Building Bridges to Improve Care in First Nations Communities

Contact: M. Janet Kasperski RN, MHSc, CHE
The Ontario College of Family Physicians
340 Richmond St. W.,
Toronto, Ontario M5V 1X2
Telephone #: 416 867 9646 Ext.26
Email: jk_ocfp@cfpc.ca
Website: www.ocfp@cfpc.ca
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Executive Summary

The Ontario College of Family Physicians (OCFP) represents over 10,000 family physicians that practice in communities throughout Ontario. While every family physician faces problems in providing and accessing the care that his/her patients need, the problems of most of them pale compared with those faced by family physicians who deliver care in First Nations communities. Following receipt of a passionate letter from one of our Members, the OCFP committed to addressing some of the issues that were described in the letter. This included a decision to establish a Task Force to support the activities of the OCFP in this regard and an outreach to the First Nations Chiefs’ Health Committee. Over the course of time, the Chiefs and the OCFP formed a joint Working Group. The Joint Working Group produced an “Action Plan” that was accepted by the First Nations Chiefs’ Health Committee and the OCFP Board.

The Action Plan includes the need to develop an advocacy agenda. The lack of educational opportunities in First Nations’ communities was chosen as our first joint advocacy initiative. The plan includes the need to gather information and to conduct research to support the advocacy agenda and to underpin the decision-making process for effective changes to the system. The Action Plan also identifies Maternal/Child Care, Mental Health and Addictions and Chronic Disease Prevention and Management as the three most important clinical issues we wished to address. All three clinical issues are interlinked since a concentration on the early years provides resilience to chronic diseases, including mental illnesses and addictions. We recognized that the short-term and long-term health of First Nations’ children was severely compromised when they and their parents are living in communities that are impoverished and have high rates of mental illnesses and addictions. Given the provincial priorities and the needs in First Nations’ communities, opiate abuse was chosen as the first clinical issue that we wished to address. Research to support this initiative revealed the depth of the problem.

This document provides information about the ideal addiction system that is needed to address opiate abuse in First Nations’ communities. The many gaps in care currently exist in the system need to addressed by concentrating on improving the level of care provided on-the-ground care in First Nations communities. More nurses with specific training in mental health and addictions, social workers and mental health workers are needed. The roles of Traditional Healers need to be supported, especially in light of the success of detoxification taking place in First Nations back-to-the-land settings. The problems that family physicians face in a system that does not offer easy to access supports for guidance and advice or timely acceptance of referrals to care in the broader healthcare system also needs to be addressed.

The document identifies the following solutions:

- A focus on healthy babies/healthy children—(healthy families living in healthy communities focused on the prevention of mental health and addictions);
- Ongoing education and supports for healthcare providers including sensitivity training and linkages with traditional healers;
- Electronic Medical Record/Electronic Health Records/Telemedicine to provide easy access to the right information about the patient and the best treatment options when needed.
- Ongoing risk assessment to identify issues that may lead to addictions;
- Pre-treatment preparation services;
- Supportive First Nations’ “Back-to-the-Land” detoxification programs;
- Access to age and gender specific Detoxification Centres with expertise in the treatment of drug addictions and the care of the dually diagnosed individuals with a mental illness and an addiction;
- Policies and procedures to ensure that regional and provincial service providers accept patients from remote/rural communities as priority patients;
- Intensive post-detox care in the community to prevent relapse; and,
- Ongoing mental healthcare and the secondary prevention of addictions.
1) Introduction: Building the Bridges to Understanding the Needs in First Nations Communities

In the fall of 2007, the Ontario College of Family Physicians received a letter from one of our Members, Dr. Murray Trusler (see Appendix A). Dr. Trusler was practicing in the remote, rural community of Moose Factory and his letter documented the many social and system issues that made the delivery of healthcare for First Nations people, as one doctor described it, “like putting a band-aid on a boil and hoping that it would go away.” His letter pointed out the following as key to finding solutions to the deprivations his patients faced on a daily basis:

1. Access to Publically Funded Healthcare Services
2. Access to Adequate Housing Built According to Provincial Standards
3. Access to Provincial Water Standards
4. Access to Provincial Policing Standards
5. Access to Education In Keeping with Provincial Standards
6. Access to Municipal Infrastructures – roads, parks, recreational facilities, etc.
7. Access to Alcohol and Drug Prevention/Treatment Programs
8. Access to Family Health Teams
9. Access to well designed and functional Electronic Medical Records, Electronic Health Records and Telemedicine
10. Access to the Chief Medical Officer of Health for Ontario.

The Ontario College of Family Physicians responded to the letter by organizing a meeting with a number of family physicians who provided care to First Nations communities, including Dr. Trusler. That meeting was followed by the decision to develop a Task Force with representatives from the Ministry of Health and Long-Term Care, the LHINs, Health Canada, First Nations Chiefs and family physicians who were devoted to serving First Nations communities, on and off reserves. The Task Force concluded that Dr. Trusler had captured the main issues physicians and their patients were facing and had identified the solutions to those issues. The Task Force agreed that the ultimate goal of government should be equal health outcomes for all Ontarians. The Task Force identified the fact that more than “equal” access to healthcare services was needed in First Nations’ communities; it would take “equitable” access to address the problems in these communities. The health of First Nations peoples was so compromised that the provision of “equal” access would simply not address the problems seen in these communities. “Equitable access” implies that more than the normal level of services is required to produce “equal” health outcomes.

In spite of the fact that First Nations people require higher than normal access to services, family physicians and community-based nurses, mental health workers and other healthcare providers struggle to provide even a minimum level of care. The main problem is that they face human resource shortages, lack of training and are working in a system that lets them and their First
Nations patients down, time and time again. The OCFP’s Task Force soon learned that we could not function in isolation. We needed to build effective bridges with First Nations leaders and with the Federal and Provincial governments if we were to make any headway at all.

2) Building Bridges with the First Nations Chiefs

As the Task Force continued to meet, it became apparent that we could not move forward without the approval of the First Nations’ Chiefs and preferably with input under their direction. A meeting was arranged with the First Nations’ Chiefs Health Committee. That meeting resulted in the establishment of The Joint First Nations’ Chiefs and the Ontario College of Family Physicians Working Group. The Working Group was struck with the full understanding that both First Nations people and the healthcare providers serving them had unmet needs. By identifying and addressing issues together, we would produce the needed results that had been elusive in previous attempts.

Over the course of the past year, the Working Group developed its Terms of Reference and developed a “Joint Action Plan”. The Joint Action Plan included an agreement that we would work together to address the following issues:

1. The need to develop joint messages in order to advocate for healthier First Nations communities. These messages would include the identification of supports needed by community members, as well as those needed by the healthcare providers serving the First Nations communities. One voice would be heard; it is easier to ignore multiple voices.

2. The development of processes to gather evidence-based information, including research to inform decision-making and the evaluation of progress made as improvement strategies are implemented. Proposed changes to the system needed to be anchored in best practices and the ability to continually improve as we moved forward.

3. A joint commitment to address the major health issues
   a. Maternal/Child Care
   b. Mental Health and Addictions – Opiate Abuse
   c. Chronic Disorders.

These three are interlinked and, if addressed effectively, represent the best opportunity to produce positive health outcomes in the long term since the prevention of chronic disorders including mental health and addictions starts with healthy babies and children.

The Joint Working Group’s Action Plan was accepted by the First Nations’ Chiefs and by the Board of the Ontario College of Family Physicians and we have proceeded to working on the Action Plan.
3) Building Effective Bridges to the Federal and Provincial Governments

An effective solution arises when the problem is well-known and the right stakeholders are at the table. The problems in First Nations communities are well-known and, on the international scene, these problems have tarnished Canada’s reputation as a caring society. Having First Nations people living in third world conditions has mobilized the country to find and implement sustainable solutions. The First Nations Chiefs and the OCFP have agreed upon the solutions that we would like to jointly implement. To do so, we need the Federal and the Provincial Governments at the same table with the Chiefs and the healthcare providers who deal with the issues on a daily basis.

To ensure that the right people are at the planning tables has required the Working Group to develop joint advocacy messages. These messages are intended to create “Win-Win” situations for First Nations peoples. The solutions that we have identified would ultimately create the supports needed to address problems in the communities themselves and to address the needs of family physicians and other healthcare providers who serve the First Nations communities. We recognized that there is now the will to address the issues through the joint efforts of the two levels of governments and the First Nations’ Chiefs, supported by the committed healthcare providers. The time is right for moving forward – together.

3.1) Our First Priority: Addressing the Need for Mental Health and Addiction Services - Focusing First and Foremost on Opiate Abuse

The mental health status of many First Nations people is unstable at best and most often tragically poor. To produce healthy babies and children, First Nations communities need to tackle the major mental health and addiction issues that are impoverishing families and communities. The reasons for poor mental health status are well-known and anchored in the past history of First Nations people, unemployment, abject poverty and lack of appropriate mental health and addiction services. The basic needs of these communities are not being met in terms of clean water, adequate housing, and equitable education and employment opportunities. The problems appear to be so overwhelming that paralysis often has set in. At this time, the First Nations’ Chiefs and the Ontario College of Family Physicians wish to identify one issue and solve it – namely opiate abuse. The problem is well-known; the solutions are known and the right people are now at the table. To do so, we need to focus on preventing and treating drug addictions in First Nations communities. With the assistance of both levels of government, we will be able to do so by:

i. Focusing on the determinants of health;

   ii. Increasing the number of appropriately trained nurses, mental health workers and traditional healers to provide on-the-ground supports in First Nations communities; and,
iii. Providing family doctors and their team members with the education and supports they need to provide expert care for patients with mental illnesses and addictions. When the system is organized to support the building of bridges between the nurses and other community providers and family physicians, the synergy that will be created will result in a situation in which $1 + 1 = 3$.

3.2) Preventing andTreating Addictions: Effectively Managing Acute and Chronic Pain

The people living in First Nations communities, like all of Ontario’s citizens, on occasion require relief after injuries or after surgical or dental procedures. The ability to undertake procedures on a day surgery basis or to reduce the length of stay for major surgeries is dependent upon the use of potent pain medications that can be delivered orally. When medications that require intramuscular or intravenous delivery methods are replaced with oral medications, the patient can receive the same level of pain relief but can take the medications on their own without the professional assistance of nurses or other healthcare professionals. This is of great benefit to the sustainability of the healthcare system and has resulted in a significant decrease in surgical inpatient beds; however, the use of opiates in this manner has led to addictions, drug diversion and chaos in families and communities throughout Ontario.

Patients with chronic pain are particularly susceptible to opiate addictions since alternatives to opiates are not readily available and physicians are reluctant to order therapies that are not evidence-based. “Psychiatric” pain is one of the most frequent causes of opiate addictions as individuals try to dull their emotional pain. The First Nations families and communities have been particularly hard hit by the problem of opiate addictions since mental anguish combined with readily available opiates leads to the perfect storm in these communities – major opiate addictions on a grand scale.

The solutions are known and include the prevention of addictions in the first place and increased capacity for evidence-based treatment programs. The identified solutions require investments in the following:

- The infrastructure needs that are the foundation of a healthy community;
- Effective maternal/child programs to create the conditions for healthy babies/healthy children;
- An increased number of appropriately trained nurses, social workers/mental health workers and traditional healers in each First Nations Community;
- Educational supports for family physicians and other healthcare providers including:
The OCFP’s CME-on-the-Road program that focuses on “weaning procedures for acute pain management” and the safe management of chronic pain;
- Evidence-based practice tools kits; EMRs with embedded decision-support tools; interactive web-based education programs and access to tele-psychiatry;
- The Collaborative Mental Health Care Network; and,
- The Medical Mentoring for Addictions and Pain (see Appendix B).

- Culturally sensitive mental health services;
- Programs for the dually diagnosed;
- Addiction Services tailored to the needs of First Nations people; and,
- Secondary prevention services in the community to prevent relapse.

3.3) The Ideal First Nations Addiction System

The features of the ideal addiction system are well-known. Our main problem is the ideal addiction system is not available in most parts of Ontario. The healthcare system in Canada was built upon the principle of “equality”. Equality does not mean “equal”. It means more services to those most in need so that the outcomes of healthcare are equal. The needs of people in First Nations Communities are acute compared to other Ontarians. If the principle of “equality” had been adhered to, the First Nations communities would have “equitable” access to the ideal addiction system. That system would have the following features:

- A focus on healthy babies/healthy children – (Healthy families living in healthy communities focused on the prevention of mental illnesses and addictions);
- Ongoing education and supports for healthcare providers and traditional healers, including cultural sensitivity training;
- Electronic medical health record/Electronic health records/Telemedicine to provide easy access to the right information about the patient and the best treatment options when needed;
- Ongoing risk assessment to identify issues that may lead to addictions;
- Pre-treatment preparation services;
- Supportive First Nations “Back-to-the-Land” detox programs;
- Access to age and gender specific Detoxification Centres with expertise in the treatment of drug addictions and the care of the dually diagnosed individual with a mental illness and an addiction;
- Policies and procedures to ensure that regional and provincial service providers accept patients from remote, rural First Nations communities as a first priority.
- Intensive post-detox care in the community to prevent relapse; and,
- Ongoing mental healthcare and the secondary prevention of addictions.
3.4) Developing the Ideal Addiction System: Addressing Community-Based Obstacles

It is important to note that each First Nations community is unique. Some face the obstacles associated with being in remote, rural parts of the province. Some have more economic struggles than others. Some have greater access to healthcare facilities but face major hurdles in terms of cultural sensitivity. Some have integrated traditional healers with their healthcare system. The most common finding is that family physicians and nurses are the predominate providers of healthcare in the communities. Family physicians are available to provide guidance and advice to the nurses who tend to reside in the communities and are on-site on a routine basis. Building on the resources available in the First Nations communities will be an essential starting point for the establishment of an ideal addiction system; however, there is much work needed in each First Nations community. The ideal addiction system cannot become a reality in First Nations Communities unless we address the following problems:

- The lack of resources to create a healthy society;
- Too few nurses with formal training in mental health and addictions;
- The lack of appropriately trained mental health and addiction workers;
- The lack of integration of traditional healers and the available healthcare providers;
- The lack of understanding and supports for the Back-to-the-Land detox program;
- The lack of access to age and gender specific detox and treatment centres and those that will accept the dually diagnosed; and,
- The lack of supportive public policy to address systemic problems (see Appendix C).

3.5) Developing the Ideal Addiction System: Addressing the Obstacles Facing Family Physicians

The following issues need to be addressed to better support family physicians and their practice teams:

- Continual emphasis on strategies to address the shortage of family physicians available to serve First Nations communities;
- The provision of educational supports for family physicians to develop additional skills to address the complex patient issues related to mental illnesses and addictions (CMHCN and MMAP);
- Increased research capacity to support the use of alternatives to narcotics for pain management, weaning protocols and alternatives to methadone;
- Cultural sensitivity training to address the specific health needs of First Nations people; and,
- Policies that support specialists, specialized service providers and organizations to readily accept referrals for care from family physicians delivering care to First Nations people, especially those in remote, rural communities.
3.6) Developing the Ideal Addiction System: Building Bridges to the Broader Healthcare System

While the essential bridge is between the community service providers and their collaborating family physicians, it is imperative that the bridge to the broader healthcare system is strengthened. The following represents the main recommendations for supports that need to be in place to better support family physicians in the care of First Nations people:

- Increased capacity for tele-psychiatry and distance education, including supports for interactive, web-based learning opportunities;
- Evidence-based decision-support tools built into the EMRs;
- Increased capacity in the Collaborative Mental Health Care Network and the Medical Mentoring for Addictions and Pain programs to provide access to medical, nursing and social work/mental health experts for family physicians and community-based providers; and,
- Policies that address the referral and access issues faced by family physicians in referring patients to detox centres and mental health and addiction services.

4) Summary

Previously, many efforts have been made to improve conditions in First Nations communities and/or to improve access to much need healthcare services. Many of these efforts failed. The trust of First Nations people has eroded with promises made and not fulfilled. We believe that this time will (and must) be different. First Nations people have suffered for far too long. Family physicians, nurses and other healthcare providers are distressed as well by their inability to improve the health of the people they serve. By addressing community and health system needs simultaneously and together, this time we will succeed in addressing the conditions in First Nations communities and show the world that Canada is truly a caring nation.