Indigenous Primary Health Care Council (IPHCC) - Brief to the House of Commons Standing Committee on Indigenous and Northern Affairs

Date: November 27, 2020

Subject: Supporting First Nations, Inuit, and Metis People during a Second Wave of COVID-19

Prepared for: The House of Commons Standing Committee on Indigenous and Northern Affairs

About IPHCC:

The IPHCC was recently incorporated on November 20, 2019, although it has been operating informally for many years. The IPHCC is made up of members and associates from 28 Indigenous community health care organizations, including Aboriginal Health Access Centres (AHACs), Indigenous Interprofessional Primary Care Teams (IPCTs), Indigenous Community Health Centres and Indigenous Family Health Teams. The sector has been around for thirty plus years, and as a result of ongoing expansion, the IPHCC made a decision to establish provincially. On behalf of our members, the IPHCC coordinates and advocates for all aspects of health and well-being for the Indigenous population. The organization promotes high quality care provision through the Model of Wholistic Health and Wellbeing (Figure 1), population needs based approach to health care planning, Indigenous informed evaluation approaches and scaling leading practices for excellence in Indigenous health. We operate in locations across Ontario and provide primary health care services to Indigenous people in urban, rural, remote and First Nations settings. As of 2016 estimates, our sector serves 66,000 people annually. We are actively updating these numbers to reflect the impact more accurately we have on the population we serve and have recently recruited a Data Quality Analyst to support this effort.

Background and Purpose:

Mental Health & Addictions

Intergenerational trauma and lateral trauma resulting from colonization and forced acculturation have led to sharply rising rates of mental illness, addictions, and suicide amongst Indigenous people. Facilities

and service have not kept pace and for many Indigenous communities and people access to mental health care and treatment is limited, exacerbated by the shortage of suitable healthcare providers.[1]

Indigenous peoples experience higher rates of addictions and mental illness specifically in communities where mental health care is not available, and social and educational disparities exist.[2] In addition, rural areas tend to have higher rates of alcohol and drug addiction.[3]

Overdose deaths have been a serious public health issue for over a decade with an average of 34 deaths per week occurring pre-pandemic. This increased to 46 deaths per week in the first 3.5 months pre-pandemic (38% increase).[4] Although many community-based mental health and addictions services remain open with some modifications, access to many services has been limited. The expected long-term consequences of a decline in access or delay in treatment has been accelerated due to COVID.

In an IPHCC member survey conducted in August 2020, when asked what the primary concerns for Wave 2 were, the top three responses all related to mental health and addictions concerns—Housing Supports for physical isolation, Mental Health and Addictions Care Capacity, and Staff Burnout.

Approximately 40,000 across Ontario are released from provincial correctional facilities into Ontario communities each year. As many as 80% of them have known mental health alerts and/or substance use challenges that require ongoing wraparound healthcare. Research looking this population shows about 60% of this population are attached to a primary care provider upon release.[5] About 15% are attached to team-based primary care (CHC, FHT, or AHAC).

The post-incarceration population has significant medical and social complexity. Most are in the lowest or second-lowest income quintiles (37.1% and 21.5%, respectively), and they have significant co-morbidities, including diabetes, asthma, COPD, mood disorders, schizophrenia, anxiety disorders, and

[1] Government of Canada, Indigenous Health - https://www.sac-isc.gc.ca/eng/1569861171996/1569861324236

[2] Statistics Canada, Perceived mental health and suicidal thoughts by Aboriginal Identity - https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=4110001101

[3] Rural Health Information Hub - https://www.ruralhealthinfo.org/topics/substance-abuse

[4] Ontario Drug Policy Research Network; Officer of the Chief Coroner for Ontario, Centre on Drug Policy Evaluation; Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during COVID-19

[5] Kouyoumdjian et al., 2019. https://www.cfp.ca/content/65/10/e433

substance-related disorders. Many will experience multiple, brief incidences of incarceration throughout their lifetime, with over 50% returned to prison at least once during the two-year study.

At the onset of COVID Ontario's inmate population decreased by 25% as thousands of inmates were released early to prevent COVID-19 spread. This only exacerbated the needs for housing and MHA supports. Ontario Solicitor General (SOLGEN) is aware of their clients' vulnerability and need for person-focused, team-based primary health care, particularly care for MHA, and, that many people leave prison in need of support for housing, employment, food security, and other material determinants of health. However, SOLGEN lacks a provincial strategy for discharge planning and many times resorts to contracting psychiatric and psychological services for their clients, often resulting in clients having to access service in SOLGEN facilities.

Data Collection & Equity

Good data are required to understand how COVID is impacting Indigenous communities. Unfortunately, current systems for collecting and governing Indigenous data are insufficient to provide a complete picture of how Indigenous communities are being affected by this pandemic.

Indigenous Services Canada (ISC) regularly posts updates on the number of cases in First Nations communities; however, that data only captures a sub-segment of the Indigenous population. In Ontario, more than 65% of First Nations people with status live off-reserve. Furthermore, there is currently no mechanism in Ontario for measuring the impact of COVID on Metis, Inuit, or First Nations people without status.

To a certain degree, data thus far published by ISC presents an encouraging picture of relatively low per-capita infection and mortality rates. These numbers, however, clearly do not tell the whole story of how Indigenous people are being impacted by COVID. The federal government, as part of its constitutional and fiduciary duty to Indigenous nations, has the responsibility to champion initiatives that seek to provide a more fulsome account COVID's impacts.

IPHCC member organizations are 'status neutral'; as a sector, we serve First Nations, Inuit, and Metis clients without regards for whether they have status. Under the oversight of our Indigenous Performance Management Committee, we are using Aboriginal Health Access Centre and Aboriginal

Community Health Centre data to tell our sector's COVID-19 story. We can track how many COVID-related encounters organizations are seeing, as well as client characteristics (e.g., age, sex). This data has revealed high levels of COVID-related fear among clients. In a separate survey, 90% of our members expressed concern that they would not have the service capacity to meet their clients' mental health needs during a second wave of COVID.

The We Count COVID-19 project in Toronto is another promising initiative. Co-funded by ISC and Ontario Health, it is co-led by Well Living House, Native Men's Residence, and Seventh Generation Midwives. It connects urban Indigenous clients to COVID testing, provides culturally safe case investigation and contact tracing services, and stewards a community-owned database of Indigenous COVID cases. We Count COVID-19 operates in accordance with an Indigenous, community-led data governance and accountability model and strives to provide culturally safe and relevant care.

Data equity is necessary to achieve health equity. Initiatives like those of the IPHCC and We Count COVID-19 are helping shed light on previously invisible aspects of how COVID is impacting Indigenous communities. These initiatives are essential and need to be supported; however, they are also stop-gap measures. The real solution is systemic change to how Indigenous data are collected and governed. It is vital that the federal government work with its provincial counterparts to ensure those broader changes occur in a timely and meaningful manner.

Testing & Vaccines

At present, vaccines pending approval (such as those by Pfizer and Moderna) are being purchased by the federal government. However, there have been no protocols established on how vaccines will be distributed, particularly to Indigenous communities. The IPHCC has been invited to discussions with the Ministry of Health and Public Health Agency of Canada but these have not yet occurred. Thus far, many conversations with government contacts have involved navigating jurisdictional disputes, which does not address the concerns being brought to the tables. Additionally, the messaging on vaccine distribution from provincial and federal governments is disconnected, and the messaging to Indigenous communities is not being tailored or receiving limited to no input from Indigenous voices. It is important to note that there exists substantial mistrust in Indigenous communities towards government vaccination programs, in response to generations of unethical medical practices carried out by the

government against our people (such as the Indian Hospitals Program and Forced and Coerced Sterilizations).

Regarding contact tracing, there are some steps being taken to increase capacity in Indigenous communities, but more action is needed. Currently there are discussions taking place about the training and orientation of volunteer Indigenous contact tracers but contact tracing efforts are being impacted by challenges in the relationship between local Ontario public health units and Indigenous health organisations. The IPHCC has a pending proposal to the Ministry of Health seeking support and resources for the contact tracing process.

Indigenous people are experiencing racism when accessing testing at mainstream testing centres, where there is a lack of cultural safety training and lack of adequate data collection. The testing strategy also does not centre comprehensive primary care around vulnerable populations, and there are limited considerations for accessibility. There are also insufficient supports for Indigenous people who need to self-isolate but do not have a place to do so, or the capacity to access an isolation centre. There have been some targeted efforts from Indigenous organisations in increasing testing of urban Indigenous populations in Toronto using mobile testing units, which were made possible with the support of a local hospital. The second unit integrated mental health and addictions supports as well as primary care as these have been areas of concern for the urban Indigenous population. In remote Indigenous communities, there are insufficient supplies for adequate testing with some communities able to test and some unable especially with respect to point of care testing. There is also no clear oversight on testing, distribution, or processes, which needs to be addressed so that communities are provided with sufficient supplies and training and can have a cohesive pandemic response.

Summary of Recommendations:

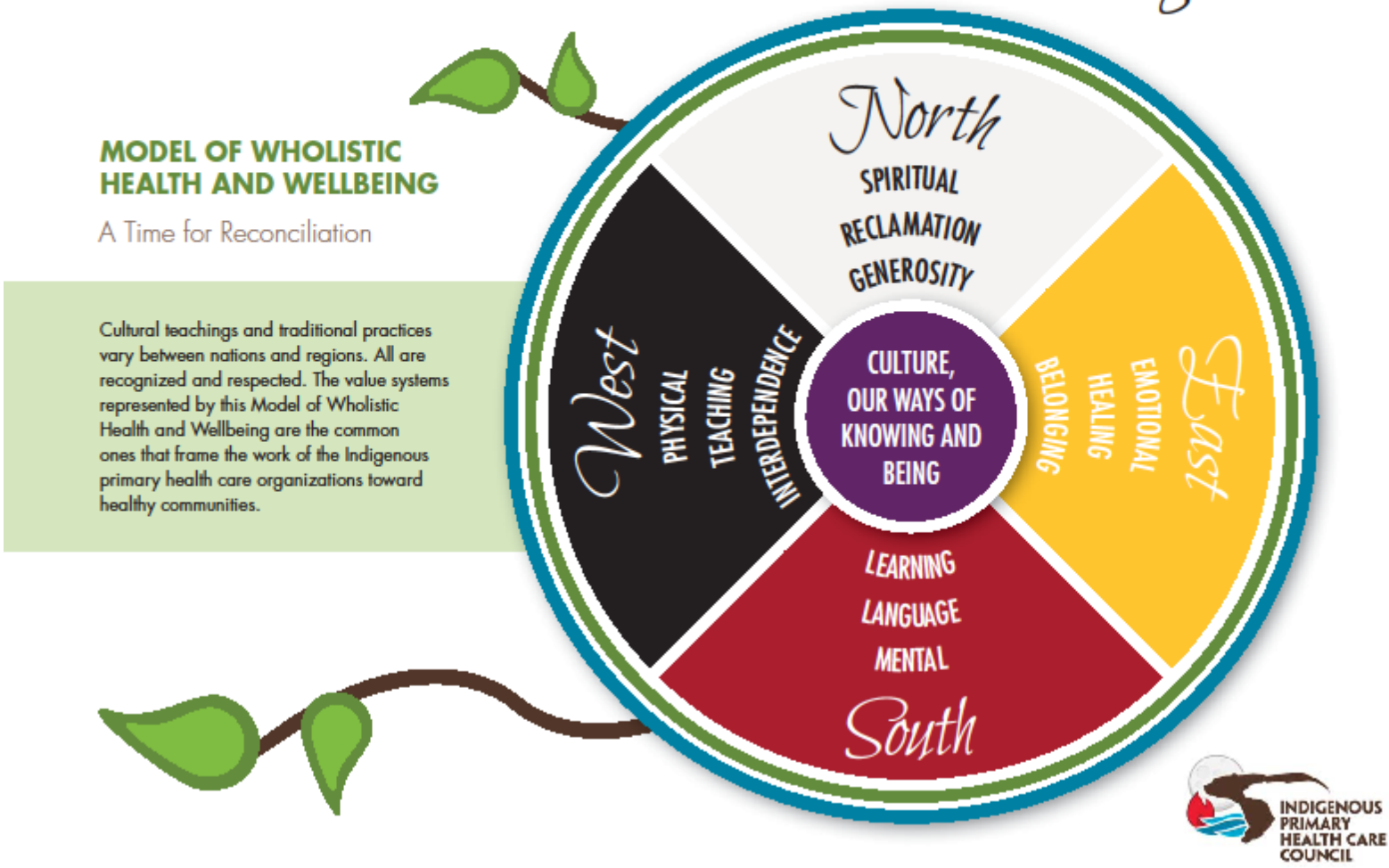
- That the government work with their provincial and territorial partners to increase supports for more Traditional Health Practitioners and land-based programming that meets the wholistic and unique needs of the Indigenous population
- That the government commit to increased resources and access to people in correctional facilities prior to their release to support discharge planning, and link them to primary care, MHA services, housing, and other social supports (wraparound care)

- That the government work with their provincial and territorial counterparts to provide for virtual equity and increasing the ability for traditional health practitioners to provide virtual Mental Health and Addictions services as well as capacity for clients to receive those services
- That the government commit to data equity and to redeveloping their approach to First Nation, Inuit, and Metis data collection for those both on and off reserve, with or without status
- That the government ensure that urban Indigenous peoples are not forgotten when creating strategies surrounding testing, case management, vaccine distribution, and data collection
- That the government commit to developing contact tracing capacity in Indigenous communities, and provide for this tracing to be conducted by Indigenous people in a culturally safe manner
- That the government work with their provincial and territorial counterparts to allow Indigenous Health Care organizations to provide testing to First Nation, Inuit, and Metis people, and ensure that testing provides a culturally safe space for Indigenous peoples
- That the government acknowledge the historic unethical medical treatment of Indigenous peoples, and commit to working with First Nations, Inuit, and Metis peoples in developing a culturally safe vaccine distribution strategy that includes appropriate public health messaging

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

Figure 1

MODEL OF *Wholistic Health and Wellbeing*



INDIGENOUS PRIMARY HEALTH CARE COUNCIL