revoked".**

- *"We are not a certified group home under the province. We are a federally funded group home under INAC. The federal government has no authority to regulate health services. ... that's the province's responsibility. When we go to the province ... they say 'you are not a certified home under the province, therefore, you are not our responsibility to clinically supervise, under Law 90 ... The Nurses Order of Quebec (OIIQ) [L'Ordre des infirmières et infirmiers du Québec] states that any nurse offering nursing services at non-certified group home is going against her license. Nurse is not allowed to do that [provide clinical services] in non-certified home. We have a group of people who need clinical nursing services and supervision. Their life depends on it. Nurses are practicing illegally to provide the care that [their clients] need with the threat that if they are reported to Nurses Order they may have their licenses revoked. They are not following Nurses Order. That is a jurisdiction issue. Federal government provides money, yet the Provincial Medicare System does not provide clinical supervision that we need."*

- **Long wait time to enter 'long term care' facility in the area for individuals requiring higher level care.**

- **Discharge from hospital is problematic – First Nations organizations are not always notified when clients are discharged from hospitals.**
- **Non Insured Health Benefits (NIHB) – Not all medical equipment is covered by the NIHB program.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Collaborative Team Work and Case Management approach among staff from Health and First Line Services (First Nations). Staff work together to plan and to deliver various prevention activities and programs (for health and prevention first line (social) services).**
  - Staff developing long term Action Plan for all youth activities offered to avoid duplication of services/activities available to the youth. Working in collaboration with internal resource providers as well as with external not for profit organizations (namely, *Avenir d'enfants and Quebec en forme*).
- **Prevention Services – First Line Services. Staff delivers various prevention activities, workshops, and individual support to community members. Staff will receive referrals from Centre Jeunesse for prevention services for children/youth. Determined which activities to offer based on focus groups held with community members. Examples of activities include:**
  - Men's Support Groups – 'King of the Grill' – annual event for men to get together and socialize. Opens the door to build a trust relationship. Emphasis placed on maintaining client confidentiality.
  - One-on-One session with individuals
  - Empowerment Groups for boys and girls, work in collaboration with staff
  - Music sessions (planning/implementation stage)
  - Traditional Drumming (proposal stage) for the youth
  - Family Kitchen – Families have use of kitchen facilities
- **Protection Services – Youth Protection (Centre Jeunesse)**
  - Some individual counseling services are available from social workers at Centre Jeunesse.
- **Health Programs – Prevention (i.e., *Brighter Futures/Addictions/Maternal Child Health*)** [\*funded under Health Canada]
  - Staff plan and deliver preventative health programs and activities (Prenatal classes, parent support groups), work in collaboration with First Line services to provide parenting classes and sessions, FAS Prevention, Child Safety Workshops, Youth in the Kitchen activities, Sports and Recreation activities (with youth) – game night, movies, sports etc.
- **Community Cultural Events – Staff work together to plan and implement large events for community members in all the seasons.** For example, *Winter Carnival; Aboriginal Day* (Entertainment, Gathering food/medicines, and Teachings – for Elders, parents, youth); *Cultural Week* – In the fall, community members go into the bush for a community hunt, there are also teachings, beadwork, and 'preventative' work. Community feast.

- [Cultural Week] – *“Participation is awesome. The younger people want to learn how to hunt, fish. There are teachings, and cooking – such as bannock. ... Gives people the opportunity to have dialogue about social issues. It’s a good gathering that receives a lot of praise. It’s working because the ideas come from the staff and also grassroots people.”*
- **Mental Health – Prevention activities and some counseling are available in the community. English-speaking psychologist is in the community one day per month.**
  - Staff plan and deliver programs in the community such as: Anger Management Workshops, Cultural activities (teachings), Cancer Walk, Self Help Meetings, One-on-One with clients, Referrals to mental health services providers, detoxification and treatment centers.
  - Psychologist – comes into the community one day per month from out of province (Ontario). Non-band members have difficulty accessing services from psychologist (not covered).
- **Addictions – Staff make referrals for clients to enter treatment centres located in Quebec (in Kitigan Zibi) and also out of province (in Ontario).**
  - Waiting lists to enter treatment centres
  - Application (Assessment) – Participants noted that the application process in Quebec (paper forms) is much more difficult to complete in comparison to the application process in Ontario (which is computerized). Further, staff noted that: *“The assessments are difficult to fill out because the forms are in French and English.”*
- **Access to various prevention projects that are proposal driven – Youth Suicide Prevention (Health Canada); Family Violence (AANDC).**

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Lack of information and notification from the province about changes to legislation pertaining to social services (information gaps)** (i.e., Bill 10: Restructuring of provincial health care services). Unclear what the impact of the provincial restructuring will be on the community.
- **Geographical location – The community is considered to be a ‘semi isolated community’, which means that service delivery is more costly (transportation, food). Community members/staff need to travel to prepare for and implement any community activity or event.**
- **Culture and Language – Even though considered an ‘English speaking First Nation’, the language is different. With First Nations communities, there are different sayings and expressions rooted in the Algonquin culture and language. There can be a lack of communication between community members and person from the outside.**
  - *“If someone is strongly rooted to the community, and has that dialect embedded in him or her that person will communicate – there may be a lack of communication between that person and whoever is from the outside.”*
- **Mental Health Services – Lack of English-language services (i.e., psychologists) for mental health in the area.**
  - Distance is a barrier to access services. Need to go out of province (three hours away) to access specialized services in English for mental health.
  - Individuals (mainly Elders) who speak Algonquin face additional barriers – require an escort/translator, and funding is not always provided.
  - Jurisdictional Issues – services may not be provided to Quebec residents
  - Long waiting lists
- **Detoxification Services – Lack of English-language services for detoxification in the area generally, and specifically in English. Need to send clients ‘out of province’ to receive English-language detoxification services.**
  - Participants reported that: *“You send them [for detoxification] to the hospital and they send them back a few hours later.”*

b.) Enhanced Prevention Focus (Prevention and Protection Services)

• **Prevention Services – First Line services**

- Participation can be challenging. Some services (such as Anger Management) that are delivered in collaboration with Centre Jeunesse. Resource person from out of province. Provided incentives, however felt that “people come for the door prize, not the service”.
- Challenges – People seek help in times of ‘crisis’. Difficult to provide prevention services when they are no long ‘in crisis’. Participants noted that program delivery is challenging due to the “stigma” associated with seeking help to address issues such as anger management.
- How activities are perceived is important in particular in a small community: *“They renamed the Anger Management workshop, they had a few more participants. ...”* Others stated: *“People have pride or even shame. If you want to pass on a message you need to do it in a subtle way. You need to have an activity, and then send out your message in a subtle way to get your point across.”*

• **Protection Services – Youth Protection (Centre Jeunesse)**

- Lack of notification – Community is not notified about situations involving their youth. Participants felt that the lack of notification could be for “confidentiality reasons”. (Participants noted that the lack of notification is unlike the situation in Ontario where bands notified when there is a court date or apprehension). *“It wouldn’t take much for parents and children to be wrongfully separated if the communication is not there.”*
- Centre Jeunesse deals directly with Aboriginal Affairs – Funding is provided to CJ to administer various social services (\*including First Line and also Assisted Living services).
- Participants report that generally speaking, there is a lack of cultural sensitivity and training about First Nations history and social issues among provincial workers (including nurses and social workers from the ‘outside’ who work in First Nations communities). One participant commented about the need for social workers to have a better understanding of the social issues for Aboriginal People, including the impact of residential schooling, and colonialism. *“At a meeting [with the province], I asked do [social] workers that come to our community receive training specifically regarding First Nations – history, residential school, oppression? That is what they are dealing with. A lot of the social problems stem from that – the remnants of residential schooling and oppression. They do receive training, but not sure how specific the training is. ...”*
- **Signalement/Reports [potential endangerment of children]** – Language barriers when individuals call the Agency to make a report (signalement). One participant stated that: *“Need to fix the 1 800 number. People don’t speak English on the phone. If we can’t get through, the person doing the reporting might hang up. That is risky for the child who may be in*

*danger.”*

- English speaking social workers from the Agency work in the community two days per week. The staff (First Nations agencies) doesn't work too closely with CJ. Participant noted that: “there is a need to establish a Protocol Agreement between Long Point and Centre Jeunesse for the Youth Protection.”
- **Family Type Resources – Foster Care**
  - Lack of information services in English about foster care (workshop sessions are all in French).
  - Lack of English language training opportunities for foster parents (First Aid, CPR, available in French only)
  - Limited number of ‘recognized’ foster homes in the community (only three homes are recognized). Yet, many family members take in their kin (nieces, nephews, grandchildren).
- **Income Assistance** – High school students 18 years of age do not qualify for IA; Home Care workers receive less than minimum from Centre Jeunesse, and are not on Payroll. Quebec's IA policy is available in French only. [Submitted in writing as part of Inventory of Social Services]

i.) SOCIAL SERVICES – EASILY ACCESSIBLE

a) General

- **Addictions** – Clients have access to support services through NNADAP, and they are referred to provincial institutions for detoxification or treatment centers. Bridging services (when clients transfer from First Nations to provincial institutions) is critical to ensure that clients can transition with the least amount of disruption as possible.
- **Mental Health** – Psychologists (Health Canada) work in the community on a contractual part time basis (weekly or monthly). Some challenges in the past with mental health services when the professional did not speak English well enough for clients to engage readily in conversation. Challenges because of travel if services are required beyond the weekly/monthly scheduling for which funding is currently available. Establishing long-term relationship with mental health professionals is important to establishing culturally safe spaces. Important that services are offered by both male and female psychologists to mitigate any issues because of gender.
- **Hospital Liaison Worker at provincial institution is helping to reduce barriers that First Nations clients face because of language and lack of cultural awareness/sensitivity. Challenge because the Liaison Worker is available on a part-time basis only.**
  - *“Hospital liaison worker at the hospital has helped to reduce perceptions of discrimination. Advocates for clients seeking assistance from the hospital, which is needed for clients who may be under the influence. Liaison only there part time basis, which is a problem. Fluently bilingual. Advocate, cultural sensitivity, and language translation (French/English).”*
  - *“Liaison noticing issues (such as discrimination) at the hospital, and members then went in to hospital and conducted drumming sessions – open forum with staff and residents.”*
- **Community provided cultural awareness training at provincial healthcare institutions (e.g. delivered to staff at local hospital). Frustration because the training is now offered on request basis only, funding is not available to provide the program on a regular basis.**
  - *“We have done our part to sensitize hospital staff. We created a program with the Tribal Council and the University of Quebec to give provincial workers in Quebec a better idea of who we are, from a First Nations, Indigenous perspective and point of view. Training is now provided at the*

*request of the hospital or other institutions. Program is there, but it doesn't have funding anymore.”*

b.) Enhanced Prevention Focus (Prevention Services)

- Prevention services are available in the community. Clients have access to family support worker, social workers. Collaborative approach amongst staff members from health and first line prevention services. Culturally sensitive approach is important to reduce social barriers (e.g. stigmas about addictions, mental health; fears of youth protection), which prevent people from accessing services. Continuum of care amongst community services providers.
  - *“How topics are presented is important. You target a specific area (for example, depression, culture). But we have gotten used to the word, ‘cultural wellness’, for example. Rather than talk about specific issues, we talk about wellness in the general and then we can narrow the focus – mental wellness, physical wellness, spiritual wellness from a cultural standpoint.”*
  - *“We have made a conscious effort to get away from stigmatizing people. You don’t necessarily have to have a drug and alcohol problem to go and visit. When talking about health related issues, health and social services, we tend to think of people who are unhealthy – mental, physical, spiritual and emotional. But if we get away from the negative part, that is the direction we need to head in. We know what the issues are, as staff. By telling people they are sick will not necessarily make them better. You need to give them solutions.”*
  - *“Good continuum of care amongst community service providers. Everyone is aware, from the street level, what the hurdles are. We are fortunate to have community members working on the team, and they are aware of the daily stuff. It’s that street level voice, they are aware of the roadblocks, hurdles. The team meets regularly.”*
- **Wellness Lodge – Build a place in the community that can offer a range of services, both western and Indigenous. Strengthen ‘kin relations’ and work towards wellness where ‘we look at everything as a whole’.**
  - *“We need a place in the community to conduct ceremonies and cultural activities. We need a place to be able to run a lodge and offer programs and services in a ‘holistic’ way. We would like to take a holistic approach to wellness – physical, emotional, spiritual. Look at the person as a whole, look at the family as a whole, the community as a whole – not just segments. We look at everything as a whole. As First Nations this is how we have done things for thousands and thousands of years, we look at things as a circle, as a whole. We want to build strong relationships, what they call ‘kin relationships’. Going beyond mother, father, brother and sister. Include grandparents, aunts, uncles, and cousins.”*

c.) Family Violence Prevention

- **Family violence** – Clients have access to programs and services offered in the community (social workers, assistance with finances).

d.) Reinvestment Strategy – Combating Poverty

- **Children and Youth – Programs and services target youth and children in the community to combat poverty (school lunch program, summer day camps, subsidies for childcare, cultural programming, and summer student employment opportunities).**
  - *“We concentrate on children and youth in the community when it comes to reinvestment. We run a lunch program in the schools. Funding to help with cultural programming. Funding for summer students going on to post-secondary education. Run a summer camp for the kids (away from community, no cell service, well structured, full of activities) help out the daycare, help parents who need daycare but cannot afford.”*
- **Collective kitchen – Activity geared for seniors to get together on a monthly basis and prepare a healthy meal, within a budget. Contributes to social inclusion for elderly.**
  - *“The collective kitchen is well attended by seniors. Program is run on a monthly basis. Choose the menu, get together and prepare together and cook together. The meal is then shared and everyone takes home their supper. Helps with social inclusion, and gets the seniors out and socializing with everyone. People really like it, and we get a chance to talk about nutrition, healthy eating, and everything is done on a budget. The meals we prepare are geared to their income.”*
- **Transition into work – Small amount of funding is available to individuals who are ‘transitioning back to work’ (e.g., to purchase items that may be necessary for work)**

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Generally speaking, there is a lack of funding to run ‘social services’ programming. Perception that staff at First Nations organizations may be ‘underpaid’**
  - *“Funding is provided for staff, office equipment, and computers to deliver services. The amount remaining is insufficient to run a program. This is a task that we face every day.”*
  - *“To run the program, we need to underpay individuals.”*
  
- **Challenges accessing training (e.g., disclosures of sexual abuse) because of language and costs can be prohibitive. Difficult for smaller communities located in remote areas to obtain training.**
  
- **Long wait times to conduct psychosocial assessments because of language**
  - *“Mental health, ADHD, requests for pediatrician. Wait list is really long in the provincial system. Some assessments for mental health. Clients are encouraged to stay in Quebec.”*
  - *“For one of our youth, the teacher wanted an assessment for ADHD. He has been removed from school until he has his assessment. We’re looking at two months that he is out of school. The reality of the wait. He is receiving two hours of tutorship, and the rest of the time he is hanging out with his parents who are also trying to work. Stress on the family, which then creates other social problems.”*
  
- **Funding is not provided for translation services**
  - *“If community needs a translator, this is paid for out of program dollars (no funding provided for translator or translations).”*

## URBAN AREA

### Native Women's Shelter of Montreal

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) General Services

- **Emergency Shelter** – The shelter provides emergency housing for Aboriginal, Inuit and Metis women in difficulty (10 to 12 weeks) – lodging and meals
- **Outreach Services** – Staff network with provincial institutions (*referrals, liaison, information sharing etc.*), including: CLSC, RAMQ, Centre Jeunesse (Batshaw/Youth Protection)) Clinics/Doctors, and Social Assistance. Better access to provincial institutions because of the networking.
- **Support Programs are readily accessible in the language and culturally based**
  - All clientele (while at the shelter and as part of outreach) have access to various support programs and services, including: Support from Elders; Art Therapist; One-on-One Therapy (3x week); Family Care Program; Link expectant women to prenatal services; Assist clients mandated to be at shelter and whose children are in Youth Protection (or at risk); Holistic Health Program; Housing – assist women with ‘second stage’ housing; Social Assistance – assist women with Social Assistance applications and/or Employability programs; Addictions Program – Refer clientele to treatment programs and provide follow up/after care treatment at the Shelter.
- **Cultural Sensitivity Training/Orientation** – Staff from the shelter provide ongoing training and orientation to staff from provincial organizations.
  - *“Opportunity to share cultural backgrounds and protocols. The dos and don’ts when working with Aboriginal clientele.”*
  - *“[The external organizations] recognize that they need more cultural awareness and training. They are willing to have us come in and provide training.”*
- **Social Assistance (Assistance with)** – Staff help clientele apply for Social Assistance (obtain documentation; ensure tax forms are completed; and fill out forms for social assistance). No barriers because of language, however, the process is lengthy.
- **Housing (Assistance with)** – Assist women to find affordable housing. Staff at shelter work with various organizations (Aboriginal and non Aboriginal), which provide low-income housing in the urban area.

- *“We have built a good relationship with an Aboriginal organization that provides low-income housing. They are flexible and willing to work with clientele. However, there is a lack of apartments available.”*

#### b.) Enhanced Prevention Focus (Protection Services)

- **Agreement with Centre Jeunesse** – Shelter has signed a Collaboration Agreement with Centre Jeunesse/Batshaw Youth and Family Centre (serves English clientele and committed to providing better services for Aboriginal families).
  - Aboriginal Team at Batshaw is responsible for the Application of Measures (Follow Up).
  - Good experiences working with the Aboriginal Team at Batshaw (Youth Protection).
  - Information Sharing – Good relationship with Protection Services. Organizations share information, while still maintaining client confidentiality.
- **Liaison Services (Youth Protection):** Staff assist clientele mandated to be at shelter by Youth Protection and/or assist clients whose children have been placed in foster care.

#### c.) Health and Social Services

- **Holistic Health and Outreach** – RAMQ provides an attestation card so that clientele can receive medical services. Doctor is available at the centre on a monthly basis. Workshops, education and awareness (sexual health, fitness, diabetes, eating well). Support for women in sex work (workshops from external resources); programs in the prisons (sexual health workshops); network with Aboriginal Aids Network; nurse provides sexual health screening (from CLSC). Traditional Healer – one-on-one sessions, Sweat Lodges; Healing Circles; Drumming and Ceremonies.
  - *“Delivery of health services with the understanding that by bringing services to the clientele in a less judgmental and efficient manner is very effective. Have the services fit the person, rather than the person fit the services.”*
- **Mental Health Services** – Clientele have access to counseling (Aboriginal and mainstream counseling) while at the Shelter and as part of Outreach program.
  - **Challenge** – Funding for counseling is now only available from Health Canada for ‘emergency services’. Funding not available for specialized services such as Art Therapy, which the staff at the shelter found valuable when working with children who had experienced trauma. To qualify for funding from Health Canada the counselor must be on the province’s Professional Order list.
  - Clientele are not going to provincial institutions for health and social services – language obstacles, racism, and long wait times.

*“If we accompany someone [to the provincial institution], the experience is vastly different than if the [client] goes alone.”*

- **Addictions Services** – Workshops (in-house and with partner organization). Mainly refer clients to treatment services from Aboriginal treatment centers (English language services and cultural component is part of treatment) and from provincial treatment centers that offer services in English.
  - **Challenges:** Provincial treatment centers – Long wait times and lack of Aboriginal component in the programming. Not all programs are available in English, even if organization states that they offer “bilingual” programming. Some programming might be “too formal”, which bring back memories of residential school for some clientele.
  - Out patient programs – Not easily accessible (distance is an issue).

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

- **Difficulties because of language when navigating the youth protection system (‘French Youth Protection’ [services outside of Batshaw]).**
  - Inuit clients have said there is a language barrier. If you don’t have comprehension of what is going on it is difficult. Requests from clients to be transferred to English section, ‘Go unheard, it’s difficult.’ Difficult to get hold of workers in Youth Protection (French System).
  - **Lack of Translation Services, and those that are provided by the province are ‘poor quality’.** Funding is not provided for translation. *“We requested a translator at a meeting from French to English, didn’t even ask of Inuktitut. The translator did not speak English. They brought in a colleague who spoke English, but it wasn’t good enough to translate. Because I speak both languages, I was able to see that they weren’t translating the important parts of the message.”*
  - **Documentation** – Court Documents are provided in French if client is in the ‘French social services’ system, and documents are provided in English, if within the English system (*ie. through Batshaw*). However, even in English system, some clients receive court documents that are a mix of English and French. Staff need to translate documents for clients.
  - **Indigenous Languages** – Unable to provide services in the language for Cree and Inuit woman for whom English may be second language. There is one Inuktitut translator in all of Montreal. Limited services for Aboriginal Peoples whose first language is their own Indigenous language.
- **Youth Protection – Aboriginal clientele face ‘Judgment and Discrimination’ from the workers at Youth Protection, in particular in the ‘Investigation Unit’. Lack of workers with an understanding of Aboriginal social issues. Lack of Aboriginal Foster Families.**

- *“Work less well with Investigation unit of Youth Protection. Although committed to do better, work force is new, young and there is a lot of turn over ...People who work in Investigation Unit [of social services] are young, privileged, often girls, straight out of school, and White. That is the lens they are investigating through. Because that is the most stressful part of YP system, they don’t stay in that position long enough to get a deeper understanding.”*
  - *“In general, the people we have worked with are somewhat ignorant of the history and special considerations that an Aboriginal client might need, they [Youth Protection workers] don’t understand that there is an overrepresentation of Aboriginal children in care, they don’t have an understanding of the history of colonialism or complex trauma.”*
  - *“There is a lack of recognition that a client is even Aboriginal. If the partner, or father is non-Native or speaks French.”*
  - *“Not a lot of Aboriginal workers or people who are part of the [Aboriginal] community working in Social Services. .... Not a lot of understanding of poverty or different parenting styles.”*
- **Housing – Staff at shelter assist women to find ‘second stage’ low cost housing. Difficult to find suitable housing that is safe, mold free, and in good repair. Language barriers when searching for housing. Aboriginal clientele face additional barriers because of discrimination (stereotyping).**
    - Long waiting lists for low cost housing
    - Lengthy process to fill out application (forms and documents required)
    - Difficult to find apartments – clients need assistance searching for apartments that are safe
    - Language – barrier to search and find apartments is difficult
    - Barriers for women who have children
    - Aboriginal women face obstacles finding low-income housing due to stereotyping (landlords saying – ‘apartment is no longer available.’)
  - **Funding – General difficulties because of the ‘structure of the funding’.**
    - **Structure of funding is problematic:** Need to reapply for funding on a yearly basis. Takes a few months to put funding proposals together. Amount of stats required to report on in a regular basis takes away from ability to provide services; a lot of time spent on applying/reporting on funding. Although there needs to be accountability, the funding cycles are too short. Also, funding is “too dependent on political situation”, which makes it difficult to provide services that are needed.

**APPENDIX 6: List of Social Services available in English-Speaking First Nations Communities in Quebec**

A total of eight (8) out of eleven (11) communities completed the Inventory of Social Services (of which six (6) were completed 'in full' and two (2) were completed in part (those completed in part are marked with an (\*\*)). Any challenges identified in the written survey (from Long Point, Gesgapeagiag, Kahnawake, and Kanasatake) are included in the 'Findings' (Section 5.0) of report.

Community	1.) Enhanced Prevention Focus	2.) Assisted Living	3.) Family Violence Prevention	4.) Social Assistance	5.) National Native Aboriginal Drug Addictions Program	6.) Other Areas
<p><b>I. Eagle Village /Kipawa</b></p>	<p><i>One-on-one support</i> (children and families) <i>Advocacy for band members</i> (facilitation of meetings between members and 3<sup>rd</sup> parties; assistance with documentation; supervised visit between parent and child; acts as a corridor for services between clients and organizations. <i>Promotion of Healthy Living</i> (newsletter articles, pamphlets, advertisements, workshops, activities, outings) <i>Training Opportunities</i> (Stress Reduction; Suicide Intervention; Safe Talk; Wellness workshops with Parents; Charlie 1 and 2 training)</p>	<p>**Currently offered through Centre Jeunesse.</p>	<p><i>One on one support</i> (children, adults &amp; families) <i>Family Movie Night</i> (Support services on site.) <i>Drumfit</i> (large motor movements for youth and families to help distress &amp; work out (First line workers on site) <i>Parents of Active Little Souls</i> (Parents and children (0-8 y.o). Safe, stimulating environment to engage discussion and support service building.)</p>	<p>**Social Assistance Department.</p>	<p><i>Client referrals</i> (treatment centers, detox services and wellness centers) <i>Follow up and aftercare Prevention Services</i> (Information sessions, workshops, "dry" activities, dissemination of resource materials) <i>Culturally based activities</i> <i>Collaboration</i> with other programs and services</p>	<p><i>Food Bank</i> (distribute food; day to day operations; corridor to other services/departments (in and out of community) <i>School Breakfast Program</i> (Healthy breakfast options; Nutritious meals) <i>Community Kitchen</i> (regular workshops to assist with food security; healthier food choices; eating habits; support low income families) <i>Community Garden</i> (fresh produce; increase knowledge on whole foods and offer variety of healthy options; promote growth and development of the community; allow community members to gain knowledge of gardening.)</p>

<p><b>2. Gesegngpegiag</b></p>	<p><b>Prevention</b>  <i>Training</i> (For the sake of the Children)  <i>Safe Talk Presentations</i> (Child abuse, family violence, addictions)  <i>Individual Therapy with psychologist</i> (on and off reserve)  <i>Wellness Workshops</i> in collaboration with Day Care, Health, Police for 'red flag' cases for early intervention  <i>Cultural Activities</i> (youth)  <b>Protection</b>  <i>Evaluation and orientation</i> of protection cases  <i>Follow Up</i> of protection cases (voluntary measures and court orders)</p>	<p>Assisted Living services are provided.  (*Information about which services are provided was not available at the time that inventory was completed.)</p>	<p>Family Support Centre recently opened to assist struggling families.</p>	<p>Social Assistance is managed by the Band Council.  (*Information about which services are provided was not available at the time that inventory was completed.)</p>	<p><i>Prevention and Promotion</i> Activities  <i>One on One counseling</i>  <i>Referrals</i> to Detoxification and <i>Rehabilitation</i>  Weekly AA meetings  <i>24/7 Crisis Hope Line</i> (Telephone and Texting)</p>	<p>No information provided</p>
<p><b>3. Kahnewake</b></p>	<p><b>Prevention</b>  *The only Program specifically funded by the Enhanced Prevention Fund is the "Where the Creek Runs Clearer Group". Services that fall under social, yet not funded by the EFP, and are listed in #6 of this chart  <i>Where the Creek Runs Clearer</i> (Life skills, and prevention programming, based on traditional cultural teachings)  <b>Protection</b>  <i>Intake Services;</i>  <i>Youth Protection Services through delegated authorities;</i>  <i>Youth Criminal Justice Services</i> through delegated authorities in partnership with the Quebec Justice system, conduct all necessary functions to support the Quebec Youth</p>	<p><i>Individual counselling and support for community members</i> living with diagnosed mental health / special needs issues  <i>Family Support and respite</i> for family members caring for individuals who are living with a variety of special needs.  <i>The Independent Living Center</i> (12-unit mental health residence that provides 24/7 security and support through a multi-disciplinary team that includes a case worker, mental health nurse, addictions worker,</p>	<p><i>Violence Prevention month</i> (July) aimed at educating the community about the effects of violence and raising awareness (activities include Movies in the Park to promote health family activities and create a venue to get the information out, print, radio and television ads; guest speakers open to the community, etc.)  <i>In-School Prevention</i> education and awareness on violence, bullying and addictions  <i>Safe Grad</i> – Promoting the healthy and safe celebration of graduating secondary school through awareness and education</p>	<p>Provided by the community of Kahnewake through the Mohawk Council of Kahnewake – Social Development and Social Assistance Unit.</p>	<p>Addictions Response Services team provides direct support to community members on an "Intensive Outpatient" model, within a continuum of care: addictions screening; in-depth addictions assessments; individual counselling; family interventions; couple and family counselling; referral to inpatient treatment short or long term; referral to withdrawal management centers; internal referral to other KSCS services; In partnership with Corrections Canada, support the re-integration and release of community members in the justice system</p>	<p><b>[NIHBI] Psychological Services Administrative and Clinical Supervision</b>  Psychological Services are integrated with all of our services (Develop and deliver appropriate psychological services by creating service plans; referrals to appropriate resources; Coordinates and monitors all off-reserve psychological and psychiatric referrals; Conducts and coordinates with contracted service)  <i>Note:</i> Kahnewake noted that many 'prevention</p>

	<p>Criminal Justice Act, such as conducting assessments for extra-judicial sanctions and probation follow-up. Funding for the Youth Criminal Justice Services is administered through the Province of Quebec.</p> <p><i>Tsi Loneka 'iamonhha "Foster Care" Program</i> (Case Aide Program; After Hours Response Services "On-call";</p> <p><b>External to KSCS and external to Kahnawake:</b></p> <p>Provincial level; formal contract pertaining to the rendering of professional services that exists between KSCS and Centre de Jeunesse de la Montérégie, which includes the 32 and 33 delegates appointed to perform exclusive duties under the Youth Protection Act and the Youth Criminal Justice Act. Objective is to attain own authority to deliver youth protection services within our community. Other provincial/regional services/resources that the Support Services team works with include: Montérégie and Montréal hospitals, schools and agencies; court system; Ministère de la Santé et des Services Sociaux; police; group homes; Régie de Rente; FNHIB; First Nations Treatment Network/Foster Pavillion; FNQLHSSC; Assurance de Maladie du Québec; AANDC Regional Office.</p>	<p>physician, psychiatrist, life skills support worker and extended family</p> <p><i>Young Adults Program</i></p> <p><i>Teen Social Club</i></p> <p><i>Facilitate access to specialized services</i> (i.e. occupational therapy)</p>	<p><i>Spirit of Wellness Month</i> (November) – aimed at promoting wellness through education and community-wide activities</p> <p><i>Memorial March Against Missing and Murdered Indigenous Women</i></p> <p><i>Leadership Program</i> (for young men based out of Kahnawake Survival School)</p> <p><i>Support groups</i> (Self-esteem and grief groups)</p> <p><i>Staff trainings</i> (Trauma Training, Conflict Resolution training)</p>	<p>Managed by the Mohawk Council of Kahnawake.</p>	<p>NNADAP activities are combined with those offered at the Mental Health Department.</p> <p>Activities include: Cultural and Spiritual workshops; visits and support to community members on an</p>	<p>based' services, programs and activities are provided for to community members with funding from Health Canada.</p>
<p><b>4. Kanesatake</b></p>	<p><b>Prevention</b></p> <p><i>First Line Services</i> are integrated and/or complement existing programs and services (health services).</p> <p><i>Recognize and support for parents</i> (including fathers), for extended family and the</p>	<p><i>Non-medical social support</i> provided to those who qualify including (not limited to): light meal preparation, housekeeping, assistance with errands,</p>	<p>Health Centre does not manage the Family Violence Program. However, there are services are provided at Health Center including, not limited to: Mental Health, Counseling, referrals to</p>	<p>Managed by the Mohawk Council of Kahnawake.</p>	<p>NNADAP activities are combined with those offered at the Mental Health Department.</p> <p>Activities include: Cultural and Spiritual workshops; visits and support to community members on an</p>	<p><i>Community Garden</i> (Summer Months)</p> <p><i>Healing Lodge</i> (Holistic approach, traditional and cultural activities/training)</p>

	<p>community in raising children. Reduce the need to remove children.</p> <p>Activities include:          Gatherings (Cultural, Awareness and prevention); Events (Family Day, Mothers/Fathers Day); Physical Activities; Workshops (Skills and Knowledge); Referral/Liaise/Accompany individuals (as required); Community Action (i.e., Community planning of activities); Support local community organizations providing services to children, youth and families; Encourage and mobilize parents to volunteer for various community, social, educational and sporting activities; Youth Center Activities</p> <p><b>Protection</b>  <i>Advocacy and support</i> are provided to parents with children in Youth Protection. <i>Provide information</i> to families to protect their child from harm and abuse. <i>Referrals to CLSC or Centre Jeunesse</i> for involvement of social worker; Occupational Therapist or psycho-educators for intensive parenting interventions. <i>Training</i> offered to families, individuals, and workers.  <i>Programming</i> for Children, Youth and Parenting</p>	<p>transportation to access other resources.  <i>Limited Respite Care</i> (arrangements can be made for a client to spend day at local elders' home (fees for this service are covered by client and Kanasatake Social Services).  <i>Access to medical equipment</i> (medical equipment loaned out to client; electric beds, with or without side rails; wheelchairs, walkers, crutches and canes, and variety of adaptive devices for bathroom.  <i>Translation Services</i> (English, French, Mohawk)</p>	<p>Shelters, psycho social services, legal aid, Anger Management <i>Services offered, but no funds.</i>          Health Centre nurses are aware of the potential for family violence, including Elder Abuse.          Nurses are alert to signs of Elder Abuse, and include this in the ongoing assessment of HCC clients. If Elder abuse is identified, it is dealt with on a case by case basis, with involvement of appropriate resources (ie. Social Services).</p>	<p>Receive Client request          Assessment of financial situation          Issue monthly allowance          Reporting</p>	<p>ongoing (continuous) basis:          Counselling (one on one); Referrals to detoxification.          Follow up in After Care.          Activities/Events in community (i.e., National Addictions week event).          NNADAP Worker.          Outreach services</p>	<p>"works well and is welcomed by participants".  <i>Site/ide Prevention. Physical Initiative. Pihwaden</i> (Reinvestment Strategy) to assist individuals to find employment (short term).  <i>A.A. Meetings</i></p>
<b>5. Kitigan Zibi</b>	<p>Life Skills coach          Youth Prevention worker          Youth Diversion worker          Mental Heal &amp; Social Worker          Community Promotion/ prevention activities          Counseling          Support Group</p>	<p>Activities that promote individual living          Social teachings          Prevention teachings          Social outings          Support to employees/ Workshops &amp; training</p>	<p>Counseling          Community events promoting the impact of violence          Referrals          Networking with outside resources          Workshops/ Teachings          Public Awareness</p>	<p>Prevention; Intervention          After Care; Awareness Activities for all age groups; Home visits; Referrals          Cultural Activities; Post Treatment          Counseling; Pre treatment Support          Family Support</p>	<p>No information provided</p>	

<b>6. Listuguj*</b>	No information provided	No information provided	No information provided	Enhanced Service Delivery Special Needs Return to Work Supplement Employability Project Employment Assistance Allowance	<i>Prevention and promotion activities</i> are ongoing and tied in with the community health plan. Referrals to external services are supported by the councilor; one/one counselling available for both child/parent Works closely with Front line prevention team. Close relationship activity planning with the Maternal Child Health support worker. Safe graduation activities.	No information provided
<b>7. Long Point*</b>	No information provided	No information provided	No information provided	Social Assistance available.	No information provided	No information provided
<b>8. Native Women's Shelter of Montreal</b>	Shelter, food and clothing Assistance to obtaining financial aid and low-cost housing; Accompaniment to appointments and advocacy; Referrals to legal, medical, educational, drug and rehabilitation; Therapeutic individual and group sessions to address sexual abuse, violence and addictions; Parenting skills; Individual psychotherapy; One-on-one or family sessions with Elders; Opportunities to participate in ceremonies; Outreach program; Community support program; Holistic Health program; Cabot Square project.	Outreach services to help elderly clientele with their needs.	Addictions worker and a Holistic health worker conduct workshops on violence.	Assist clientele in applying for social assistance and child tax benefits, if applicable.	Shelter has an addictions worker (funded through ESDC (Employment and Social Development Canada) Referrals to addictions services in the city. Only one external service that is culturally appropriate, Omento:kon, located in Kanehsatke	<b>Outreach Program:</b> The Outreach worker is a service to those who have moved out of the shelter; or any Aboriginal woman living in the city. The outreach worker responds to emergency situations, provides home visits, advocacy, support and referrals.

# APPENDIX A.1

***Addendum* – Portrait of the Situation for English-speaking First Nations:  
Accessing Health and Social Services in the Province of Quebec**

By:

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Submitted to:

Onkwata'karitáhtshera

and

Coalition of English Speaking First Nations Communities in Quebec (CESFNCQ)

January 12, 2015

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# 1. INTRODUCTION

## 1.1 Foreword

The project “Expanding and Building our Partnerships to Improve Access” is a three-year project that started in 2012 with funding from Health Canada’s Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera; an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal).

The goal of the project was to establish a coalition among English-speaking First Nations Communities in Quebec (CESFNCQ) in order to expose and improve access to health and social services in federal and provincial systems.

The Coalition is comprised of several First Nations – Naskapi, Mi’gmaq, Mohawk, and Algonquin, from nine (9) First Nations communities and one (1) First Nation organization. The communities are from various geographical areas (remote, rural and urban), and are located in different administrative regions across Quebec.

The majority of the communities have been part of the Coalition since its inception. The First Nation communities or organizations that are part of the Coalition, as of November 2014, include:

- Kawawachikamach
- Gesgapegiag
- Listuguj
- Kanesatake
- Kahnawake
- Akwesasne
- Eagle Village First Nation / Kipawa
- Kitigan Zibi
- Timiskaming
- Native Women’s Shelter of Montreal

In working towards solutions to mitigate the ‘disproportionate burden of illness’<sup>1</sup> carried by Aboriginal Peoples, the Coalition oversaw research to document a portrait of the diverse challenges facing First Nations when accessing health and social services in English. The research, conducted over a one-year period from November 2012 to October 2013, resulted in a report entitled “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec” (herein called “Access Report (2013)”).<sup>2</sup>

In the fall of 2014, the First Nation community of Akwesasne and the Native Women’s Shelter of Montreal joined the Coalition. Thus, the communities were invited to participate in ‘additional research’ to document their perspectives of accessing health and social services, and also to identify strategies and solutions to overcome access challenges.

In addition, the research about access issues facing English-speaking First Nations communities was presented at a forum in Montreal with the First Nation communities, and their federal and provincial partners. The research presentation took place on November 19, 2014.

The following report ‘*Addendum – Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec*’ is a compilation of the research conducted with Akwesasne and the Native Women’s Shelter of Montreal.

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<sup>1</sup> O’Neil, John, et al. “Community Healing and Aboriginal Self-Government.” *Aboriginal Self-Government in Canada*. 2<sup>nd</sup> ed. Ed. John Hylton. Saskatoon: Purich, 1999: 139 -142. Print. See: Access Report (2013)

<sup>2</sup> Chamberlin, Amy. “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec”. [Access Report (2013).] Submitted to: Onkwata'karitáhtshera and Coalition of English Speaking First Nations Communities in Quebec (CESFNCQ). October 21, 2013.

## **1.2 Mandate and Purpose**

The mandate for the research was to document a portrait of the situation for English-speaking First Nations people when accessing health and social services in English from federal and provincial health care systems.<sup>3</sup> The Coalition oversaw the direction of the research, and the Organizational Development Services (ODS) provided management support for the project.<sup>4</sup>

This additional research was conducted to include the perspectives and issues from new members of the Coalition. The purpose of the research was to expose and identify:

- Access issues and challenges
- Strategies and solutions to mitigate access issues

## **1.3 Scope and limitations**

This research sought to document the perspectives of English-speaking First Nations when accessing health and social services from provincial and federal health care systems.

Limitations of the ‘additional research’:

- Time constraints – The research was conducted during a limited period of time, thus the researcher could not collect as much information as she would have liked for the research.
- Data collection – Ensuring that data (perspectives) was gathered equally (breadth and depth) from the participants.<sup>5</sup>

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<sup>3</sup> Access Report (2013).

<sup>4</sup> The Organizational Development Services (ODS) is a First Nation consulting/training business within the Kahnawake Shakotiiia'takehnhas Community Services (KSCS).

<sup>5</sup> The issue of ensuring adequate community participation and awareness about the HSIF access research was raised at the HSIF Forum. (Research Presentation. “Expanding and Building our Partnerships to Improve Access.” HSIF Forum. Delta Hotel. Montreal. November 19, 2014).

## 1.4 Data Collection

- All data was collected over a one month period from September 30 to November 3 2014
- The researcher contacted the participating community and organization to determine the appropriate method to gather data (focus groups, questionnaires or individual interviews).
- Due to time constraints, staff availability, and community research guidelines, it was determined that the research participants would complete questionnaires and submit data to the researcher.
- The questionnaires were conducted with key staff from the participating community/organization; research was not conducted with ‘community members’ or clientele of the respective organizations who took part in this research.
- A total of five (5) participants took part in this additional research; three (3) key informants from the Native Women’s Shelter and two (2) key informants took part from Akwesasne.<sup>6</sup>

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<sup>6</sup> To date, a total of 135 participants have taken part in the access research for the Coalition (from November 2012 to January 2015).

## 2. METHODOLOGY

### 2.1 Goal and objectives

The overarching goal of the research was to seek out the perspectives of English-speaking First Nations people when accessing health services and social services from the federal and provincial systems in English.<sup>7</sup>

Objectives:

- *Expose challenges* – Identify the specific issues and challenges that the First Nations communities face when accessing health services and social services in English from federal and provincial systems.
- *Explore strategies* – Share and explore strategies (best practices) utilized by First Nations to address the challenges of accessing English-language health services and social services from the province.

### 2.2 Research approach

The research used a participatory (action) approach to document the perspectives of English-speaking First Nations. Participatory (or action) research is a way of conducting research that allows participants to be directly involved in the research process – determining questions, gathering data, reflection, and deciding on a course of action.<sup>8</sup>

The participating communities had the opportunity to determine the best method to collect data from their respective organizations (e.g., focus groups, interviews, or questionnaires). For the Native Women’s Shelter of Montreal, questionnaires were used to gather the perspectives from the staff. It was decided that questionnaires would be the most appropriate method to gather information because of the limited availability of the

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<sup>7</sup> Access Report (2013).

<sup>8</sup>Chilisa, Bagele. *Indigenous Research Methodologies*. California: Sage, 2012 : 226-227. Print. See: Access Report (2013).

workers, and also to respect the fact that “the needs of the clientele come first.”<sup>9</sup>

Likewise, in the community of Akwesasne, because of their strict research guidelines, the community (collaboration between Health and Social Services departments) gathered its own data and submitted their findings to the researcher.<sup>10</sup>

The researcher provided both of the participating communities with research tools (Consent Form and Questionnaire) by which to gather the data from their respective organizations (Appendix 1).

### **2.3 Activities**

Research activities included:

- Contact the participating communities to explain the research and determine the best approach to gather data
- Provide the communities with research tools
- Gather and compile the data from the participants
- Draft the ‘Additional Research Report’
- Review the Additional Research Report with the Coalition, and seek out additional data if required
- Submit final report to the Coalition

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<sup>9</sup> Nakuset. Director of the Native Women’s Shelter of Montreal. Personal Conversation. 30 Sept. 2014

<sup>10</sup> Cynthia Francis-Mitchell. Assistant Director of Health, Mohawk Council of Akwesasne. E-mail Correspondence. 25 Sept. 2014.

## **3.0 COMMUNITY PROFILES**

### **3.1 Coalition Communities**

The English-speaking First Nations communities /organization that comprise the Coalition are situated in seven of Quebec's eighteen public health regions; including: Outaouais, Abitibi-Témiscamingue, Côte-Nord, Gaspésie-Îles-de-la-Madeleine, Laurentides, Montérégie and Montréal.

The Coalition communities are located in isolated, rural, and urban areas. With respect to language, approximately 64.5 % of the total Aboriginal population are predominately English-speaking, or English is the first official language spoken after their own Indigenous language.<sup>11</sup>

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<sup>11</sup> Aboriginal Affairs and Northern Development Canada, 2012 and Ministère de la Santé et des Services sociaux du Québec, 2012. See: Access Report (2013).

**Table 1. Community Profiles – Location, Population, and Administrative Regions**

<b>Coalition of English Speaking First Nations Communities in Quebec (CESFNQC)</b>			
<b>Coalition Member</b>	<b>Location</b>	<b>Population</b>	<b>Administrative Region</b>
<b>Kawawachikamach</b>	Kawawachikamach is situated at the south end of Lake Matemace, about 16 kilometers northeast of the Town of Schefferville on the Quebec-Labrador border	Total population of 1,170 persons (with 857 living in the community and 313 living outside of the community <sup>12</sup> )	La Côte-Nord (09), Remote
<b>Gesgapegiag</b>	Gesgapegiag is located on the southern Gaspé coast, on the north shore of the Cascapedia Bay (about 45 kilometers west of Bonaventure)	Total population 1,412 (with 672 living within and 740 living outside of the community)	La Gaspésie-Iles-de-la-Madeleine (11), Rural
<b>Listuguj</b>	Listuguj is located in the southwestern part of the Gaspé Peninsula. Surrounded by the Appalachian Mountains, the community is situated on the northern banks of the Restigouche River, across from the province of New Brunswick ( <i>Border community with New Brunswick</i> ).	Total population 3,672 (with 2,086 living within and 1,586 living outside of the community)	La Gaspésie-Iles-de-la-Madeleine (11), Rural
<b>Akwesasne</b>	Akwesasne is located along the St. Lawrence River. An International border (United States, New York State) runs through Akwesasne Territory, and the northern portion of Akwesasne includes the Canadian Provinces of Ontario and Quebec. (Located 120 km southwest from Montreal.)	Total Population: Northern Portion of Territory: 12,000 Southern Portion: 11,000	Montréal (16), Urban

<sup>12</sup> Quebec. Secretariat aux affaires autochtones. “Aboriginal Population in Quebec.” [Aboriginal Affairs and Northern Development Canada, Indian Register, December 31, 2012.] Quebec. 27 May 2012. Web. March 2013.’ See: Access Report (2013). Information about Akwesasne and the Native Women’s Shelter of Montreal was derived from: HISF Forum Information Package, November 2014; and online resources (Native Women’s Shelter and Mohawk Council of Akwesasne).

<b>Kahnawake</b>	Kahnawake is located on the South Shore of the St. Lawrence River, 10 kilometers southwest of the city of Montreal	Total population 10,336 (with 7,745 living within and 2,591 living outside of the community)	Montréal (16), Urban
<b>Kanesatake</b>	Kanesatake is situated approximately 60 kilometers North West of Montreal, on the banks of the Rivière des Outaouais (Ottawa River)	Total population 2,321 (with 1,383 living within and 938 living outside of the community)	Laurentides (15), Rural
<b>Kitigan Zibi</b>	The Kitigan Zibi Anishinabeg community is situated just outside the municipality of Maniwaki. The community is 130 kilometers north of Gatineau/Ottawa. It is bound on the north by Riviere de l'Aigle and Riviere Desert ( <i>Border community with Ontario</i> )	Total population 3,021 (with 1,593 living within and 1,428 living outside of the community)	L'outaouais (07), Rural
<b>Eagle Village   Kipawa</b>	Eagle Village First Nation is located 10 kilometers west of Temiscaming, on the bank of Lake Kipawa ( <i>Border community with Ontario</i> )	Total population 951 (with 276 living within and 675 living outside of the community)	L'Abitibi-Témiscamingue (08), Rural
<b>Timiskaming First Nation</b>	Timiskaming First Nation is located at the head of Lake Temiskaming, approximately 600 km from Ottawa ( <i>Border community with Ontario</i> )	Total population 1,923 (with 641 living within and 1,285 living outside of the community)	L'Abitibi-Témiscamingue (08), Rural
<b>ORGANIZATION</b>			
<b>Native Women's Shelter of Montreal</b>	The Native Women's Shelter of Montreal provides shelter and support to First Nations, Inuit and Metis women and children who are in difficulty. The shelter is located in downtown Montreal.	530 clients per year	Montréal (06), Urban

## 4.0 FINDINGS – ACCESS ISSUES AND CHALLENGES

The following section is a compilation of the findings for the Mohawk Council of Akwesasne and the Native Women’s Shelter of Montreal, respectively. The information for each community was organized as follows:

- a.) Key Access Issues and Challenges
  - b.) General Access Issues and Challenges
  - c.) English language access issues
  - d.) Access issues related to culture (Aboriginal)
  - e.) Positive Experiences
- 

### 4.1 Mohawk Council of Akwesasne

#### a.) Key Access Issues and Challenges (Health and Social Services)

- **Jurisdictional issues – Provincial and International Boundaries**
  - There is an identified need for one unified health system for the territory of Akwesasne.
  - Being advised that you are not within [the province’s] catchment area.
- **Attitudes and Perceptions**
  - Community members’ refusal to go to other areas in Quebec.
- **Language Barriers (Communicating)**
- **Training in English (Lack of English language resources)**
- **Documentation**
  - English forms, reports, and documentation
- **Long Wait Time and Travel**
- **Access to Licensed professionals and services**

## b.) General Access Issues and Challenges

### **Jurisdictional Issues – Provincial and International borders**

- Challenges arise when we are advised that we are out of the catchment area, and clinics cannot provide services to our community members, or not recognized as a service in Quebec and deemed “ineligible to receive funding from Quebec” and denied additional funding.
- Social Services – Challenges because of jurisdictional boundaries (provincial and international) with respect to adoptions
  - There are no problems when the adoption takes place in the same jurisdiction in which the file originated; problems occur when the adoptive family resides in a different jurisdiction of Akwesasne.
  - Some adoptions are “not progressing because we need direction and/or guidance on how to pursue an “International Adoption” ... we need to ... identify a process that will enable children to achieve permanency – that satisfies all requirements and reduces the amount of time that children and adoptive families are left in limbo, waiting for their adoption to be finalized.

### **Foster-care Rate Structure – Reported there are differences in foster-care rate structure between Ontario and Quebec, which are creating inequalities for children who are in care.**

- A child in care may receive an allowance or benefit in one province that a child in care from the other province will not receive.

### **Long wait times for general and specialized services**

- Special Needs is an area of concern for RAMQ carriers. Wait lists for a diagnosis is extremely long for this [children/youth] age group and Akwesasne Child Care Program (ACCP) is unable to secure speech and OT professionals in the Quebec centers and most professionals in Cornwall will not accept RAMQ without a diagnosis. Often we refer children to the US side to obtain services, but lines are long on both sides of the border.
- Community has expressed the wait time is quite extensive and you may wait 4-6 hrs for appointments in crowded, not very well ventilated small hospital and doctors’ offices.

**Lack of access to general and specialized services – Difficult to access doctors; laboratory and diagnostic testing is limited. Struggle to access health professionals for foot care, physical therapy and occupational therapy.**

- We need to have providers that are registered with certain hospitals otherwise the community does not have access to services.
- Doctor availability is limited here; we have no coverage of another physician when ours is on leave. The community is left with no Doctor.
- Laboratory Services/Diagnostic Testing very limited for services in Quebec
- Access to other health professionals, foot care, physical therapist, and occupational therapist has been an ongoing struggle.

**Difficulties accessing updates from the province about changes to health and social services' legislation and/or legislation**

**Social Services (Child Protection) – Service delivery and planning is a challenge because the “working relationship with ‘Quebec Liaison Officer’ needs significant improvement. (Lack of availability, and unable to respond to questions or requests in English-language)**

- Our supervisors often require access to the Liaison Officer to answer or respond to questions raised in a timely fashion. Quite often the Liaison Officer is not available, does not return messages or responds to questions raised; this has an impact on our service delivery as well as our ability to resolve issues and conduct the appropriate planning for the families we serve.
- This is an issue because [in Akwesasne] we rely on the Liaison Officer to offer clinical support, notification of access to training, linkages to support services, link to Quebec Resource staff to answer questions in regards to provincial requirements, address issues (ex. Related to adoption, tutorship, curatorship or current court cases, etc.)

c.) English language access issues

**Language barriers (communicating) – specialists more likely to speak English, less so for nurses, front line workers**

- [Social Services] – We have one French speaking Liaison Officer to do the interpretation; if they are not in then we search for other avenues to get information (for example, Google translate or utilize other workers that may speak French).
- Limited access to English speaking resources (for placements of youth and support services for youth placed in Quebec residential facilities)
- Community members comment that the physicians and their teams are all English speaking it is the nursing staff, etc. that often give them a hard time with language.

**Documentation from the province is primarily in French.**

- Catchment areas send the medical information back from referral appointment in French language.
- Language barrier has always been an issue, whether it's correspondence that is received for health card, appointment information or even reporting that comes back to providers in French with patients results. The margin for error is greater when translating.
- Social Services – language barrier creates problems in our ability to access English forms and resources

**English-speaking professionals face barriers registering with Quebec's Professional Order because of French language requirements.**

- Registering professionals is almost impossible even if the physician/nurse practitioner/nurses/social worker has trained in the province of Quebec, they are not exempt from the French language requirement.
- Social Worker Registration – French language requirement
  - There may be a potential impact on our agency. Our supervisory staff was informed by our Quebec Liaison that there may be a requirement for one of our supervisors who carry the D.Y.P. authorization to be a registered Social Worker. We need to explore the possibility of an exemption if this will be required.

**Limited access to training in English in Quebec**

**Lack of access to health and social services in English at provincial institutions**

- Services we have been told are and will be provided in English at all facilities, hospital, labs etc. this is not always the case.

d.) Access issues related to culture (Aboriginal)

**Discrimination and lack of cultural sensitivity**

- Our culture is considered to an extent, depending on who goes with a family member that is receiving services in Montreal, normally a family member will stay with a person receiving surgery, it's our way, this is not always a possibility in certain hospitals.
- The stigmatism that goes with being native, for example if the client is referred for hepatic disease, then the assumption is that the client is an alcoholic, this happens often and is very upsetting to community members and their families.

e.) Positive Experiences

**Clients report that services in Quebec have been timely and care “excellent”.**

**Clients report that: “referral process in Quebec is quicker than Ontario”.**

- Community members have voiced their opinion on areas of access, while they were not happy to be referred to Quebec; they have received services in a timelier manner and have received excellent care.
- Referrals process is often quicker than if we are being referred to Doctors' offices in Ontario

**Clinics are developing a ‘go to’ list of providers that are taking on new patients**

- Most often times, we learn by trial and error, which often results in the information that is brought back by the patients, they advise us of what worked and what was a barrier. The clinics have a “go to” listing of those providers that will take new patients and those that refuse.

## 4.2 Native Women's Shelter of Montreal

### a.) Key Access Issues and Challenges

- **Cultural Discrimination / Lack of Cultural Sensitivity**
  - Condescension, rude comments, racist comments when accessing services at provincial institutions (CLSCs, Hospitals)
  - Lack of knowledge about First Nations' cultures, languages, existence
  
- **Attitudes and Perceptions**
  - Impatience from service providers
  - There is a lot of rudeness and abruptness from services providers. (Example: hanging up phones)
  - Lack of respect for homeless population
  - Providers [at provincial institutions] are often unwilling to provide information about services. Or they provide limited information rather than the complete information.
  
- **Communication – Language barriers**
  - Service providers refusing to speak English
  - Being served in language of choice
  
- **Lack of respect homeless population**
  
- **Financial barriers**
  - Money required to replace health cards and ID

### b.) General Access Issues and Challenges

#### **Attitude and Perceptions**

- General attitude/rudeness and unwillingness to be flexible. Many of the barriers are at the first stage of access (reception, telephone operators)

#### **Long wait times – health cards and detoxification services**

- Wait times. Regular loss of ID and health card and time it takes to replace them.
- Lack of space for detoxification and wait times for detoxification beds

#### **Financial barriers**

- Money it takes to replace ID and health cards

c.) English language access issues

**Language barriers (communicating)**

- Unwillingness to speak English [staff at provincial institutions]
- I spoke in English and [provincial staff workers] answered me in French.
- Several of my clients are spoken to in French when they do not understand French.

**Documentation from the province is primarily in French – Signage**

- When I went to the Régie de l'assurance maladie office ... [there is] a sign when you enter stating that French is the official language of Quebec and you should expect to be served in that language

**Lack of access to health and social services in English at provincial institutions**

- Lack of access to health care in English from our CLSC (other CSLCs provide more bilingual services)
- CLSC [...] is hesitant to provide services in English. Very few interpreters available. Wait times are discouraging.

d.) Access issues related to culture (Aboriginal)

**Discrimination and lack of cultural sensitivity**

- Staff at the [Native Women's] shelter often say that: when they bring clients to hospital or addictions centers the [provincial] staff make global comments about Aboriginals: "You have the red carpet for services", "People like her" or "She should attend the treatment centre in Kahnawake."
- [Provincial workers express] surprise at people being of First Nations backgrounds. Lack of knowledge about First Nations' cultures, languages, existence.
- Lack of understanding that even English is a second language for many people.
- I have seen discrimination at [hospital] against several of my clients. The hospital employees showed no understanding of First Nations' culture and history (they even show surprise at meeting a First Nations person.)

e.) Positive Experiences

- Positive experiences with a social worker from CLSC metro Itinerant Program. The social worker was flexible, had a cell phone, and was able to meet with a client quite quickly. She spoke plainly and was very friendly with my clients.
- Cree Patient Services seems to have a model that works well (working with small team that is culturally aware, sets up appointments with doctors and psychologists, provides transport and place to stay while accessing services)

- Some CLSCs have drop in services for health cards (seen quickly, reduce charges) works well.

## 5.0 STRATEGIES AND SOLUTIONS

**The following is a compilation of strategies and solutions (in place or recommended) from both Akewasne and the Native Women's Shelter of Montreal**

- Legislation
  - Remove the French language requirement from legislation where it pertains to any individual working in a First Nations community.
  - Establish an 'English language Mailing List' to receive updates from the province about any changes to legislation and/or regulations.
- Information and Awareness
  - Identify provincial clinics that are taking new patients
  - First Nations organizations can utilize their own communications' department to ensure that any information that is going out is accurate and made available at all times.
  - Share information using social media platforms (Facebook, YouTube, etc.)
  - Utilize culture and community in communications (i.e., in radio ads, pictures of community members, etc.) Focus on positive images – *“what we do here as opposed to what we cannot access outside lessens the hardship”*.
  - Provide pamphlets and information in Aboriginal languages.
  - Social Services – Identify what support services are available from provincial institutions (i.e., Les Centres Jeunesse de la Montérégie); determine if the services are similar to those available in Ontario (Ontario Association of Children's Aid Societies – OACAS)
- Translation Services – bilingual staff (internally) can assist with translation and First Nations can establish partnerships with external agencies or organizations
  - Bilingual staff provide assistance with translation (i.e., translation of documents)
  - Bilingual professionals can assist with areas of concern
  - By having French speaking individuals on staff and partnerships with other outside agencies or associations, First Nations organizations have been able to access support or assistance in translating forms or letters.
- Maintain a consistent and standard approach of care across the continuum of services
  - [In Akwesasne], we have applied forms, resources and/or tools across the continuum of services so that consistency and a standardize approach is maintained for all community members and delivery of services.

- Collaborate with other departments to ensure that a community member will not go without (Akwasasne).
- Jurisdiction– Provincial and International Borders (Akwasasne)
  - Reconcile rate structure for children in foster care
  - Determine the ‘foster-care rate scales’ in Ontario and Quebec to determine what (if any) differences exist (e.g., allowance and benefits). Develop a rate structure that would be used by Akwasasne for all children in care and for that rate structure to be accepted by all parties, so our costs would be allowable and reimbursed.
- Establish guidelines for provincial Liaison Officers (i.e. Social Services) who work with/for First Nations communities (Akwasasne)
  - Liaison Officer needs to be able to provide services to the community in English, and in a timely manner.
  - When the primary Liaison Officer is unavailable, an alternate Liaison Officer should be identified.
  - If issues are not resolved, then a new Liaison Officer should be identified to work with the community.
- Attitudes and perceptions
  - The current culture of receiving service in the province of Quebec is becoming the norm, and the community is adapting to the services that are being offered and are made available (Akwasasne).
  - We use art based programming for education and prevention that can be more accessible to clients than didactic workshops (Native Women’s Shelter of Montreal).
- Cultural Sensitivity – Awareness and Training
  - [First Nations] have offered training sessions to organizations and a hospital on First Nations history and anti-oppressive practice (example: racism 101).
  - There needs to be training and laws that require service providers to not only speak English, but also to treat people with respect. I have been in many cross-culture situations that work and often language is not the issue. It has more to do with attitude and respect (Native Women’s Shelter)
  - I strongly believe in offering workshops on cultural sensitivity, which [the Native Women’s Shelter of Montreal] provides
- Complaints’ process

- At the Native Women's Shelter we bring a form when we escort clients. It is called "Incident report for Outside Occurrences". Staff will fill out the form when an incident happens and then we send it to the organization afterwards, requesting a meeting with their supervisor. (Appendix 2 – 'Incident Report')
- [The shelter] will launch complaints on behalf of clients in instances of discrimination and racism.
- Systematically track quantitative data about 'complaints'
  
- Financial Support
  - [The shelter] provides short term loans to women to obtain ID
  - Reduce financial barriers for individuals on social assistance (i.e., waive fees for those on welfare to replace ID)
  
- Advocate and Escort – Support to clients who are seeking services from provincial service providers (Native Women's Shelter of Montreal)
  - I have had to be personally present to advocate and mediate with service providers. This seems to work, but is humiliating for clients, stressful for me, and a waste of money to have to pay my salary to attend appointments with other social workers and service providers.
  - Women report that they are treated with more respect when they access health services with a worker.

## 6.0 CONCLUSION

In Quebec, English speaking First Nations face diverse issues and challenges when accessing health and social services from the province. This research was conducted with two ‘communities’: the Mohawk Council of Akwesasne and the Native Women’s Shelter of Montreal. This additional research was conducted to document the perspectives of English-speaking First Nations when accessing health and social services from provincial systems. The research was conducted with the two members who joined the Coalition in the fall of 2014.<sup>13</sup> In addition, the research documented strategies and solutions (either in place or recommended) to mitigate the access issues and challenges. This additional research is intended to supplement the research report that was produced for the Coalition entitled “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Quebec” (2013).

The data collection for this additional research took place over a one-month period in the fall of 2014. The participating communities were approached about the research, and it was determined that each community would gather its own data by way of questionnaires. Subsequent to the data collection, the researcher then grouped the data from each community into broad categories: a.) Key access issues and challenges; b.) General access issues and challenges; c.) English language access issues; d.) Access issues related to culture (Aboriginal); and e.) Positive experiences. Secondly, the data from both communities pertaining to ‘strategies and solutions’ (either in place or recommended) was compiled and presented together.

The research revealed that English-speaking First Nations face diverse challenges when accessing health and social services from the provincial health system. Indeed, participants reported that First Nations face obstacles accessing services because of

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<sup>13</sup> The research was conducted with members of the Coalition of English Speaking First Nations Communities of Quebec. When the research was presented at the HSIF Forum in November of 2014, participants suggested that further research be conducted with English-speaking First Nations communities that are not currently part of the Coalition, and in particular with communities whose first language is their own Indigenous language (Research Presentation. HSIF Forum. Nov.19, 2014).

“language”. In particular, participants noted challenges in the following areas: language requirements for professionals working in the communities; documentation from the province (forms, letters, etc.); signage at provincial institutions; lack of financial resources for translation services; lack of training opportunities in English, and difficulties when communicating with provincial workers (reception, telephone operators). For Aboriginal Peoples, however, the issue of language is particularly significant because of their distinct historic and socio/cultural experiences in Canadian society. As stated in the opening remarks at the HSIF Forum, Aboriginal Peoples have already experienced the loss of language through colonialism; thus, for Aboriginal Peoples it is argued that “there needs to be an appreciation for how we became English-speaking communities – we were forced to learn English.”<sup>14</sup> Moreover, today many Aboriginal Peoples are working to retain or relearn their own respective Aboriginal Language.<sup>15</sup>

Although language presents obstacles to accessing services, the research revealed that language itself is not necessarily the predominant or key challenge. Rather, participants reported that there are challenges resulting from “cultural insensitivity” and a general lack of awareness about Aboriginal culture and history. As stated by one participant from the Native Women’s Shelter of Montreal: “*I have been in many cross-culture situations that work and often language is not the issue. It has more to do with attitude and respect*”. Participants noted that the “lack of respect” is having an impact on those who are most vulnerable in society: notably, within the **homeless population**. Coupled with a lack of respect, ‘financial barriers’ was also considered a key access issue (i.e., to replace personal identification and health cards).

In addition, the participants also spoke about obstacles accessing services because of administrative jurisdictions over health care – both within Quebec and among provinces. Furthermore, in the Mohawk territory of Akwesasne, there are jurisdictional issues not only because of provincial borders, but also because of international boundaries. (An International border (United States, New York State) runs through Akwesasne Territory,

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<sup>14</sup> Rheena Diabo. Coalition Chair. Opening Remarks. HSIF Forum. Nov. 19 2014.

<sup>15</sup> Access Report (2013).

and the northern portion of Akwesasne includes the Canadian Provinces of Ontario and Quebec). Specifically, in the area of Social Services, it was noted that jurisdictional issues are having an impact on the services available to **children, youth and caregivers** in areas of adoption and foster care. Finally, participants spoke about challenges accessing general and specialized services in English (lack of access to licensed professionals), long wait times, and issues because of travel.

To conclude, although English-speaking First Nations face obstacles when accessing health and social services, nevertheless the participants who took part in this research expressed their continued desire to access – and to provide – consistent and standard health care across the continuum of services. This research documents the various solutions and strategies that participants have in place, or would recommend, to overcome those challenges.

Finally, the research affirms the need to work in a cross-cultural manner – among First Nations, federal and provincial authorities – to ensure that Aboriginal Peoples may access health and social services in a manner that respects their unique cultures and history.

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## APPENDIXES

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### APPENDIX 1 – Consent Form and Questionnaire

Project: Expanding and Building our Partnerships to Improve Access”  
Research for: Coalition of English Speaking First Nation Communities in Quebec (CESFNCQ)  
Sponsored by: Onkwata'karitáhtshera  
Funded under Health Canada's Health Services Integration Fund (HSIF)  
Project Researcher: Amy Chamberlin, M.A.

#### CONSENT FORM

I, \_\_\_\_\_, (your name) voluntarily agree to participate in the research for the project “Expanding and Building our Partnerships to Improve Access.” This project is funded under Health Canada's Health Services Integration Fund (HSIF) and sponsored by Onkwata'karitáhtshera, a health and social services agency of Kahnawake.

I understand that the research is being conducted by Amy Chamberlin (Researcher). The goal of the research is to **document a portrait of the situation for English-speaking First Nations when accessing health and social services in English in the province of Quebec**. The results of the research will be shared at a forum with the First Nation communities, and their federal and provincial partners. Your name will not be used in the report; however, the names of participating communities or organizations will be used.

Thank you for taking the time to participate in this research project. Your assistance is appreciated. For the research:

- I agree to fill in the questionnaire.
- If additional information is required, do you agree to participate in a follow up focus group or short interview?  
Yes    No
- Can the interviewer record the session for transcription purposes? (i.e., video, audio, and/or note taking) Yes    No

By signing this form, I fully accept to participate in this research, in agreement with the terms established on this form. I also understand that I can withdraw from the research at any time and that I am not obligated to answer any particular question.

---

Interviewee name

---

Signature

Please provide contact information (address, email or telephone), if follow up information is required, or to verify data:

## QUESTIONNAIRE

**Name of Organization:**

**Your position in the organization:**

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The following questionnaire has been designed to identify the challenges, obstacles and issues that you, or your clientele, may have had when accessing health and social services from the province of Quebec. As well, the objective is to identify strategies to overcome those challenges.

1. What were some of the general obstacles that you faced when accessing health or social services from the province?
2. Did you experience any challenges because of language and culture? (Who, what, where?)
3. Can you describe any positive experiences when accessing services? (highlight what is working)
4. What do you think are the top five (5) most pressing challenges, issues or concerns that need to be addressed with respect to accessing health and social services in English from the province?
5. What are some of the ways that you have overcome the barriers you faced when accessing English language health and social services from the province?
6. Recommendations – In your view, what is needed to make sure that you and your clientele can access English language health and social service from the province? (i.e. What are the best ways to share information? Can culture play a role?)
7. Any other comments? Or Questions?

**Appendix 2 – Incident Report (Native Women’s Shelter of Montreal)**

**Incident Report for Outside Occurrences**

Native Women’s Shelter of Montreal

Organization involved: \_\_\_\_\_  
Professionals involved: \_\_\_\_\_  
\_\_\_\_\_  
Supervisor at location: \_\_\_\_\_  
Employee number(s): \_\_\_\_\_  
Contact information for professionals  
(email/phone): \_\_\_\_\_

People affected: \_\_\_\_\_  
Place of incident: \_\_\_\_\_  
Date of incident: \_\_\_\_\_  
Time of incident: \_\_\_\_\_  
Time of report: \_\_\_\_\_  
Report submitted by: \_\_\_\_\_  
Signed: \_\_\_\_\_

Incident involved:

- Language barrier
- Barriers to accessing services
- Unfair treatment
- Verbal racism
- Behaviour showing racism
- Lack of cultural or historical knowledge
- Systemic or institutional racism (Policies, practices and structures which place Aboriginal people at a disadvantage.)
- Other forms of discrimination (poverty, class, gender, etc.)
- Other: \_\_\_\_\_

Details of incident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Effect on person:

\_\_\_\_\_  
\_\_\_\_\_

Action plan:

- Request meeting with supervisor at location
- Write a letter to organization/institution.
- Submit incident report to organization
- Suggestion of workshop or training to organization.
- Complaint to ombudsman or formal complaint process.
- Debrief/offer support to persons affected.
- Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# APPENDIX B

**English-Speaking First Nations in Quebec:  
A Portrait of the Situation when Accessing Social Services**

**– Final Report –**

*Submitted to:*

Coalition of English Speaking First Nations Communities in Quebec  
(CESFNCQ)

*By:* A. Chamberlin, M.A., Ph.D. student in Canadian Studies at Carleton University

March 21, 2016

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## 1.0 INTRODUCTION

### 1.1 Overview of Research

In 2012, a Coalition of English-speaking First Nations Communities in Quebec (CESFNCQ) launched a multi-year project entitled “Expanding and Building our Partnerships to Improve Access”. The CESFNCQ is comprised of First Nations communities/organizations from different parts of the territory in Quebec, including: Naskapi, Mi’gmaq, Mohawk, and Algonquin nations. **This research presents a portrait of the situation for English-Speaking First Nations in Quebec when accessing social services from provincial and federal systems.** At the present time, the First Nations communities that are part of the CESFNCQ include: Kawawachikamach, Gesgapegiag, Listuguj, Akwesasne, Kahnawake, Kanasatake, Eagle Village First Nation/Kipawa, Kitigan Zibi, Long Point First Nation/Winneaway, Timiskaming First Nation, and the Native Women’s Shelter of Montreal.

This research was conducted at a time of heightened public awareness about the inequities Indigenous peoples face in health and social service sectors. For example, the issue of equitable access to social services came to the public’s attention, in 2007, when the House of Commons adopted Jordan’s Principle. This Principle is considered to be “a child-first principle intended to ensure that First Nations children do not experience denials, delays, or disruptions of services ordinarily available to other children due to jurisdictional disputes”.<sup>1</sup> The research took place as the Truth and Reconciliation Commission released its final 4000-page report, in December of 2015, telling ‘what happened’ to Indigenous children who attended government residential boarding schools.<sup>2</sup> The research was conducted against the backdrop of growing awareness on the topic of violence against Indigenous women, and the announcement by the federal government, in December of 2015, of the launching of a national inquiry into Missing

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<sup>1</sup>Jordan’s Principle Working Group. *Without denial, delay, or disruption: Ensuring First Nations children’s access to equitable services through Jordan’s Principle*. Ottawa, Ontario: Assembly of First Nations, 2015. p.4

<sup>2</sup> Mas, Susan. “Truth and Reconciliation chair says final report marks start of ‘new era’.” *CBC News*. 15 Dec. 2015. Web. 16 Feb. 2016

and Murdered Indigenous women and girls. Finally, in January of 2016, the Canadian Human Rights Tribunal passed its landmark ruling, which found that the federal government “discriminates against children living on reserve by failing to provide them with the same quality of welfare services available to children elsewhere in the country.”<sup>3</sup> The commissions, inquiries, and tribunals are part of the background, the context for this research, which documents and highlights English-speaking First Nations voices and experiences, the challenges and also solutions, when accessing *social services* in the province of Quebec.

In November of 2012, the CESFNCQ began a multi-year community-based research initiative to document the situation of English-speaking First Nations when accessing health and social services from provincial and federal healthcare systems. This research resulted in a comprehensive report entitled “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec” (2013).<sup>4</sup> The research uncovered many of the challenges that English-speaking First Nations face when attempting to access health services from the provincial and federal health care systems. It became apparent that there are issues resulting not only because of language barriers, but also because of a lack of cross-cultural understanding between Aboriginal and non-Aboriginal peoples.

The research findings attest that English-speaking Aboriginal peoples living in Quebec face a ‘double discrimination’ when accessing services because of both language and culture. This research primarily uncovered issues, challenges and what is working well when accessing *health services* from the healthcare system in the province of Quebec. Thus, the CESFNCQ initiated a second phase of community-based research to investigate the situation when First Nations access *social services* from provincial and federal systems.

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<sup>3</sup> Canadian Press. “Federal government discriminated against First Nations children through welfare funding: human rights tribunal,” *National Post*. 26 January, 2016. Web. 16 Feb. 2016

<sup>4</sup> Chamberlin. Amy. “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Quebec.” Final Research Report. Coalition of English Speaking Communities of Quebec. [Kahnawake, Quebec] 2013

In February of 2015, the second phase of the community-based research began. The purpose was to investigate the situation for English-speaking First Nations people who live in Quebec when accessing social services from provincial and federal systems.

The research focused on services funded under the federal government's Indigenous and Northern Affairs Canada's (INAC) 'social development' programs and also Health Canada's 'National Native Alcohol and Drug Abuse Program' (NNADAP). The research was funded under Health Canada's Health Services Integration Fund (HSIF).

Onkwata'karitáhtshera, an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal), sponsored the project.

## **1.2 Objectives**

- i) Investigate and describe the social services' programs available to First Nations living on Reserve in Quebec from the federal government under INAC's social development programs and also under Health Canada's National Native Alcohol and Drug Abuse Program.
- ii) Document the perspectives of English-speaking First Nations living in Quebec when accessing social services from provincial and federal systems.
- iii) Produce an 'Inventory of Social Services' from the participating communities (identify a list of social services available in the participating First Nations communities, along with agreement types).

### 1.3 Limitations

- Literature Scan – The review of documentation about social programs was primarily limited to government reports
  
- Time Constraints –
  - *Interviews* – All communities were invited to participate in the interview phase. Most interviews were conducted by telephone, with the exception of two communities where the researcher was able to conduct the interviews in person because of the proximity of the communities. The goal was to ensure that organizations who deliver social services in community had the opportunity to participate in the research.
  - *Inventory of Social Services* – Data gathering was limited due to time constraints and staff availability.

#### **List of common abbreviations used throughout this report:**

AANDC – Aboriginal Affairs and Northern Development Canada

AFNQL – Assembly of First Nations Quebec-Labrador

CESFNCQ – Coalition of English-speaking First Nations Communities in Quebec

FNQLHSSC – First Nations of Quebec and Labrador Health and Social Services Commission

INAC – Indigenous and Northern Affairs Canada

MSSS – Ministère de la Santé et des Services Sociaux

NNADAP – National Native Alcohol and Drug Abuse Program

## 2.0 METHODOLOGY

### 2.1 Methods

The data for this research were gathered between April 28 – June 15, 2015; and between January 4 – February 26, 2016. All eleven (11) of the CESFNCQ communities were invited by letter to participate in the research (interviews and survey) (**Appendix 1, ‘Letter of Invitation’**). The researcher used an ‘action based’ qualitative research approach, and worked with the CESFNCQ throughout all stages of the research design, interviews, and data analysis.<sup>5</sup> Decisions about ‘research questions’, focus of the research were developed collaboratively between the CESFNCQ and the researcher. The research was guided by values – respect, equity, and reciprocity – in an effort to achieve an “ethical space” in the researcher<sup>6</sup> (**Appendices 2 and 3, ‘Inventory of Social Services Questionnaire’ and ‘Interview Questions’**).

In all stages, the researcher strove to gather data in a consistent and collaborative manner; and, at the same time, ensure that the research process remained in keeping with protocols of the participating First Nations communities and organizations. The CESFNCQ members reviewed the research questions and data collection methods, and each community had the option to participate in either group or individual interviews, to best meet their needs.

#### Interviews

The voices and findings shared in this report are drawn from the transcripts of eighteen (18) in-depth interviews with 49 individuals. The interviews were all conducted in English, with the exception of one interview that was conducted in both English and French. The interviews were conducted during April, May and June of 2015 and January/February of 2016 (**Appendix 4, ‘Interview Chart, Social Services’**). The research participants included front line workers, managers, coordinators, and directors

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<sup>5</sup> Chilisa, Bagele. *Indigenous Research Methodologies*. California: Sage, 2012. pp. 226-227

<sup>6</sup> Assembly of First Nations Quebec-Labrador (AFNQL). *First Nations in Quebec and Labrador’s Research Protocol*. Wendake [Quebec], 2014. p.5

responsible for the delivery of social development programming in (or with) First Nations communities.

A letter of invitation was sent to each of the participating communities, and the researcher worked directly with either the CESFNCQ member from each community or with a liaison worker from the community. In either case, the researcher spoke by phone with each lead person to explain the research.

Each community liaison identified staff members to take part in either group or individual interviews (depending on their preference and availability). For the most part, the participants work in social services sectors that are funded by Indigenous and Northern Affairs Canada's 'social development' programs (e.g., First and Second Line Social Services, Assisted Living, Family Violence Prevention) or under Health Canada's Addictions Services (NNADAP) programs. In addition, some communities chose to include individuals who provide services that interface with social services programming (for example, Daycare staff, Mental Health/ Wellness workers, staff who deliver programs to fight child poverty/food security). The design of the research allowed for flexibility to ensure that each community could invite participants who could best speak about experiences accessing 'social services', and in doing so, potentially uncover the themes, variations and nuances in the articulation of challenges, as well as solutions when accessing social services from provincial and federal systems.

Some communities preferred individual interviews, which were an average of one hour in length, while others chose group interviews, which were on average two hours in length. The interview questions focused on four general areas – 'what social services are easily accessible, and why', 'where are the challenges', and what solutions do communities have in place, or would recommend, to overcome any access issues.

The interviews followed a conversational structure, which allowed each community to present their own experiences and for variance in voices to emerge. The objective was to 'document a portrait of the situation' for English-speaking First Nations when accessing social services, thus it was important not to impose a predetermined picture of the situation when accessing social services onto the First Nations' communities. Further,

the objective was to identify themes common amongst the communities, but also to see and understand the nuances and variances that exist and to uncover potential reasons *why* there are differences when accessing social services amongst the participating communities.

All interviews were digitally recorded and transcribed. Transcripts were shared with each participating community, respectively, to ensure accuracy. The researcher presented the findings to research to the CESFNCQ at each stage (either in person or over video conference), and next steps were determined collaboratively. The findings were analyzed for emergent themes, and are presented in Section 5 of this report. The individual findings from each community were also summarized and are presented in the ‘appendices’ section’. (**Appendix 5, ‘Community Findings’ for the individual findings from each of the participating communities**). Generally speaking, the objective was to shed light on the collective and unique voices and experiences of English-Speaking First Nations when accessing social services from federal and provincial healthcare systems.

### Inventory of Social Services

In addition to the interviews, this research also included an ‘Inventory of Social Services’ survey that was designed to identify a list of social services that are currently provided in each community, along with agreement types. The purpose of this inventory was to develop a list of services by which to see the range of social services that are available in First Nations communities/organizations. All eleven (11) CESFNCQ communities were invited to complete the ‘Inventory of Social Services’ questionnaire. A total of eight (8) communities completed the ‘Inventory of Social Services’ questionnaire (of which six (6) were completed ‘in full’ and two (2) were completed ‘in part’). (**Appendix 6, ‘List of Social Services available in English-speaking First Nations communities in Quebec’**). Throughout this research the CESFNCQ members worked collaboratively, while recognizing that each First Nation community or organization has autonomy and enters into agreements with their provincial or federal funding partners based on their own unique cultural, social, and health priorities and needs.

## 3.0 OVERVIEW – FIRST NATIONS’ SOCIAL PROGRAMS

### 3.1 General Background

Aboriginal peoples have complex health and social needs stemming, in part, from Canada’s long history of colonial policies and legislation. Before European contact, however, Aboriginal peoples had systems of care in place for the health and wellbeing of their families, communities and Nations. The 1996 Royal Commission on Aboriginal peoples affirmed that Aboriginal families and communities “cared for their children in accordance with their cultural practices, laws, and traditions.”<sup>7</sup> Further, the Commission found that a shared cultural view among Aboriginal peoples was that children are viewed as “gifts from the creator” with a strong value placed on “extended family interdependence”.<sup>8</sup> In the Colonial Era, however, with the arrival of European settlers and the imposition of colonial legislation, notably the *Indian Act* of 1876, there were “restrictions on Aboriginal self-government [that] disposed Aboriginal people from their original lands.”<sup>9</sup> The *Indian Act*, it is well acknowledged, has contributed to ‘restrictions’ in the ability to “live well” in Canadian society.<sup>10</sup> The impact and effects of colonial legislation is visible in the disparity that exists between the health status of Aboriginal and non-Aboriginal peoples.<sup>11</sup>

Canada’s *Constitution Act, 1867* outlines the jurisdictional responsibilities of the federal, provincial and territorial governments. More specifically, in the area of health, under s. 92(7) of the *Constitution Act*, the provinces were responsible for establishing, maintaining and managing hospitals, asylums, charities, and charitable institutions, while the federal government was responsible for quarantines and marine hospitals. In

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<sup>7</sup> Sinha, V. and A. Kozlowski quoting Royal Commission in “The Structure of Aboriginal Child Welfare in Canada.” *The International Indigenous Policy Journal*. 4.2 (2013). p.3

<sup>8</sup> Ibid. p.3

<sup>9</sup> Allana S. W. Beavis, Ala Hojjati, Aly Kassam, Daniel Chodhury, Michelle Fraser, Renee Masching and Stephanie A. Nixon. “What all students in healthcare training programs should learn to increase health equity: perspectives on postcolonialism and the health of Aboriginal Peoples in Canada,” *BMC Medical Education* (2015) 15. p.2

<sup>10</sup> Ibid.

<sup>11</sup> Waldram, James, D. Ann Herring, and T. Kue Young. *Aboriginal Health in Canada*. 2nd Edition. Toronto, Ontario: Univ. of Toronto Press, 2012

addition, in 1876, the *Indian Act* was enacted by parliament providing the federal government with “exclusive jurisdiction” over Aboriginal people – ‘Indians and Lands reserved for the Indians’ (under s. 91(24) of the *Constitution Act, 1982*.)

Over the years, Aboriginal peoples in Canada have faced policies intended for assimilation into colonial culture.<sup>12</sup> There has also been an *absence* of legislation by which to develop policies for a ‘social services system’ (such as a child welfare system) for First Nations people living in communities on Reserve. In 1951, there were major revisions to the *Indian Act*. Notably, the introduction of Section 88 to the *Indian Act* meant that for the first time provincial/territorial laws “of general application” could be applied on Reserve (such as child welfare services).<sup>13</sup> However, initially, provinces and territories only provided services in ‘extreme circumstances’.<sup>14</sup> Section 88 recognizes that provincial laws could be applied on Reserve, yet the actual implementation of those laws was not clearly defined.

The longstanding jurisdictional dispute between the federal and provincial/territorial governments’ over the responsibility for First Nations has created gaps when accessing health and social services. In communities, this divide is visible in the ‘two systems’ of healthcare: First Nations health and social services’ centers and a provincial network of health and social services programs. First Nations and provincial network are not formally linked through legislation or policies.<sup>15</sup> There are jurisdictional ambiguities, disputes, and gaps amongst the various levels of governments and institutions responsible

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<sup>12</sup> Milloy, John. *A National Crime: The Canadian Government and the Residential School System, 1879 to 1986*. Winnipeg: University of Manitoba Press, 1999

<sup>13</sup> In 1951, Section 88 was introduced to the *Indian Act*, which made “all laws of general application from time to time in force in any province applicable to and in respect of Indians in the province”. This was interpreted to mean that: “for the first time, provincial or territorial child welfare applied on-reserve” (Sinha and Kozlowski).

<sup>14</sup> By the mid 1950s the federal government allocated funds to provinces/territories to support services provided on-reserve. The number of children in care “increased sharply”. First Nations Studies Program. “Sixties Scoop,” *University of British Columbia*. 2009. Web. 9 Feb. 2015.

<sup>15</sup> As stated by the AFNQL and First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) under the current [health care system] First Nations communities are “situated on the periphery of the [provincial] health and social services. At the local level, [First Nations] must establish corridors of access to care to overcome this distance and must do so while taking into account the cultural and linguistic differences that exist among their populations.” Blackstock, Cindy, Tara Prakash, John Loxley and Fred Wien. *Wen:de: Coming to the light of day*. Ottawa, Ontario: First Nations Child and Family Caring Society of Canada, 2005. p. 5

for Aboriginal health – First Nations, provincial and federal, which in turn impact Aboriginal peoples’ access to health and social services.

### 3.2 Time Line – First Nations Social Programs (1951- 2016)

#### Time line of social programs

- **1951:** Introduction of Section 88 to the *Indian Act*, provincial/territorial laws “of general application” could be applied ‘on Reserve’.
- **1964:** The federal government’s **Income Assistance Program** is approved. The Treasury Board of Canada authorizes Indian Northern Affairs Canada (INAC) to administer income assistance at provincial or territorial rates and eligibility requirements.
- **1974:** Health Canada’s **National Native Alcohol and Drug Abuse Program** (NNADAP) launched as a pilot project.
- **1978:** First federally funded **shelters for abused women** were constructed under CMHC Non-profit Housing Program.
- **1980s:** **First Nations child welfare agencies** established with federal funding.
- **1980s:** The federal government (INAC) negotiated with provinces and territories to have income assistance administered by First Nations authorities. The Department provided funding for the program, and communities delivered programs and services.
- **1980s:** ‘**Assisted Living Program**’ (formerly called the ‘Adult Care’ program). Assisted Living evolved at a regional level as part of the federal government’s general policy to provide services on reserve that were reasonably comparable to the services provided at the provincial/territorial level.
- **1982:** **National Native Alcohol and Drug Abuse Program** (NNADAP) is made a permanent program, mainly under the authority of First Nations communities.
- **1984:** A **Memorandum of Understanding (MOU)** was signed between INAC and Health Canada to set out their respective responsibilities for ‘assisted living’ services and programs. INAC took on “limited responsibility” for non-medical institutional care provided ‘on Reserve, while Health Canada funded the Home and Community Care Program and the Non-Insured Health Benefits Program (medical care).
- **1988:** **Family Violence Prevention Program (FVPP)** – The federal government (joint initiative between AANDC and Health Canada) launched the ‘Family Violence Initiative’.

- **1988:** Restrictions imposed on the construction of new residential care facilities on reserve for the **assisted living program**. *Reasons:* escalating costs; INAC's unclear authority over 'adult care'; and the lack of a national policy framework.
- **1990:** The Indian Northern Affairs Canada (INAC) received Cabinet and Treasury Board authority to implement its **First Nations child and family services policy**, including the funding model 'Directive 20-1.' As well, the policy stipulated that services were to be 'culturally appropriate' and 'reasonably comparable' with services provided 'off Reserve' in similar circumstances.
- **1994:** INAC's budget for core services (such as Income Assistance) capped at 2% per year; in contrast, provincial and territorial (off Reserve) basic rates for IA continued to increase.
- **1995:** INAC unilaterally stopped providing adjustment for inflation for **Child and Family Services**.
- **1998:** The federal government launched the **National Child Benefit Reinvestment (NCBR) program**. The NCBR program (which is the 'on Reserve counterpart to the National Child Benefit Program) provides child benefits to all low-income families regardless of their source of income (i.e., social/income assistance, low wage employment, Employment Insurance, or other income support program). The NCBR also has a 'reinvestment component' – provinces 'reinvest' into programs and supports for low-income families.
- **2007:** The federal government implemented a new funding approach – Enhanced Prevention Focused Approach (EPFA) for the delivery of First Nations Child and Family Services.
- **2013:** Federal Government launched the **Enhanced Delivery Service Program** to address the high number of Aboriginal young adults (ages 18-24) who are dependent on Social Assistance as their main source of income.
- **2014:** the Government of Canada released its five-year *Action Plan to Address Family Violence and Violent Crimes Against Aboriginal Women and Girls* (2015-2020).
- **2015:** the Government of Canada launched a national inquiry into Missing and Murdered Indigenous women and girls (December 8, 2015).
- **2016:** the Canadian Human Rights Tribunal passed its landmark ruling, which found that the federal government discriminates against children living on reserve by failing to provide them with the same quality of welfare services available to children elsewhere in the country (January 26, 2016).

### 3.3 Indigenous and Northern Affairs Canada – Social Programs

The federal government, under the Department of Indigenous and Northern Affairs Canada (INAC), funds a range of social programs. The social development areas investigated for this research included:

- i) Enhanced Prevention Focus (Prevention and Protection)
- ii) Assisted Living Program
- iii) Family Violence Prevention Program
- iv) Income Assistance Program
- v) National Child Benefit Reinvestment Strategy

#### i.) Enhanced Prevention Focus – Prevention and Protection

Since the early 1980s, First Nations agencies have been administering and delivering a range of programs and services for children who are vulnerable under the **First Nations Child and Family Services** program (also referred to as ‘Enhanced Prevention Focus’). The services delivered under Enhanced Prevention Focus include: ‘first line services’ (*preventative and culturally adapted services*), and also ‘second line’ or protection services (*for example, Child and Youth Protection, Foster Homes, Group Homes*).<sup>16</sup>

In the early 1980s, First Nations child welfare agencies were established with federal funding. At that time, in 1981, there were just four agencies, however, by 1986 there was a total of thirty agencies throughout Canada. A federal moratorium on the “recognition of new agencies” was put into place, and was lifted in the early 1990s. At the same time that the moratorium was lifted, the federal government approved a ‘First Nations child welfare policy’. This national policy included the implementation of the National Funding formula (Directive 20-1)<sup>17</sup> and a Program Manual for First Nations child welfare

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<sup>16</sup> FNQLHSSC. “Areas of Intervention – Social Services.” 2011. Web. 15 March 2015

<sup>17</sup> According to Aboriginal Affairs and Northern Development Canada (AANDC), Program Directive 20-1 funding models are based on child population and previous year children-in-care rates. (AANDC. “First Nations Child and Family Services Program.” 7 March 2013. Web. 26 Feb. 2015.) Also see: *Wen:de: Coming to the light of day*, which describes the federal government’s position about funding as such: on

agencies. The FNCFS policy recognized the need for “culturally appropriate child and family services controlled by First Nations for the benefit of on Reserve children and their families” (Auditor General of Canada, 2008).

As of 2008, there were 125 First Nations Child and Family Services agencies in Canada.<sup>18</sup> The vision shared by many First Nations is not only to control the “delivery of services”, but also to assume “full jurisdiction and governance” over child welfare.<sup>19</sup>

However, even though the First Nations’ child welfare policy recognizes the need for ‘culturally appropriate child and family services’, and services are delivered in many communities, nevertheless, Aboriginal children continue to be overrepresented in the care of child welfare agencies. It is estimated that approximately five percent of all children living on Reserves are ‘in care’, which is an estimated eight times the proportion of children who live off Reserve.

### ***Aboriginal-specific Provisions in Legislation (Child and Family Services)***

Across Canada, there are varying child welfare legislation for Aboriginal children enacted by the provinces and territories. There are six main ‘Aboriginal-specific’ provisions in legislation<sup>20</sup>, including:

- Band notification of court or placement;
- Aboriginal involvement in case management;
- Aboriginal involvement in service planning or delivery;
- Prioritization of kinship care;
- Band submission of cultural connection plan invited; and
- Connection to Aboriginal culture –best interest of child.

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reserve “child and family services’ are funded “pursuant to policy directive (20-1) –not, according to them, as a result of a fiduciary obligation but as a matter of administration” (p. 89).

<sup>18</sup> Sinha, Vandna, Nico Trocmé, Barbara Fallon, Bruce MacLaurin, Elizabeth Fast, Shelley Thomas Prokop, et al. *Kiskisik Awasisak: Remember the Children – Understanding the overrepresentation of First Nations Children in the Child Welfare System*. Ontario: Assembly of First Nations, 2011. p. x

<sup>19</sup> First Nations Child and Family Caring Society of Canada. *A Literature Review and Annotated Biography Focusing on Aspects of Aboriginal Child Welfare in Canada*. Marlyn Bennett and Cindy Blackstock. Manitoba: Centre of Excellence for Child Welfare, 2002. p.30

<sup>20</sup> Sinha and Kozlowski. pp.8-11

The most common provision in the provincial/territorial legislation – except in the provinces of Quebec and New Brunswick – is the “requirement to notify Aboriginal bands of court hearings involving Aboriginal children”.<sup>21</sup> As well, in addition to the provincial/territorial legislation for child welfare, the literature on this topic also recognizes that Aboriginal laws and customs continue to shape child welfare practices.<sup>22</sup>

### **Child and Family Services: Services Available and Access Issues**

- 1990: The Indian Northern Affairs Canada (INAC) received Cabinet and Treasury Board authority to implement its First Nations child and family services policy, including the funding model ‘Directive 20-1.’ As well, the policy stipulated that services were to be ‘culturally appropriate’ and ‘reasonably comparable’ with services provided ‘off Reserve’ in similar circumstances.<sup>23</sup>
- 1995: INAC unilaterally **stopped providing adjustment for inflation.**<sup>24</sup>
- 1999: INAC and the Assembly of First Nations convened at the First Nations Child and Family Services Joint National Advisory Committee (NAC) to oversee a review of Directive 20-1.
  - Gaps and issues identified by the National Advisory Committee: First Nations children received **twenty two percent less funding** for child welfare than other children; significant problems with the funding formula; lack of emphasis on ‘least disruptive’ measures; lack of funding, or insufficient funding, to achieve ‘equitable and culturally appropriate’ social work practice.<sup>25</sup>
- 2007: Assembly of First Nations filed a Canadian Human Rights Complaint against the Government of Canada alleging “**racial discrimination against First Nations**

<sup>21</sup> Sinha and Kozlowski. p.8

<sup>22</sup> Sinha and Kozlowski explain that in some jurisdictions First Nations have taken the position that “First Nations have pre-existing rights over the well-being of First Nations ...” For example, the position of the Federation of Saskatchewan Indian Nations is that First Nations ‘have the authority to make, adopt an enact laws’ with respect to First Nations’ child welfare and that these laws ‘honour and take precedence over’ provincial laws” (Ibid. p.11).

<sup>23</sup> According to the First Nations Child and Family Caring Society of Canada, at that time (1990s), First Nations expressed concern that “the structure and amount of funding in Directive 20-1 were problematic” (First Nations Child and Family Caring Society of Canada. “I am Witness’- First Nations Child and Family Services Funding.” 2013. Web. 26 Feb. 2015).

<sup>24</sup> First Nations Child and Family Caring Society of Canada noted that in 2006, “the federal government provided some funds to redress the inflation losses incurred by First Nations child and family services between 1995-2005. The amount provided is estimated to be less than a third of what was needed” (Ibid).

<sup>25</sup> First Nations Child and Family Caring Society of Canada. “I am Witness’- First Nations Child and Family Services Funding.”

**children** resulting from the Government of Canada’s First Nations child and family services program” (First Nations Child and Family Caring Society).

- 2007: Member of Parliament, Jean Crowder (NDP) tabled Private Members Motion 296 in support of Jordan’s Principle. On December 12, 2007, Jordan’s Principle passed unanimously in the House of Commons.<sup>26</sup>
- 2007: The federal government implemented a new funding approach – **Enhanced Prevention Focused Approach (EPFA)**.
  - According to AANDC, this approach provides funding for prevention services in Reserve communities, comparable to services provided in by the province or territories.
  - The Enhanced Prevention Focused Approach is intended to replace the National Funding formula (Directive 20-1)
- 2008: The Auditor General of Canada found that AANDC **funding arrangements** (including the Directive 20-1 and the enhanced funding arrangement) continue to be **‘inequitable’ with provincial/territorial programs and services**. (As of May 2013, six (6) provinces have adopted this new model – Alberta, Saskatchewan, Nova Scotia, Quebec, PEI and Manitoba.)<sup>27</sup>
- 2008: **Information Management** – Under Canada’s Economic Action Plan, the federal government allocated funds to develop an automated information management system for the FNCFS program. This system was to be implemented over three phases beginning in April 2013 until June 2014.
- 2016: **Canadian Human Rights Tribunal** found that the federal government discriminates against children living on reserve by failing to provide them with the same quality of welfare services available to children elsewhere in the country.

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<sup>26</sup> First Nations Child and Family Caring Society of Canada. “I am Witness’ - First Nations Child and Family Services Funding.”

<sup>27</sup> AANDC. *Aboriginal Affairs and Northern Development Canada Role as a Funder in First Nations Child and Family Services*. PowerPoint. May 2013. p.5

## ***Child and Family Services – Quebec Region***

In Quebec, First Nations ‘Child and Family Services’ agencies are responsible for the “management of youth protection services” depending on the different agreements concluded between Indigenous and Northern Affairs Canada (INAC) and the Band Councils or youth centres (Government of Quebec). This means that depending on the types of agreements established there are different services available.<sup>28</sup> The agreements (bipartite or tripartite agreements) specify the level of delegation in the ‘on Reserve’ application of Quebec’s *Youth Protection Act*. In addition, Quebec’s Youth Protection Act (Section 37.5) allows for “agreements for the establishment of special youth protection programs, which are designed to better adapt the act to the realities of life in First Nations communities”.<sup>29</sup> However, as of yet, First Nations have not entered into any agreements with province under Section 37.5 of the Youth Protection Act.<sup>30</sup>

**In the Quebec Region, there are two ‘Aboriginal-specific’ provisions for children, families and communities in the legislation for child welfare:**

- Aboriginal involvement in service planning or delivery<sup>31</sup>
- Prioritization of kinship care<sup>32</sup>

(Sinha and Kozlowski)

<sup>28</sup> FNQLHSSC. “Youth Protection”. 2011. Web. 23 Feb. 2015

<sup>29</sup> Sinha and Kozlowski. p.9

<sup>30</sup>At this point, the CESFNCQ is not aware of any existing agreements between the province and First Nations resulting from 37.5. CESFNCQ Meeting. “Research Presentation and Discussion.” Montreal. 14 April 2015.

<sup>31</sup> This provision is reflected in Section 37.5 of the Youth Protection Act – provides “limited provision for Aboriginal involvement”. Also, this provision is reflected in Section 32(c.) of the YPA, allowing child responsibilities be enacted by (c) a member of a Native community designated by the director within the scope of an agreement between an institutions operating a child and youth protection centre and the Native community. (Vandna Sinha. “Question\_The Structure of Aboriginal Child Welfare in Canada.” Message to A. Chamberlin. 21 April 2015. E-mail.)

<sup>32</sup>This provision ‘prioritization of kinship of care’ is “not specific to Aboriginal children or to children in care, but is a general component of Quebec practice and standards, grounded in section 4 of the YPA” (Sinha. “Question\_The Structure of Aboriginal Child Welfare in Canada”. E-mail.

## Overview of First Nations Child and Family Services in Quebec

- In Quebec, a total of 15 agencies provide services to 19 First Nations communities with funding from Indigenous and Northern Affairs Canada. There are 3 youth centres, under the responsibility of the provincial government, which serve the remaining 8 communities.<sup>33</sup>
- First Nations and the federal government agreed at the First Nations Socioeconomic Forum held in Mashtouiatsh in October 2006 to invest and implement a “first-line social services [prevention services] project in First Nations communities”. The purpose of the pilot project was to “generate lessons” that would guide the implementation of similar prevention programs in Quebec.<sup>34</sup>
- Enhanced Prevention Focused Approach –Starting in 2007, the federal government began to provide additional funding (over and above the existing FNCFS budget allocation) for the implementation of the Enhanced Prevention Focused Approach.<sup>35</sup> (The EPFAs are implemented through tripartite frameworks on a province-by-province basis).
  - **In this research, CESFNCQ members raised concerns with the Enhanced Prevention Focused Approach.**
  - The intention of the Enhanced Prevention Focused Approach appears to be to invest additional resources in prevention activities, thereby creating less need for placement, and thus generating a “savings,” which could be reinvested into additional prevention activities. However, under its current structure, any “savings” generated will be deducted in subsequent years by reducing revenue. This creates a vicious cycle for a community: attempts to invest in activities to generate creative solutions to address youth protection issues are thwarted because of the overall long term reduction in revenues necessary to carry out such activities.
  - There are additional challenges for First Nations due to the lack of provincial and federal investment in prevention services, generally.<sup>36</sup>
- Framework Agreement: In 2009, Quebec (*Ministère de la Santé et des Services Sociaux (MSSS)*), First Nations (*represented by the First Nations of Québec & Labrador Health & Services Commission (FNQLHSSC)*), and Canada (*Indian and Northern Affairs Canada (INAC)*) signed a framework agreement ‘Quebec Partnership Framework for Enhancement Focused Approach - August 2009’.

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<sup>33</sup> In Quebec, there are a total of 27 ‘non treaty’ communities [and 28 ‘treaty’ communities] (FNQLHSSC. *Implementation of Evaluation of the First-Line Social Services Pilot Project in Four Quebec First Nations Communities*. [Wendake (Quebec)], 2011 p.1). The CESFNCQ includes both ‘treaty’ and ‘non treaty’ communities.

<sup>34</sup> *Implementation of Evaluation of the First-Line Social Services Pilot Project in Four Quebec First Nations Communities*. p.2

<sup>35</sup> AANDC. *Audit of the Implementation of Child and Family Services Enhanced Prevention Focused Approach*. Internal Audit. September 2012. p. 1

<sup>36</sup> CESFNCQ. Review of Research Report. E-mail from CESFNCQ member. 27 July 2015

- The FA build on prevention-based pilot projects started in 2006.
- The purpose of the agreement is as follows: “This Partnership Framework establishes the parameters for an enhancement initiative to create quality, community-based, integrated, culturally appropriate 1<sup>st</sup> Line Prevention Services for the benefit of FN children, families and communities.”<sup>37</sup>

## ii.) Assisted Living

The ‘**Assisted Living**’ program (formerly called the ‘Adult Care’ Program) evolved at a regional level largely “in the absence of a national policy framework”. The program came into existence in 1980-1982 as part of the federal government’s general policy to provide “First Nations on reserves” with services “reasonably comparable” to the services provided at the provincial/territorial level. The program developed in varying ways across the regions, depending on needs and availability of resources.<sup>38</sup>

According to INAC, the Assisted Living program is “complementary” to Health Canada’s Home and Community Care Program and the Non-Insured Health Benefits Program. In 1984, a Memorandum of Understanding (MOU) was signed between INAC and Health Canada to set out their respective responsibilities. At this time, INAC took on “limited responsibility” for non-medical institutional care provided on Reserve.

Today, INAC’s Assisted Living Program offers assistance (non-medical social support services) to the elderly and to individuals living with chronic illnesses or disabilities (mental and physical). The program is available to individuals who are living on Reserve. The objective of the program is to ensure that individuals living with chronic illness or disabilities (mental or physical) “can maintain functional independence and achieve greater self-reliance”. The Assisted Living program has three main components: in-home care, adult foster care, and institutional care. The in-home care provides financial assistance for non-medical personal care for individuals who need help with activities of

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<sup>37</sup>AANDC. “Quebec Partnership Framework for Enhancement Prevention Focused Approach.” 13 Feb. 2012. Web. 27 Feb. 2015

<sup>38</sup> Minister of Indian Affairs and Northern Development. *Assisted Living Program – National Standards and Guidelines Manual*. Ottawa. Feb. 2005. p.12

daily living. The Adult foster care and institutional care provides funding for “eligible individuals” who need non-medical care in a “supported living environment”. In addition, the Assisted Living program includes a “disabilities initiative”. This initiative funds projects on a yearly basis to “improve the coordination and accessibility of existing disability programs and community services to persons living on reserve”.

Although the Assisted Living program is intended to provide services for both elderly care and also for individuals with disabilities, First Nations participating in this research expressed concern that there is “much less support” for the disabilities side of the Assisted Living program.<sup>39</sup>

### ***Long Term Care Homes***

According to the Assembly of First Nations, there are a total of thirty-one (31) long-term care facilities that are located on Reserves across Canada. The facilities, which provide various levels of care, include: Seniors Lodges, Personal Care Homes, and Long Term Care Homes. The facilities are located in the following six provinces: Manitoba (8 facilities); Quebec (7 facilities); Saskatchewan (4 facilities); Ontario (3 facilities); British Columbia (1 facility) and Nova Scotia (1 facility).<sup>40</sup>

### ***Quebec Region***

A report produced for the First Nations of Quebec and Labrador Health and Social Services Commission lists the long-term residential homes located in Quebec (Note: communities marked with an ‘\*’ are part of the CESFNCQ).<sup>41</sup> The residential centers are for people “with loss of autonomy requiring less than two and a half hours of care per day”; the First Nations’ residential centers are not considered part of Quebec’s network.<sup>42</sup>

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<sup>39</sup> CESFNCQ. Review of Research Report. E-mail from CESFNCQ member. 27 July 2015. Further research is required to identify which services are available from Assisted Living for ‘elderly care’ and ‘care for people with disabilities’.

<sup>40</sup> Assembly of First Nations quoted in Nova Scotia Department of Health. *Aboriginal Long Term Care in Nova Scotia*. Aboriginal Health Transition Fund Project. Home Care on-Reserves Project. 2010. p.15

<sup>41</sup> Simon, Linda. *Living Conditions of the Elders of the First Nations of Quebec*. Final Report. [Wendake (Quebec)]. FNQLHSSC, 2010. p. 16

<sup>42</sup> AFNQL and FNQLHSSC. *Brief on Bill 10: an act to amend the organization and governance of health and social services network, in particular by abolishing the regional agencies*. (2014). Note: Although the institutions are not part of Quebec’s network, nevertheless some “operate under a private institution permit issued by the Quebec’s Ministère de la Santé et des Services Sociaux (MSSS)” (Ibid. p.2).

## First Nations Long Term Residential Homes in Quebec

Name of Centre	Community
Tiosehrohon Tsiiontientahkwa	Kahnawake*
Kaniatarakta iontorishentahkhwa	Kanesatake*
Kiweda	Kitigan Zibi*
Centre Tshishemishk	Mashteuiatsh
Anishnabe Long Term Care Centre	Timiskaming*
Foyer Tshenuat	Uashat mak Mani-Utenam
Résidence Marcel-Siouï	Wendake

### 'Assisted Living' Programs – Overview of Services and Exposing Gaps and Issues

- **1980s:** Federal Government's general policy to provide services in First Nations' communities ('on Reserve') that are comparable with those at the provincial or territorial level ('off Reserve'). Residential care facilities were constructed 'on Reserve'.
- **1988:** Restrictions were imposed on the construction of new residential care facilities on Reserve. The reasons for the restrictions include: escalating costs; INAC's unclear authority over 'adult care'; and lack of national policy framework.
- **1989:** Joint Working Group (INAC/Health Canada) was established to develop 'comprehensive community-based continuing care program'.
- **1997:** Joint Study *National Summary: First Nations Continuing Care Services and Issues*. Study revealed "serious gaps" in services available on Reserve in comparison to services available in provincial or territorial programs – clients on Reserve "did not have access to the same scope and quality of in-home services as those offered by provincial or territorial programs" (Quoted in 'Assisted Living Manual. p. 14). Second, the "regional funding levels were inadequate to meet the existing needs of First Nation clients on reserves".<sup>43</sup>
- **2000 onwards:** INAC approves funding for new facilities, however there are several conditions/restrictions that must be met before constructing new facilities. To counter restrictions, INAC increased the availability of 'in home' support services.

<sup>43</sup> *Assisted Living Program – National Standards and Guidelines Manual*. p.14

- **2005:** The *‘Assisted Living Manual’* (2005), identified gaps in services because of jurisdictional issues between the federal and provincial authorities in particular with respect to ‘medical’ and ‘non medical’ care. Generally speaking, ‘higher level’ of care (e.g., care beyond ‘non medical’, types I and II) is not provided for ‘on Reserve’. Consequently, First Nations people requiring ‘higher level medical care’ must leave their home communities to receive care in either provincial or private institutions off Reserve. First Nations argue that the situation is “unacceptable” due to the “isolation from family support systems” and the “lack of culturally specific services”.<sup>44</sup>

### iii.) Family Violence Prevention Program

The federal government’s **Family Violence Prevention Program (FVPP)** is considered to be the “largest program” devoted to addressing and stopping family violence, in particular violence aimed at Aboriginal women.<sup>45</sup> This program began in 1978 when the first federally funded shelters for abused women were constructed under CMHC Non-profit Housing Program.<sup>46</sup> Ten years later, in 1988, the federal government (joint initiative between Aboriginal Affairs and Health Canada) launched the ‘Family Violence Initiative’. Then, in 1991, Aboriginal Affairs received funds for community-based prevention services on Reserves; the funds were used “to provide operational funding for 20 shelters on reserve.”<sup>47</sup> There are three key components to the FVPP program: Women’s Shelters; Prevention Based Projects; and the National Aboriginal Circle Against Family Violence.

In 2014, the Government of Canada released its five-year *Action Plan to Address Family Violence and Violent Crimes Against Aboriginal Women and Girls* (2015-2020). The *Action Plan* addresses family violence and violent crimes against women and children under ‘three pillars’: Preventing Violence; Supporting Aboriginal Victims; Protecting Aboriginal Women and Girls (investing in shelters and continuing to improve Canada’s

<sup>44</sup> *Assisted Living Program – National Standards and Guidelines Manual*. pp.16-17

<sup>45</sup> Lamontagne, Manon. *Violence Against Aboriginal Women – Scan and Report*. Canadian Women’s Foundation. Jan. 31 2011. p. 3

<sup>46</sup> AANDC. *Evaluation of the Family Violence Prevention Program*. February 2012. p.2

<sup>47</sup> *Ibid.* p. 2

law enforcement and justice systems).<sup>48</sup> First Nations communities, Native Women's Associations across Canada, Aboriginal leadership, activists and Aboriginal peoples and their allies, have expressed the pressing need for a national inquiry into the large numbers of murdered and missing Aboriginal women. In December of 2015, the federal government announced the launching of a national inquiry into Missing and Murdered Indigenous women and girls.

### Women's Shelters

The FVPP program provides funding for a network of forty-one (41) shelters nationwide; the shelters provide services to ensure the safety and wellbeing of women and children during times of crisis. It is estimated that the Aboriginal Affairs funded shelters serve approximately 329 First Nations communities (55% of First Nations communities).<sup>49</sup>

### ***Quebec Region***

In Quebec, there are six (6) INAC funded shelters for women and children who live (or are 'ordinarily resident') on Reserve.<sup>50</sup> Most of the INAC funded shelters are located 'on Reserve', while some are located off Reserve.<sup>51</sup> There are also other 'non profit' shelters, that do not receive funding from INAC, yet which serve Aboriginal clientele. The following chart lists the shelters located in Quebec for Aboriginal women and children, including both INAC-funded shelters and also non-profit shelters<sup>52</sup> (\* are located in communities/organizations that are part of the CESFNCQ).

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<sup>48</sup> Government of Canada. *Action Plan to Address Family Violence and Violent Crimes Against Aboriginal Women and Girls*. 2014. p1.

<sup>49</sup> AANDC. "Family Violence Prevention Program – Frequently Asked Questions". 10 Dec. 2014. Web. 27 Feb. 2015

<sup>50</sup> AANDC. *Evaluation of the Family Violence Prevention Program*. February 2012. p.26

<sup>51</sup> Ibid. p.5

<sup>52</sup> Quebec Native Women Inc. "Promotion of non Violence and Women's Shelters". N.d. Web. 12 March 2015

## Native Women’s Shelters in Quebec

Name of Shelter	Community
Haven House*	Listuguj
Ashpukun Mitshuap	Schefferville ( <i>Run by Montagnais</i> )
Tipinuaikan	Sept-Iles
Asperimowin	La Tuque (off Reserve)
Waseya House*	Kitigan Zibi
Missinak	Quebec City (INAC funded shelter)
Native Women's Shelter*	Montreal (Urban) (non profit organization)

### Women’s Shelters – Exposing Gaps and Issues

- **Program gaps** – Aboriginal Affairs’s evaluation (2012) of the FVPP found that some communities do not have access to services, and even for those that do “program gaps still exist” (lack of men’s services, children’s programming, follow up and outreach services, and training for shelter staff)<sup>53</sup>
- **Lack of parity with provincial programs** – National Aboriginal Circle Against Family Violence (NACAFV) reported that [Aboriginal Affairs] funded women’s shelters are not funded at the same level as provincially funded non-Native shelters<sup>54</sup>
  - In 2005, Quebec instituted increases to provincial shelters; Aboriginal women’s shelters did not receive any increase to core funding.<sup>55</sup>
  - The Quebec Native Women’s Association and the Native Women’s Shelter Network Committee are “advocating for parity” in funding between on and off Reserve women’s shelters.
  - The ‘Family Violence Initiative’ (non Aboriginal) receives support (financial) from several federal departments, while the on Reserve counterpart ‘Family Violence Prevention Program’ receives its budgetary allocation from one department – Aboriginal Affairs.

<sup>53</sup> *Evaluation of the Family Violence Prevention Program* (2012). p.vi.

<sup>54</sup> National Aboriginal Circle Against Family Violence. *Addressing Funding Policy Issues: INAC-Funded Women’s Shelters*. [Kahnawake, Quebec: 2008]. p. 1

<sup>55</sup> Alberta Council of Women’s Shelters. *November is Family Violence Prevention Month*. PowerPoint. [2005]

- **Administration of funds** – Shelters face challenges because funding for shelters must “flow through” the Chief and Council (or Administration) through Comprehensive Funding Arrangements; as such, the Band Council may “apportion the funds to the detriment of the shelter”.
- There is a 10% holdback of the total annual funding to the shelters by Aboriginal Affairs, which “translated into a potential lack of available services for women and children in crisis”.<sup>56</sup>

### Prevention Based Projects

The FVPP also provides funding for prevention-based projects (on and off Reserve). The family violence prevention projects are “proposal-based activities” – developed in response to community needs; including: public outreach and awareness, education campaigns, conferences, seminars, workshops, counseling, support groups, and community needs assessments.

*Funding Formula for the ‘family violence prevention projects’*: AANDC’s evaluation (2012) of the FVPP program found that “in some regions, family violence projects are funded on a project basis, while in other regions bands are provided funding on a per capita basis.”<sup>57</sup>

### National Aboriginal Circle Against Family Violence

The FVPP provides core funding to the **National Aboriginal Circle Against Family Violence**. This organization, which emerged from grassroots initiatives in 1999, began to receive AANDC funding in 2001.<sup>58</sup> Today, the National Aboriginal Circle Against

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<sup>56</sup> *Addressing Funding Policy Issues: INAC-Funded Women’s Shelters*. p.2

<sup>57</sup> *Evaluation of the Family Violence Prevention Program* (2012). p.5

<sup>58</sup> National Aboriginal Circle Against Family Violence. “History”. 2015. Web. 25 Feb. 2015 and *Evaluation of the Family Violence Prevention Program*. (2012). p.3

Family Violence provides a national coordinating role for AANDC shelters (both on and away from the Reserve), Aboriginal specific shelters and second stage housing, and Aboriginal and family violence outreach programs.<sup>59</sup> The NACAFV contact office is located in Kahnawake.

#### **iv.) Income Assistance Program**

The federal government's Income Assistance Program was approved in 1964. Income assistance ("social assistance" or "welfare") is a program intended to alleviate "extreme poverty by providing a monthly payment to people with little or no income."<sup>60</sup> When the program was first established, in the early 1960s, the Treasury Board of Canada authorized Indian Northern Affairs Canada (INAC) to administer income assistance at "provincial or territorial rates and eligibility requirements."<sup>61</sup>

In the 1980s, the federal government (INAC) negotiated with provinces and territories to have income assistance administered by First Nations authorities. The Department provided funding for the program, and communities delivered their own programs and services.<sup>62</sup>

In the late 1990s, the provinces/territories began restructuring their income assistance programs (generally called 'welfare reform'). Prior to this, the federal government shared the cost of income assistance and social services with provinces/territories on a 50/50 basis. However, with the reforms, under the Canada Health and Social Transfer (CHST), the federal government provided a *fixed amount* of funding to the provinces. Subsequently, the provinces "reduced or froze rates, restricted eligibility requirements,

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<sup>59</sup> National Aboriginal Circle Against Family Violence. "History". 2015. Web. 25 Feb. 2015

<sup>60</sup> Assembly of First Nations. "Income Assistance." N.d. Web. 17 Feb. 2015. Income Assistance is defined by AANDC as follows: "Income Assistance: a program of last recourse that provides financial supports to meet basic needs (food, clothing, and shelter) and special needs, and employment-related support for individuals and families. Also commonly referred to as "social assistance" and "welfare"." (AANDC). *First Nations National Child Benefit Reinvestment– Progress Report for Year Ending March 31, 2009*. (2012). p.iv

<sup>61</sup> Indian and Northern Affairs Canada, Audit and Evaluation Sector. *Evaluation of the Income Assistance Program*. Dec. 2007. p.1; emphasis added

<sup>62</sup> Assembly of First Nations. "Income Assistance." N.d., Web. 17 Feb. 2015

and introduced ‘welfare to work’.<sup>63</sup> These two ‘active measures’ – fixed amounts and “welfare to work” – were put in place in an attempt to reduce the number of people dependent on social assistance, and, to “encourage individuals to become more self sufficient.”<sup>64</sup>

In contrast, the reforms made to social assistance at the provincial level were not implemented in First Nations communities: the only changes implemented were rate reductions (e.g., INAC reduced rates for First Nations in provinces that reduced rates). The federal government’s evaluation of the Income Assistance program (2007) reported that dependency rates on Social Assistance programs in First Nations communities remained “unchanged” during the period of social assistance reforms.

Eventually, in the years following the provincial reforms, the provinces/territories began to increase basic rates for Income Assistance. However, the basic rates for IA did not increase in First Nations communities. In fact, in 1997, INAC’s budget for core services (such as IA) was capped at 2% per year. The review of IA program (2007) affirmed that: “in recent years provinces and territories increased basic rates or introduced enhancements to programs and INAC’s budget has been unable to keep pace”.<sup>65</sup> To summarize, the key difference in the delivery of ‘Income Assistance’ between the provinces and First Nations is that First Nations are providing services without ‘program enhancements’ (e.g., active measures) and with budgets capped at a rate that was deemed “insufficient” to meet the demands on the IA program.<sup>66</sup>

### ***Quebec Region – First Nations Income Assistance***

- **Agreements** – In 2003, the *First Nations of Quebec Income Security Agreement* was signed between INAC and Quebec First Nations, which led to establishment of the Quebec Social Development Office. This unit delivers support services in many communities. This agreement was put in place to “better adapt provincial income

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<sup>63</sup> *Evaluation of the Income Assistance Program* (2007). p.2

<sup>64</sup> *Ibid.* p.2

<sup>65</sup> *Ibid.* p. 3

<sup>66</sup> *Ibid.* p.3

assistance programming for bands”.<sup>67</sup>

- Funding Formula – In Quebec, First Nations communities are funded for Income Assistance as such: 25% reimbursed and 75% fixed funding agreements (as of 2007)<sup>68</sup>
- IA Dependency Rates– In 2012-2013, the on Reserve income assistance dependency rate was 33.6% (compared to just over 5% for the Canadian population). In Quebec, in that same time period, the dependency rate for on Reserve population was 28.5%.
- Enhanced Service Delivery (ESD): In 2013, the federal government launched the Enhance Service Delivery (ESD) as part of its *Economic Action Plan*. This program was developed to address the high numbers of Aboriginal young adults (aged 18-24), who are dependent, for various reasons, on Income Assistance.<sup>69</sup>
  - Across Canada, a total of 22 First Nations organizations (representing 70 First Nations) received funding “as part of the initial stage” of the Enhanced Service Delivery (ESD) in 2013/2014<sup>70</sup>

In the province of Quebec, four organizations participated in program in the first ‘intake round’,<sup>71</sup> including two communities that are part of the CESFNCQ: Listuguj Mi’gmaq Government and the Mohawk Council of Kahnawake.

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<sup>67</sup> *Evaluation of the Income Assistance Program* (2007). p. 38

<sup>68</sup> Ibid. p.20

<sup>69</sup> The Enhanced Delivery Service program is intended to assist individuals between the ages of 18-24, and who are currently on Income Assistance, to become more employable. Individuals have a “range of services and programs” available to them (such as basic life-skills training, formal education, skills training, and career counseling). As well, there can be “incentives and disincentives” put in place, which are similar to provincial social assistance programs. Finally, there can also be wage subsidies to encourage employers to hire Income Assistance Clients. (AANDC. “Background – Income Assistance Reform: Enhanced Service Delivery” 14 Jan. 2015. Web. 17 Feb. 2015).

<sup>70</sup> AANDC. “Backgrounder – Improved On-reserve Income Assistance Program”. Jan. 31, 2013. Web. 11 Feb. 2015

<sup>71</sup> Ibid

## v.) National Child Benefit Reinvestment

The **National Child Benefit program**, which is a broad national (off Reserve) program, was launched in 1998. The objectives of the program are as follows: prevent and reduce child poverty; promote attachment to workforce by ensuring that families are better off working; and reduce overlap and duplication by simplifying administration of benefits for children.<sup>72</sup> This program provides child benefits to all low-income families regardless of their source of income (i.e., social/income assistance, low wage employment, Employment Insurance, or other income support program). The program was put in place to ensure that individuals “moving from [income assistance] to work would not face an interruption or loss of supports for their children”.<sup>73</sup> The NCB has two components: a.) Financial benefits components; and b). Reinvestment Component. For First Nations, the **National Child Benefit Reinvestment** program is the “on reserve counterpart” to the broader National Child Benefit (NCB) initiative.

In Quebec, although the government “agrees with the basic principles” of the National Child Benefit, nevertheless, Quebec chose not to participate in this national initiative. Instead, Quebec adopted its own similar approach to the National Child Benefit (Treasury Board of Canada).

In the Quebec Region, First Nations communities have the authority to use Income Assistance funding for projects to fight child poverty, depending on the availability of funding in their respective communities and the types of agreements signed. However, due to the pressure on Income Assistance program in First Nations’ communities to address other social needs, there have been fewer ‘Reinvestment Projects’ – notably since 2012/2013.<sup>74</sup>

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<sup>72</sup> *First Nations National Child Benefit Reinvestment– Progress Report for Year Ending March 31, 2009*. p.iii

<sup>73</sup> *Ibid.* p.3

<sup>74</sup> INAC Key Informant, Quebec Region. Telephone Conversation. 8 June 2015. As well, the key informant from INAC indicated that because First Nations access funds from one department (INAC), there is “less access” to funding for Reinvestment Projects compared to their provincial counterparts who can access funding from various government departments to fight child poverty.

### 3.4 Health Canada's National Native Alcohol and Drug Abuse Program

Health Canada's National Native Alcohol and Drug Abuse Program (NNADAP) evolved from a pilot project that was initiated in 1974.<sup>75</sup> The program, which was made permanent in 1982, is mainly under the authority of First Nations communities. From the beginning, the goal of the program has been to: "help First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations."<sup>76</sup> The NNADAP design did not include services that were considered medical such as "adult custodial care, detoxification, and trauma treatment." According to the program evaluation conducted by Health Canada in 1998, these services were not included because "presumably such services were considered by department officials to be services normally provided through the respective provincial health care system."<sup>77</sup> NNADAP provides both prevention and treatment services for substance use problems. Through NNADAP, there are over 500 prevention programs in First Nations communities, including:

- Prevention Activities (for example, public awareness campaigns, public meetings, school programs)
- Intervention Activities (recreation activities for youth, discussion groups)
- Aftercare Activities (for example, counseling, sharing circles, support groups).
- NNADAP supports a "nationwide network of 52 residential treatment centres," with approximately 700 treatment beds.<sup>78</sup>

#### *Quebec Region*

In the Quebec Region, there are a total of six NNADAP alcohol and drug treatment centres.<sup>79</sup> Five of the six treatment centres are geared for individuals ages 18 and over, and one centre is geared for youth (12-17 years of age). The treatment centres all opened

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<sup>75</sup> This program first began as a joint initiative between the INAC and Health Canada. The emphasis was on "alcohol abuse" (Health Canada. NNADAP Review Steering Committee. *National Native Alcohol and Drug Abuse Program General Review* (1998). Final Report. p.6)

<sup>76</sup> Health Canada First Nations & Inuit Health. "National Native Alcohol and Drug Abuse Program". 4 Jan. 2013. Web. 2 March 2015

<sup>77</sup> *National Native Alcohol and Drug Abuse Program General Review*. (1998). p.6

<sup>78</sup> "National Native Alcohol and Drug Abuse Program." Web.

<sup>79</sup> FNQLHSSC. *Regional NNADAP Needs Assessment – First Nations of Quebec*. Final Report. [Wendake, Quebec] June 2009. p. 20

between the years 1987 to 1996 (*the majority of which opened between 1987 and 1991*). There are a total of 74 treatment beds in the Quebec Region (representing approximately 10.57% of the total number of beds nationwide). There are English language services available at four of the six centres.<sup>80</sup>

The following is a list of the treatment centres located in Quebec (communities marked with an ‘\*’ are part of the CESFNCQ)<sup>81</sup>.

### First Nations Treatment Centres in Quebec

Name of Centre	Location
Wanaki Centre	Kitigan Zibi*
Mawiomi Treatment Services Inc.	Gesgapegiag*
Onen'tó:kon Treatment Services	Kanesatake*
Walgwan Centre (First Nations Youth Rehabilitation Centre)	Gesgapegiag*
Centre de réadaptation Wapan	La Tuque
Centre de réadaptation Miam Uapukun Inc.	Sept-Îles

Since its inception, the NNADAP program has been reviewed on a nationwide basis on two occasions: a limited review was conducted in 1989, and an in-depth review was conducted in 1998. Then, in 2009, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) reviewed the NNADAP programming and services in the Quebec Region.<sup>82</sup> The Commission highlighted the fact that in the past addiction and alcoholism problems were central issues that needed to be addressed. However, the Commission argued that there are many other forms of addictions (e.g., gambling, internet addiction, sex addiction, etc.), many of which are concurrent with

<sup>80</sup> See: *Regional NNADAP Needs Assessment – First Nations of Quebec*. pp.20-22

<sup>81</sup> Health Canada. First Nations & Inuit Health. “Treatment Centre Directory.” 10 June 2013. Web. 16 March 2015

<sup>82</sup> The FNQLHSSC’s *Regional NNADAP Needs Assessment – First Nations of Quebec* provides detailed information (based on the results of the First Nations and Inuit Regional Longitudinal Health Survey about the prevalence of drug use methods, addictions, and co-morbidity in First Nations communities. The review includes data about risk factors and possible consequences of addictions.

mental health problems, thus a spectrum of programs and services is required.<sup>83</sup>

### ***Provincial Organization of Addictions' Services***

Quebec's health and social services' network (which does not include First Nations organizations) has a 'Dependencies' program'. The goal of this program is to: "prevent, reduce and treat dependency problems by broadening the range of drug addiction and pathological gambling services and ensuring the provision of these services throughout the territory of Quebec."<sup>84</sup>

Quebec's network provides 'frontline services' at the local Health and Social Services Centres (CSSS). The CSSS provides services such as: screening, outpatient detoxification, and early interventions. The centres can also "ensure methadone maintenance services and refer individuals to more specialized rehabilitation centres (*centres de réadaptation pour personnes alcooliques et autres toxicomanes - CRPAT*)."<sup>85</sup> The CRPATs provide second line (specialized) services for people with addictions.

According to the Commission, a key difference between the First Nations network of services and the province's network is that First Nations treatment centres provide services oriented towards "substance use problems regardless of specific problems" (limited treatment), while the province provides services on "a continuum of care" in an effort to "meet the needs of the individual".<sup>85</sup> In sum, there are differences in the programs and services available to individuals for addictions 'on Reserve' and 'off Reserve' from the province. As noted by the Commission, there are addictions' issues in First Nations communities beyond alcohol and drug misuse/abuse. Although First Nations have access to treatment centres from Health Canada, there is limited access to a continuum of care of services for a spectrum of addictions and mental health wellness.

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<sup>83</sup> *Regional NNADAP Needs Assessment – First Nations of Quebec*. p. 9

<sup>84</sup> *Ibid.* p. 22

<sup>85</sup> *Ibid.* p.24

### 3.5 First Nations Social Programs – Issues and Gaps Emerging in the Literature

#### **First Nations Access to Social Programs – Compilation of Issues and Gaps**

The review of documentation revealed some of the issues and gaps that First Nations in Quebec are facing when accessing social services (AANDC funded and from Health Canada’s National Native Alcohol and Drug Program). These issues and gaps highlight some of the differences between services available ‘on Reserve’ compared with services available ‘off Reserve’ (mainstream population). The gaps emerging from the literature scan include:

- Lack of or insufficient funding to achieve ‘equitable and culturally appropriate service’ (lack of parity with provincial social services).
- Lack of a national policy (or policies) for First Nations’ social services and programs.
- Challenges due to the moratoriums and/or restrictions on the construction of ‘new facilities’ (*i.e., assisted living, and child and family services*)
- Gaps in services available ‘on Reserve’ compared to ‘off Reserve’ (e.g., care beyond ‘non medical’ care, care to treat concurrent conditions (addictions, mental health)).
- Jurisdictional ambiguity over responsibility for services (*between federal departments and also between federal and provincial/territorial governments*).
- Information Gaps – lack of data for First Nations social services’ and program (*Government evaluations/reviews and reports are not conducted with the same depth and breadth across social services’ programs and among regions.*)
- Networks – There is a need to investigate the level of support (human, financial and technical) that is provided to First Nations to operate as a ‘network’ for the various social services’ programs (*i.e., treatment centres, women’s shelters*)

## 4.0 FIRST NATIONS' COMMUNITY PROFILES

### 4.1 Quebec Region

In Quebec, there are a total of 55 First Nations and Inuit communities. The CESFNCQ is comprised of ten First Nations communities and one Aboriginal organization (as of March 2016).

The communities are situated in seven of Quebec's eighteen public health regions; including: Outaouais, Abitibi-Témiscamingue, Côte-Nord, Gaspésie-Îles-de-la-Madeleine, Laurentides, Montérégie and Montréal. The communities are located in isolated, rural, and urban areas.

In Quebec, an estimated 64.5 % of the total Aboriginal population are predominately English-speaking, or English is the first official language spoken after their own Indigenous language.<sup>86</sup>

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<sup>86</sup>Percentage inferred from data; source: Aboriginal Affairs and Northern Development Canada, 2012 and Ministère de la Santé et des Services Sociaux du Québec, 2012

**Chart 1. Community Profiles – Location, Population, and Administrative Regions**

<b>Coalition of English Speaking First Nations Communities in Quebec</b>			
<b>Coalition Member</b>	<b>Location</b>	<b>Population</b>	<b>Administrative Region</b>
<b>Kawawachikamach</b>	Kawawachikamach is situated at the south end of Lake Matemace, about 16 kilometers northeast of the Town of Schefferville on the Quebec-Labrador border	Total population of 1,170 persons (with 857 living in the community and 313 living outside of the community) <sup>87</sup>	La Côte-Nord (09), Remote
<b>Gesgapegiag*</b>	Gesgapegiag is located on the southern Gaspé coast, on the north shore of the Cascapedia Bay (about 45 kilometers west of Bonaventure)	Total population 1,467 (with 701 living within and 766 living outside of the community) <sup>88</sup>	La Gaspésie-Iles-de-la-Madeleine (11), Rural
<b>Listuguj*</b>	Listuguj is located in the southwestern part of the Gaspé Peninsula. Surrounded by the Appalachian Mountains, the community is situated on the northern banks of the Restigouche River, across from the province of New Brunswick ( <i>Border community with New Brunswick</i> ).	Total population 3,827 (with 2,083 living within and 1,744 living outside of the community)	La Gaspésie-Iles-de-la-Madeleine (11), Rural
<b>Akwesasne</b>	Akwesasne is located along the St. Lawrence River. An International border (United States, New York State) runs through Akwesasne Territory, and the northern portion of Akwesasne includes the Canadian Provinces of Ontario and Quebec. (Located 120 km southwest from Montreal.)	Total Population: Northern Portion of Territory: 12,000 Southern Portion: 11,000 <sup>89</sup>	Montréal (16), Urban
<b>Kahnawake*</b>	Kahnawake is located on the South Shore of the St. Lawrence River, 10 kilometers southwest of the city of Montreal	Total population 10,667 (with 7,857 living within and 2,810 living outside of the community)	Montréal (16), Urban

<sup>87</sup> Quebec. Secretariat aux affaires autochtones. “Aboriginal Population in Quebec.” [Aboriginal Affairs and Northern Development Canada, Indian Register, December 31, 2012.] Quebec. 27 May 2012. Web. March 2013

<sup>88</sup> ‘\*’ AANDC. “First Nations Profiles”. Registered Population as of February 2015. January 23, 2015. Web. 3 March 2015. AANDC population data (2015) was used for all communities marked with an ‘\*’. The figure for ‘population within community’ also includes those living in other First Nations communities (reserves) and on Crown Land.

<sup>89</sup> CESFNCQ. HSIF Forum Information Package, November 2014

<b>Kanesatake*</b>	Kanesatake is situated approximately 60 kilometers North West of Montreal, on the banks of the Rivière des Outaouais (Ottawa River)	Total population 2,436 (with 1,385 living within and 1,051 living outside of the community)	Laurentides (15), Rural
<b>Eagle Village First Nation   Kipawa*</b>	Eagle Village First Nation is located 10 kilometers west of Temiscaming, on the bank of Lake Kipawa ( <i>Border community with Ontario</i> )	Total population 972 (with 278 living within and 694 living outside of the community)	L’Abitibi-Témiscamingue (08), Rural
<b>Kitigan Zibi*</b>	The Kitigan Zibi Anishinabeg community is situated just outside the municipality of Maniwaki. The community is 130 kilometers north of Gatineau/Ottawa. It is bound on the north by Riviere de l’Aigle and Riviere Desert ( <i>Border community with Ontario</i> )	Total population 3,146 (with 1,605 living within and 1,541 living outside of the community)	L’outaouais (07), Rural
<b>Long Point First Nation*   Winneway</b>	It is situated on the south shore of the Winneway River, 114 kilometres east from Ville-Marie, a small town in Temiscamingue.	Total population 835 (with 466 living within and 369 living outside of the community)	L’Abitibi-Témiscamingue (08), Rural
<b>Timiskaming First Nation*</b>	Timiskaming First Nation is located at the head of Lake Temiskaming, approximately 600 km from Ottawa ( <i>Border community with Ontario</i> )	Total population 2,064 (with 597 living within and 1,467 living outside of the community)	L’Abitibi-Témiscamingue (08), Rural
<b>ORGANIZATION</b>			
<b>Native Women’s Shelter of Montreal</b>	The Native Women’s Shelter of Montreal provides shelter and support to First Nations, Inuit and Metis women and children who are in difficulty. The shelter is located in downtown Montreal.	530 clients per year <sup>90</sup>	Montréal (06), Urban

<sup>90</sup> HSIF Forum Information Package, November 2014.

## 5.0 FINDINGS

**The following is a compilation of the findings from participants who took part in this research to document a portrait of the situation for English-Speaking First Nations Communities in Quebec when accessing social services. The findings from the participating communities were organized in the following manner:**

**5.1 Global Overview** – Social programs and services that are ‘easily accessible’ and areas where there are challenges

**5.2 Compilation of Findings** for each of the six main social program areas:

- Enhanced Prevention Focus (Prevention and Protection);
- Assisted Living;
- Family Violence Prevention Program;
- Income Assistance Program;
- National Child Benefit Reinvestment Strategy; and
- National Native Alcohol and Drug Abuse Program

**5.3 Inventory of Social Services** – Compilation of information gathered from the ‘Inventory of Social Services’ questionnaire

**5.4 Strategies and Solutions** – List of strategies and solutions to mitigate access issues based on information from the participating communities.

## 5.1 Global Overview

### Global Overview: Social Services that are ‘easily accessible’

- **Indigenous approach to wellness** – Participants reported that First Nations community members are ‘more likely’ to access prevention services when programs and services emphasize Indigenous cultural values and norms
- **Joint case management and teamwork approach** enhances clients’ access to services from community organizations and from external provincial agencies.
- **Linkages, networking and collaborative agreements with provincial institutions** (e.g., local hospitals, schools) contributing to community members’ access to professional services from provincial network (\*informal and formal linkages)
- **Bi-cultural approach (western and Indigenous practices)**
- **Documents and training** (social services’ sector) are available in English from the First Nations Quebec Labrador Health and Social Services Commission.
- **Training (social services)** – Participants reported that some training is available in English on specific topics (e.g., suicide prevention)
- **Cultural Awareness and Sensitivity Training**– Some participants spoke about developing and providing ‘cultural awareness and sensitivity’ training for workers at provincial institutions (e.g., hospitals, group homes).
  - *“Rather than talk about specific issues, we talk about wellness in the general and then we can narrow the focus – mental wellness, physical wellness, spiritual wellness from a cultural standpoint,”* (Timiskaming).
- **Fewer access issues when services or programs are managed and delivered by First Nations communities/organizations.**

## Global Overview: challenges accessing social services

- **Transportation and distance** is a challenge when accessing services (health and social) outside of the community. Travel is particularly difficult for single parents without vehicles. [Remote, rural and urban communities]. Transportation is not provided from the CLSC (province) if services are accessed ‘out of province’.
- **Jurisdictional Issues** – Community members are unable to access health and social services (in English and closer) from ‘out of province’ due to provincial jurisdictional boundaries. Jurisdictional challenges are particularly exacerbated in communities that have been ‘divided up’ by several jurisdictions. Difficulties with funding to cover cost of services from ‘out of province’.
  - *“Akwasasne has always been Akwasasne. The government divided us up into three different jurisdictions. We go through a ‘jurisdictional nightmare’ on a daily basis ...”*
- **Lack of Cultural Sensitivity and Awareness – Generally speaking, there is a lack of awareness and understanding among staff at provincial institutions about Aboriginal social issues (including intergenerational effects of colonial policies). Lack of general understanding about Aboriginal worldview and approaches.**
  - Some participants spoke about the lack of ‘culturally safe’ spaces at provincial institutions (e.g., for ceremonies, or for families to gather).
  - Prevention Workers felt that their work and experience is at times devalued by external non-Native organizations.
  - Aboriginal clientele facing “judgment and discrimination” from workers at Youth Protection (provincial) and from neighbouring non-Native communities (general public).
  - *“Our own people are suffering. There is a stigma with ‘being Native’. We are treated differently at the hospital because we are Native. Feel like we are being judged because we are Native ... we are treated in a paternalistic manner in the Court System because we are Native,”* (Gesgapegiag).
- **Colonial policies and legacy of residential school era.** Participants stated that ‘Echoes from residential schools’ are ‘alive today’ in the programs and services offered through the provincial Youth Protection (Intervention) Services.
- **Corridors of Service** – If community is in a ‘unilingual French jurisdiction’, unable to obtain services (in English) from other administrative jurisdictions in Quebec. Some communities noted that: “if resources are accessed from another corridor, funding is not provided.”

- **Language barriers** – Communication barriers (language and lack of cultural sensitivity) when working with or seeking services from provincial health and social services institutions. Difficult to establish partnerships or to network with provincial institutions due to language barriers. Additional barriers for Aboriginal peoples whose first language is their own Indigenous language.
  - *“Some clients ‘feel intimidated’ by professional workers and have a hard time expressing themselves accurately,”* Listuguj.
  - *“I was told at a meeting by the program manager at the CLSC that when the province comes in to evaluate their program, they have to hide all the English language pamphlets. They have to watch the English. They take away the pamphlets, and then put them back out,”* (Kitigan Zibi).
  
- **Difficult to access specialized ‘social services’ in English in Quebec.** Services that are difficult to access in English include: mental health, medical, counseling, addictions’ services, child psychologists, art therapy, legal aid, Occupational Therapy, speech language (evaluation and therapy), psychosocial evaluations, psycho-educator, psycho-educational assessment, child development assessments, autism evaluations, social workers, nutritionist.
  - *“Access to English services for Addictions is a nightmare in general, and it’s a disaster for someone with Mental Health Issues,”* (Kahnawake).
  - *“The “corridor of service” policy has severely impacted our clientele who do not speak French. ... English language child developmental and autism evaluations were not available in our region. It took over two years for this child to be assessed and to receive needed services,”* (Kanesatake).
  
- **Lack of English language training opportunities for front line workers (generally speaking) in Quebec.**
  
- **Lack of English language services for Mental Health**
  - Services available at provincial institutions are primarily in French, long wait times for English language services. Some participants noted that there is a lack of services for the 18-25 age range.
  - Distance is a barrier for remote and rural communities.
  - Participants spoke about not being satisfied with quality of services for assessments, treatment planning and follow up care. Miscommunication because there is a lack of cross cultural understanding and language barriers.
  - Community members seeking services for mental health (English language and culturally based) from private agencies out of province.
  - Lack of security available at hospital for mental health patients.
  - *“For psychological care, for Anglophones, they have to go farther. Social worker is available, but for specialists they need to go farther. And, then they will need transportation, [Centre Jeunesse does not provide that] ... many [people] do not have their permit, they are limited,”* (Kanesatake).

- **Documentation from province for health and social services is primarily available in the French language** (e.g., health information/awareness, assessments, reports, funding proposal (municipal), contracts, placement agreements, assessments)
- **Funding is not provided to communities/organizations for translation services (e.g., to translate documents).** Organizations are paying for translation services from administrative or program budgets. Bilingual staff members are providing ‘translation services’ to community members and co-workers.
- **Lack of clarity between the Federal and Provincial governments about who is responsible to pay for some services (i.e., Group Home placements) for individuals with Special Needs – First Nations are ‘caught in the middle’.**
- **Crisis Situations** – Individuals who are suicidal have limited access to mental health services while in crisis situations to adequately ensure their well being and safety. Increased stress and pressure on prevention workers (health) and also on their families. [Remote Community]
  - *“It’s a sad reality ... We almost have to wait for someone to try to kill themselves before they can be sent out [by the CLSC],”* (Kawawachikamach).
- **Lack of funding for renovations and construction of ‘health and social’ services buildings.**
- **Provincial Restructuring** – Challenge at the present time to work with the Province due to the restructuring of their health network. Uncertainty about what services will be available with the closing of provincial hospitals. Challenge to maintain relationships with provincial institutions and committees due to “high staff turnover rate” and “restructuring”.

## 5.2 Compilation of Findings

\*As noted previously, findings for each individual community are available in the appendixes' section of this report (Appendix 5, Community Findings).

### Compilation of Findings: Social Services that are 'easily accessible'

#### i.) Enhanced Prevention Focus

##### Prevention (First Line)

- **Safety Plan for crisis situations.** Having a 'safety plan' in place between First Nations and provincial institutions contributes to ensuring that individuals receive required services during times of crises.
- **Community engagement and prevention programs are breaking down stigma associated with 'social services'** – Participants spoke positively about sharing information, building trust, and working with all members of the community (men, women, elders, children) in the delivery of prevention-based social services.
  - *Examples of prevention-based activities and programs:* Addictions Awareness Week, Suicide Prevention, Honouring Sobriety, Traditional Support, parenting programs. Prevention topics are integrated into activities. Participants highlighted programming available for youth, and the importance of cultural-based activities, teachings and practices (for instance, community feasts, harvesting, and hunting).

##### Protection (Second Line)

- **Protection services** (Sections 32 and 33 of Youth Protection Act) are delivered by some First nations' organizations. Staff will conduct evaluations, assessments, and provide supervised visits to clientele under Youth Protection.
- **Adult Care (Protection)** – In some communities, adults and elderly with physical limitations and mental health issues have access to in home support services.
  - In border communities, establishing agreements with institutions 'out of province' is enabling community members to access institutions in other jurisdictions, thus reducing barriers 'because of distance or language'.
- **Foster Care** – In communities responsible for foster care, participants spoke about having a 'good connection' with families and being able to 'address issues' quickly. Some participants spoke about accessing training tools in English from other jurisdictions (e.g., from Ontario).

- *“Our intent is to always seek child placement with a child’s own extended family members first; this is in direct alignment with our Kanien’keha:ka tradition of families taking care of each other,” (Kahnawake).*
- **Restorative Justice** – Some participants spoke positively about clients’ access to ‘restorative justice’ programs rather than going through the penal system for some offences (e.g., non indictable offences).
- **Court System** – Some communities reported having few barriers because of language or distance when going through the court system.
  - Some communities (larger communities closer to Ontario border) reported that hearings are held in English, access to legal services is provided to children in protection from Centre Jeunesse. Transportation is available for the children.
  - Social workers (Case workers under Support Services) work with courts to ensure that court measures are completed (Second Line)
  - Hearings may be held in English. **Challenge:** Some participants stated that the ‘cultural context’ of the situation is not always considered or understood by the judiciary.
- **Young Offenders** – Some participants reported providing a ‘presentencing report’ to judges, which helps to give a ‘well rounded’ view of the youth’s strengths and weaknesses.
- **Tracking Information** – One community spoke about having an electronic database in place to track information about clientele (Enhanced Service Protection). **Challenge:** Database is available in French language only.
- **Transportation** – No major barriers with transportation if the services being accessed are in line with the Non Insured Health Benefits (NIHB) program.

## ii.) Assisted Living

- Services available through ‘assisted living’ program varied greatly amongst the communities. Some participants stated they were ‘not aware’ of the assisted living program, others offer minimal home support services, while some communities provide a full range of programming intended to ‘bring individuals to their maximum independence’.
- **‘Independent Living Centre’ or ‘Group Homes’** are available in some communities, which provide support to ‘semi-autonomous’ individuals who cannot live on their own. Needs identified: establish partnerships with provincial hospitals for mental health services; develop a ‘profile of statistics’ to determine community needs; legal assistance (i.e., to help families set up plan of care and trust funds for members with physical and/or cognitive needs)

- **Activities for Seniors** – Participants spoke positively about activities geared for seniors (for example, ‘meals on wheels’, lunches, and cooking together). Social outing for seniors and helps with social inclusion.
  - *“The collective kitchen is well attended by seniors. Program is run on a monthly basis. Choose the menu, get together and prepare together and cook together. The meal is then shared and everyone takes home their supper. Helps with social inclusion, and gets the seniors out and socializing with everyone,”* (Timiskaming).
- **Day Programs** – Some communities offer day programs for multi-disabled community members (adults)

### iii.) Family Violence Prevention

- Women and children experiencing family violence can access **short-term residency** at ‘safe houses’ in First Nations communities. Front line workers reported fewer access issues (for individuals experiencing family violence) if the shelters are located in their own communities. Some communities with ‘safe houses’ reported that they provide educational programming to both men and women about domestic abuse, and also other topics (addictions, building healthy relations). **Challenge:** ‘Safe houses’ need to provide services to all genders, and also provide services beyond ‘family violence’ (e.g., addictions, homelessness, crisis situations).
- **Networking with other First Nations Safe Houses** – Some participants reported having ‘good relationships’ with Native organizations geared for Native women and violence prevention at the provincial and national level (access to training, information sharing, and networking).
- **Joint Case Management** is important to ensure that clients may access services and programs offered by other organizations in the community
- **Provincial Liaison for Victims’ Services** – Some participants reported that having a ‘good relationship’ with provincial liaison worker (bilingual and culturally sensitive) is critical to ensuring access to services from the province. Liaison worker assists women to navigate the legal system where there can be *“barriers because of cultural differences and language,”* (Listuguj).
- **Information** (in English) about family violence prevention is available from the First Nations of Quebec and Labrador Health and Social Services Commission.

#### iv.) Income Assistance Program

- Some communities offer ‘last resort financial assistance’ to community members. Participants with agencies located in the community spoke about being ‘sensitive to the needs of clientele’.
- Some participants spoke about the ‘**Enhanced Services Delivery**’ program geared for individuals between the ages 18 to 24. Participants spoke about the goal of encouraging youth to gain the skills and experience needed to either return to school or the workplace.
  - *“We recognize that we have generational clients on assistance – parents and grandparents have been on SA. How do we break the cycle? ... We conduct assessments of clients and with our partnerships, we direct them to services they need to break the cycle of dependency (education, mental health, and addictions.)”* (Akwesasne).

#### v.) National Child Benefit Reinvestment Strategy (Most of the participants were unaware of any programs or services available with funding from NCBR)

- **Funding (limited)** is available for projects to address poverty. Program is managed and controlled by the community.
- One community noted that ‘a small amount’ of funding is available to assist individuals transitioning back to work.
- **Challenge** – Funding has been decreased and is only available on a year-to-year basis.

#### vi.) National Native Alcohol and Drug Abuse Program (NNADAP) [Addictions]

- Participants noted that clients have “**access to workshops**” [in English], which are provided in-house and/or with partner organizations.
- **Referrals** – Participants refer clients to treatment services from Aboriginal treatment centers where English language services and cultural component is part of treatment and from provincial treatment centers that offer services in English.
- In some communities, individuals with addictions have access to ‘**after care**’ services [in English]. Some organizations provide **information and support** about addictions to youth at schools.
- **Team work** – Participants spoke about addictions services being part of ‘prevention services’ programming by health center and/or first line services.
- **Adolescent Treatment Centre (Addictions)** – Culturally relevant addictions’ treatment programming is available in some communities.

## i.) Enhanced Prevention Focus

### Prevention (First Line)

- **Participants noted a ‘lack of prevention services’, generally (remote communities) and for specialized services in English (urban and rural).** The lack of prevention services was apparent in communities that did not have agreements for prevention programs from Indigenous Affairs. These communities provide ‘prevention type services’ through Health Canada (i.e., for addictions and residential school survivors)
- **Perceptions, fears and stigma associated with ‘social services’: lack of understanding about ‘first line prevention-based services’ (fear that children will be taken away).**
  - *“People have pride or even shame. If you want to pass on a [prevention] message you need to do it in a subtle way. You need to have an activity, and then send out your message in a subtle way to get your point across,”* (Long Point First Nation/Winneway).

### Protection (Second Line)

- **Signalement/Reports [potential endangerment of children]** – Language barriers when individuals call the Agency to make a report (signalement). (Remote and rural communities)
- Generally speaking, a **lack of ‘protection services’ in some communities (notably in remote and rural areas)** (e.g., participant in a remote community waited one year for follow up from a call to Protection Services). Obstacles accessing services outside of some communities due to distance (rural and remote).
- **Lack of English language services from local CLSCs for youth in protection related to special needs.** Participants noted some staff may be English-speaking, however programs are not readily available in English. *Services required*: clinical support for Autism Spectrum Disorder and also Respite Care.
- **Lack of English language services from the province for sexual assault victims (in particular youth) and physical assault victims.**
  - *“Interviews by police are mandatory under Youth Protection Act can be delayed because there is a lack of English speaking officers trained and authorized to conduct the interviews,”* (Kitigan Zibi).
- **Documentation for Youth Protection and Young Offenders (including court orders) from the province is primarily available in French.**

- *“Court Orders and Signalement (Official Complaints from Youth Protection) are often times only provided to the First Nation organization in French; the organization has to translate the documents at their own expense,” (Gesgapegiag).*
- **Lack of English language training opportunities in Quebec for front line Youth Protection and Prevention workers**
  - *“Training up north to help kids deal with texting and bullying and it was only in French ... There is training to prevent conjugal violence, family violence, but it was not available in English,” (Eagle Village/Kipawa).*
  - *“Training has been an issue. Minimal training from Quebec. Repeated requests for training. We do receive annual training, but it is just a refresher of the Youth Protection Act,” (Akwasasne).*
- **Lack of cultural sensitivity amongst workers at provincial institutions in social services’ sectors.** Provincial staff have limited or no formal training or orientation to ensure cultural safety for First Nations’ clientele.
  - *“In general, the people we have worked with are somewhat ignorant of the history and special considerations that an Aboriginal client might need, they [Youth Protection workers] don’t understand that there is an overrepresentation of Aboriginal children in care, they don’t have an understanding of the history of colonialism or complex trauma,” (Native Women’s Shelter of Montreal).*
  - *“There are differences between non-Native and Native peoples, which in turn affects how to proceed with Interventions and Follow Up Measures. You cannot go there and do a ‘cop job’ and say you have to do ‘this and this’ ... Parents won’t listen, they won’t be involved in the relationship ... I highly suggest a training – What are the ‘Indians’? What is their history”? (Kanesatake)*
  - *“If someone is strongly rooted to the community, and has that dialect embedded in him or her that person will communicate – there may be a lack of communication between that person and whoever is from the outside,” (Long Point First Nation/Winneway).*
- **Lack of support services in the area for Sex Offenders (general lack of services, and also because of language).**
- **Lack of notification.** Provincial institutions in the Quebec Region are not notifying First Nations organizations when clients being followed by Youth Protection are being discharged even if this requirement is noted in their file (for example, if a client obtains services for Mental Health reasons at the provincial hospital).

- *“It wouldn’t take much for parents and children to be wrongfully separated if the communication is not there,”* (Long Point First Nation/Winneway).
- **Not satisfied with the quality of services received from the provincial Liaison Worker (where agreements are in place with Centre Jeunesse):** Lack of communication and follow up is an issue.
- **Lack of communication and information sharing between First Line (prevention) and Second Line (protection) social services in some communities.** (e.g., Lack of notification from Youth Protection (Centre Jeunesse) about any YP files involving band members.)
  - *“It’s difficult because there is no sharing of files (with Centre Jeunesse in Quebec). There is no collaboration,”* (Eagle Village First Nation/Kipawa).
- **Lack of information, notification of updates about Quebec’s Youth Protection legislation** (i.e., Changes to legislation, Standards).
  - *“It’s like we’re aliens to them. ... It has to come from the CLSC to take initiative to say ‘we have a First Nation reserve close to us. We have to work better with them’. We always have to run after them [the CLSC],”* (Kitigan Zibi).
- **Lack of information about any funding** available from Quebec Region for Youth Protection.
- **Lack of ‘accommodation’ of cultural norms and practices in the application of provincial laws for Social Services;** areas of concern included:
  - **Bill 125** – [An Act to amend the Youth Protection Act and other legislative provisions]: very short term placements for children and youth *“six months, maximum one year.”* Concerns about inequities in amounts foster families are receiving.
  - **Bill 24** – Family Type Resources – Establishing ‘employee/employer’ relationships for the provision of foster care.
  - **Bill 21** – Some Social Workers experience difficulties when dealing with the Professional Order [Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec] due to language barrier
  - **Bill 10** – An Act to modify the organization and governance of the health and social services network. Confusion and lack of clarity about how Bill 10 will impact Youth Protection Services in First Nations communities.
- **Respite Services (Youth Protection)** – Some participants noted that parents are not able to easily access ‘Respite Services’, increased risk of children being placed in foster care.
- **Some participants noted a lack of ‘coordination’ between Youth Protection and provincial police**

- **Court System**
  - Language barriers, lack of information about judicial processes, financial barriers, distance (Remote Community and some rural communities)
  - Delays in court proceedings due to language barriers. Some participants noted that there is a ‘lack of judges and lawyers’ who are bilingual. Social services (bilingual) staff providing informal translation services of court proceedings for clients.
  - Some participants noted that court proceedings take place “all in French” and court documentation is provided in French. Lawyers are bilingual, and speak to clients in English. It is “very stressful” to go to court. Parents face further obstacles to attend court hearings due to lack of transportation (distance).
  - “[*Child and families*] lose their voice in the [*legal*] system ... The [*legal*] process is too fast. Parents need a stronger voice to speak on their behalf when it comes to court,” (Listuguj).
  
- **Reintegrating offenders into the community – obstacles accessing services due to lack of transportation**
  
- **Foster Care**
  - Lack of information in English about services available for foster families (workshop sessions are all in French).
  - Lack of English language training opportunities for foster parents (First Aid, CPR, available in French only)
  - Some participants noted that: “*homes in the community are not being assessed*” notably in communities where prevention services are delivered by the province, which is resulting in a lack of “Native Foster homes”. Concern that some families are “*losing their children*” once they are placed in the foster care system.
  - Some spoke about a “lack of Anglophone foster homes” when children are sent out of the community. If children are sent to homes ‘out of province’ (due to language barriers), there are further obstacles accessing services because of provincial jurisdiction for Medicare.
  - Some participants reported that children are being placed with relatives in home that are not accredited as a ‘foster home’, and thus families are not receiving any financial compensation from the province.
  
- **Group Homes**
  - Lack of English language social services and instruction (education) at secure group home in some regions (Gaspé).

## ii.) Assisted Living

- **Lack of specialized services (in general), and long waiting lists for English-language specialized services for ‘Special Needs’ clientele** (e.g., dentists, Occupational Therapist, Speech Language, psycho-educator for families, dietician, physiotherapist).
  - *“It is critical to have English-language services for individuals with Special Needs due to obstacles with communication that are already present because of their diagnosis,”* (Kahnawake).
- **Difficult to obtain early diagnosis (in English) for children with potential cognitive development disorders** (such as autism spectrum disorders). Differences between federal and provincial governments with regards to ‘assessment tools’.
  - *“Assessment Tools – difficult to get the province and federal government to ‘speak the same language’ with regards to assessments,”* (Kahnawake).
- **Difficulties due to language to obtain professional assessments for Elderly people who may be showing signs of Dementia or Alzheimer’s. Long wait for an English Speaking social worker. First Nations staff providing translation services due to language barriers, which requires high degree of “trust” on the client’s part.**
- **Assessment reports are often prepared in French, funding is not provided for translation.**
- **Long wait time to enter ‘long term care’ facility in the area for individuals requiring higher level care.**
- **Lack of communication and collaboration between Provincial and First Nations organizations for ‘Assisted Living’ services.** Discharge from hospital is problematic – First Nations organizations are not always notified when clients are discharged from hospitals.
- **Challenges because of language when accessing services from the pharmacy –** pharmacists are usually bilingual, less likely that the technicians will be able to speak English – delays for the clients and First Nations’ staff need to verify information (remote and rural communities)
- **Communication barriers when escorting clients to hospitals due to language barriers**
- **Jurisdictional Issues**
  - Unclear regulations between federal and provincial governments when declaring an individual ‘incompetent’ and for making a report of Elder Abuse.
  - Communities with ‘long term care facilities’: long-term care facilities are federally funded; however, regulations for Medicare System (clinical

services) are provincially regulated. First Nations are caught “in between” jurisdictions. One participant stated: “*Nurses are practicing illegally (under Law 90, which outlines responsibilities that a nurse can undertake) to provide the care that the clients need with the threat that they may have their licenses revoked,*” (Kitigan Zibi).

- Lack of clarity between the Federal and Provincial governments about who is responsible to pay for some services (i.e., Group Home placements) for individuals with Special Needs – First Nations are ‘caught in the middle’.
  - Corridors of Services – unable to obtain services (in English) from other administrative jurisdictions in Quebec. If resources are accessed from another corridor, funding is not provided.
- **Lack of First Nations involvement in decision-making and policy adjustments for the Assisted Living program, notably in communities not directly involved in managing or administering the Assisted Living program.**
    - “*We don’t have any say. We have an outside organization [from the province] that is coming in making decisions. ... It’s complicated because we don’t control the program,*” (Eagle Village/Kipawa).
  - **Transportation – barriers for clients to access services that are outside of the community.** Difficult for family members to visit.
  - **Lack of consistent personal care workers (staff) –** hired on a contract basis (burn out, lack of employment security). Some participants noted challenges when hiring Personal Care Workers because of policies that stipulate that ‘personal care workers’ cannot be related to the client.
  - **Lack of training opportunities for front line workers working with individuals with Special Needs from the province because of language. Lack of funding to access training opportunities from other administrative jurisdictions in Quebec.**
  - **Non Insured Health Benefits (NIHB) – Not all medical equipment is covered by the NIHB program. Good access to equipment that is covered by NIHB, but lack of funding for installation.** Participants noted that there is a long wait time to receive approval for some medical equipment through NIHB compared to provincial system.
  - **Long wait time to enter ‘long term care’ facility in the area for individuals requiring higher level care.**

### iii.) Family Violence Prevention

- In communities that do not have a shelter or safe house, participants noted challenge access services, including:
  - **Language barriers** (lack of English language services at provincial shelters);
  - **Transportation** is issue if the shelter is located at distance from the individual's home community.
  - **Non community members** may not be able to access programs and services offered in the community (i.e., other first line services)
- **Safe Houses are needed for men**
- **Jurisdictional issues** when accessing services from other provincial jurisdictions (e.g., for English language services and/or culturally relevant programming)
- **Difficult to access second stage housing**
  - *“Women may be forced to go back to unsafe situations because they don't have any other alternatives,”* (Akwasasne).
  - *“Aboriginal women face obstacles finding low-income housing due to stereotyping”* (Native Women's Shelter of Montreal).
  - *“Reality is landlords are not quick to rent their apartments to First Nations Indian People. There is a stigma. Overcrowding, too much drinking, lower standard of living. Not quick to readily house clients of ours who are trying to find apartments and are trying to start over,”* (Kitigan Zibi).
- **Communication barriers because of language when working with provincial agencies. Difficult to navigate the provincial health network.**
- **Applications for Subsidy Forms** – Some participants stated that clients at the Shelter experience barriers filling in applications because of language.
- **Lack of information about and disconnected from the Quebec health care network, generally speaking, and specifically with regards to Family Violence Prevention.** Limited networking or access to services from safe house in Quebec's health care system.
- **Difficult to access specialized services in English in Quebec** (*services such as: Mental Health, Medical, Counseling, Addictions' Services*). Assessments are available in Quebec, but lack of services.
- **Some participants noted that documentation from the province is mainly available in French – general information [family violence] and official court documents**
- **Lack of training opportunities in English from the province in the area of family violence prevention**

- **Shelter is not able to provide services to individuals referred to shelter for reasons other than family violence** (i.e., clients seeking services for addictions, detoxification, mental health, homelessness).
- **Some shelters are not accessible for individuals with limited mobility** (lack of funding to renovate to ensure shelter is accessible by individuals with physical disabilities).

#### iv.) Income Assistance Program

- **Some participants reported limited networking, lack of availability of information (in English), lack of awareness about services provided by Quebec. Barriers because of language and some participants reported experiences of discrimination at provincial institutions** (e.g., filling out application forms).
- **Individuals do receive Social Assistance; however, funding is inadequate.**
- **Food Security** – Lack of awareness and limited connections with Quebec networks to address issues resulting from poverty. Some participants noted that: “food banks are being used more frequently”.
- **Challenges because of stigma associated with relying on ‘income of last resort’.**

#### v.) National Native Alcohol and Drug Abuse Program (NNADAP) [Addictions]

- **Lack of services for addictions (detoxification and treatment) in English from provincial institutions in Quebec.** Barriers accessing services because of language, distance, lack of cultural sensitivity, and long wait time for services in English.
  - *“Some programming [at provincial treatment centres] might be “too formal”, which brings back memories of residential school for some clientele,”* (Native Women’s Shelter of Montreal).
  - *“You send clients [for detoxification] to the hospital and they send them back a few hours later,”* (Long Point First Nation/Winneway).
- **More ‘out patient treatment services’ required for people with addictions, in particular for people with children and families**
- **Some participants spoke about challenges establishing linkages with provincial institutions for addictions’ referrals.**
- **Services are needed to address the misuse and abuse of prescription medication** (in particular for Youth).

- **Lack of prevention work to address addictions. Difficult for individuals to break the cycle of dependency.**

Adolescent Treatment Centre (Addictions)

- **Some participants reported challenges because of an inability to service sister communities in Quebec because the treatment centre is not recognized as a National Native Alcohol and Drug Abuse Program (funding is not available for clients from Health Canada).**

### 5.3 Inventory of Social Services

First Nations communities participating in this research had the option to complete an Inventory of Social Services. The purpose of the inventory was to identify the specific social services available in each community and to identify Agreement Types.

A total of eight (8) out of eleven (11) communities completed the Inventory of Social Services (of which six (6) were completed ‘in full’ and two (2) were completed in part (marked with an ‘\*’.)

As noted previously, a list of specific activities is provided in the appendixes’ section of this report (Appendix 6, List of Social Services available in English-speaking First Nations communities in Quebec).

#### **List of Abbreviations used in the ‘Inventory of Social Services’:**

CJ – Centre Jeunesse

CLSC – Centre Local de Services Communautaires

CSSSRT-K –Health and Social Service Centre

ESDC – Employment and Social Development Canada

FNQLHSSC – First Nations Quebec Labrador Health Social Services Commission

HC – Health Canada

INAC – Indigenous and Northern Affairs Canada

NIHB – Non Insured Health Benefits

## Inventory of Social Services

**Chart 2: Inventory of Social Services available in English-speaking First Nations Communities in Quebec – Availability of Services and Agreements**

<b>Community</b>	<b>Social Services</b>	<b>Services Available (Yes or No)</b>	<b>Agreements (Partners)</b>
<b>1. Eagle Village /Kipawa</b>	1.) Enhanced Prevention Focus (a.)Prevention and b.) Protection) 2.) Assisted Living 3.) Family Violence Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment Strategy 6.) National Native Alcohol and Drug Abuse Program 7.) Other – Fight Against Poverty	1.) Yes 2.) Yes 3.) Yes 4.) Yes 5.) Yes 6.) Yes 7.) Yes	1.) G.Theberge School; - Community; INAC; CSSSRT-K; FNQLHSSC Centre Jeunesse Kebaowek Health Centre 2.) Currently offered through Centre Jeunesse 3.) Health Canada 4.) Info. not provided 5.) Info. not provided 6) Local School; CSSSRT-K; Treatment and Detox Centers 7.) FNQLHSSC; Community; Local School; Chief and Council; Local Grocery Store
<b>2. Gesgapegiag</b>	1.) Enhanced Prevention Focus (a.)Prevention and b.) Protection) 2.) Assisted Living 3.) Family Violence Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment Strategy 6.) National Native Alcohol and Drug Abuse Program	1.) Yes 2.) Yes 3.) Yes 4.) Yes 5.) No 6.) Yes	1.) a.) INAC and b.) Centre Jeunesse Gaspésie-Les Îles ( <i>Bipartite Agreement</i> ) 2.) INAC 3.) HC 4.) INAC 5.) N/A 6.) HC
<b>3. Kahnawake</b>	1.) Enhanced Prevention Focus (Prevention and Protection) 2.) Assisted Living 3.) Family Violence Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment Strategy 6.) National Native Alcohol and Drug Abuse Program 7.) Other – Psychological Services	1.) Yes 2.) Yes 3.) Yes 4.) Yes 5.) No 6.) Yes 7.) Yes	1.) Centre Jeunesse Monteregie; Foster Care – INAC 2.) INAC 3.) INAC 4.) Info. not provided 5.) Not applicable 6.) HC 7.) Health Canada (NIHB)
<b>4. Kanesatake</b>	1.) Enhanced Prevention Focus (Prevention and Protection) 2.) Assisted Living 3.) Family Violence	1.) Yes 2.) Yes (Provided by province) 3.) Yes	1.) a.) INAC and CLSC and b.) Centre Jeunesse des Laurentides ( <i>bipartite agreements between CJ and INAC</i> ) and CLSC

	Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment Strategy 6.) National Native Alcohol and Drug Abuse Program	4.) Yes 5.) No 6.) Yes	2.) CJ (Note: Community is in the process of taking over the Assisted Living services) 3.) INAC 4.) INAC ( <i>managed by Mohawk Council</i> ) 5.) Info N/A 6.) HC
<b>5. Kitigan Zibi</b>	1.) Enhanced Prevention Focus (a.) Prevention and b.) Protection) 2.) Assisted Living 3.) Family Violence Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment Strategy 6.) National Native Alcohol and Drug Abuse Program	1. Yes 2.) Yes 3.) Yes 4.) Yes 5.) No 6.) Yes	1. a.) INAC and CJ b.) Centre Jeunesse de l'Outaouais ( <i>Bipartite Agreement</i> ) 2.) INAC 3.) INAC 4.) INAC 5.) Services Not Available 6.) HC
<b>6. Listuguj*</b>	1.) Income Assistance 2.) National Native Alcohol and Drug Abuse Program	1.) Yes 2.) Yes	1.) INAC 2.) HC
<b>7. Long Point First Nation*</b>	1.) Income Assistance	1.) Yes	1.) INAC (Contribution Agreement)
<b>8. Native Women's Shelter of Montreal</b>	1.) Enhanced Prevention Focus (Prevention and Protection) 2.) Assisted Living 3.) Family Violence Prevention 4.) Income Assistance 5.) National Child Benefit Reinvestment 6.) National Native Alcohol and Drug Abuse Program 7.) Other – Outreach Program	1. Yes 2.) No Services Available 3.) Yes – Staff do provide workshops on Family Violence. 4.) Yes – Support Services 5.) No 6.) Yes- Support Services 7.) Yes	1.) CJ 2.) Not applicable 3.) Not applicable 4.) Not applicable 5.) Not applicable 6.) Not applicable 7.) ESDC

## Enhanced Prevention Focus – Youth Protection

The following chart outlines the types of agreements that First Nations communities have with Centre Jeunesse for Youth Protection. This chart was developed based on information from the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).<sup>91</sup>

**Chart 3: Type of bipartite agreements and delegated responsibilities under YPA (Québec)**

Nation	Community	Bipartite agreement with Centre Jeunesse**	Delegated responsibilities / Art. 32 YPA (Assessment)	Delegated responsibilities / Art. 33YPA (Application of measures)
<b>Algonquin</b>	Kitigan Zibi	Centre Jeunesse de l'Outaouais		X
	Timiscaming First Nation and Long Point	Centre Jeunesse de l'Abitibi-Témiscamingue (CJAT)		
	Eagle Village*	Centre Jeunesse de l'Abitibi-Témiscamingue (CJAT)	X	X
<b>Mi'gmaq</b>	Listuguj	Centre Jeunesse Gaspésie-Les Îles	X	X
	Gesgapegiag	Centre Jeunesse Gaspésie-Les Îles	X	X
<b>Mohawk</b>	Akwesasne*	Centre Jeunesse de la Montérégie	X	X
	Kanesatake	Centre Jeunesse des Laurentides		
	Kahnawake	Centre Jeunesse de la Montérégie	X	X
<b>Naskapi</b>	Kawawachikamach	<i>There is no agreement with CJ for this community. The community is served by the CPRCN (Centre de protection et de réadaptation de la Côte-Nord) and services are funded by Quebec. The responsibilities defined in Articles 32 and 33 of the YPA are exercised by the DYP and authorized employees of CPRCN.</i>		
<b>Urban Community</b>	Native Women's Shelter*	<i>Three year Collaboration Agreement with the Batshaw Youth and Family Centre (Note: Because of Quebec's Bill 10, Batshaw recently merged with 'CIUSS' – Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal.)</i>		

\* Information added/changed by the researcher based on review of the data by the First Nations Communities.

\*\*The coloured boxes identify bipartite agreements between Aboriginal communities and CJ, whereas white boxes indicate bipartite agreements between a CJ and Indigenous and Northern Affairs Canada.

<sup>91</sup> FNQLHSSC. "Type of bipartite agreements and delegated responsibilities under YPA." Key Informant. Message to A.Chamberlin 21 May 2015. E-mail.

## 5.4 Strategies and Solutions

The following is a compilation of all ‘strategies and solutions’ identified by the participants during the interviews. The strategies marked with an ‘\*’ were noted by participating communities from remote, rural and urban areas.

### i.) Empowering Communities

- **Cultural Awareness and Sensitivity\*** **There is a need for increased awareness about the past to address issues of racism and discrimination. “Break the colonial legacy of alcoholism, addictions, and abuse.”**
  - Address the colonial legacy in a proactive way.
  - Demystify Aboriginal ‘ways of knowing’ (e.g., spirituality and cultural practices)
  - Develop an approach that integrates both Indigenous and non-Indigenous ways of healing and prevention.
  - Anti-Racism Strategy – Workshops, Information, and Training to address racism and to foster increased cross-cultural understanding between Aboriginal peoples and non-Indigenous Canadians working in health and social services.
  - Ensure that external professionals and agencies have sensitivity training or orientation sessions prior to working with the First Nations communities and people.
  
- **Networking and Information Sharing\***
  - Within the community;
  - Among First Nations communities in Quebec; and
  - With Provincial network
  
- **Capacity Building / Training\***
  - **Work with other First Nations communities to share strategies, successes and to ‘lead by example’. Bring English resources to communities.**
  - **Prevention** – Front line workers need to be equipped and trained to address disclosures of any type of abuse.
  - **Assisted Living** – Ensure that Personal Care Workers (Assisted Living Program) receive training opportunities in English.
  
- **Culturally Appropriate Services\*** – Develop a framework to provide culturally appropriate social services in English and French for First Nations. *(Some participants noted that there is a lack of cultural services for French-speaking Aboriginal clientele in urban areas.)*
  
- **Empower Community Members – “Raise People Up”**
  - Be more vocal to empower people to use their voices in a good way
  - Address negative stereotypes about people who need to use social services *(Social Assistance (Welfare), Shelter, etc.)*

- Ensure that victims of violence (physical and/or sexual) receive the services required. Remove labels and stereotypes placed on people – victims are not always heard
  - Move away from ‘crisis’ to ‘prevention’ services by focusing on wellness and culture among community members.
- **Escorts for community members when accessing services at provincial institutions in Quebec to overcome obstacles because of language and to ensure cross cultural understanding/communication (funding is not always provided for escorts).**

## ii.) Administrative and Leadership

- **Establish Partnership Agreements with provincial organizations (health and social services) to improve access to and delivery of services for First Nations\***
  - Define Service Delivery with the Province –Identify ‘Who is responsible for which services’ (First Nations and Provincial Agencies)
- **Inter Sectoral Approach – Establish Protocols with other agencies in the community (e.g., Police, Education) and with Province (e.g., Centre Jeunesse) when intervening on crisis situations (i.e., Suicide, Family Violence, Child Protection Measures)\***
  - Avoid duplication of services
  - Reduce the ‘silo effect’ of organizations working in isolation (in particular within First Nations communities)
  - Ensure continuity of services (between First Nations and Provincial Organizations)
- **Increased involvement of First Nations** in the decision making and management of all ‘Social Services’ programs (e.g., ‘Assisted Living’ program)
- **Aboriginal Liaison when working with provincial institutions**
  - Support for community members if an individual is receiving services from a provincial institution in Quebec – cultural sensitivity, mitigate language issues, ensure ‘continuity of care’ and cultural attachment).
  - Need a worker who has a deep understanding about what it means to work with Aboriginal people at provincial institutions.
- **Improve communication with Provincial Institutions (hospitals, provincial public health/Santé Publique) to break down barriers, to make connections and to develop better communication about the services.**

- **Border Agreements – Address inter-provincial jurisdictional issues**
  - Establish agreements with provincial institutions ‘out of province’ to ensure that community members can access services (i.e., Hospital, including the Mental Health Services, Group Homes, Youth Facility).
  - Notify organizations when clients followed by First Nations’ organizations are released.
  
- **Develop a Protocol to provide services to clientele who are ‘non-Community’ members’ – mitigate jurisdictional issues among communities and between provinces.**

### iii.) Priority Areas

#### **Addictions\***

- **Detoxification Services** (in communities) – increase access to detoxification services
- Need **local outpatient services** for individuals with addictions
- Prevention services/programs for addictions (education and awareness about the impacts and effects of illegal drug use generally).

#### **Mental Health and Special Needs\***

- More services/resources in English for individuals experiencing mental health issues
- Improve follow up for children/youth with multiple diagnoses.
- Early Diagnosis
- Urban Mental Health Unit for Aboriginal peoples
- Resources (Financial, Human and Material) to provide services on Reserve to individuals with Mental Health and Special Needs (Comparable level of care)

#### **Foster Care\***

- Foster Families – Need to recruit Aboriginal Foster Families (**Notably in communities where First Nations organizations do not deliver Second Line Services**).
- Alternatives to Foster Care (e.g., a home that could provide 24/7 care to young children who are in vulnerable situations.)
- Find ways to keep large families together (prevent siblings from being separated).

#### **Enhanced Prevention Focus (Prevention (First Line) and Protection (Second Line))**

- Establish a formal mechanism (for example an Aboriginal Liaison or Protocol between Organizations) to share information and ensure collaboration between Prevention (First Line) and Protection (Second Line)\*

- For communities that do not provide Second Line Services, establish an Aboriginal Liaison position (community worker) to work with Youth Protection (Centre Jeunesse)

**‘Safe Houses’ / Wet Shelters for individuals who are ‘in crisis’ (Mental Health, Addictions, and Homelessness) \*Second Stage Housing required**

**Restorative Justice** – Move towards Circle of Care resolutions. Restorative Justice Circles for families and communities when children are placed in care (rather than going through court system).

**Video Conferencing for court hearings** (Youth Protection and Young Offenders) – reduce barriers because of distance when families need to attend court.

**Group Homes** – Access to culturally appropriate services in English to youth who need care in a secure setting. After Care’ Support Services. Ensure that individuals continue to receive consistent support and after care services when transitioning from an external institution (e.g., Group Home) back into their family or the community (Rural and Remote areas)

**Assisted Living**

- **Employment** – Recruit community members to work as ‘Personal Care Worker Positions’ (Assisted Living Program) in full time positions rather than as casual workers.\*
- **Continuity of Care** – Ensure that provincial institutions inform First Nations’ organizations when clients are discharged
- **‘Portrait of Needs’** to identify and document community members’ needs in the community to ensure independent living (i.e., the number of individuals with Special Needs and Mental Health Issues). Ensure that adequate resources are available based on projections.

**‘Healing Centre’/Spirituality**

- Establish a place in communities to offer cultural programming/traditions teachings for parents, families and youth.
- *“We need to stand up and work ... Each community should look into their own traditions, and start working with Elders and Youth. They need to go into the land. Need to accept who they are, and where we are now by helping themselves and helping each other” (Kawawachikamach).*

**Residential Resource for people with severe disabilities (Special Needs, Cognitive disorders associated with ageing)**

- *“The community wants individuals to stay on the Reserve. It’s not acceptable for the family or community to send people out to receive care when they are no longer*

*able to live independently. If the resources are not available in English in Quebec, then we need to be able to provide those services for ourselves on Reserve,”*  
(Kahnawake)

iv.) Resources Required

- **Translation Services – (translate documents and communication purposes)\***
- **Resources (e.g., clinical staff) need to be brought into the First Nations community, rather than sending people out of the community to access services\***
  - Cost effective
  - Reach more people
- **Documentation Center**
  - Create a ‘documentation centre’ that will allow the staff at First Nations organizations to easily access relevant information in English in a variety of formats (i.e., written, video, audio)

## 6.0 CONCLUSION

The research was conducted with First Nations in Quebec from different nations and territories – Naskapi, Mi'gmaq, Mohawk, Algonquin, and the Urban Area (Montreal). The research documented a portrait of the situation for English-speaking First Nations in Quebec when accessing social services from provincial and federal systems. Each community's situation is different. There are differences because of geography, population, culture, and history. As well, there are also differences in the services that are available because each First Nation community (and their respective organization(s)) enters into different funding agreements with government (both Federal and Provincial); thus, depending on agreements reached, there are different social programs and services available.

The report begins with an overview of the social programs available to First Nations communities and organizations from Indigenous and Northern Affairs Canada and from Health Canada's National Native Alcohol and Drug Addictions programs. The purpose of the literature scan was to gain a general understanding of social services' program areas and to identify differences (if any) between the two systems (First Nations and provincial). The literature scan revealed some of the gaps and issues that First Nations face when accessing social services in Quebec. The 'gaps and issues' suggests that there are differences in terms of which services are available in First Nations communities in comparison to services available from the Provincial Network in Quebec. Specifically, the access issues identified in the literature include:

- Lack of or insufficient funding to achieve equitable and culturally appropriate services;
- Lack of a national policy (or policies) for First Nations' social services and programs (resulting in differences among and within regions);
- Challenges accessing services because of moratoriums and/or restrictions on the construction of 'new facilities' for social services;

- Gaps in services available on Reserve compared to off Reserve (e.g., care beyond ‘non medical care’, ability to treat concurrent conditions (addictions and mental health));
- Jurisdictional ambiguity (e.g., between government departments, provincial jurisdictions);
- Information gaps (differences in information available about First Nations services compared to Provincial services); and
- Lack of communication mechanisms (formal) that would allow for ‘networking’ between provincial and First Nations health care systems.

Second, this research documented First Nations’ perspectives when accessing social services from Indigenous and Northern Affairs Canada program areas and also prevention services for addictions funded by Health Canada. Interviews were conducted with front line workers and managers responsible for the delivery of social services in the participating First Nations communities. The ‘Community Perspectives’ captures the situation for English-Speaking First Nations in Quebec when accessing social services: which services are easily accessible (and why) as well as which services are difficult to access (and why). The research documented how English-Speaking First Nations of Quebec envision moving forward to access social services in an equitable and culturally appropriate manner. There are several key themes that were expressed by participants with respect to improving access to social services, including:

- ***Empowering Communities*** – There is a need for increased cultural sensitivity and awareness about Aboriginal social issues and Aboriginal culture (generally and specific to each community).
- ***Administration and Leadership*** – Establish partnership agreements with provincial institutions and with institutions from other Regions to mitigate access issues (in particular issues resulting from language and culture). Identify ways in which First Nations can become involved in decision-making with federal and provincial partners. Ensure that appropriate resources are available to mitigate barriers resulting from language or culture (e.g., funding for translation services, cultural

safety and sensitivity training).

- ***First Nations' Framework for Health and Social Services*** –There is need to identify common ‘priority areas’ for social programs and services among English-speaking First Nations communities in Quebec (e.g., Mental Health, Addictions, Cultural Sensitivity, Translation Services, Resources for individuals in crisis or living in conditions of poverty (e.g., food security and homelessness). Participants spoke about their firm desire to provide culturally appropriate services in a ‘holistic’ way in working towards a vision for wellness (individual, family, community and nation). As well, participants expressed their commitment to share information, resources, and to ‘work together’ (with other First Nations and also with provincial organizations) to improve access to health and social services. Participants expressed the need to be involved in decision-making about programs and services for their community members.
- ***Resources*** – Funding for translation services (communication purposes, translation of documents). All the English-speaking First Nations communities that participated in this research identified that they are drawing from ‘program funds’ for translation services that are necessary for their clientele. Social Services need to be provided in the community, rather than sending individuals out of the community.

This research was conducted with and for English-Speaking First Nations communities and an urban organization in Quebec. The research documented many of the issues that First Nations face when accessing social services. This research affirmed that English-speaking First Nations in Quebec are seeking to access, develop and deliver culturally appropriate social services in English, and, ideally, in their own territory or community. First Nations voiced their firm desire for social services that are culturally relevant and that meet the health care priorities of their respective community members.

Participants also voiced solutions. As stated by one participant, there is a need to provide social services in accordance with the “norms, values and ideologies” of each First

Nation community. A participant spoke about community wellness and a desire to strengthen 'kin relations', as expressed in the following statement:

*We need a place in the community to conduct ceremonies and cultural activities. We need a place to be able to run a lodge and offer programs and services in a 'holistic' way. We would like to take a holistic approach to wellness – physical, emotional, spiritual. Look at the person as a whole, look at the family as a whole, the community as a whole – not just segments. We look at everything as a whole. As First Nations this is how we have done things for thousands and thousands of years, we look at things as a circle, as a whole. We want to build strong relationships, what they call 'kin relationships' (Timiskaming).*

Many of the participants expressed the view that it is essential to foster a deeper understanding and awareness about the historic and contemporary realities of Aboriginal peoples to improve 'community wellness'; to ensure individuals may access social programs; and to strengthen partnerships among First Nations, Provincial and Federal institutions, systems, and people.

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Gesgapegiag

## COALITION OF ENGLISH SPEAKING FIRST NATIONS COMMUNITIES IN QUEBEC

Expanding and Building Our Partnerships to Improve Access Project  
Health Services Integration Fund (HSIF) ~ Health Canada

April 2015

Kahnawake

Greetings,

Kanesatake

This letter is to inform and to invite you to participate in community-based research that is being conducted by the Coalition of English-speaking First Nations Communities of Quebec. We are conducting research to investigate the situation of English-speaking First Nations when accessing social services in the province of Quebec.

Kitigan Zibi

Eagle Village  
First Nation-  
Kipawa

In 2012, a Coalition of English-speaking First Nations Communities of Quebec launched a project entitled "Expanding and Building our Partnerships to Improve Access". This project afforded the opportunity for English-speaking First Nations communities to establish a Coalition. This multi-year project is funded under Health Canada's Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera, – an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montreal).

Listuguj

The Steering Committee Members include:

Timiskaming  
First Nation

Rheena Diabo, Project Chairperson (Kahnawake)  
Donna Metallic, Project Vice-Chairperson (Listuguj)  
Joyce Bonspiel-Nelson, Executive Director (Kanesatake)  
Robin Decontie, Director of Health and Social Services (Kitigan Zibi)  
Jimmy Peter Einish, Addictions Specialist Counsellor (Kawawachikamach)  
Carol McBride, Director of Health and Social Services (Timiskaming)  
David McLaren, Director of Health (Eagle Village First Nation | Kipawa)  
Nakuset, Executive Director (Native Women's Shelter of Montreal)  
Eleanor Pollock, Director of Health (Gesgapegiag)  
Jerry Polson, Director of Health (Long Point First Nation | Winneway)  
April White, Director of Health, (Akwasasne)

Kawawachikamach

Akwasasne

Native Women's  
Shelter of  
Montreal

The Coalition oversaw research to document a portrait of the issues and challenges facing English-speaking First Nations when accessing health and social services from provincial and federal healthcare systems. The final report, "Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in the Province of Quebec" (2013), is available online at: [www.odsconsulting.ca/project-information](http://www.odsconsulting.ca/project-information).

Long Point First  
Nation/Winneway

In 2015, the Coalition is launching a second phase of community-based research to document the situation of English-speaking First Nations when accessing social services from provincial and federal systems.

The objectives for this research are to:

- i) Investigate the social services' programs available from the federal government (literature review);
- ii) Produce an 'Inventory of Social Services' from the participating communities/organizations; and
- iii) Document First Nations perspectives when accessing social services from provincial and federal systems.

A researcher, Amy Chamberlin (based out of Listuguj, Quebec), will be working with the communities to conduct this research from April - May of 2015. The research activities will include: 1.) Complete a questionnaire 'Inventory of Social Services' and 2.) Conduct interviews with key informants working in social services. (The plan is to conduct 2 to 3 interviews in each of the participating communities. Each interview will last approximately 30 minutes to one hour.)

All the data collected from the communities will be compiled and a report will be produced that will be shared with the participating communities.

Should you have any questions or concerns about this research, you may contact the Project Management Team: Dale Jacobs, Winnifred Taylor and Christine Loft of Organizational Development Services (ODS) - Kahnawake, Quebec at T: 450 632-6880 and email: [dalej@ksckahnawake.ca](mailto:dalej@ksckahnawake.ca) and [winniet@ksckahnawake.ca](mailto:winniet@ksckahnawake.ca)

In Peace and Friendship,

  
*for* Rheena Diabo,  
HSIF Project Steering Committee Chairperson

APPENDIX 2

Social Service Program Area	Description	Are services or activities provided in your community for this area of social services? Indicate: Yes, No, or Unknown	Agreements (Type of Agreement and between or among Whom) (i.e., Community and AANDC; or Centre Jeunesse and AANDC)	List of services or projects that are available (or a general description of the activities your community provides)
1.) Enhanced Prevention Focus	<p>i.) First Line Prevention Services (Prevention services aimed to reduce the number of children being placed under Youth Protection)</p> <p>ii.) Protection Services (Second Line) – (Intervention, Protection, Foster Care, Group Homes)</p>			
<p>2.) Assisted Living Program</p> <p>[NOTE: There is also a program a different program called 'Home and Community Care' program that is funded by <b>Health Canada</b>, which may be available in your community.]</p>	<p>Assisted Living Program provides assistance <u>(non-medical social support services—such as housekeeping, meal preparation)</u> to the elderly and to individuals living with chronic illnesses or disabilities (mental and physical). The program is available to individuals who are living on Reserve. The objective of the program is to ensure that individuals living with chronic illness or disabilities (mental or physical) “can maintain functional independence and achieve greater self-reliance”.</p>			

3.) Family Violence Prevention Program	The federal government's <b>Family Violence Prevention Program (FVPP)</b> is considered to be the "largest program" devoted to addressing and stopping family violence, in particular violence aimed at Aboriginal women  a.) Women's Shelters b.) Prevention Based Projects			
4.) National Child Benefit Reinvestment Strategy	This program provides child benefits to all low-income families regardless of their source of income (i.e., social/income assistance, low wage employment, Employment Insurance, or other income support program).  a.) Financial benefits b.) Reinvestment Component [Projects]			
5.) Income Assistance (also called 'Social Assistance' or 'Welfare')	Income Assistance: a program of last recourse that provides financial supports to meet basic needs (food, clothing, and shelter) and special needs, and employment-related support for individuals and families.			

<p>6.) National Native Alcohol and Drug Abuse Program) - NNADP</p>	<p>The goal of the NNADAP program is to:  “help First Nations and Inuit communities set up and operate programs aimed at reducing high levels of alcohol, drug, and solvent abuse among on-reserve populations.”</p> <p><b>NNADAP provides both prevention and treatment services for substance use problems.</b></p>			
<p>7.) OTHER INITIATIVES in the area of social services (<i>ie., Fight Against Poverty</i>)</p>	<p>Describe goal of program/activity/project</p>			

## APPENDIX 3 – Research Tool ‘Interview Questions’

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### Project Background

- In 2012, a Coalition of English-speaking First Nations Communities of Quebec launched a project entitled “Expanding and Building our Partnerships to Improve Access”.
- This multi-year project is funded under Health Canada’s Health Services Integration Fund (HSIF).
- The Coalition is conducting research to document the situation of English-speaking First Nations of Quebec when accessing ‘social services’.
- A researcher, Amy Chamberlin (based out of Listuguj, Quebec), will be working with the communities to conduct this research from April – May of 2015.
- All data collected from the communities will be compiled and a report will be produced that will be shared with the participating communities.

Should you have any questions or concerns about this research, you may contact the Project Management Team: Dale Jacobs, Winnifred Taylor and Christine Loft of Organizational Development Services (ODS) – Kahnawake, Quebec at T: 450 632-6880 and email: [dalej@ksckahnawake.ca](mailto:dalej@ksckahnawake.ca)

**Thank you in advance for taking the time to participate in this research.**

## INTERVIEW QUESTIONS

As part of this access research, we are conducting individual interviews with key informants from each of the participating First Nations communities/organizations. The purpose of the interviews is to document First Nations 'community perspectives' with respect to accessing social services.

The data from the interviews will be compiled, and presented in a report; however, the names of individuals who take part in this research will not be used in the final report.

Your participation in this research is completely voluntarily. You do not need to answer any questions that you do not feel comfortable answering, and if you wish to end the interview, for any reason, you may do so at any time.

Thank you for taking the time to participate in this research.

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- 1.) Name of the organization for which you work: \_\_\_\_\_
  
- 2.) What is your role or position at the organization: \_\_\_\_\_
  
- 3.) Please list and describe the social services and programs that you are involved with at your organization: \_\_\_\_\_
  
- 4.) With respect to the social services that are available at your organization, what is working well in terms of accessibility of social services? (i.e., Identify which services are easily accessible along with reasons why)
  
- 5.) What are the challenges when accessing social services from either within or outside of the community?
  
- 6.) What are some of the strategies or solutions that your organization has put in place to overcome any challenges that you may face when accessing social services?

**Appendix 4 – Interview Chart\_Social Services** (\*Note: All interviews were conducted by the researcher – Amy Chamberlin, M.A.)

<b>First Nation Community</b>	<b>Individual and/or Group Interview</b>	<b>Social Services* Area of Intervention</b>	<b>Total Number of Interviews</b>	<b>Total Number of Participants</b>	<b>Interview Dates</b>
Gesgapegiag	Individual Interviews	Enhanced Prevention Focus (Prevention and Protection) ( <i>Nepising'o'igam / the Healing Lodge</i> )	2	2	April 28, 2015
Listuguj	Individual Interviews	Enhanced Prevention Focus (Prevention, <i>Families First Support Services</i> and Protection, <i>Child and Family Service</i> ); Assisted Living; Family Violence Prevention ( <i>Haven House</i> ); and Social Assistance.	5	10	May 5, May 19 and May 26 2015
Kitigan Zibi	Group Interview	Enhanced Prevention Focus (Prevention and Protection); Family Violence Prevention ( <i>Maseya House</i> ); Assisted Living ( <i>Kiwedda Group Home</i> )	1	9	April 29, 2015
Eagle Village /Kipawa	Group Interview	Enhanced Prevention Focus (Prevention) and Fight Against Poverty	1	3	May 21, 2015
Long Point First Nation	Group Interview	Enhanced Prevention Focus (Prevention); Health Services (Brighter Futures/Maternal Health, Mental Health/NNADAP (Health Canada program)).	1	5	May 20, 2015
Kanesatake	Group Interview	Enhanced Prevention Focus (Protection) with Centre Jeunesse; Assisted Living with Centre Jeunesse	1	2	May 27, 2015
Akwesasne	Group Interview	Enhanced Prevention Focus (Prevention and Protection); Family Violence Prevention; Social Assistance ( <i>Community Support</i> ); National Child Benefits Reinvestment Strategy; Adolescent Treatment Centre (Addictions), and Community Daycares	1	6	May 28, 2015
Kahnawake	Individual Interviews + Written response	Enhanced Prevention Focus (Prevention and Protection); Assisted Living.	2	3	June 12, June 15 2015
Kawawachikamach	Group Interview	Health Services, Addictions, Mental Health (Health Canada program)	1	3	May 20, 2015
Native Women's Shelter of Montreal	Group Interview	Outreach workers.	1	3	May 14, 2015

Timiskaming	Group Interview	Clinical supervisor (social services) and cultural coordinator; Centre Jeunesse front line manager (Youth Protection and Assisted Living)	2	3	February 2, 2016, February 26, 2016
<b>TOTAL</b>			<b>18</b>	<b>49</b>	

## Appendix 5 \_ COMMUNITY FINDINGS

### NASKAPI

#### Kawawachikamach

##### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

**Note: In the community of Kawawachikamach, this research did not uncover services/programs for social services based on agreements or funding from Aboriginal Affairs, with the exception of some services available for Family Violence Prevention. However, there are Prevention Services delivered in the community with funding from Health Canada (e.g., Wellness programs, NNADAP, Activities for Residential School Survivors, etc.).<sup>1</sup>**

##### a.) Prevention Services (Health Canada – Programs and Services)

- Community Members have access to various addictions (prevention services), mental health and cultural activities, including: One on one counseling, Sobriety Events (Honour individuals living in sobriety), Elders Activities, and Cultural Activities for Youth & Adults (Sewing and Traditional Craft Courses).
- Activities for Residential School Survivors
- Prevention Work – Addictions Awareness Week, Suicide Prevention
- Suicide Training – Staff work together as a team
- Holistic Approaches – Talking circles combined with different activities.
- Focus on physical activity and wellness

##### b.) Social Assistance

- Social Assistance clientele receive vouchers at Christmas time to purchase groceries.
- Thrift Shop available in the community.

##### c.) Family Violence Prevention

- Workshops –Working with women and men (separately and also together)
- Counselors work individually with people
- Developing a traditional parenting program to break the cycle of violence
  - *“Working on creating a parenting program with Elders and Naskapi resources. We’ve had parenting workshops over the years, developed by outsiders, but we think we can reach more people by doing something*

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<sup>1</sup> Conversation with a representative from Provincial Network (CLSC Naskapi) Quebec Region. 25 May 2015. Further research required to identify which ‘social services’ are provided in the community, including any services that may be provided by the Province that would be equivalent to services available to other First Nations from AANDC (e.g Assisted Living program)

*traditional, going back to the roots.”*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Transportation is a challenge when accessing services (health and social) – geographical location of the community (‘remote’ area). Lack of open roads into the community (accessible by train or plane only)**
- **Jurisdictional Issues (Provincial Boundaries)** – Community members are unable to access health and social services (in English and closer) from ‘out of province’ (in Labrador) due to provincial jurisdictional boundaries. Transportation is not provided from the CLSC (province) if services are accessed ‘out of province’.
  - *“Not allowed to send people to Labrador because of provincial rules. They want us to keep people in Quebec. But, [out of province] it’s a lot closer and Anglophone services are available in Labrador.”*
  - *“If people go out of the province, it’s on their own. They’re not able to access funding for transportation. Province made a rule that you can’t send people out of province (to receive services from hospitals, treatment centers)”*
- **Lack of services in the community (health and social services) – both general and specialized. Lack of services in English. Costly to send people out of the community to receive services, therefore not as many people access services (less of an impact).**
  - *“If we had the services here, we could save money and we would be able to serve more people ... Provincial system feels it is easier to send people out. But more people could be impacted if we had the service here.”*
- **Lack of services for mental health in the community. Not satisfied with quality of services for assessments, treatment planning and follow up care. Miscommunication because there is a lack of cross cultural understanding and language barriers. Community members seeking services (English language and culturally based) from out of province.**
  - Psychiatrist in the community two weeks per month. Only works with adults, no services for children
  - *“Lack of treatment plan, follow up plan. It is unclear what kind of assessment the psychologist or psychiatrist do when they are working with our People [at provincial institutions].”*
  - *“You might get a psychiatrist from provincial institution who speaks a little bit of English, or none at all.”*
  - *“Some of our people from the community do not understand English. When they go to get assessments from a psychiatrist, they don’t know what they are doing there ... We do have a translator in Sept Iles, but she cannot help all the clients who are there.”*

- *“Regarding ethics, when people go into hospitals, clients have a right to receive proper services...”*
- **Individuals who are suicidal have limited access to mental health services while in crisis situations to adequately ensure their well being and safety. Increased stress and pressure on prevention workers (health) and also on their families.**
  - *“We are not able to send individuals who are suicidal [out of the community]. We’ve been told ‘you have enough resources to deal with them.’ But we don’t have a hospital so it’s very hard on workers when trying to deal with very suicidal people ... We find that difficult. We need a safe place for those individuals.”*
  - *“It’s a sad reality ... We almost have to wait for someone to try to kill themselves before they can be sent out [by the CLSC]”.*
  - *“There are huge gaps. We need to start talking about those issues [suicide prevention] in the community. We need to strategize solutions. Resource [people] are running around. Families don’t want to accept their relatives who are suicidal. They say, ‘They are afraid, they’re scared. In the morning, they will be hanging in the basement.’ Or, something else might happen. We don’t have any place for them. One client slept outside. The police cannot keep them – they have nowhere to go.”*
- **Documentation from province for health and social services is available primarily in the French language (e.g., health information/awareness, assessments, reports, funding proposal (municipal).)**
  - Youth Protection (documents) available in French language only. Only provided to Health Centre if they have permission to be involved with the file.
  - Cannot take advantage of opportunities for funding from municipal government because information is only available in French.
  - *“Its really sad that people are not provided with documents in English. Even documents for wellness – from the province, we received great poster but they are only available in French ... You need to seek out information or resources from other provinces.”*
- **Experiences of discrimination and racism, lack of cultural sensitivity, at provincial institutions.**
  - *“Often, [provincial] workers do not understand the culture, the history, or the contemporary realities in the communities”*
- **Colonial policies and legacy of residential school era. Participants stated that ‘Echoes from residential schools’ are ‘alive today’ in the programs and services offered through the provincial Youth Protection (Intervention) Services.**

- *“I always go back to residential school, how they wanted to change things, Native People. And they didn’t comply, the Native People. In the olden days, I remember as a child, we didn’t have social services, but our People managed to support one another and to take care of one another. ... The way the department of Youth Protection is processing their program through the community. They are saying, “We will take care of your child.” And, those echoes come from those residential schools. “We will take care of your child. They will become doctors or lawyers when they come home.” But instead every individual that came from the residential school was very destructive. They drank alcohol. Even the parents did not understand why they took their children away from them. They stripped everything from them – the teachings of our culture, traditional ways. The boy that would have become a good hunter. When I came out from the Boarding School, after so many years, I had to start hunting at the age of fifteen. I had to go fishing with my father. But, all the stuff I saw my father doing was a blur to me. Those things are still alive today, when I see the Youth Protection, in regards to intervention. They say, “We will take away your child, they will be living somewhere else, with a bilingual family.” But, when the children come back they are lost. Then, they drink. They do alcohol and drugs. I went to one of the Youth Protection Workers, I said ‘I saw a child who was in an institution, and he is here in the community and he’s not improving. Can you provide a service for him?’ All she said was ‘No, he was discharged already. Why don’t you go to the counselors working there [health centre], and maybe they can provide some services.’ What did they do with him in there? It’s an institution, where they lock them there. When they need to walk, they open the doors, they walk and then go back to the building ... They call it protection services, but for me I say ‘No, they are not protected.’ They come back home, and they slash their hands, their arms. You can see the scars. What kind of protection is that? That is why I say ... the Naskapi need to go forward, they need to do more for the Nation. We need to survive ... I was in a Boarding School and they tried to change me, and they didn’t succeed. ... I cannot live the way the White People live. I am a Naskapi, a Native. I respect what you have, but somehow, sometime they have to respect what we have. If we are to survive with our children, we need to do something [about Youth Protection, about the Boarding School] ... We need to make choices in our Nation.”*

- **Funding from the federal and provincial governments are not provided for translation services from French to English/Naskapi**
  - Community members rely on bilingual (French/English) workers at the Health Centre to translate documents that they receive from the province (health and social services’ related documents).
- **Lack of funding for renovations or construction of facilities (health, daycare, prevention services).**

b.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of social services – Prevention or Protection – in the community.**
  - Lack of cultural sensitivity amongst workers
    - *“One of our weakest allies is Youth Protection. We are trying to make better relations. Trying to make workers more culturally sensitive.”*
  - Language barriers
    - Majority of community members speak Naskapi – lack of translators and services in Naskapi language.
    - Very little material in English, everything is in French.
  - Human Resources – Lack of Youth Protection Workers in the area (worker burnout and long wait times)
    - *“Province doesn’t put enough [youth protection] workers in the area. Workers are overworked, and they get burnt out.”*
    - *“There aren’t any intake workers.”*
    - *“Waited one year for follow up after making a Signalement (Report) to the Centre Jeunesse.”*
  - Prevention (First Line) Services are not available in the community (*other than what is provided by health centre from Health Canada*)
    - *“There are no prevention services available. We don’t have a lot of services from the province.”*
  
- **Foster Care – Homes in the community are not being assessed, resulting in a lack of Native Foster Homes, resulting in children being sent out of the community if they are being placed. Children are being placed with relatives, who are not being accredited as a ‘foster home’, and thus not receiving any financial compensation from the province. Children are being placed in Montreal, because there are English homes. Some families are losing their children once they are placed in the system.**
  - *“There is a lot of removal. Trying to get them to allow us to solicit Foster Families in the community that are Native instead of sending children out.”*
  - *“Need to ask people to be a foster home – but, they’ve never asked. They won’t do it.”*
  - *“When they do recruit family members to take care of kids it’s because they don’t want to pay foster. [Youth Protection] places the child with the aunt, and they don’t make her a foster family, and then they don’t have to pay her. She pays for everything out of her own pocket.”*
  
- **Court System –**
  - Language barriers when families go to Court. They don’t understand the decision or their rights.
  - Procedures they have to go through in Youth Protection are difficult to understand.
  - People have financial barriers – difficult for people to pay their fines.
  - Distance – Hearings take place out of the community at a distance (South)

- Local Court – approximately four times per year for minor infractions. Not as many barriers.
- **Lack of understanding and accommodation of Aboriginal worldview in Social Services and Youth Protection**
  - *“My point of view is that Social Services is not compatible with Native clients. It’s too clinical and the policies are not relative to the person [Native client] ... They do not see what the person needs. Social Services should adapt to our norms, values, ideologies instead of the community adapting to them ... ”*

c.) Family Violence Prevention

***Women’s Shelter – (challenges)***

- Community members use women’s Shelter in neighbouring community on occasion.
- Language barriers – Services are provided in either Innu (Montagnais) or in French (*lack of services in either Naskapi or English languages*).
- Shelter is only accessible for women who have been abused. Cannot send individuals who are suicidal to the shelter to be watched (unless the woman is in an abusive relationship).
- Dry Shelter – not available for women who are intoxicated
- Lack of Transportation – Individuals are responsible for their own transportation while at the shelter.

## MI'GMAQ

### Gesgapegiag

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Protection and prevention social services are readily available in the community – Organization is accredited. Staff are able to conduct evaluations and assessments of Youth Protection files**
  - All Social Services – Protection [under Youth Protection Act] and Regular Services [Prevention] – are provided under one organization and at one location, Nepising'o'goam / the Healing Lodge.
  - Protection – Provide 'protection' services upon notification of a Signalement [or official report] from the Province.
  - Able to provide supervised visits at the Healing Lodge (*hands on activities, such as baking together, crafts*)
  - Preventions Services: the Healing Lodge has an agency car, an office phone, *"the staff can get out of the offices and see people"*.
  
- **Services at the Healing Lodge emphasize Mi'gmaq values, culture and language**
  - *"The vision for the Healing Lodge is to be a place where people come in for help, to get services, to be a real healing lodge and for the lodge to be adapted to the needs of the community ... We are dedicated to the community"*
  - *"Being welcomed in the language [Mi'gmaw] helps out a lot."*
  - *"We are bringing back more spirituality and it's working here [at the Healing Lodge]."*
  - *"It's important for families to take care of their children, their families – the extended family system is important. We are bringing back our values, our beliefs – We made baskets, we took care of our children, we taught them beautiful things."*
  
- **Staff engage and work in a hands on manner with the youth – Serve as 'Role Models'**
  - There are [prevention] activities for the young girls and the young boys (offered separately).
  - *"[The staff] are like role models for them. We offer other avenues, other options to drugs and alcohol. [The Lodge] is a place where [the youth] can come in and vent about what is happening in the home."*
  - Staff encouraged to: *"explore the talent of the children that they deal with. To give them something to dream about."*

- **Team Work Approach and Positive Atmosphere at the Lodge**
  - *“When people arrive at the Lodge they’re made to feel welcome.”*
  - *“Staff work together, in the same direction; we are working to break the cycle of abuse. Working in the best interest of the people.”*
- **Establishing linkages with local hospitals to address health priorities (misuse/abuse of prescription medication) helps to address health priorities of the community**
  - Establishing links with local hospital to address the issue of ‘use and misuse’ of prescription medication
- **Program Informatique Jeunesse (PIJ) system – Tracking information**
  - Implementing an electronic database to document information about Enhanced Prevention Services’ clientele. Linked with the provincial system. *Available in French only.*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Obstacles communicating with staff at provincial institutions because of language (for example, at provincial group homes)**
  - *“Difficult to communicate with provincial institutions if you don’t know French. To work here [First Nations’ social services] you have to be bilingual.”*
- **Obstacles because of language in the Court System – long delays and staff at First Nations organizations are providing translation services ‘in kind’.**
  - Judges and lawyers in the Gaspé region are mainly French speaking.
  - Social Services’ staff from First Nations organizations are translating court proceedings for their clients. There needs to be a lot of trust [between the worker and the client due to the confidential nature of the information being translated]
  - *“There was a case for sexual abuse, it was delayed at least two months to go to court. We were waiting for a judge. There is a shortage of judges, and it is hard to find someone who can speak English.”*
- **Documentation from the province is mainly in French – Courts and Youth Protection**
  - *“The documentation is terrible. Difficult to obtain English documentation.”*
  - *“Constantly running after documentation”*
  - *“Court Orders and Signalement (Official Complaints from Youth Protection) are often times only provided to the First Nation organization in French; the organization has to translate the documents at their own*

*expense.”*

- **Lack English-language services for Mental Health**
  - Lack of services, in particular for individuals in the 18 -25 year old age range: services available at provincial institutions are primarily in French.
  - Services that are available in English are difficult to access due to distance.
  - Although psychologists provide services to clientele, their availability is limited due to the large territory that they serve.
  
- **Language – Many of the family services (from province) are in French.**
  
- **Discrimination – Lack of cross-cultural understanding presents obstacles when accessing social services from provincial institutions (including the local hospital and when going the Court System)**
  - *“Our own people are suffering. There is a stigma with ‘being Native’. We are treated differently at the hospital because we are Native.”*
  - *“Feel like we are being judged because we are Native.”*
  - *“Feel that we are treated in a paternalistic manner in the Court System because we are Native.”*
  - *“Need to address Community Members’ negative perceptions about White [non-Native] people.”*
  
- **Perceptions and fears associated with social services – the view that “children will be taken away”: impedes community members from accessing social services**
  - Challenge is the stigma associated with social services. Because of what happened in the past, people think that social services is there to take their kids away.
  - Healing Lodge is trying to make certain that: *“all children are either adopted or tutored. There needs to be long term commitment. All children need to belong to a family. Try not to place children in Foster Care. As First Nations, we take care of our children.”*
  
- **More ‘out patient treatment services’ are required for people with addictions, in particular for people with children and families**
  - People don’t want to access treatment services [for addictions] if they need leave their families for months.
  - Lack of treatment plans when people finish detoxification
  - *“Need more ‘out patient’ services to work close with the family to help rebuild the home. That is where addictions can be treated. People need everyday help. We need to be there at all levels or the cycle will continue.”*

- **Obstacles establishing linkages with local provincial institutions – addictions referrals**
  - Difficult to obtain services from local CLSCs for clients’ with addictions: *“Called the CLSC, left message but haven’t returned my calls. I was looking for referral services for client with addictions”*
  
- **Services required to address “misuse and abuse” of prescription medication: alternative treatment options are needed, in particular for Aboriginal Youth.**
  - Need to work with physicians to address over-prescription of prescription medication.
  - Youth are being prescribed prescription medication, alternatives needed: *“Sleeping pills were prescribed to a sixteen year old girl living in a group home. I made an official complaint to the hospital. There needs to be more awareness about good nutrition and exercise.”*
  
- **Provincial Laws creating obstacles to the delivery of social services by First Nations Communities – Lack of recognition of Mi’gmaq Vision and Involvement in decision making and delivery of services.**
  - **Bill 125** – [An Act to amend the Youth Protection Act and other legislative provisions]: very short term placements for children and youth *“six months, maximum one year.”*
  - **Bill 24** – Family Type Resources – Establishing ‘employee/employer’ relationships for the provision of foster care.
  
- **Family Violence – More training and awareness required for community resources**
  
- **Lack of a ‘safe house’ for women who are in crisis (psychologically distressed)**
  - There is a need to provide shelter (short term) to women who are ‘psychologically distressed’, but may not be in an abusive situation (local shelter is only available for women and their children experiencing family violence).
  
- **Family Type Resources (Foster Care) – Challenges maintaining family ties and for parents to access parent groups [Submitted in writing as part of Inventory of Social Services]**
  
- **Transportation – distance to access services, particularly difficult for single parents without vehicles. [Submitted in writing as part of Inventory of Social Services]**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention Services)

- **Community Members access various prevention-based services from ‘Families First Support Services’ in the First Nation community.** Programming – Aboriginal “circle type format” and also non-Aboriginal “mainstream” services. Workers develop individual plans for each client (individual, family or organization) depending on their needs.
  - *Examples of services:* Parenting programming, Grief and Loss, One-on-One Support, Cultural Based ceremonies, circles, mediation, empowerment groups for young girls (GEMS), support clients at Court.
- **Team of community-based prevention workers provides services to community members** (*Intake Worker, Administration, Home Support Workers, Community and Cultural Coordinator*).
  - Staff is well connected with community members, which helps in the delivery of services. Non-hierarchical approach
  - “*We [Prevention Services] are there to support families and individuals.*”
- **Case management approach. Staff will work with other organizations in the community and with provincial organizations to develop plans for clients (Individual Service Plans).**
  - Case management approach allows individuals to access the different services that they need from a team of workers.
  - Meetings are held on a monthly basis among the Case Management Team (includes First Nations and non-First Nations) – review each case.
  - Refer clients to provincial institutions, and the province will refer clients to First Nations’ organizations for prevention services.
- **Safety Plan – First Nations and local provincial institutions have a ‘Safety Plan’ in place to make certain that individuals receive the services that they need during times of crises. Having a plan in place helps to ensure that community members “are not sent home” during times of crises.**
- **Staff provide support services to First Nations’ community organizations during times of loss – (for example, debriefing, medicines in work environment, having circles with and among staff).**
- **Networking with provincial organizations (for example, CLSC, Re-adaption Centre). Good connection with some provincial institutions. Able to access professional/clinical services required by some families; however, services in English are limited (i.e., occupational therapy for children with Autism)**

- Some provincial workers will make a real effort to speak in English. They will ask for help, and they have a good attitude. That makes a difference.
- **Good communication and support with the local elementary community school and the high school in the area. Workers offer prevention services for the youth at local schools (life skills). Also, support other organizations when they deliver programs/workshops in the schools.**
- **Community Action and Mobilization – Share information and build trust so that people use the prevention services. Building a healthy balance in the community by working with Men, Elders, Women and Youth. Create awareness in the community about social issues in a non-hierarchical manner.**
  - *“Trying to mobilize men in the community. Identify activities/services men are seeking, and to determine their role. Need to identify their gifts, what they would like to offer to give back to the community”.*
- **Work in collaboration with Youth Protection [Child and Family Services]**
  - Consent to release information to Youth Protection (Listuguj Child and Family Services), as required by law (i.e., Disclosures of any type of abuse, threats to one self, suicide or harming others)

b.) Enhanced Prevention Focus (Protection Services)

- **Access to services under Youth Protection (Sections 32 and 33 of Youth Protection Act).** Evaluate situation and determine if Protection or Prevention services are required. Follow up services (either voluntary or court imposed measures)
- **Support services for the family (Family Enhancement)** Programming available such as parenting, discipline, and life skills.
- **Adults and Elderly with physical limitations and mental health issues have access to in home support services.** Families are supported if the individual needs to be placed in a nursing home or adult group home.
- **Foster Care (Children and Youth) – ‘Child and Family Services’ is responsible for the recognition of foster homes, follow up with families, and payment.**
  - Staff has good connection with foster families and homes. Able to address issues quickly.
  - *“We think it is really important to keep responsibility for our community – the children and the homes.”*
- **Young Offenders: Staff work with youth who break the law (12 to 17 years old).** Provide a ‘presentencing report’ to the court, which gives the judge a well-rounded view of the youth’s strengths and weaknesses.

- **Access to Restorative Justice:** Individuals can access ‘restorative justice’ rather than going through the penal system for some situations (*i.e.*, non indictable offences).
- **After Care and Follow Up – Addictions:** Individuals with addictions have access to after care services from organizations in the community and from external agencies (out of province). Also, organizations (internal and external) provide information and support to youth in schools.
- **Agreements recently established with nursing home and Adult Group Homes (Mental or Physical limitations) in New Brunswick allowing community members to enter institutions ‘out of province’. Reduces barriers because of distance and language.**

c.) Assisted Living

- **Community members can access ‘Home Management’ services (Meal Preparation, Light Housekeeping) “easily and readily”.**
  - There is a ‘point of entry’ at the Listuguj Health Centre.
  - Home Care nurse conducts assessments (using the provincial Multi-Clientele Assessment Tool (M-CAT)) to determine which services the client needs to live independently.
  - A Committee at the Listuguj Health Centre meets regularly and reviews clients’ files.
- **Assisted Living (*home management services*) and Home and Community Care (*nursing services*) are managed and delivered by staff at the Listuguj Health Centre. Delivering the services in a complementary manner helps to ensure clients have access to all services from both programs (funding from Aboriginal Affairs and Health Canada, respectively).**
- **Personal Care Workers – provide assisted living services to community members.** Listuguj Health Centre manages the team of PCWs who work on a rotational basis in different homes. The schedule helps to maintain a ‘worker’ and ‘client’ relationship (reduces potential risk for abuse of power).
- **Training (Personal Care Workers (PCWs))** – English-speaking trainers brought in to the community to provide training (easily accessible and no barriers because of language). Video Conferencing – information on different health topics made available to PCWs at Health Centre. *Challenge – difficult to find training in English in Quebec.*
- **Discharge Planning** – Nurse Liaison from Listuguj Health Centre assists with discharge planning (from New Brunswick hospital only).

- **Social Worker** – Bilingual social worker available one day per week at the Health Centre. Provides information to families about resources available in the region and assists families who ask for respite care from provincial institutions.
- **Occupation Therapist available on a part time basis (Home assessments, develops plan for each client).** Assesses medical equipment to ensure equipment meets safety requirements (up to code)
- **Clients have good access to Medical Equipment from the Non Insured Health Benefits (NIHB) program.** Health Centre installs medical equipment for clients; however, funding is not provided for installation.
- **Meals on Wheels – One day per week meals are provided to clients.**
- **Life Line** – Clients can be set up with ‘life line’ services (clients with reduced mobility able to access emergency services).
- **Prescription Medication** – Funding available for prescriptions from the NIHB program. Some pharmacies are familiar with the funding process, while others are “less familiar”. Information about medication is readily available in English (orally and written).

d.) Family Violence Prevention

- **Women and children who are experiencing family violence in the home may access to short-term residency at the shelter located in the community. Open to community members and also to First Nation individuals from other First Nations communities in the area (Quebec and out of Province).**
  - Women feel “at home, safe and comfortable” at Haven House.
  - Staff able to communicate in the Mi’gmaq language with clientele. *“This helps especially with the Elders.”*
  - Clients have choice of mainstream or traditional service delivery – services are accessible by “all clients” while at Haven House.
  - Clients have access to outreach services, anger management programs, and assistance with life skills (budgeting, grocery shopping)
- **Public Relations – Information and Awareness campaigns to address family violence**
  - Access to information about family violence through social media
  - Community- based activities to build awareness about family violence prevention (*Wellness Fair, Commemorative Events, Awareness Walks, Workshops*).
- **Community members have access to 24/7 Crisis Line run by the Shelter**

- **Good relationships established with Native organizations (provincially and nationally) geared for Native women and violence prevention.** Access to: Training, Information Sharing, and Networking (no obstacles because of language; Translations are provided if meetings are held in Quebec.)
- **‘Joint Case Management’ (Circle of Care) – Key Resources from within community brought together (i.e., Youth Protection, Health, Prevention, and Police). Discuss in confidence situations for mutual clients deemed high risk.**
  - Share relevant information without breaking confidentiality (*“helps to take down silos built up among the community service providers”*)
  - Reduce duplication of services
  - Improve communication among service providers
- **Good Relationship with Provincial Liaison from Victim’s Services – Liaison is bilingual, and aware of the needs of Aboriginal clientele.**
  - Empowering for women who need to navigate the legal system.
  - *“Staff have developed a good relationship with [Liaison]; it’s not so intimidating over there [at Court] ... She is our link to that system [legal] It’s all French. It has made the whole situation easier.”*

e.) Social Assistance

- **Last Resort’ assistance – last resort assistance to on Reserve Listuguj community members. Agency is located in the community – easily accessible and sensitive to the needs of First Nations clientele.**
  - *“[With having First Nations staff] we are more sensitive to the needs of First Nations people, rather than someone from out of town.”*
  - Refer clientele to resources in the community to assist with life skills – Set up banking, Obtain Medical Cards, Income Tax Returns
  - Provide counseling services and/or referrals to clients who may be experiencing financial difficulties.
- **Refer clientele to resources (training, counseling) located in the community**
  - *“Always all kinds of postings up [training opportunities] at the local training centre that Social Assistance clientele can access.”*
- **Enhanced Services Delivery. Program available for social assistance clients ages ‘18 to 24 years of age’ who have completed high school and/or post-secondary education**
  - Clients are assessed by counselors – Identify any barriers, and determine if client qualifies to go into the ESD program (workshops and Job Placements). Goal is for youth to gain work experience and return back to school. *“Some do come back here. But, some [youth] go back to school. They don’t want to see us [Social Assistance] anymore.”*
  - ESD program is delivered at the local training centre – career counseling available. Encourage Younger Generation to obtain training/education.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- **Communication barriers with provincial workers because of language and lack of cultural sensitivity. Some clients ‘feel intimidated’ by professional workers and have a hard time expressing themselves accurately.**
  - *“One mom almost lost her children because the lawyer did not fully understand the situation. ... “*
- **Limited number of English-speaking social workers available at provincial institutions. Participants noted that there is a high turn over rate among English-speaking staff at provincial institutions.**
  - Obstacles obtaining assessments (Mental Health, Disabilities) because there are a limited number of clinical workers at the province who provide such services in English.
- **Documentation from the province (i.e., correspondence, emails, reports, and meetings) is primarily available in French.**
- **Translation Services – Funding is not available for translation of reports, documents, and written material provided by the province to First Nations organization. Bilingual staff members will provide assistance with translation of documents, e-mails or reports.**
- **Challenges establishing partnerships and working with the province because of language.**
  - *“If we’re going to develop partnerships [with the province], then meet us half way. We’re not French speaking. This is a big issue – it’s about attitude and willingness to try to work together.”*
- **Jurisdictional Issues (Provincial) – Difficult to access services for mental health from provincial institutions in New Brunswick due to provincial boundaries – obstacles to go ‘out of province’ to access services in English.**
  - *“Clients may access ‘emergency’ mental health services from out of province; however, follow up and treatment can only be accessed from hospital in Quebec Region where there are limited English-language services and clients must travel further distance.”*
- **Long waiting list for mental health services from provincial institutions**
- **Lack of Cultural Sensitivity and Awareness – Generally speaking, there is a lack of awareness and understanding among staff at provincial institutions about colonialism and its impact on First Nations’ access to social services.**
  - *“When accessing specialized services (Social Workers, Psychologists, etc.) it is difficult to find someone who understands the situation from an Aboriginal understanding and approach.”*

- **Racism and discrimination among First Nations and non-First Nations in the region. Prevention Services has a role to play in addressing racism, especially among the youth.**
- **Prevention Workers felt that their work and experience is at times devalued by external non-Native organizations/committees (Clinical Approach vs. Life Experiences/Teachings)**
  - “[First Nations Prevention] team members feel that their work is less valued. They will come back from a meeting [with non Native resource people] and say ‘they didn’t really want to hear what I had to say. They want to hear it from a professional’.”
  - Devalues the meaningful work that is being done by prevention workers whose qualifications may differ from workers at the provincial level.
- **Communication and information sharing between First and Second Line Services. Need to balance ‘client confidentiality’ with ‘holistic community approach’.**
- **Follow up with external resources: Need to ensure that once referrals are made to external resources that First Nations continue to stay involved with a file.**

b.) Enhanced Prevention Focus (Protection Services)

- **Barriers communicating because of language**
  - Court – Limited number of English-speaking lawyers. Court proceedings in French. First Nations workers provide some translation to families. Translator is brought in from the province, but not always available.
  - Group Homes – Lack of English services at Group Homes in Quebec Region (i.e., Secure Group Home in Gaspé). To access services in English, youth need to travel farther distance in Quebec or go out of province. Lack of English-language instruction (education) for Youth who attend ‘Secure Group Home’ in Quebec Region (Gaspé Area).
- **Local CLSC – Difficult to access services from local CLSC because of language.**
  - Some staff may be English-speaking, however programs are not readily available in English. Services required: Clinical support for Autism Spectrum Disorder and also Respite Care.
- **Lack of specialized services for Mental Health and Addictions (Detoxification and Treatment) in English from provincial institutions in Quebec. (Barriers accessing services because of language, distance, and lack of cultural sensitivity). Long wait time for services in English.**

- Community members mainly access specialized services for mental health from private agencies out of province.
  - Long wait time for psychological assessments.
  - Lack of residential care for youth with disorders such as autism or who require specialized psychological services.
- **Documentation from provinces is provided in French**
    - Court Orders (Youth Protection and Young Offenders) mainly provided in French. Difficult to find a translator (need to maintain confidentiality)
- **Court – (Young Offenders and Youth Protection) – Obstacles accessing services due to financial barriers and ‘preconceived notions’ about legal process.**
    - Financial barriers – Parents are showing up in court without legal representation.
    - Parents/Children lack of understanding about the legal process (generally speaking)
    - Preconceived notion of court creating obstacles for families. Parents view the courts as a ‘penal system’ as opposed to a support system to get outside agencies to create a better family environment.
    - “[*Child and families*] lose their voice in the [*legal*] system ... The [*legal*] process is too fast. Parents need a stronger voice to speak on their behalf when it comes to court.”
- **Distance – difficult to access some social services because of distance**
    - Court –Funding is not provided for parents to travel to court. Some parents do not have vehicles, difficult to participate in legal proceedings.
    - Youth Treatment Centres (Substance Abuse) – Access to Youth Treatment Centres (English language and cultural programming); however, distance is an issue (located one hour away). Wait time to access treatment services (clients accepted on cycle basis).
- **Provincial Laws creating obstacles to the delivery of social services by First Nations Communities – Lack of recognition of Mi’gmaq Vision and Involvement in decision making and delivery of services.**
    - Provincial Legislation is changing how foster care services may be delivered in communities (*recognition of foster homes and payment for services*). [Bill 125 – An Act to amend the Youth Protection Act and other legislative provisions]
    - Inequities in amounts foster families are receiving – different rates for homes accredited from the province.
- **Jurisdictional Boundaries – Provincial Boundaries**
    - Lack of access to specialized services for Mental Health and Addictions from provincial institutions that are located ‘out of province’ (in New Brunswick). (*Psychological services, Detoxification, and Treatment*).

- Long wait list if individuals are able to access services from out of province.
- **Lack of support services in the area for Sex Offenders (general lack of services, and also because of language).**
- **Discharge – Lack of notification.** Provincial institutions in the Quebec Region are not notifying First Nations organizations when clients being followed by Youth Protection are being discharged even if this requirement is noted in their file (for example, if a client obtains services for Mental Health reasons at the provincial hospital).
- **Lack cultural sensitivity/awareness – Generally, staff at provincial institutions (e.g., Group Homes) are not aware of the history, social and cultural needs of First Nations’ clientele.**
  - *“Staff at provincial institutions may not know anything about our culture. Even something basic like smudging.”*

c.) Assisted Living

- **Good access to medical equipment, but funding is not available to install medical equipment or to build any infrastructure (i.e., wheelchair ramps).** Participants noted that there is a long wait time to receive approval for some medical equipment through NIHB compared to provincial system (“Non Natives access medical equipment faster at the CLSC”).
- **Some obstacles when individuals are discharged from hospitals in Quebec Region – language barriers and lack of communication**
  - Discharge reports from hospitals in Quebec region are written in French,
  - Hospitals may notify the Health Centre that community members are being discharged.
- **Lack of Personal Care Workers.** Workers are mainly hired on a casual basis, which makes it difficult to recruit workers (*staff burn out, lack of benefits for workers, lack of employment security*).
- **Transportation is not provided to assist clients with ‘daily living’ activities (i.e., grocery shopping, run errands, banking, etc.)**
- **Funding is not provided for translation services. Bilingual staff members at the Listuguj Health Centre provide assistance with translation, which “takes up their time from other duties”.**
- **Specialized services – (dietician and physiotherapy). Limited services in English, long wait times at provincial institutions.**

d.) Family Violence Prevention

- **Lack of Detoxification Services / Addictions Services in the area generally, and English-language services specifically.**
  - The shelter is being used as a place for women who are waiting to go into detoxification. Difficult for other clients and the staff if the woman is going through withdrawals.
- **Lack of English-speaking mental health services (such as psychologists) at provincial institutions in Quebec.**
  - *“We have to get services [mental health] for our clientele from out of province at private institutions. Costly for the organization. Funding is not provided to pay for mental health services (e.g., psychologists).”*
- **Obstacles communicating with provincial government agencies because of language.**
- **Minimal networking or communication with provincial mainstream organizations for family violence prevention**
  - Provincial Network (mainstream shelters): *“They meet regularly. We’re never invited to their meetings. We do not receive any information or documentation.”*
  - Organization for women (mainstream) – *“Rarely call us. Difficult to establish partnerships. We have a meeting, and then we never hear from them again.”*
- **Difficult to navigate the provincial network (e.g., local CLSC). Lack of English-language services for health and social services.**
  - *“We rarely go to provincial institutions in Quebec.”*
- **Communication issues when working with shelters in the area (out of province) – misinformation and obstacles because of language**
  - Staff at local shelter (in New Brunswick) was unaware that they could accept ‘out of province’ clientele.
  - Obstacles because of language (staff mainly speak French) – *“clients don’t stay [at the shelter] very long”*
- **Shelter is not able to provide services to individuals referred to shelter for reasons other than family violence (i.e., clients seeking services for addictions, detoxification, mental health, homelessness).**
  - Staff is not trained in these areas, nor is there medical personnel available if required.
  - Compromises the safety of staff and other clientele
- **Working with the local police (First Nations) – Dialogue is needed to ensure that police force is informed about the resource available for victims of family violence at the Shelter. More attention required for victims of sexual assault.**

- **Shelter is not accessible by individuals with limited mobility**
  - Funding is not available to make any renovations or to ensure that the home is accessible by people with physical disabilities.

e.) Social Assistance

- **Stigma associated with relying on ‘income of last resort’**
  - Staff help clientele who face obstacles because of literacy levels, social stigma
  - *“This is the last place some people thought they would end up. They are almost in tears.”*
  - *“Sometimes it’s embarrassing for the client. I ask the questions, and fill out the form. It’s less degrading.”*
- **Rules and Regulations – Organization is required to follow rules and regulations set by Aboriginal Affairs and the First Nations Health and Social Services Commission (Framework). Difficult for community to set their own priorities for social assistance.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Community members have access to range of prevention and protections services** – (programming provided in schools and community). *Including: one-on-one with clients, group settings (support groups), service planning and referrals.*
- **Protection Services are readily available** – Community organization is mandated to provide child protection services in both the Quebec and Ontario districts of Akwesasne.
  - Networking helps with access – Member of Ontario Association of Children's Aid Society (Ontario) – Staff able to access training (front line and management) in English *“We are connected with Ontario association, we can network, share resources, problem solve ... that has helped our Agency out a lot.”*
  - Foster Homes – Training Tools available from Ontario (Ontario Tools are implemented across the board, such as screening foster homes and training for foster parents).
- **Protocol established with Akwesasne Mohawk Police** – Youth Protection workers able to receive support from police, if required. Police will refer individuals to the child and family services' organization.
  - *“We have a good relationship with Akwesasne Mohawk Police. We have a Protocol with them, if we have to go in for situations if they need to go in and accompany workers, for their safety, they will do that.”*
- **Joint Case Management Team** – Community agencies (Health, Social, Police, Justice, Housing) meet to discuss complex and challenging cases. Better able to meet the needs of the client when resources work together.
  - *“Many times, it's mental health and addictions issues, on top of poverty, or criminal charges in there also. To meet the needs of a family or individual, we come together and sit and discuss in case management.”*
  - *“We will brainstorm on how to share resources, and coordinate some type of support [for clients]. We've been able to come together and resolve issues.”*
- **Court System** – All the court hearings are held in English. First Nations organization provides information to families (i.e., legal aid, directions to court). The organization and children in protection have access to legal from Quebec's Centre Jeunesse. Transportation is available for the children.

## b.) Family Violence Prevention

- **Community members have access to a safe house and also to educational programming (men and women).** Curriculum includes: domestic violence, as well as other topics –addictions, (including addictions’ assessment and treatment), employment & education counseling, health, and building healthy relationships. Programming is open to all community members (whether they stay at shelter or not) both men and women have access.
  - *“Work is beyond just being a ‘safe house’. There is prevention work and programming provided to clients.”*
  - *“Requested to start training other First Nations communities about the curriculum provided at the shelter.”*
  - *“Safety Planning and Prevention Services – Reduction in number of women seeking services (fewer people coming in to reside at facility) due to safety planning and education being offered in community.”*
- **Networking with other Shelters – Information sharing, resources, and best practices.**
  - Member of National Aboriginal Circle Against Family Violence (*National network*)
  - Shelter Net (*Provincial network for Aboriginal and non-Aboriginal organizations in Ontario*)
  - Native shelters (in Ontario)

## c.) Social Assistance

- **Social Assistance is delivered in the community under the Ontario Works’ Social Assistance program for all clients (Quebec and Ontario districts). Few barriers because of language (delivered under Ontario’s framework).**
- **Networking** – Strong support mechanism in Ontario. First Nations belong to an association that meets biannually. Discuss any policy changes, training. All available in English.
  - Limited networking with Quebec – lack of information, awareness of services, and there are language barriers.
- **Education and Training opportunities** – Created strong network and partnership with Adult Education Program in the community to deliver programming (training and education) to SA clientele.
  - Clients have access to transportation (to attend training/education)
  - Successfully worked with Economic Develop (internal agency) to identify labour market trends and needs in the community (for training)
  - Moving program to become more education and training focused, rather than continuing the dependency cycle of Social Assistance. *“We recognize that we have generational clients on assistance – parents and*

*grandparents have been on SA. How do we break the cycle? ... We conduct assessments of clients and with our partnerships, we direct them to services they need to break the cycle of dependency (education, mental health, and addictions)."*

d.) National Child Benefits Reinvestment Strategy (Available through Ontario Works (Social Assistance) program)

- **Funding is available for projects to address poverty from National Child Benefits Reinvestment Strategy. Program effectively addresses poverty, managed and controlled by the community.** – *“The people who need help the most, actually get the support.”*
  - Community evaluates proposals (Community Based Committee) for projects that address poverty.
  - Committee reviews applications based on priority areas established for NCBR. Dispersed funding not only for community funding, but also to community groups. Children living in poverty able to access support that they need, so they have a little bit extra available to them.
  - **Challenge** – Funding has been decreased; only available on a year to year basis.
  - Note: **Akwesasne** indicated that services are provided under NCBR strategy. Although the mandate still exists to provide NCBR projects in Quebec, First Nations communities have limited availability to funding through their Social Assistance programs for such projects.<sup>2</sup>

e.) Adolescent Treatment Centre (Addictions)

- **Culturally relevant treatment program offered in the community of Akwesasne.**
  - *“Culture and traditions are built right into the programming.”*
  - Clients have access to other services available in the community (Prevention, Medical)
- **Staff is well experienced** –Life experiences and formally trained.
- **Partnership Agreement established with Northern Cree** – Networked with the communities, agreement established – *“Good partnership with the Cree communities.”*
  - Maintain close communication and relationship with partner.
  - First Nations clients from more remote areas have access to medical, optometry, and dental services available in the community while at the treatment centre
  
- **Recognize the importance of After Care and Relapse Prevention for Youth**

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<sup>2</sup>Conversation with a representative (Marie-Pierre Bessette) from AANDC Quebec Region. 8 June 2015.

- *“Adolescents in facility do well. They grow and improve. But, once they transition back into community the supports aren’t there. We are trying to help communities to build capacity and have the supports necessary for when the youth are back home. Recognize that that is an area that needs to be strengthened for treatment.”*

- **Networking and Information Sharing – Sharing ‘wise practices’ with other Nations at Conferences and other forums.**

- Provide training to other communities
- Provide information and resources to parents.
- Community information sessions in Akwesasne (for all districts, regardless of provincial/national borders)

f.) Community Day Cares (*Daycare included in this research due to the connection that Daycare has with Social Services*)

- **Case management approach (schools, health care, prevention services, and daycare centre) – helps to ensure that children have access to all resources**

- *“Good networking in the community, but still very stand alone and working outside of Quebec (lack of information, awareness, and funding opportunities.)”*

- **Special Needs – Services available for clients with Ontario Medical Cards; however for residents with Medical Cards from Quebec there are obstacles accessing specialized services (OT, and speech therapy) from specialists located in Ontario (Jurisdictional issues – see below)**

- Centre able to complete developmental assessments on children using a developmental tool.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **‘Jurisdictional Issues’ (Provincial and International borders) – General challenge because of jurisdictional issues identified by all social services providers. Also, face discrimination and racism when ‘crossing the border’.**

- *“Akwesasne has always been Akwesasne. The government divided us up into three different jurisdictions. We go through a ‘jurisdictional nightmare’ on a daily basis ...In our community, no matter where you are – in Quebec or Ontario – you have to travel through New York State to get to each ‘district’. We are constantly in and out of New York State. That is why things are so challenging and frustrating in how we work and operate ... The racism is still there. You go through that on a day-to-day basis.”*

b.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of English language services for children and youth in protection related to Special Needs**
- **Lack of Anglophone Foster Homes for adolescents in Quebec. Access services ‘out of province’ (residential placements for Youth); then face obstacles accessing medical services because of provincial jurisdiction for Medicare.**
  - *“Difficult to have residential placements in Quebec. We’ve had occasions where youth have been placed in French-speaking facilities. We place them in Ontario, but then we have a problem because health providers have an issue with Quebec health insurance. There are differences in rates. [In Ontario] they are refusing Quebec medical card.”*
- **Lack of information and notification about Quebec’s Youth Protection legislation (i.e., Changes to legislation, Standards).**
  - Staff need to know the YP legislation for both Ontario and Quebec, yet information is not readily available about legislation in Quebec Region.
  - *“We don’t know if we are meeting standards, or even what standards exist in Quebec.”*
  - *“We’ve heard some talk about social workers needing to be registered, but we haven’t been notified.”*
  - *“We are one community, yet we have portions of our reserve in Qc, Ontario, and NY State. When we are looking at bringing children into care and placing them, there are challenges in terms of licensing regulations for foster homes. There are some things allowed in one province, but not in another ... we need this information.”*
- **Lack of information about any funding available from Quebec Region for Youth Protection.**
  - *“Connected with Aboriginal Affairs out of Ontario, but services are provided to residents who live in Quebec region ... We don’t receive any information or funding from Quebec.”*
- **Not satisfied with the quality of services received from the provincial Liaison Worker (agreement in place with Centre Jeunesse): Lack of communication and follow up is an issue.**
  - *“We work with a Liaison Worker for First Nations’ communities. Relationship has deteriorated over the years. ... Would like a back up person, need more than one person to connect with for support.”*
  - *“We’ve asked the Liaison, but haven’t received any responses. We’ve asked for information, but we don’t receive direction or training.”*
- **Lack of training opportunities in Quebec Region for Youth Protection Workers**

- *“Training has been an issue. Minimal training from Quebec. Repeated requests for training. We do receive annual training, but it is just a refresher of the Youth Protection Act.”*
- *“Mainstream agencies must receive training, but we don’t receive any.”*

c.) Family Violence Prevention

- **Jurisdictional Issues (Provincial) – Issues with funding services (family violence prevention) for clients from ‘out of province’: residents with Quebec Medicare seek services from shelter because services are in English and programming is culturally based.**
  - *“Shelter is on Ontario side. Services are provided, for residents from Quebec region, but organization is not provided with funds from Quebec. We receive referrals from Quebec because we provide English-language services, cultural is a component in all the programming that is offered. Transportation provided to Quebec residents – cost (out of pocket). Quebec not providing any funding for individuals .... It angers me, because it’s not fair.”*
  - **Second Stage Housing** – Funding is not provided for “non-residents” to stay and use the programming from ‘Second Stage Housing’. *“Women may be forced to go back to unsafe situations because they don’t have any other alternatives.”*
- **Detoxification Centers in Quebec– Language Barriers, and long wait period to access English language services.**
  - *“When clients go [to some treatment services in Quebec] they have difficult because it’s all in French. Staff speaks French. They just don’t like to go there. They often won’t stay because it’s too difficult. Long wait period to access English language services.”*
- **Applications for Subsidy Forms**– Clients at the Shelter experience barriers filling in applications because of language. Often the applications (*housing, subsidy forms for Daycare, Schools*) are all in French. Difficult for clients. Clients often relocate to Ontario side.
- **Communication barriers because of language when calling provincial institutions.**
  - Called the information network and it was “really difficult to get an English-speaking person on the phone.”
- **Difficult to access specialized services in English in Quebec** (*services such as: Mental Health, Medical, Counseling, Addictions’ Services*)
  - *“Very frustrating, people tend to use the Ontario services rather than in Quebec because of language”.*

- *“We can get an assessment for a child, or parenting capacity assessment done in Quebec. But beyond that, we don’t know where to go for more services.”*
- **Documentation from the province is mainly available in French – General Information and Official Court Documents**
  - *“When you call the province and request information, they will send it to you in French.”*
  - *“Information from Court System is mainly provided in French. Difficult to read the documents from Court System in Quebec (mix of French and English); long wait period when the province translates the documents, funding is not provided for translation.”*
- **Lack of Information about and disconnected from the Quebec Health Care Network, generally speaking, and specifically with regards to Family Violence Prevention.**
  - Disconnected from Quebec. Not fully aware of what services are available (support, medical). Funding, subsidies – lack of information.
  - Doctors may have license for both provinces (Ontario and Quebec), however, (the professionals) are more familiar with the network in Ontario. We have that disadvantage of not being fully aware of what is available.
  - Family Violence Prevention workers do not currently network with any Family Violence Prevention organizations in the Quebec Region. *“We don’t attend any meetings in Quebec. Not invited. Costs money because translation would be required for meetings. Quebec Shelter Network... not aware or invited to any conferences.”*

d.) Social Assistance

- **Language Obstacles and facing discrimination as First Nations when filling out application forms (i.e., driver’s license)**
  - *“It was a racism issue, and specific to Akwesasne because of the border. [Workers at the province] were adamant that I prove where I live. Passport was inadequate — it was a nightmare. I hate going there.... Because I’m First Nations, and I live in Akwesasne, I had to provide more documents. They said ‘how do I know that I don’t live in New York State?’”*
- **Disconnected from Quebec’s Social Assistance program – lack of support and resources from Quebec, yet there are residents who live in ‘Quebec district’ of Akwesasne.**
  - *“The unfortunate thing is that we are so disconnected from Quebec. Even though we are following Ontario model, we should have support and resources from Quebec. By not being aware of it, are we doing a disservice to the clients?”*

- **Food Security – Community member have access to a food bank in Quebec; however, drawback is the distance (food bank is about one hour away) - not readily accessible. Lack of awareness and limited connections with Quebec networks to address issues resulting from poverty.**

e.) Adolescent Treatment Centre (Addictions)

- **Inability to service sister communities in Quebec because the treatment centre is not recognized as a National Native Alcohol and Drug Abuse Program (funding is not available for clients from Health Canada).**
  - *“The culture and traditions are built right into the programming. It would be really fortunate for the other communities to have access, to provide youth with that type of Treatment. Because of Health Canada and NNADAP, and lack of funding, and not being able to designate another facility as a NNADAP organization. We could in the past (when it was a Group Home), however, once transitioned to a treatment centre they were unable to provide the service.”*

f.) Community Daycares *(Included in this research due to the connection that Daycare has with Social Services)*

- **Jurisdictional Issues (Provincial) – Community has three fully functioning centers (one in Ontario and two in Quebec). Historically, received funding from Ontario. Not recognized in Quebec. Community was told they were not ‘situated in Quebec’, therefore not eligible for funding subsidies (yet two of the centres are physically located in Quebec).**
- **Financial Obstacles– Families pay full rate for places at daycare (unlike daycares in Quebec, which are subsidized). Daycare seats subsidized from various ‘social assistance’ programs in the community. Limited funding available to subsidize seats. Financial barriers for families and children who are ‘at risk’.**
  - Distance is an issue when children need to access services from Quebec health system (i.e., specialists to address developmental delays and special needs)
  - Long wait for services from Quebec Medical System.
  - Difficult to access services from Quebec institutions because of language issues. Some parents are “not comfortable” going to institutions in Quebec due to language barriers –not comfortable explaining their child’s situation to specialists.

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention Services)

- **Collaborative approach among social services’ providers: Reduces duplication of services and ensures that clients are aware and have access to all programs/services that are available in the community.**
  - *“Multidisciplinary work between Prevention and Support workers, i.e. shared cases. (First Line and Second Line)”*
  - *“Networking amongst various services within the community to meet the needs of community members”*
  - *“Prevention Worker and the nurse will go into the school together to deliver programs on healthy sexuality – nurse will cover the topic from a medical perspective, while the prevention worker provides a social perspective – holistic approach.”*
  
- **Prevention programs and services are readily available in the community for families, individuals and groups. Prevention topics (e.g., family violence, addictions, healthy sexuality,) are integrated into activities.** Resource binders (modules and curriculum) have been developed and available for staff to use in their programs. Healthy meals/snacks provided for some programs (healthier food choices and increase awareness about diabetes prevention) from Prevention Services at KSCS
  
- **The Family and Wellness Center offers the following services: Traditional Support, Parenting, Satatenikonrarak, Indian Residential School and smoking cessation**
  
- **The Whitehouse offers youth programming** (ie Our Gang and Mad Group)
  - The team offers *support and guidance, resource information, workshops, groups and activities* designed to meet the needs of Kahnawake families.
  - *Parenting Programs* geared for different age groups (i.e., 0-6 years old, Youth). Curriculum focuses on topics such as: life skills, budgeting, parent child exercises, arts and crafts, healthy sexuality and children, and one-on-one services to assist with the development of skills such as scheduling (with children), discipline, attachment parenting.
  - *Parent- child interactive workshops* that promote parent child interaction through activities that stimulate development and self esteem
  - *Nobody’s Perfect Program* which is a 6-8 week program for parents with children from 0-6 years, offering interactive workshops and experiential learning on a variety of parenting issues such as child development, understanding children’s feelings and behavior, stress amongst parents, etc.

- *Traditional Prenatal Group*- offered for mothers seeking prenatal teachings from a Traditional perspective. The group marries the Traditional teachings with the Medical information available today.
  - *Kids in the Middle* is a parenting program offered to parents who are separating/ divorcing and offers information and skills building to ensure children are not in the center of their issues during family breakdown
  - *Where the Creek Runs Clearer Traditional Youth Group* –prevention programming based on traditional cultural teachings (for example, roles and responsibilities of men and women; traditional skills – hunting and harvesting).
  - *Our Gang (After School Programs and Summer Camp)* for school-aged youth – offers assistance with homework, support and prevention education (healthy sexuality, family violence, life skills, social skills) integrated into all activities.
  - *Making Adult Decisions (Teen Group)* – Mental health, addictions, life skills, social skills, and building on Leadership skills.  
Promotion and Education Services- “*Prevention workers will meet with teens who are experimenting with drinking and drugs to offer education, awareness, and prevention work for teens.*” In addition to this various campaigns such as bullying prevention, Spirit of Wellness month, Safe Grad, Violence Prevention, and Suicide Prevention are offered on a yearly basis.
  - *Support Groups offered based on identified needs*, i.e. Addictions Education, Grieving/ Loss Group, Divorce and Separation, Self Esteem Group, Youth Groups for empowerment.
  - *Traditional Services* - offers one on one sessions, Group teachings, Sweats, roles and responsibilities for men and women, and various ceremonies based on traditional Iroquois teachings.
- **Mental Health –Access to counseling services in the community from Traditional Support Counsellors and Support Counsellors (under the umbrella of Prevention Services).** Workers offer individual therapy/ counseling to work on issues. Clients have an opportunity to receive services from a Traditional Iroquois perspective (using both the natural and spiritual realms of Iroquois Teachings) and/or from the mainstream western perspective.
  - **Addictions Services –Access to services for many kinds of addiction (smoking, gambling, drug and alcohol).**
    - *Challenge (treatment services)* – Clients are referred to treatment centers outside of the community and access is limited in Quebec due to language barrier.
  - **Youth Criminal Justice** – Social workers (Case workers under Support Services) work with courts to ensure that court measures are completed (Second Line)
    - Case workers are assigned to provide the judge with a “pre-decisional report”, and will follow the youth throughout the process.

- Hearings are held in English; however, the “context” of the situation is not always considered or understood by judiciary.
- Some documentation (letters, Court Orders) may be sent in French and require translation.
- Under Section 84 - members of Prevention and Support Services, along with the Director of Justice and members of Corrections Canada, **assist individuals released from federal penitentiaries to transition back to their community**. The committee is in place to assist the individual with support and acts as a means of accountability during their transition
- **Networking** – staff network with external agencies in the community, i.e. Hospital, Peacekeepers, Fire Brigade, Kahnawake Diabetes Prevention, Community Schools, Mohawk Council of Kahnawake etc. Also, in the past, we have been able to bring outside resources in to the community to assist with youth programs (i.e., drama programs)
- Satatenikonrarak Component which provides the community with **awareness and prevention information regarding Fetal Alcohol Spectrum Disorder, HIV/AIDS, Healthy Sexuality, Smoking Cessation Initiatives and Suicide prevention**
- **Protocols** – There are protocols in place with police (Kahnawake) for situations involving family violence.
  - Police will send referrals for individuals experiencing family violence to receive prevention services.
  - KSCS and the Kahnawake Schools Partnership is in place to meet the needs of the youth with a spectrum of prevention activities and services to help ensure the children’s educational and social goals are reached. Programs include person and social development, Leadership and Empowerment Group for girls, Health and Sexuality, and Leadership for men Group.

b.) Enhanced Prevention Focus (Protection Services) [Response submitted in writing]

- **Intake Services provided by the Organization: assess and screen each request. Ensure that each request has been properly assigned and followed up.**
  - *“Intake Services is responsible to provide immediate responses to all requests placed to KSCS for any of the service areas (although many of the calls related to elders services and assisted living services may be sent directly to those service areas)”*
- **Youth Protection Services Provided by the Organization through delegated authorities through the Director of Youth Protection of the Centre Jeunesse (Monteregie). Since the 1980s, Kahnawake has entered into specific**

**agreements with the Province to provide services to its own population. Work with provincial partners to implement institutional or Group Home Placements.**

- *“We will continue to assume this responsibility [Youth Protection Services].”*
  - *“We collaborate with the Tsi Ionteksa’tanonhnha Foster Care Program to implement foster care placements”*
  - *“Our family members sometimes require more structured environments to help stabilize their current situation. To support these situations, we rely on the support of our partners at the Child Services of Akwesasne, the CJ Monterege, and the CJ Batshaw”*
  - Roster Services: *“Ensures that someone is available to respond immediately to emergencies and/or new intakes when the demand is necessary.”*
- **Youth Criminal Justice Services are provided by the Organization through delegated authorities (e.g., assessments for extra-judicial sanction and probation follow up).**
    - *“In partnership with the Quebec Justice system, we conduct all necessary functions to support the Quebec Youth Criminal Justice Act, such as conducting assessments for extra-judicial sanctions and probation follow-up. Funding for the Youth Criminal Justice Services is administered through the Province of Quebec.”*
- **Tsi Ionteksa’tanonhnha “Foster Care” Program is provided by the organization. The main responsibility of the Foster Care Program is to provide a safe, stable environment for children who may be at risk in their family environment. Organization recognizes foster homes and provides support and training for foster families.**
    - *“Our intent is to always seek child placement with a child’s own extended family members first; this is in direct alignment with our Kanien’keha:ka tradition of families taking care of each other.”*
    - *“Since before 1982, Kahnawake has recruited, assessed, recognized and approved our own foster homes, using standards equitable to the provincial standards, but also in keeping with our own values and traditions. We believe we are the **only** agency who has the mandate, the right and the knowledge of who should be caring for our children.”*
    - *“All of our foster homes and extended family members are provided with the support, and training if required, maintain children in their care. This support may include financial assistance, counselling, training, support group meetings and any other support determined by the Foster Care Team Leader.”*
    - *“Funding for the foster care program is administered through the AANDC, and is accordance with the rates provided within the province.”*

- **Institutional Care and Group Home placement provided by our partners, (Batshaw, Centre Jeunesse).**
- **Case Aide Program provided by the Organization:** The main responsibility of the Case Aide program is to provide essential services to children who are in foster care, institutions, and group homes such as providing transportation and facilitating supervised visits. Case Aides are frontline workers who directly observe the clients' situation and family environment, and provide valuable input into service and treatment planning.
  - *“Through supervised visits, the case aide, as an extension of KSCS, provides an opportunity for families in crisis to interact, enjoy activities and outings that enable them to maintain their bond and re-establish the family unit in a more familiar environment.”*
  - *“These visits are normally held after school hours and on weekends. Therefore, cases aides must be flexible in their availability to provide this service.”*
  - *“Case aides also provide transport to children and youth when deemed necessary. These may include transports to school, to supervised visits, to special activities, and any other transport that is clinically appropriate.”*
  - *“Transport areas include the surrounding communities, as well as Akwesasne, Kanasatake, Shawbridge, Ottawa and the Eastern Townships.”*
  - *“Case Aides able to provide emergency childcare within KSCS in the event there is an emergency and childcare services are required.”*
- **After Hours Response Services “On-call” provided by services in the community. Staff work collaboratively with other agencies in the community (Kahnawake Peacekeepers, Kahnawake Fire Brigade, Kateri Memorial Hospital Center). Specific emergency services are provided to community members.**
  - Respond to emergencies after hours.
  - Collaborate with the Kahnawake Mohawk Peacekeepers and other emergency services to intervene on clients who require immediate attention
  - Conduct court-ordered or requested “spot checks” with high-risk families to ensure the safety of minor children
  - Conduct “outreach” calls with clients who are in distress or crisis;
  - First access point for engaging the rest of KSCS during a community emergency.

c.) Assisted Living

- **Community members have access to Assisted Living services in two main areas ‘Special Needs’ (Ambulatory and Cognitive Issues) and ‘Mental Health’ (severe and persistent disorders– schizophrenia, bipolar, oppositional disorder).**

- **Individual and Group programs are available for individuals with Special Needs. Programming focuses on Social and Life Skills to bring individuals to their maximum independence.** Provide support and respite services to their families. Each client has a social worker attached to their file to conduct an assessment and to determine needs).
  - **Life Skill Support Workers** – assist with one-on-one focused activities; **Adult Program**, 18 years and over (runs during the week, and occasionally in the evenings and weekends); **Teen Social Club** (runs after school and summer day programs).
  - “[Adult Program] is essentially for individuals who are no longer eligible to attend school, keep up their social and life skills, keep them connected to community around them, mindfully engaged so they don’t lose what they have from school or continue to learn.”
  - “[Teen Social Club] focuses on life skills to bring participants to maximum independence. Respite for families. A lot of the caregivers are aged ... one family is in their 80s. This is support for families and also for individuals.”
  
- **Organization is developing a profile of statistics of individuals with special needs to better prepare for what is coming in the future (chart of needs)**
  
- **Mental Health (Independent Living Centre)** – A 12-Bed ‘Residence’ facility. One-bedroom studio, no kitchen facilities, one-bedroom studio-type setting. Provide 24/7 security. Day staff available (Monday to Friday) – social workers, life skills workers. Activities keep individuals socially connected and integrated in the community. Work with Mental Health Nurses, doctors, psychiatrist, and pharmacy.
  - “Multi-disciplinary approach. Clients typically don’t re-enter hospitals. We have a long history of stability in their health.”
  - “Mental Health side of the services have evolved ... we have access to psychiatrist, mental health nurse, support for medication. Carved out our own resources on Reserve ... We are able to care for our own here, and as a result they do have better services (access and quality).”
  
- **Support for clients with severe and persistent mental health issues** (day programs, and access to multi-disciplinary health team).
  - “Typically, the individuals tend to be isolated, or self-isolating, so we help them to keep connections with the community.”
  
- **Court System** – Organization able to contract English-speaking lawyers. Minimal involvement with Court System. Organization assists families with setting up ‘Plans of Care’ and financial plans. Able to obtain resources in English from province to set up Trust Accounts.
  
- **Partnerships established with some provincial hospitals for Mental Health – good access to English language resources, training opportunities for staff, and continuity of care (relocate clients).**

- *“Partnership with the hospital helps community members who are seeking services for mental health reasons “to stay connected or reconnect with the community ...”*

d.) Addictions Response Services (*Consolidated Health Agreement, established in partnership with Health Canada*) [Response submitted in writing]

- **Addictions Response Services provided by the community – direct support to community members on an “Intensive Outpatient” model, within a continuum of care.**
  - Services that community members have access to include: Addictions screening; In-depth addictions assessments; Individual counseling; Family interventions; Couple and family counseling; Referrals to inpatient treatment short or long term; Referrals to withdrawal management centers; Internal referral to other KSCS services; and in partnership with Corrections Canada, support the re-integration and release of community members in the justice system.

e.) Other Initiatives: Psychological Services (Administrative and Clinical Supervision) [Response submitted in writing]

The Psychological Services Team is integrated with all services at the Organization. The team provides highly specialized guidance, referral and support to staff members and community members.

- Develops and delivers appropriate psychological services for members of the Kahnawake Community, by creating service plans and making referrals to appropriate resources.
- Coordinates and monitors all off-reserve psychological and psychiatric referrals.
- Conducts and coordinates with contracted service providers (Psychologists) psychological assessments, and conducts youth protection court ordered psychological assessments.
- Demonstrates psycho-legal expertise in terms of parental capacity evaluations for the Department of Youth Protection.
- Participates as consultants on various community initiatives, such as: FASD prevention, Mental Health Team, efficacy of service approaches and consultation on cases.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- Lack of access to specialized services (i.e., Clinical Workers, Mental Health) because of language.
  - “[In Quebec] French is the first language. You are expected to function in French. The services provided in Kahnawake are 100% in English. But, if you need to go to the provincial system (CLSC) the services are completely in French.”
- Law 21 has had an effect on the way in which we offer services.
- Some Social Workers experience difficulties when dealing with the Professional Order [Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec] due to language barrier
- Lack of services in English for Addictions (Treatment Centers) in Quebec.
- Provincial Boundaries – difficult to access English language services from out of province (services for addictions and also from Women’s Shelter)
  - Lack of funding to cover services from out of province
- Transportation costs are not covered for services received ‘out of province’.

### b.) Assisted Living

- **Difficult to obtain early diagnosis for children (two or three years of age) with potential cognitive development disorders (such as autism spectrum disorders)**
  - “We are not a position to get optimal early intervention unless it is a disability that is easily visible at birth (such as Down syndrome, Cerebral palsy). Something outside (such as autism), is not getting the early diagnosis and that advantage of early intervention. That’s a problem.”
- **Lack of specialized services (in general), and long waiting lists for English-language specialized services for ‘Special Needs’ clientele (e.g., dentists, Occupational Therapist, Speech Language, psycho-educator for families). Also, lack of English-speaking specialists who are able to treat individuals with Special Needs. Lack of funding for some specialized services (such as Occupational Therapy)**
  - “Clients with a diagnosis, such as autism, there is only one English-speaking dentist who specializes in treating special needs’ patients. Dental care can be a big problem for someone with severe autism ... It’s quite a challenge just for dental care.”
  - “We have good access to general practitioners at the hospital in the community (Kateri Memorial Hospital) – long waiting lists for specialized services (in general) and longer wait for specialized services ‘in English’. It is critical to have English-language services for individuals with Special Needs due to obstacles with communication that are already present because of their diagnosis.”

- *“Huge problem to obtain English-language services, in general on the South Shore, and even more challenging for individuals with Special Needs or Mental Health issues.”*
- **Lack of English-language resources for individuals with Special Needs (even in jurisdictions that provide English-language services to the population)**
  - *“English-language resources are slim at best for Special Needs across [Quebec] the Island of Montreal and South Shore ...”*
- **Corridors of Service – Community is in a ‘unilingual French jurisdiction’; unable to obtain services (in English) from other administrative jurisdictions in Quebec. If resources are accessed from another corridor, funding is not provided.**
  - *“[Kahnawake] is an English island in the middle of a francophone jurisdiction. Our ‘go to resource’ off Reserve, [at the provincial level] for families with individuals with Special Needs is exclusively French ... trying to partner in terms of resources is really difficult.”*
  - *“If we access English-language resources from Re-adaptation Centres located in another administrative region (West Montreal), then there is a cost that we don’t have the budget for.”*
- **Lack of residential resources for individuals with Special Needs on Reserve. Lack of English-speaking resources from the province.**
  - *“It gets to a point where someone needs placement, they no longer have a caregiver ... in our area, there are almost no English-language resources.”*
- **Lack of training opportunities for front line workers working with individuals with Special Needs from the province because of language. Lack of funding to access training opportunities from other administrative jurisdictions in Quebec.**
  - *“In terms of shared training opportunities, what the province has they offer in French. Cannot partner up to access what they provide.”*
  - *“It’s hard for staff to access what they don’t understand. If we access training from other jurisdictions, it comes at a cost ... It’s a struggle.”*
- **Jurisdictional Issues – Lack of clarity between the Federal and Provincial governments about who is responsible to pay for some services (i.e., Group Home placements) for individuals with Special Needs – First Nations are ‘caught in the middle’.**
  - *“Volleyed back and forth between the provincial and federal government. If someone is assessed for a Group Home off Reserve, if they fall within a certain number they are provincial responsibility, but if below that number they are federal responsibility ... For our Special Needs clients, they are in limbo – everyone is saying it’s not my responsibility.”*

- *“Assessment Tools – difficult to get the province and federal government to ‘speak the same language’ with regards to assessments.”*
- **Mental Health and Addictions Services – “Access to English services for Addictions is a nightmare in general, and it’s a disaster for someone with Mental Health Issues.”**
  - Limited treatment options in English in Quebec (adult population) – addictions and mental health.
  - Lack of treatment services for younger population (youth). Not able to go ‘out of province’ for English language treatment services (no funding)
  - Lack of Detoxification Services
- **Transportation – Funding for transportation is available if within ‘corridor of services’; however, if clients obtain services from other jurisdictions (because of language), funding [from Health Canada’s Non Insured Health Benefits Program] is not provided to cover transportation costs.**
- **Provincial Restructuring – Challenge at the present time to work with the Province due to the restructuring of their health network. Uncertainty about what services will be available with the closing of provincial hospitals.**
- **Networking – Difficult to network with provincial institutions because of language barriers (i.e., Services to assist and support families and individuals with Special Needs)**
  - *“It’s very difficult [to network] within our area because it’s all francophone resources. We’re eligible to go to the CLSC [provincial network], to receive services for Special Needs, but all the services are in French.”*
  - *“Nothing available through the structure itself. We’re very isolated in trying to meet the needs of families in the communities ... “*
- **Lack of resources to provide services to Youth/Young Adults (16 to 24 age range) requiring services for Mental Health Issues. Wait lists for Mental Health Services (younger population).**
- **Lack of English language documentation from the province (e.g., Contracts, Placement Agreements, Assessments). Funding is not provided to translate documents (no budget for translation).**
  - *“Trying to get documents from the province in English is impossible (i.e., contracts, placement agreements, assessments for individuals placed at provincial institutions). We have to get documents and information translated. We have no budget for translation. It’s such a labour intensive struggle.”*

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Protection Services)

- **Protection Services are available and provided by Social Workers from the Centre Jeunesse** –Responsible for Evaluation and Application of Measures (Follow Up) – *Court Imposed and Volunteer Measures.*
- **Families can reach social workers from Centre Jeunesse if they need information about Youth Protection.**
  - *“The Youth Protection laws are the same for everyone in Quebec.”*
- **Social Workers refer clients to the Health Centre (First Nations) to receive prevention (First Line) services – helps to reduce the number of children being placed in Youth Protection.**
  - Easy to access due to the proximity of the services (clients do not have to leave the community).
  - Prevention services that are easily accessible include: Anger management counseling, Family Support program, Speech Languages program, and medical support (doctors and nurses).
  - First Line support worker provides “coaching” for parental support, including providing strategies for parenting.
  - *“The proximity of the resources [makes a difference] ... that is why most of the families in my caseload can keep their children – because they have access to [prevention] services, easily.”*
- **Strength of the Community – Everyone is willing to give food and clothes to help support children who are in need.**

b.) Assisted Living

- **Social worker from Centre Jeunesse conducts assessments of individuals (using the provincial Multi-Clientele Assessment Tool (M-CAT) to determine which services the client needs to live independently. Staff from CLSC use a computerized system) to determine the number of hours for which the client is eligible to receive services.**
  - *“[Centre Jeunesse] does not have access to the program [to determine number of hours]. All information is sent to the CLSC and they tell us the number of hours.”*
  - *“Access to completed OEMC by nursing in order to develop therapeutic nursing care plan and/or complete the holistic picture are inconsistent. [Challenge]”*
- **Social Worker from Centre Jeunesse provides assisted living clients with a list of homemakers.**

- Set up initial contract between the ‘Care Worker’ and the ‘Client’.
  - Homemakers are hired on a ‘casual’ basis. Many workers are on Social Assistance, so they are “afraid of losing benefits” if they work too many hours. [Translated]<sup>3</sup>
  - Many of these clients are followed by HCC [Home Community Care] nurses who would encourage a reporting mechanism to be in place so that the observations of these homemakers can be considered and round out the therapeutic nursing plan, if necessary
  - The HCC program is well established in the community and provides all the initial assessments, treatment plans, and clinical evaluations of HCC clientele while incorporating the principles of community health nursing.
- **Services available – Homemaker Services and Respite Care (rarely accessed).**
    - *“Ideally, these services would be coordinated by the Kanestate Health Centre/Home Community Care nurse based on ongoing nursing assessments and available respite services.”*
- **Assisted Living services mainly accessed by Elders, there are no restrictions because of income levels.**
    - *“Services available for short term, younger clientele needs as well; lack of staff has been an issue.”*
- **Clients have access to Medical Equipment “that is all good”; however, there is no funding to provide any modifications to homes (wheel chair ramps etc.) or to install the medical equipment.**
    - *“Equipment requested, usage and evaluation is initially done either by medical, OT, or nursing assessment; requires documentation of needs assessment, equipment loaned and duration of use, etc.”*

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Difficult to access English-speaking specialists/resources in the area, in particular for Mental Health Services. Additional obstacles accessing services because of distance (lack of funding for transportation).**
  - *“For psychological care, for Anglophones, they have to go farther. Social worker is available, but for specialists they need to go farther. And, then they will need transportation, [Centre Jeunesse does not provide that] ... many [people] do not have their permit ... they are limited.”*
  - *“Psychology referrals in the public system have long wait times and services in English are limited. Private psychology costs are prohibitive, and few people have private insurance.”*

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<sup>3</sup> Interview conducted in French and English – translation by researcher.

- **[Response submitted in writing as part of Inventory of Social Services] Difficult to access specialized (prevention) services: child psychologists, Art therapy, Legal Aid, Occupational Therapy, Speech Language (evaluation and therapy), Psychosocial evaluations, Psycho-Educator, Psycho-educational assessment, Child Development Assessments, Autism Evaluations, Social Workers, Nutritionist.**
  - *“Challenges because of service area restrictions; clients are not able to access services in their language.”*
  - *“Community [Kanesatake] is included in in the mandate of our local CLSC, services are most often not available in English. E.g. We have had long waits or NO service availability for a nutritionist that speaks English, and in fact, this is true of most of the services listed [above].”*
  - *“A long standing problem for prevention services has been the lack of a Social Worker in the community to do prevention and promotion work with families. Clients are not able to trust a DPJ SW wearing two hats.”*
  - *“The “corridor of service” policy has severely impacted our clientele who do not speak French. E.g. One child, later diagnosed with autism, was bounced back and forth due to the “corridor of service” as English language Child Developmental and Autism Evaluations were not available in our region. It took over two years for this child to be assessed and to receive needed services.”*
  - *“Kanesatake Education has a costly contract with West Island Therapy Centre to provide interdisciplinary services to the Kanesatake schools including: Psycho -Educational Evaluations, OT, Speech Language, Social Work, and Psychologist. Unfortunately these services have not always been timely or consistent.”*
  
- **[Response submitted in writing as part of Inventory of Social Services] Limited Prevention and Protection Services provided by the province**
  - *“Selective clientele from Social Services (Centre Jeunesse) – when it comes to Signalements [Reports] e.g., threatening vs. non-threatening; Native vs. non-Native.”*
  
- **Court System – Court proceedings take place “all in French” and court documentation is provided in French. Lawyers are bilingual, and speak to clients in English. It is “very stressful” to go to court. Parents face further obstacles to attend court hearings due to lack of transportation (distance).**
  - *“Centre Jeunesse will always provide a translator for the families because the hearing is always in French. Lawyers are bilingual and talk to clients in English. But, a translator is required when judge is speaking. No issues finding a translator.”*
  - *“Social Worker will sit with clients to go over court documents “to let them know what is in there.”*
  
- **Social Workers from the Province learn about the culture and community by working with the clients – there is no formal training or orientation provided.**

- There are differences between non-Native and Native peoples, which in turn affects how to proceed with Interventions and Follow Up Measures.
  - *“You cannot go there and do a ‘cop job’ and say you have to do ‘this and this’ ... Parents won’t listen, they won’t be involved in the relationship ... I highly suggest a training – What are the ‘Indians’? What is their history? When I talk to them it’s still fresh in their memory their history and what they have been through.... You cannot do things fast. Need to respect their pace, and you need to know that.”*
  - The FNIHB [First Nations and Inuit Health Branch], in collaboration with Université de Montreal, is developing a community health nursing competency framework, which includes cultural competency and sensitivity awareness.
- **Respite Services (Youth Protection) –Parents are not able to easily access ‘Respite Services’. In the community, there are families with large number of children (up to eight children); there are many single parent families (“famille monoparentale”). Parents are “tired”; yet, there are “no resources to give them respite”. Children at risk for being placed in foster care.**
    - *“Parents are really tired and they cannot give the proper needs to their kids ...kids may have to be entrusted to foster families because parents are not fully there – physically, mentally because they are tired. They are on the limit. ...”*
- **Distance – obstacles accessing services outside of the community because of a lack of transportation.**
    - Accessing specialized services out of the community
    - Youth protection – Parents face challenges visiting their children if placed out of the community and also difficult for some parents to travel if required to appear in Court
- **Foster Families – There are no First Nations’ foster families in the community of Kanasatake; difficult to find Anglophone foster families outside of the community; siblings of large families are “being split up” because it is difficult to find one foster home able to care for all the children.**
    - First Nations families are “not applying”.
    - Ageing population and may not be in good health, therefore not able to become foster families
    - Difficult to recruit foster parents because of issues with housing in the community (*e.g., mold, insulation, water may not be safe*). Lack of funding for renovations.
- **Working with ‘high risk and vulnerable’ youth – Social Workers are not able to properly provide services for Youth who are “running away” from Group Homes.**

- **Social Services’ workers from Youth Protection (Centre Jeunesse) are not able to receive support from the police (provincial), if required due to “community policies”.**
  - *“[In the community] there is a policy that the cops cannot enter the houses if the owner refuses to let them in. In one case, I had a teenager that ran away from resource she was entrusted to. His mother hid him in the home. The cops couldn’t enter the house. I couldn’t do my part as a social worker. ... If we have a report that a person might be dangerous or aggressive usually we ask for the police to accompany us in case it degenerates. But, [the police] are limited because of political issues. They don’t want to go through the ‘crise d’Oka’ what they went through in the 90s. The [police] have an agreement with [Kanesatake]– they are limited in what they can do.”*
- **Addictions – Lack of prevention work to address addictions. Difficult for individuals to break the cycle of dependency.**
  - *“Adults are using drugs, and they have their kids ... It’s not specific to Youth Protection, but there needs to be more prevention work, with the community and environment. It’s a big risk factor.”*

b.) Assisted Living

- **Lack of access to Mental Health services – need to travel farther distance to access specialized services for mental health in English.**
  - *“[To access services in English] they have to go to Montreal, it’s farther than if they had been speaking French. They could go to city just beside us.”*
- **Obstacles because of language when accessing services from provincial hospitals.**
  - *“Clients speak English or Mohawk, and the hospitals in region mainly provide services in French language.”*
- **[Response submitted in writing as part of Inventory of Social Services] Difficult to access the following services – Personal Care (Bathing), Day Program, Respite Care, Assistance with errands and as medical accompaniment.**
- **Lack of communication and collaboration between Provincial and First Nations organizations for ‘Assisted Living’ services**
  - *“Communication among the CLSC, KHC [Kanesatake Health Center] and HCC [Home Community Care] can be improved so as to improve inter-collaborative practice and facilitate multidisciplinary cooperation.”*
  - *“Lack of inter-collaborative approach and reporting/documentation between services and nurses who are responsible for the assessment, monitoring, treatment and evaluation of clients jointly served: question of legal accountability and follow up.”*

- *“Lack of inter-disciplinary communication between service providers to avoid gaps and duplication, and also to maintain standards for professional accountability and legal documentation.”*
- **Challenges when hiring Personal Care Workers because of the policy that stipulate that ‘personal care workers’ cannot be related to the client.**
  - *“Difficult to hire ‘Personal Care Workers’ because of the rule that stipulates that the homemaker cannot be related to the user [client].”*
  - *“It is difficult to find workers in a small community where “almost everyone is related.”*
- **Lack of consistent homecare workers (staff) [Response submitted in writing as part of Inventory of Social Services]**
- **Barriers because of transportation when accessing services that are outside of the community. Difficult for family members to visit.**
  - *“For Elders – all services that are outside of the community are difficult to access. A lot of people don’t drive, or they don’t have money to afford going away from the community to access services (if an individual is hospitalized outside).”*
- **Jurisdictional Issues between federal and provincial governments with declaring an individual ‘incompetent’ and for making a report of Elder Abuse.**
  - *“The CLSC in the region did not want to do the evaluation for the community members ....(translated)’ – When we called the ‘Curateur Public’ (office of the government) they always told us that they can’t help with the community, that we have to deal with Indian Affairs or the Band Office or other services. But in reality they have to offer that same service to them [First Nations community members].”*

c.) Family Violence Prevention [Response submitted in writing as part of Inventory of Social Services]

- **Funding – Lack of funds to cover costs to stay at shelters**
- **Counseling – lack of referrals**
- **Lack of direct client care (Funding mainly used for training/activities for youth and children**
- **Training**
- **Under skilled personnel managing program**

d.) Social Assistance [Response submitted in writing as part of Inventory of Social Services]

- Individuals do receive Social Assistance; however, funding is inadequate. There are people living in impoverished [conditions]. Food banks are being used more frequently (local and outside of community).

## ALGONQUIN

### Eagle Village First Nation – Kipawa

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) Enhanced Prevention Focus (Prevention Services)

- **First Line (Prevention) Services are readily available and accessible in the community.** (Geared for children ages 0-18 years of age and their families. Main objective is to reduce child placements in the community). “We’ve been working with the community, they’re not afraid to call. We’ve built *up trust, and maintained client confidentiality.*”
  - **Counseling services** – meet ‘one-on-one’
  - **Referrals/Corridor of Services** – Compiled list of all resources available in the community and from external agencies. Provided this information to all front line workers (health, police, first line services). “*Important that clients are aware of all the options in the community and from provincial institutions.*”
  - **Guardian Angel Program** – Students hired during summer months to work alongside First Nations’ police. “*More youth are asking questions about other resources that are available, including seeking counseling for issues they are facing themselves.*”
  - **Documents and information is available in English from the First Nations Quebec Labrador Health and Social Services Commission.**
  
- **Prevention-based activities (such as Family movie night, community kitchen) are helping to “support the family unit”. Increased awareness among community members that prevention based social services is “not intervening in a negative way.” Workers are sensitive to the needs of Aboriginal families.**
  - “*[Prevention services] works with families in a comfortable level ... we are getting out in the field and really helping. ... Taking a more sensitive approach, we are all First Nations so we understand the hardships we’ve been through and we’re sensitive to that.*”
  
- **Legal Aid – When contacting legal aid, lawyers speak English (no communication issues were noted with legal because of language)**
  
- **Corridor to other services – refer clients other agencies in the community for prevention services. Good communication with other sectors – health and police in the community.**
  
- **Collaborative Agreement with hospital in Temiscaming (Quebec) – Regular meetings with Addictions and Mental Health teams. Information sharing and good continuity of care between First Line services and external agencies.**

- **First Line staff has established a “good relationship” with ‘English section’ of the local school; however, there are barriers because of language when working with students from the community who attend the ‘French section’ of the school. First Line services is unable to provide any programming or awareness building with the students in the French section because of language barriers.**
- **National Aboriginal Youth Suicide Prevention strategy (funded by Health Canada): Reaching the youth population and community members have access to training (for suicide prevention).**
  - Reaching out to youth. Doing activities throughout summer to work with kids to identify cultural beliefs, get out in the environment and away from technology. Introduce youth teachings such as – smudging, storytelling. *“Work on bringing back the culture to the Youth.”*

b.) Assisted Living

- **Home Support Program – Individuals have access to support services (retain their autonomy and ability to live at home). Issues with how the program is being administered (\*see challenges).**

c.) Family Violence Prevention

- **Family Violence Prevention program – Programming is open to all community members (e.g., Drum fit for family empowerment).**
- **Awareness and Information – Community members have access to information about ‘healthy relationships’ (English language and culturally appropriate).**
  - Regular communications (through newsletter) with community members about family violence to raise awareness and understanding on the topic and also to provide information about resources that are available.
  - Calendar – Wellness tips, healthy recipes, available in Algonquin language.
- **PALS – Parents of Active Little Souls.** Engage families and get them out and provide them with unique experiences. While children (ages 0-5) play, workers can communicate with families – share information and build awareness about ‘family violence’ prevention.
- **Information (in English) about family violence prevention is available from the First Nations of Quebec and Labrador Health and Social Services Commission. Organization actively seeks out information (in English).**
- **Protocols established and networking among service providers for situations involving family violence,**

- Between First Line services and Health Directorate, which outlines steps to follow should staff encounter a situation that involves family violence.
- Work with community police should an individual need assistance
- Shelter in North Bay – willing to take individuals from the community (English language services are available) – Out of Province

d.) Fight Against Poverty Programs – (funded by First Nations Quebec Labrador Health Social Services Commission)

**Food Bank – Community members (at risk/vulnerable) have access to a food bank in the community. Networking with local businesses, and creating awareness about ‘food security’ issues among the community to help break down barriers.**

- *Community members are willing to access the food bank because they know that confidentiality will be maintained.*
- Partnerships – Established a partnership with local grocery store (recently opened in neighboring community) to solicit donations.
- Information and Awareness about ‘food security’ – Presented information about ‘what a food bank is’ at local school.

**Addressing Food Security and Health and wellness through the Community Garden – Community members have access to information and opportunity to ‘grow their own food’ at the community garden.**

Community Garden – Access to food, education/skill, and promotion of healthier eating and lifestyles among community members. Volunteer based. Incorporated workshops into programming (topics such as: nutrition, benefits of community garden, how to start a garden). Would like to implement a green house in the community. Garden is located at the Health Centre (easily accessible).

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention Services)

- **Perceptions and fears associated with ‘social services’** – Main focus to separate ‘First Line’ (prevention) services from Second Line (protection) services provided by Centre Jeunesse.
  - *“That [lack understanding about first line services] was a big problem. No one wanted to access services. People weren’t sure who we were or what we did. We spent a few years breaking down barriers and getting into peoples homes and providing them with the help and support that they need.”*
  - *“We’ve noticed that people aren’t waiting until there is a crisis; they are coming in before that happens [because of the approach, understanding, and the location of services].”*

- **Lack of communication and information sharing between First Line (prevention) and Second Line (protection) social services. Lack of notification from Youth Protection (Centre Jeunesse) about any YP files involving band members.**
  - *“It’s difficult because there is no sharing of files (with Centre Jeunesse in Quebec). .... when a band member has a file opened by CAS [Children’s Aid Society] in Ontario we get that file. We are aware of what is going on, we can reach out if the person is in close range and we can offer support. Quebec doesn’t do that ...there is no collaboration.”*
- **Lack of training opportunities in English from provincial agencies in Quebec for front line ‘prevention’ workers.**
  - *“Training up north to help kids deal with texting and bullying and it was only in French ... There is training to prevent conjugal violence, family violence, but it was not available in English.”*
- **Difficult to access specialists (health and social services), generally and specifically for English language services – Child psychologist, language and speech therapist, audiologist.**
  - *“We are mainly an English speaking community, but our provincial partner has mainly French-speaking professionals. Although they claim to be bilingual, accessing the services is very difficult. ... If you don’t have someone who is bilingual you are in a tough spot. Because we are so close to the border [with Ontario] our first instinct is to access services in Ontario.”*

b.) Assisted Living

- **Home Support Program –** Centre Jeunesse administers the home support programs for Elders from the community. The difficulty is that an “outside organization” takes care of First Nations’ community members. Personal Care Workers have felt discriminated against because of being Native. Lack of First Nations involvement in management.
  - Limited amount of services (cook, clean, run errands).
  - Policy needs to be updated (determine new threshold)
  - Program is only available to lower income individuals
  - Individuals (clients) are not comfortable having their needs assessed by an outside resource person (lack of cultural sensitivity, communication barriers due to language)
  - Clientele is responsible for hiring their own home support worker – lack of administrative support to hire, oversee, and if necessary, ‘let go’ of the Personal Care Worker.
  - Home care workers are hired on a ‘casual’ basis. Told by agent, “it’s not a job.” Low morale among home support workers. Home care workers do not receive any training. Lack of job security.

- Agents (from the Province) do not receive any sensitivity training to work with Aboriginal communities.
- Lack of First Nations involvement in decision-making and policy adjustments for the Assisted Living Program. *“We don’t have any say. We have an outside organization [from the province] that is coming in making decisions. ... It’s complicated because we don’t control the program.”*

c.) Family Violence Prevention

- **Lack of training opportunities in English on the topic of family violence prevention.**
  - *“There is a lot of training available in the area, but it is all in French.”*
- **Networking with provincial institutions – staff were not aware of any partnerships or networking with provincial shelters (in Quebec)**
- **Distance is a barrier for individuals seeking services from a shelter (local shelters are located one hour away from community). Transportation difficult, and lack of family support system.**
  - *“There are a lot of women who will not leave the community. They just want a place to sleep, but they are not willing to leave.”*

d.) Fight Against Poverty (Food Bank and Community Garden)

- **Food Bank – Difficult to establish partnerships with local food bank (provincial) and community members ‘in need’ may not access services due to stigmatism and negative perceptions associated with accessing services from food bank.**
  - Obstacles establishing partnerships with neighboring food bank.
- **Community Garden – Difficult to get volunteers and community involvement. Working on a campaign to publicize the garden.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Courts (Youth Protection):** Judges and lawyers are generally all bilingual
- **Documentation from the Courts is available in English upon request**
- **Mental Health Services –**
  - Psychologist and psychotherapist are accessible in the community. These services are available through federal government’s Non Insured Health Benefits program (Health Canada).
  - Long wait times for English language mental health services (province).
- **Bilingual staff at CLSCs. Participants noted that certain positions at the CLSCs are designated as being ‘bilingual’; however, programs are not necessarily provided in English.**
- **Community members can easily and readily access the Enhanced Prevention services provided in the community –**
  - *“It is not a perfect system, but we have our own people in these roles to deliver services for our own people. Generally, this keeps our community statistics low (e.g., mortality and morbidity rates are low (youth suicide/suicide).”*
- **Good working relationship with Centre Jeunesse**
  - Work collaboratively with the province when intervening with a family on a situation – works “really well”.
  - The respective roles and responsibilities of the First Nations and Province are “clear” and “transparent” – Intervention and Application of Measures.
  - Provincial Interveners speak English.
- **Youth Protection Social Worker who works in the community is familiar with Algonquin culture, the political process, and how programs work on the reserve –familiarity with community helps ensure good access.**
- **Good communication and working relationship with local schools (on and off Reserve) – “We try to help each other to the best that we can”.**
- **Access to some social services (for example, specific programs for anger management) from the province in adjacent town [Maniwaki] in English**

- **No major barriers with transportation if the services being accessed are in line with the Non Insured Health Benefits (NIHB) program. Some issues with funding for transportation, however, accessing services ‘out of province.’**
  - *“Sometimes, clients will need to access services in Montreal, which is four hours away, rather than the same service in Ottawa, which is one hour away – transportation may not be funded for services that are out of province, despite the fact that the service required is in closer proximity.”*

#### b.) Family Violence Prevention

- **Clients of the Waseya House [Woman’s Shelter] who are members of Kitigan Zibi have access to all the services delivered in the community** (i.e., *Enhanced Prevention, Mental Health, NNADAP*). Prevention services are not easily accessible by non-Kitigan Zibi Members who are staying at the shelter (status individuals from neighbouring First Nations communities).
- **Staff members provide referrals and work with other shelters in the area to meet the needs of clientele, which are beyond family violence** (e.g., *addictions, homelessness, second stage housing*)
- **Networking with other external organizations with a mandate to address violence against women helps to ensure “information sharing” and to maintain lines of communication among service providers.** (Round Table comprised of different services providers for Family Violence)
- **Work well with other front line workers from nearby First Nations communities to address family violence**

#### c.) Assisted Living

- **Kiweda Group Home** – Nine-bed Group Home for semi-autonomous individuals who cannot live on their own (including both younger people and also elderly who need assistance with daily living).
  - Access to all services in the community.
  - Good access to provincial services from the CLSC (e.g. Occupational Therapy and equipment, social worker, and some ‘clinical nursing services’ (i.e., wound care).
  - Pharmacy – communicating, delivery, and changes to medication works well. Pharmacist speaks English, and will go out of the way to communicate to clients. Documentation is provided in English.
  - Entering the Group Home – no major access issues identified: *“To enter the home takes about one week to conduct the assessment and determine if the individual meets the criteria to be eligible to enter the home. No delays to get into the home unless there is a lack of availability or space”*

- **Weekly Lunch for Seniors**– Once a week provides seniors (55+) a lunch. *“It’s their social outing and their time to get together in the community. It’s almost become an institution in the community.”*
- **Nicholas Stevens Centre** – Day program for multi-disabled community members (Adults) – Physical handicaps and mental health conditions/mental development. No major access issues identified.

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Lack of English language services for Addictions (Youth and Adults) – Clients need to travel great distances (2 to 4 hours) to obtain services (including assessments). Discouraging for clients when they are “shifted from one municipality to another ...”**
  - *“Clients are being referred to several different agencies in order to get an assessment done in English. The agencies are often time located in different municipalities, and require the client to travel anywhere from two to four hours.”*
  - *“Discouraging [for clients] when they are shifted from one municipality to another, and all the travel in between. Individual may not follow through with assessment or treatment plan.”*
- **Lack of English language services for sexual assault victims (in particular youth) and physical assault victims. Sexual Abuse victims – Interviews by police (mandatory under Youth Protection Act) are delayed because there is a “lack of English speaking officers trained and authorized to conduct the interviews”.**
  - *“There was a situation where the Report [for sexual abuse] came in, and we wouldn’t have an English-speaking officer who was authorized to do this kind of interview. Had to wait two weeks once for a video taped session to be arranged to have it all legally done. You are allowing the child to go home to potentially receive this abuse by a family member. There is a delay because of language.”*
  - *“Wait time at hospital to conduct physical assessment of the child to make certain that the staff can speak English.”*
  - *“It’s difficult to facilitate and ease parents to try to be relaxed and be calm during very sensitive situations when you don’t have workers [because of language] from the provincial system helping you.”*
- **Mental Health Services – Lack of resources at First Nations organizations. Long waiting list for mental health services generally, and in particular for English language services from Provincial Institutions. There are differences in how mental health problems are perceived by staff at First Nations and**

**Provincial organizations. Participants observed that: “Patients are not kept for the duration of the mental health evaluation at Provincial institutions”.**

- First Nations organizations are expected to provide CLSC equivalent services on Reserve funded by Indian Affairs, however First Nations do not have the same resources as the CLSC. Cannot readily and easily access Mental Health Services in Quebec due to language. Difficult to access services from other regions (distance and jurisdictional issues)
- **Lack of English-language training opportunities – i.e., for Mental Health**
  - *“Hospital offers training, but it is only offered in French. [First Nations organizations] receive English language training from out of province.”*
- **Bilingual First Nations staff members are “providing translation services”: Assisting with professional assessments, translating reports verbally for clients and coworkers. Participants noted that the translation work can be “time consuming” and requires “trust”. Translation services are possible depending on the “language proficiency of the staff.” Funding not provided.**
- **Lack of English-language documentation (information, reports and assessments)**
  - *“When reports and assessments are requested from the province (i.e., Mental Health evaluations), they are only provided to the First Nation organization in French. Organization responsible for translation of documents. Funding comes out of program dollars.”*
- **Participants noted at “lack of understanding at the front line CLSC level” about the Ministry’s regulations with regards to the availability and accessibility of front line public health information in English – “the individual seeking services is the one who gets hurt”**
  - With regards to English-language front line public health information at CLSCs on participant noted that: *“I was told at a meeting by the program manager at the CLSC that when the province comes in to evaluate their program, they have to hide all the English language pamphlets. They have to watch the English. They take away the pamphlets, and then put them back out.”*
- **Perceptions and Attitudes about First Nations People – facing discrimination from neighbouring non-Native communities (including the general public and service providers). Participants note that it is more difficult for First Nations’ who only speak English to “connect” with the town of Maniwaki.**
- **Provincial Laws impact access to social services –**
  - **Bill 10** – *“There is a lot of confusion and it is unclear how Law 10 will impact Youth Protection services being delivered in First Nations communities.”*

- *Law 21* – Limits English speaking Social Workers from being licensed professionals under the Social Services’ Association of Quebec. *Impact – Fewer professionals who can conduct assessments. It was noted that First Nations remain “dependent” on the CLSCs to perform assessments.*
- **Challenge to maintain relationships with provincial institutions and committees (such as Mental Health Table at the CLSC) due to the province’s “high staff turnover rate” and “restructuring” of their organizations.**
  - *“Always need to reeducate workers because there is a high turn over rate at provincial institutions. The restructuring at provincial agencies is confusing. Difficult for follow up. Don’t know if the intervention is working because there are new workers [at agencies where we refer our clients].”*
- **Jurisdictional Issues (Provincial boundaries) – Accessing social services (in particular Mental Health Services or for victims of sexual or physical assault) in other provinces (i.e., Ontario) can be difficult.**
  - Community members may prefer to access services from outside of the community for reasons of privacy and confidentiality. However, it is challenging to access services out of province due to jurisdictional issues.
- **Lack of information and updates from the province about health and social services protocols for Mental Health Services (i.e., Suicide Prevention).**
  - *“It’s like we’re aliens to them. ... It has to come from the CLSC to take initiative to say ‘we have a First Nation reserve close to us. We have to work better with them’. We always have to run after them [the CLSC].”*
- **Reintegrating Offenders into the Community – Obstacles accessing services due to lack of transportation**
  - Lack of parole and probation officers in the area generally, and in particular for English-language services. Clients are required to travel outside of the community on a weekly basis to visit with parole officer. Transportation is a major obstacle.

b.) Family Violence Prevention

- **Woman’s Shelter – Clients (battered women and their children) at Wasaya House who are from other English-speaking Algonquin communities cannot access services that are available in Kitigan Zibi (such as, Enhanced Prevention services, Clinics, Doctors, mental health services, addictions services, counseling).**
  - *“On Reserve band memberships are entitled to receive the services. In Kitigan Zibi, if you are not a band member, but you are in our community, you cannot access our services even if you are First Nations. That is the political stance of our leadership. We have limited resources to provide*

*services to our band memberships. That is an issue with Indian Affairs.”*

- **Lack of services for mental health crises/psychiatric services**
  - *“There is a gap in services for individuals who are experiencing mental health issues. Wasaya House cannot offer psycho/social services and assessments.”*
- **Lack of security available at the hospital for mental health patients**
- **Lack of Access to low income housing – difficult to access low income housing in neighboring non-Native community.**
  - *“As First Nations, there are barriers accessing low-income housing in local community. You need to be a resident of Maniwaki for one year before you qualify for low-income housing.”*
  - *“Clients become discouraged and give up ... They often go back to their home communities and the cycle continues.”*
- **Negative perceptions about First Nations People presenting obstacles for individuals who are seeking low income housing**
  - *“Reality is landlords are not quick to rent their apartments to First Nations Indian People. There is a stigma. Overcrowding, too much drinking, lower standard of living. Not quick to readily house clients of ours who are trying to find apartments and are trying to start over.”*

c.) Assisted Living

- **Difficulties due to language to obtain professional assessments for Elderly people who may be showing signs of Dementia or Alzheimer’s. Long wait for an English Speaking social worker. First Nations staff providing translation services due to language barriers, which requires high degree of “trust” on the client’s part. Assessment reports are prepared in French, funding is not provided for translation.**
  - *“Clients are very trusting. If I wasn’t there, there would be serious trust issues. The client would be hesitant to be evaluated. Clients have asked me “What is she saying?” Why is she here?” The client had not idea why [social worker conducting evaluation] was there.”*
- **Communication barriers when escorting clients to hospitals due to language barriers – “There are challenges with how well the escort can relay information to the client. If they don’t speak French, then there will be communication breakdown.”**
- **Lack of bilingual staff at the local CLSCs Home Care Services. First Nations providing translation services – “time consuming”**
  - *“When you access services from the local CLSC Home Care Services, they all speak French. Some of the nurses servicing the clients will be able to*

*get by in English. But, when it comes to details and providing information they have difficulty to do so. [First Nations' workers] will step in and do the translation, so that is a barrier. It takes away from other work that I could be doing because I have to work as a translator. Time consuming."*

- **Challenges because of language when accessing services from the pharmacy – pharmacists are usually bilingual, less likely that the technicians will be able to speak English – delays for the clients and First Nations' staff need to verify information.**

- *"Bilingual pharmacist is not always available, and the technicians don't always speak English. When they call the Group Home and give information to my workers, who primarily speak English. I will need to call back to verify or obtain information."*
- *"The pharmacy will sometimes send information about a client's medication in French. Workers cannot read the dosages, so we need to call back and request instructions in English."*

- **Jurisdictional Issues – The Long Term Care Facility is federally funded; however, regulations for Medicare System (clinical services) are provincially regulated. First Nations are caught "in between" jurisdictions. It was noted that: "Nurses are practicing illegally (under Law 90, which outlines responsibilities that a nurse can undertake) to provide the care that the clients need with the threat that they may have their licenses revoked".**

- *"We are not a certified group home under the province. We are a federally funded group home under INAC. The federal government has no authority to regulate health services. ... that's the province's responsibility. When we go to the province ... they say 'you are not a certified home under the province, therefore, you are not our responsibility to clinically supervise, under Law 90 ... The Nurses Order of Quebec (OIIQ) [L'Ordre des infirmières et infirmiers du Québec] states that any nurse offering nursing services at non-certified group home is going against her license. Nurse is not allowed to do that [provide clinical services] in non-certified home. We have a group of people who need clinical nursing services and supervision. Their life depends on it. Nurses are practicing illegally to provide the care that [their clients] need with the threat that if they are reported to Nurses Order they may have their licenses revoked. They are not following Nurses Order. That is a jurisdiction issue. Federal government provides money, yet the Provincial Medicare System does not provide clinical supervision that we need."*

- **Long wait time to enter 'long term care' facility in the area for individuals requiring higher level care.**

- **Discharge from hospital is problematic – First Nations organizations are not always notified when clients are discharged from hospitals.**
- **Non Insured Health Benefits (NIHB) – Not all medical equipment is covered by the NIHB program.**

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

a.) Enhanced Prevention Focus (Prevention and Protection Services)

- **Collaborative Team Work and Case Management approach among staff from Health and First Line Services (First Nations). Staff work together to plan and to deliver various prevention activities and programs (for health and prevention first line (social) services).**
  - Staff developing long term Action Plan for all youth activities offered to avoid duplication of services/activities available to the youth. Working in collaboration with internal resource providers as well as with external not for profit organizations (namely, *Avenir d'enfants and Quebec en forme*).
- **Prevention Services – First Line Services. Staff delivers various prevention activities, workshops, and individual support to community members. Staff will receive referrals from Centre Jeunesse for prevention services for children/youth. Determined which activities to offer based on focus groups held with community members. Examples of activities include:**
  - Men's Support Groups – 'King of the Grill' – annual event for men to get together and socialize. Opens the door to build a trust relationship. Emphasis placed on maintaining client confidentiality.
  - One-on-One session with individuals
  - Empowerment Groups for boys and girls, work in collaboration with staff
  - Music sessions (planning/implementation stage)
  - Traditional Drumming (proposal stage) for the youth
  - Family Kitchen – Families have use of kitchen facilities
- **Protection Services – Youth Protection (Centre Jeunesse)**
  - Some individual counseling services are available from social workers at Centre Jeunesse.
- **Health Programs – Prevention (i.e., *Brighter Futures/Addictions/Maternal Child Health*)** [\*funded under Health Canada]
  - Staff plan and deliver preventative health programs and activities (Prenatal classes, parent support groups), work in collaboration with First Line services to provide parenting classes and sessions, FAS Prevention, Child Safety Workshops, Youth in the Kitchen activities, Sports and Recreation activities (with youth) – game night, movies, sports etc.
- **Community Cultural Events – Staff work together to plan and implement large events for community members in all the seasons.** For example, *Winter Carnival; Aboriginal Day* (Entertainment, Gathering food/medicines, and Teachings – for Elders, parents, youth); *Cultural Week* – In the fall, community members go into the bush for a community hunt, there are also teachings, beadwork, and 'preventative' work. Community feast.

- [Cultural Week] – *“Participation is awesome. The younger people want to learn how to hunt, fish. There are teachings, and cooking – such as bannock. ... Gives people the opportunity to have dialogue about social issues. It’s a good gathering that receives a lot of praise. It’s working because the ideas come from the staff and also grassroots people.”*
- **Mental Health – Prevention activities and some counseling are available in the community. English-speaking psychologist is in the community one day per month.**
  - Staff plan and deliver programs in the community such as: Anger Management Workshops, Cultural activities (teachings), Cancer Walk, Self Help Meetings, One-on-One with clients, Referrals to mental health services providers, detoxification and treatment centers.
  - Psychologist – comes into the community one day per month from out of province (Ontario). Non-band members have difficulty accessing services from psychologist (not covered).
- **Addictions – Staff make referrals for clients to enter treatment centres located in Quebec (in Kitigan Zibi) and also out of province (in Ontario).**
  - Waiting lists to enter treatment centres
  - Application (Assessment) – Participants noted that the application process in Quebec (paper forms) is much more difficult to complete in comparison to the application process in Ontario (which is computerized). Further, staff noted that: *“The assessments are difficult to fill out because the forms are in French and English.”*
- **Access to various prevention projects that are proposal driven – Youth Suicide Prevention (Health Canada); Family Violence (AANDC).**

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Lack of information and notification from the province about changes to legislation pertaining to social services (information gaps)** (i.e., Bill 10: Restructuring of provincial health care services). Unclear what the impact of the provincial restructuring will be on the community.
- **Geographical location – The community is considered to be a ‘semi isolated community’, which means that service delivery is more costly (transportation, food). Community members/staff need to travel to prepare for and implement any community activity or event.**
- **Culture and Language – Even though considered an ‘English speaking First Nation’, the language is different. With First Nations communities, there are different sayings and expressions rooted in the Algonquin culture and language. There can be a lack of communication between community members and person from the outside.**
  - *“If someone is strongly rooted to the community, and has that dialect embedded in him or her that person will communicate – there may be a lack of communication between that person and whoever is from the outside.”*
- **Mental Health Services – Lack of English-language services (i.e., psychologists) for mental health in the area.**
  - Distance is a barrier to access services. Need to go out of province (three hours away) to access specialized services in English for mental health.
  - Individuals (mainly Elders) who speak Algonquin face additional barriers – require an escort/translator, and funding is not always provided.
  - Jurisdictional Issues – services may not be provided to Quebec residents
  - Long waiting lists
- **Detoxification Services – Lack of English-language services for detoxification in the area generally, and specifically in English. Need to send clients ‘out of province’ to receive English-language detoxification services.**
  - Participants reported that: *“You send them [for detoxification] to the hospital and they send them back a few hours later.”*

b.) Enhanced Prevention Focus (Prevention and Protection Services)

• **Prevention Services – First Line services**

- Participation can be challenging. Some services (such as Anger Management) that are delivered in collaboration with Centre Jeunesse. Resource person from out of province. Provided incentives, however felt that “people come for the door prize, not the service”.
- Challenges – People seek help in times of ‘crisis’. Difficult to provide prevention services when they are no long ‘in crisis’. Participants noted that program delivery is challenging due to the “stigma” associated with seeking help to address issues such as anger management.
- How activities are perceived is important in particular in a small community: *“They renamed the Anger Management workshop, they had a few more participants. ...”* Others stated: *“People have pride or even shame. If you want to pass on a message you need to do it in a subtle way. You need to have an activity, and then send out your message in a subtle way to get your point across.”*

• **Protection Services – Youth Protection (Centre Jeunesse)**

- Lack of notification – Community is not notified about situations involving their youth. Participants felt that the lack of notification could be for “confidentiality reasons”. (Participants noted that the lack of notification is unlike the situation in Ontario where bands notified when there is a court date or apprehension). *“It wouldn’t take much for parents and children to be wrongfully separated if the communication is not there.”*
- Centre Jeunesse deals directly with Aboriginal Affairs – Funding is provided to CJ to administer various social services (\*including First Line and also Assisted Living services).
- Participants report that generally speaking, there is a lack of cultural sensitivity and training about First Nations history and social issues among provincial workers (including nurses and social workers from the ‘outside’ who work in First Nations communities). One participant commented about the need for social workers to have a better understanding of the social issues for Aboriginal People, including the impact of residential schooling, and colonialism. *“At a meeting [with the province], I asked do [social] workers that come to our community receive training specifically regarding First Nations – history, residential school, oppression? That is what they are dealing with. A lot of the social problems stem from that – the remnants of residential schooling and oppression. They do receive training, but not sure how specific the training is. ...”*
- **Signalement/Reports [potential endangerment of children]** – Language barriers when individuals call the Agency to make a report (signalement). One participant stated that: *“Need to fix the 1 800 number. People don’t speak English on the phone. If we can’t get through, the person doing the reporting might hang up. That is risky for the child who may be in*

*danger.”*

- English speaking social workers from the Agency work in the community two days per week. The staff (First Nations agencies) doesn't work too closely with CJ. Participant noted that: “there is a need to establish a Protocol Agreement between Long Point and Centre Jeunesse for the Youth Protection.”
- **Family Type Resources – Foster Care**
  - Lack of information services in English about foster care (workshop sessions are all in French).
  - Lack of English language training opportunities for foster parents (First Aid, CPR, available in French only)
  - Limited number of ‘recognized’ foster homes in the community (only three homes are recognized). Yet, many family members take in their kin (nieces, nephews, grandchildren).
- **Income Assistance** – High school students 18 years of age do not qualify for IA; Home Care workers receive less than minimum from Centre Jeunesse, and are not on Payroll. Quebec's IA policy is available in French only. [Submitted in writing as part of Inventory of Social Services]

**i.) SOCIAL SERVICES – EASILY ACCESSIBLE**

**a) General**

- **Addictions** – Clients have access to support services through NNADAP, and they are referred to provincial institutions for detoxification or treatment centers. Bridging services (when clients transfer from First Nations to provincial institutions) is critical to ensure that clients can transition with the least amount of disruption as possible.
- **Mental Health** – Psychologists (Health Canada) work in the community on a contractual part time basis (weekly or monthly). Some challenges in the past with mental health services when the professional did not speak English well enough for clients to engage readily in conversation. Challenges because of travel if services are required beyond the weekly/monthly scheduling for which funding is currently available. Establishing long-term relationship with mental health professionals is important to establishing culturally safe spaces. Important that services are offered by both male and female psychologists to mitigate any issues because of gender.
- **Hospital Liaison Worker at provincial institution is helping to reduce barriers that First Nations clients face because of language and lack of cultural awareness/sensitivity. Challenge because the Liaison Worker is available on a part-time basis only.**
  - *“Hospital liaison worker at the hospital has helped to reduce perceptions of discrimination. Advocates for clients seeking assistance from the hospital, which is needed for clients who may be under the influence. Liaison only there part time basis, which is a problem. Fluently bilingual. Advocate, cultural sensitivity, and language translation (French/English).”*
  - *“Liaison noticing issues (such as discrimination) at the hospital, and members then went in to hospital and conducted drumming sessions – open forum with staff and residents.”*
- **Community provided cultural awareness training at provincial healthcare institutions (e.g. delivered to staff at local hospital). Frustration because the training is now offered on request basis only, funding is not available to provide the program on a regular basis.**
  - *“We have done our part to sensitize hospital staff. We created a program with the Tribal Council and the University of Quebec to give provincial workers in Quebec a better idea of who we are, from a First Nations, Indigenous perspective and point of view. Training is now provided at the*

*request of the hospital or other institutions. Program is there, but it doesn't have funding anymore."*

b.) Enhanced Prevention Focus (Prevention Services)

- Prevention services are available in the community. Clients have access to family support worker, social workers. Collaborative approach amongst staff members from health and first line prevention services. Culturally sensitive approach is important to reduce social barriers (e.g. stigmas about addictions, mental health; fears of youth protection), which prevent people from accessing services. Continuum of care amongst community services providers.
  - *"How topics are presented is important. You target a specific area (for example, depression, culture). But we have gotten used to the word, 'cultural wellness', for example. Rather than talk about specific issues, we talk about wellness in the general and then we can narrow the focus – mental wellness, physical wellness, spiritual wellness from a cultural standpoint."*
  - *"We have made a conscious effort to get away from stigmatizing people. You don't necessarily have to have a drug and alcohol problem to go and visit. When talking about health related issues, health and social services, we tend to think of people who are unhealthy – mental, physical, spiritual and emotional. But if we get away from the negative part, that is the direction we need to head in. We know what the issues are, as staff. By telling people they are sick will not necessarily make them better. You need to give them solutions."*
  - *"Good continuum of care amongst community service providers. Everyone is aware, from the street level, what the hurdles are. We are fortunate to have community members working on the team, and they are aware of the daily stuff. It's that street level voice, they are aware of the roadblocks, hurdles. The team meets regularly."*
- **Wellness Lodge – Build a place in the community that can offer a range of services, both western and Indigenous. Strengthen 'kin relations' and work towards wellness where 'we look at everything as a whole'.**
  - *"We need a place in the community to conduct ceremonies and cultural activities. We need a place to be able to run a lodge and offer programs and services in a 'holistic' way. We would like to take a holistic approach to wellness – physical, emotional, spiritual. Look at the person as a whole, look at the family as a whole, the community as a whole – not just segments. We look at everything as a whole. As First Nations this is how we have done things for thousands and thousands of years, we look at things as a circle, as a whole. We want to build strong relationships, what they call 'kin relationships'. Going beyond mother, father, brother and sister. Include grandparents, aunts, uncles, and cousins."*

c.) Family Violence Prevention

- **Family violence** – Clients have access to programs and services offered in the community (social workers, assistance with finances).

d.) Reinvestment Strategy – Combating Poverty

- **Children and Youth – Programs and services target youth and children in the community to combat poverty (school lunch program, summer day camps, subsidies for childcare, cultural programming, and summer student employment opportunities).**
  - *“We concentrate on children and youth in the community when it comes to reinvestment. We run a lunch program in the schools. Funding to help with cultural programming. Funding for summer students going on to post-secondary education. Run a summer camp for the kids (away from community, no cell service, well structured, full of activities) help out the daycare, help parents who need daycare but cannot afford.”*
- **Collective kitchen – Activity geared for seniors to get together on a monthly basis and prepare a healthy meal, within a budget. Contributes to social inclusion for elderly.**
  - *“The collective kitchen is well attended by seniors. Program is run on a monthly basis. Choose the menu, get together and prepare together and cook together. The meal is then shared and everyone takes home their supper. Helps with social inclusion, and gets the seniors out and socializing with everyone. People really like it, and we get a chance to talk about nutrition, healthy eating, and everything is done on a budget. The meals we prepare are geared to their income.”*
- **Transition into work – Small amount of funding is available to individuals who are ‘transitioning back to work’ (e.g., to purchase items that may be necessary for work)**

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

### a.) General Challenges

- **Generally speaking, there is a lack of funding to run ‘social services’ programming. Perception that staff at First Nations organizations may be ‘underpaid’**
  - *“Funding is provided for staff, office equipment, and computers to deliver services. The amount remaining is insufficient to run a program. This is a task that we face every day.”*
  - *“To run the program, we need to underpay individuals.”*
  
- **Challenges accessing training (e.g., disclosures of sexual abuse) because of language and costs can be prohibitive. Difficult for smaller communities located in remote areas to obtain training.**
  
- **Long wait times to conduct psychosocial assessments because of language**
  - *“Mental health, ADHD, requests for pediatrician. Wait list is really long in the provincial system. Some assessments for mental health. Clients are encouraged to stay in Quebec.”*
  - *“For one of our youth, the teacher wanted an assessment for ADHD. He has been removed from school until he has his assessment. We’re looking at two months that he is out of school. The reality of the wait. He is receiving two hours of tutorship, and the rest of the time he is hanging out with his parents who are also trying to work. Stress on the family, which then creates other social problems.”*
  
- **Funding is not provided for translation services**
  - *“If community needs a translator, this is paid for out of program dollars (no funding provided for translator or translations).”*

## URBAN AREA

### Native Women's Shelter of Montreal

#### i.) SOCIAL SERVICES – EASILY ACCESSIBLE

##### a.) General Services

- **Emergency Shelter** – The shelter provides emergency housing for Aboriginal, Inuit and Metis women in difficulty (10 to 12 weeks) – lodging and meals
- **Outreach Services** – Staff network with provincial institutions (*referrals, liaison, information sharing etc.*), including: CLSC, RAMQ, Centre Jeunesse (Batshaw/Youth Protection)) Clinics/Doctors, and Social Assistance. Better access to provincial institutions because of the networking.
- **Support Programs are readily accessible in the language and culturally based**
  - All clientele (while at the shelter and as part of outreach) have access to various support programs and services, including: Support from Elders; Art Therapist; One-on-One Therapy (3x week); Family Care Program; Link expectant women to prenatal services; Assist clients mandated to be at shelter and whose children are in Youth Protection (or at risk); Holistic Health Program; Housing – assist women with ‘second stage’ housing; Social Assistance – assist women with Social Assistance applications and/or Employability programs; Addictions Program – Refer clientele to treatment programs and provide follow up/after care treatment at the Shelter.
- **Cultural Sensitivity Training/Orientation** – Staff from the shelter provide ongoing training and orientation to staff from provincial organizations.
  - *“Opportunity to share cultural backgrounds and protocols. The dos and don’ts when working with Aboriginal clientele.”*
  - *“[The external organizations] recognize that they need more cultural awareness and training. They are willing to have us come in and provide training.”*
- **Social Assistance (Assistance with)** – Staff help clientele apply for Social Assistance (obtain documentation; ensure tax forms are completed; and fill out forms for social assistance). No barriers because of language, however, the process is lengthy.
- **Housing (Assistance with)** – Assist women to find affordable housing. Staff at shelter work with various organizations (Aboriginal and non Aboriginal), which provide low-income housing in the urban area.

- *“We have built a good relationship with an Aboriginal organization that provides low-income housing. They are flexible and willing to work with clientele. However, there is a lack of apartments available.”*

#### b.) Enhanced Prevention Focus (Protection Services)

- **Agreement with Centre Jeunesse** – Shelter has signed a Collaboration Agreement with Centre Jeunesse/Batshaw Youth and Family Centre (serves English clientele and committed to providing better services for Aboriginal families).
  - Aboriginal Team at Batshaw is responsible for the Application of Measures (Follow Up).
  - Good experiences working with the Aboriginal Team at Batshaw (Youth Protection).
  - Information Sharing – Good relationship with Protection Services. Organizations share information, while still maintaining client confidentiality.
- **Liaison Services (Youth Protection):** Staff assist clientele mandated to be at shelter by Youth Protection and/or assist clients whose children have been placed in foster care.

#### c.) Health and Social Services

- **Holistic Health and Outreach** – RAMQ provides an attestation card so that clientele can receive medical services. Doctor is available at the centre on a monthly basis. Workshops, education and awareness (sexual health, fitness, diabetes, eating well). Support for women in sex work (workshops from external resources); programs in the prisons (sexual health workshops); network with Aboriginal Aids Network; nurse provides sexual health screening (from CLSC). Traditional Healer – one-on-one sessions, Sweat Lodges; Healing Circles; Drumming and Ceremonies.
  - *“Delivery of health services with the understanding that by bringing services to the clientele in a less judgmental and efficient manner is very effective. Have the services fit the person, rather than the person fit the services.”*
- **Mental Health Services** – Clientele have access to counseling (Aboriginal and mainstream counseling) while at the Shelter and as part of Outreach program.
  - **Challenge** – Funding for counseling is now only available from Health Canada for ‘emergency services’. Funding not available for specialized services such as Art Therapy, which the staff at the shelter found valuable when working with children who had experienced trauma. To qualify for funding from Health Canada the counselor must be on the province’s Professional Order list.
  - Clientele are not going to provincial institutions for health and social services – language obstacles, racism, and long wait times.

*“If we accompany someone [to the provincial institution], the experience is vastly different than if the [client] goes alone.”*

- **Addictions Services** – Workshops (in-house and with partner organization). Mainly refer clients to treatment services from Aboriginal treatment centers (English language services and cultural component is part of treatment) and from provincial treatment centers that offer services in English.
  - **Challenges:** Provincial treatment centers – Long wait times and lack of Aboriginal component in the programming. Not all programs are available in English, even if organization states that they offer “bilingual” programming. Some programming might be “too formal”, which bring back memories of residential school for some clientele.
  - Out patient programs – Not easily accessible (distance is an issue).

## ii.) CHALLENGES WHEN ACCESSING SOCIAL SERVICES

- **Difficulties because of language when navigating the youth protection system (‘French Youth Protection’ [services outside of Batshaw]).**
  - Inuit clients have said there is a language barrier. If you don’t have comprehension of what is going on it is difficult. Requests from clients to be transferred to English section, ‘Go unheard, it’s difficult.’ Difficult to get hold of workers in Youth Protection (French System).
  - **Lack of Translation Services, and those that are provided by the province are ‘poor quality’.** Funding is not provided for translation. *“We requested a translator at a meeting from French to English, didn’t even ask of Inuktitut. The translator did not speak English. They brought in a colleague who spoke English, but it wasn’t good enough to translate. Because I speak both languages, I was able to see that they weren’t translating the important parts of the message.”*
  - **Documentation** – Court Documents are provided in French if client is in the ‘French social services’ system, and documents are provided in English, if within the English system (*ie. through Batshaw*). However, even in English system, some clients receive court documents that are a mix of English and French. Staff need to translate documents for clients.
  - **Indigenous Languages** – Unable to provide services in the language for Cree and Inuit woman for whom English may be second language. There is one Inuktitut translator in all of Montreal. Limited services for Aboriginal Peoples whose first language is their own Indigenous language.
- **Youth Protection – Aboriginal clientele face ‘Judgment and Discrimination’ from the workers at Youth Protection, in particular in the ‘Investigation Unit’. Lack of workers with an understanding of Aboriginal social issues. Lack of Aboriginal Foster Families.**

- *“Work less well with Investigation unit of Youth Protection. Although committed to do better, work force is new, young and there is a lot of turn over ...People who work in Investigation Unit [of social services] are young, privileged, often girls, straight out of school, and White. That is the lens they are investigating through. Because that is the most stressful part of YP system, they don’t stay in that position long enough to get a deeper understanding.”*
  - *“In general, the people we have worked with are somewhat ignorant of the history and special considerations that an Aboriginal client might need, they [Youth Protection workers] don’t understand that there is an overrepresentation of Aboriginal children in care, they don’t have an understanding of the history of colonialism or complex trauma.”*
  - *“There is a lack of recognition that a client is even Aboriginal. If the partner, or father is non-Native or speaks French.”*
  - *“Not a lot of Aboriginal workers or people who are part of the [Aboriginal] community working in Social Services. .... Not a lot of understanding of poverty or different parenting styles.”*
- **Housing – Staff at shelter assist women to find ‘second stage’ low cost housing. Difficult to find suitable housing that is safe, mold free, and in good repair. Language barriers when searching for housing. Aboriginal clientele face additional barriers because of discrimination (stereotyping).**
    - Long waiting lists for low cost housing
    - Lengthy process to fill out application (forms and documents required)
    - Difficult to find apartments – clients need assistance searching for apartments that are safe
    - Language – barrier to search and find apartments is difficult
    - Barriers for women who have children
    - Aboriginal women face obstacles finding low-income housing due to stereotyping (landlords saying – ‘apartment is no longer available.’)
  - **Funding – General difficulties because of the ‘structure of the funding’.**
    - **Structure of funding is problematic:** Need to reapply for funding on a yearly basis. Takes a few months to put funding proposals together. Amount of stats required to report on in a regular basis takes away from ability to provide services; a lot of time spent on applying/reporting on funding. Although there needs to be accountability, the funding cycles are too short. Also, funding is “too dependent on political situation”, which makes it difficult to provide services that are needed.

**APPENDIX 6: List of Social Services available in English-Speaking First Nations Communities in Quebec**

A total of eight (8) out of eleven (11) communities completed the Inventory of Social Services (of which six (6) were completed 'in full' and two (2) were completed in part (those completed in part are marked with an (\*\*)). Any challenges identified in the written survey (from Long Point, Gesgapegiag, Kahnawake, and Kanasatake) are included in the 'Findings' (Section 5.0) of report.

Community	1.) Enhanced Prevention Focus	2.) Assisted Living	3.) Family Violence Prevention	4.) Social Assistance	5.) National Native Aboriginal Drug Addictions Program	6.) Other Areas
<p><b>I. Eagle Village /Kipawa</b></p>	<p><i>One-on-one support</i> (children and families) <i>Advocacy for band members</i> (facilitation of meetings between members and 3<sup>rd</sup> parties; assistance with documentation; supervised visit between parent and child; acts as a corridor for services between clients and organizations. <i>Promotion of Healthy Living</i> (newsletter articles, pamphlets, advertisements, workshops, activities, outings) <i>Training Opportunities</i> (Stress Reduction; Suicide Intervention; Safe Talk; Wellness workshops with Parents; Charlie 1 and 2 training)</p>	<p>**Currently offered through Centre Jeunesse.</p>	<p><i>One on one support</i> (children, adults &amp; families) <i>Family Movie Night</i> (Support services on site.) <i>Drumfit</i> (large motor movements for youth and families to help distress &amp; work out (First line workers on site) <i>Parents of Active Little Souls</i> (Parents and children (0-8 y.o). Safe, stimulating environment to engage discussion and support service building.)</p>	<p>**Social Assistance Department.</p>	<p><i>Client referrals</i> (treatment centers, detox services and wellness centers) <i>Follow up and aftercare Prevention Services</i> (Information sessions, workshops, "dry" activities, dissemination of resource materials) <i>Culturally based activities</i> <i>Collaboration</i> with other programs and services</p>	<p><i>Food Bank</i> (distribute food; day to day operations; corridor to other services/departments (in and out of community) <i>School Breakfast Program</i> (Healthy breakfast options; Nutritious meals) <i>Community Kitchen</i> (regular workshops to assist with food security; healthier food choices; eating habits; support low income families) <i>Community Garden</i> (fresh produce; increase knowledge on whole foods and offer variety of healthy options; promote growth and development of the community; allow community members to gain knowledge of gardening.)</p>

<p><b>2. Gesegngpegiag</b></p>	<p><b>Prevention</b>  <i>Training</i> (For the sake of the Children)  <i>Safe Talk Presentations</i> (Child abuse, family violence, addictions)  <i>Individual Therapy with psychologist</i> (on and off reserve)  <i>Wellness Workshops</i> in collaboration with Day Care, Health, Police for 'red flag' cases for early intervention  <i>Cultural Activities</i> (youth)  <b>Protection</b>  <i>Evaluation and orientation</i> of protection cases  <i>Follow Up</i> of protection cases (voluntary measures and court orders)</p>	<p>Assisted Living services are provided.  (*Information about which services are provided was not available at the time that Inventory was completed.)</p>	<p>Family Support Centre recently opened to assist struggling families.</p>	<p>Social Assistance is managed by the Band Council.  (*Information about which services are provided was not available at the time that Inventory was completed.)</p>	<p><i>Prevention and Promotion</i> Activities  <i>One on One counseling</i>  <i>Referrals</i> to Detoxification and <i>Rehabilitation</i>  Weekly AA meetings  <i>24/7 Crisis Hope Line</i> (Telephone and Texting)</p>	<p>No information provided</p>
<p><b>3. Kahnewake</b></p>	<p><b>Prevention</b>  *The only Program specifically funded by the Enhanced Prevention Fund is the "Where the Creek Runs Clearer Group". Services that fall under social, yet not funded by the EFP, and are listed in #6 of this chart  <i>Where the Creek Runs Clearer</i> (Life skills, and prevention programming, based on traditional cultural teachings)  <b>Protection</b>  <i>Intake Services;</i>  <i>Youth Protection Services through delegated authorities;</i>  <i>Youth Criminal Justice Services</i> through delegated authorities in partnership with the Quebec Justice system, conduct all necessary functions to support the Quebec Youth</p>	<p><i>Individual counselling and support for community members</i> living with diagnosed mental health / special needs issues  <i>Family Support and respite</i> for family members caring for individuals who are living with a variety of special needs.  <i>The Independent Living Center</i> (12-unit mental health residence that provides 24/7 security and support through a multi-disciplinary team that includes a case worker, mental health nurse, addictions worker,</p>	<p><i>Violence Prevention month</i> (July) aimed at educating the community about the effects of violence and raising awareness (activities include Movies in the Park to promote health family activities and create a venue to get the information out, print, radio and television ads; guest speakers open to the community, etc.)  <i>In-School Prevention</i> education and awareness on violence, bullying and addictions  <i>Safe Grad</i> – Promoting the healthy and safe celebration of graduating secondary school through awareness and education</p>	<p>Provided by the community of Kahnewake through the Mohawk Council of Kahnewake – Social Development and Social Assistance Unit.</p>	<p>Addictions Response Services team provides direct support to community members on an "Intensive Outpatient" model, within a continuum of care: addictions screening; in-depth addictions assessments; individual counselling; family interventions; couple and family counselling; referral to inpatient treatment short or long term; referral to withdrawal management centers; internal referral to other KSCS services; In partnership with Corrections Canada, support the re-integration and release of community members in the justice system</p>	<p><b>[NIHBI] Psychological Services Administrative and Clinical Supervision</b>  Psychological Services are integrated with all of our services (Develop and deliver appropriate psychological services by creating service plans; referrals to appropriate resources; Coordinates and monitors all off-reserve psychological and psychiatric referrals; Conducts and coordinates with contracted service)  <i>Note:</i> Kahnewake noted that many 'prevention</p>

<p>Criminal Justice Act, such as conducting assessments for extra-judicial sanctions and probation follow-up. Funding for the Youth Criminal Justice Services is administered through the Province of Quebec.</p> <p><i>Tsi Loneka 'iamonhha "Foster Care" Program</i> (Case Aide Program; After Hours Response Services "On-call";</p> <p><b>External to KSCS and external to Kahnawake:</b></p> <p>Provincial level; formal contract pertaining to the rendering of professional services that exists between KSCS and Centre de Jeunesse de la Montérégie, which includes the 32 and 33 delegates appointed to perform exclusive duties under the Youth Protection Act and the Youth Criminal Justice Act. Objective is to attain own authority to deliver youth protection services within our community. Other provincial/regional services/resources that the Support Services team works with include: Montérégie and Montréal hospitals, schools and agencies; court system; Ministère de la Santé et des Services Sociaux; police; group homes; Régie de Rente; FNHIB; First Nations Treatment Network/Foster Pavillion; FNQLHSSC; Assurance de Maladie du Québec; AANDC Regional Office.</p>	<p>physician, psychiatrist, life skills support worker and extended family</p> <p><i>Young Adults Program</i></p> <p><i>Teen Social Club</i></p> <p><i>Facilitate access to specialized services</i> (i.e. occupational therapy)</p>	<p><i>Spirit of Wellness Month</i> (November) – aimed at promoting wellness through education and community-wide activities</p> <p><i>Memorial March Against Missing and Murdered Indigenous Women</i></p> <p><i>Leadership Program</i> (for young men based out of Kahnawake Survival School)</p> <p><i>Support groups</i> (Self-esteem and grief groups)</p> <p><i>Staff trainings</i> (Trauma Training, Conflict Resolution training)</p>	<p>Managed by the Mohawk Council of Kahnawake.</p>	<p>NNADAP activities are combined with those offered at the Mental Health Department.</p> <p>Activities include: Cultural and Spiritual workshops; visits and support to community members on an</p>	<p>based' services, programs and activities are provided for to community members with funding from Health Canada.</p>
<p><b>4. Kanesatake</b></p>	<p><b>Prevention</b></p> <p><i>First Line Services</i> are integrated and/or complement existing programs and services (health services).</p> <p><i>Recognize and support for parents</i> (including fathers), for extended family and the</p>	<p><i>Non-medical social support</i> provided to those who qualify including (not limited to): light meal preparation, housekeeping, assistance with errands,</p>	<p>Health Centre does not manage the Family Violence Program. However, there are services are provided at Health Center including, not limited to: Mental Health, Counseling, referrals to</p>	<p>Managed by the Mohawk Council of Kahnawake.</p>	<p><i>Community Garden</i> (Summer Months)</p> <p><i>Healing Lodge</i> (Holistic approach, traditional and cultural activities/training</p>

	<p>community in raising children. Reduce the need to remove children.</p> <p>Activities include:          Gatherings (Cultural, Awareness and prevention); Events (Family Day, Mothers/Fathers Day); Physical Activities; Workshops (Skills and Knowledge); Referral/Liaise/Accompany individuals (as required); Community Action (i.e., Community planning of activities); Support local community organizations providing services to children, youth and families; Encourage and mobilize parents to volunteer for various community, social, educational and sporting activities; Youth Center Activities</p> <p><b>Protection</b>  <i>Advocacy and support</i> are provided to parents with children in Youth Protection. <i>Provide information</i> to families to protect their child from harm and abuse. <i>Referrals to CLSC or Centre Jeunesse</i> for involvement of social worker; Occupational Therapist or psycho-educators for intensive parenting interventions. <i>Training</i> offered to families, individuals, and workers.  <i>Programming</i> for Children, Youth and Parenting</p>	<p>transportation to access other resources.  <i>Limited Respite Care</i> (arrangements can be made for a client to spend day at local elders' home (fees for this service are covered by client and Kanasatake Social Services).  <i>Access to medical equipment</i> (medical equipment loaned out to client; electric beds, with or without side rails; wheelchairs, walkers, crutches and canes, and variety of adaptive devices for bathroom.  <i>Translation Services</i> (English, French, Mohawk)</p>	<p>Shelters, psycho social services, legal aid, Anger Management <i>Services offered, but no funds.</i></p> <p>Health Centre nurses are aware of the potential for family violence, including Elder Abuse.</p> <p>Nurses are alert to signs of Elder Abuse, and include this in the ongoing assessment of HCC clients. If Elder abuse is identified, it is dealt with on a case by case basis, with involvement of appropriate resources (ie. Social Services).</p>	<p>Receive Client request          Assessment of financial situation          Issue monthly allowance          Reporting</p>	<p>ongoing (continuous) basis:          Counselling (one on one); Referrals to detoxification.          Follow up in After Care.          Activities/Events in community (i.e., National Addictions week event).          NNADAP Worker.          Outreach services</p>	<p>"works well and is welcomed by participants".  <i>Site/ide Prevention. Physical Initiative. Pihawaden</i> (Reinvestment Strategy) to assist individuals to find employment (short term).  <i>A.A. Meetings</i></p>
<p><b>5. Kitigan Zibi</b></p>	<p>Life Skills coach          Youth Prevention worker          Youth Diversion worker          Mental Heal &amp; Social Worker          Community Promotion/ prevention activities          Counseling          Support Group</p>	<p>Activities that promote individual living          Social teachings          Prevention teachings          Social outings          Support to employees/ Workshops &amp; training</p>	<p>Counseling          Community events promoting the impact of violence          Referrals          Networking with outside resources          Workshops/ Teachings          Public Awareness</p>	<p>Prevention; Intervention          After Care; Awareness Activities for all age groups; Home visits; Referrals          Cultural Activities; Post Treatment          Counseling; Pre treatment Support          Family Support</p>	<p>No information provided</p>	

<b>6. Listuguj*</b>	No information provided	No information provided	No information provided	Enhanced Service Delivery Special Needs Return to Work Supplement Employability Project Employment Assistance Allowance	<i>Prevention and promotion activities</i> are ongoing and tied in with the community health plan. Referrals to external services are supported by the councilor; one/one counselling available for both child/parent Works closely with Front line prevention team. Close relationship activity planning with the Maternal Child Health support worker. Safe graduation activities.	No information provided
<b>7. Long Point*</b>	No information provided	No information provided	No information provided	Social Assistance available.	No information provided	No information provided
<b>8. Native Women's Shelter of Montreal</b>	Shelter, food and clothing Assistance to obtaining financial aid and low-cost housing; Accompaniment to appointments and advocacy; Referrals to legal, medical, educational, drug and rehabilitation; Therapeutic individual and group sessions to address sexual abuse, violence and addictions; Parenting skills; Individual psychotherapy; One-on-one or family sessions with Elders; Opportunities to participate in ceremonies; Outreach program; Community support program; Holistic Health program; Cabot Square project.	Outreach services to help elderly clientele with their needs.	Addictions worker and a Holistic health worker conduct workshops on violence.	Assist clientele in applying for social assistance and child tax benefits, if applicable.	Shelter has an addictions worker (funded through ESDC (Employment and Social Development Canada) Referrals to addictions services in the city. Only one external service that is culturally appropriate, Orento:kon, located in Kanehsatake	<b>Outreach Program:</b> The Outreach worker is a service to those who have moved out of the shelter; or any Aboriginal woman living in the city. The outreach worker responds to emergency situations, provides home visits, advocacy, support and referrals.