FIRST NATIONS MENTAL WELLNESS

AND THE

NON-INSURED HEALTH BENEFITS (NIHB)
SHORT TERM CRISIS
INTERVENTION MENTAL HEALTH COUNSELLING (STCIMHC)
BENEFIT

Document for Discussion
Produced by the Assembly of First Nations

Approved by the AFN-FNIHB NIHB Joint Review Steering Committee
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CHAPTER ONE

SETTING THE CONTEXT:

FIRST NATIONS MENTAL WELLNESS OUTCOMES
AND THE CURRENT PROGRAMMING LANDSCAPE

PRODUCED BY THE ASSEMBLY OF FIRST NATIONS
FOR THE AFN-FNIHB NIHB JOINT REVIEW STEERING COMMITTEE
A fulsome understanding of the role and effectiveness of the Non-Insured Health Benefits (NIHB) Short-Term Crisis Intervention Mental Health Counselling (STCIMHC) benefit requires a clear articulation of the context of mental health and wellness within the First Nations population. It also requires understanding the STCIMHC benefit itself, as well as where to situate the NIHB STCIMHC benefit within the suite of mental health programs and services that can and should be available to First Nations people. The following document seeks to achieve these tasks.

Defining Mental Wellness

The First Nations Mental Wellness Continuum Framework defines mental wellness as:

A balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: purpose in their daily lives whether it is through education, employment, care-giving activities, or cultural ways of being and doing; hope for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of belonging and connectedness within their families, to community, and to culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history.\(^1\)

Benefit Overview: Short Term Crisis Intervention Mental Health Counselling (STCIMHC)

What follows is a description of what the NIHB STCIMHC benefit provides. This section does not include an analysis of the efficacy or suitability of the benefit from a First Nations perspective. However, this task is taken up in later chapters through feedback received by the AFN.

The NIHB STCIMHC benefit is intended to provide coverage for mental health counselling to address crisis situations when no other mental health services are available and/or being provided. This benefit is intended to support the provision of immediate psychological and emotional care to individuals in significant distress to stabilize their condition, minimize potential trauma from an acute life event and, as appropriate, transition them to other mental health supports. The program defines “crisis” as:

- Distress manifested by symptoms of physical, cognitive, emotional or behavioral disturbance;
- Inability to care for self and without individual, family, and/or community support and resources to deal with the issue; and/or,
- Nature of the circumstances requires the individual to resolve the issue urgently.\(^2\)

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1 Mental Wellness Continuum Framework (n.p.)
The STCIMHC benefit provides up to a maximum of 15 one-hour sessions (plus 5 additional sessions if needed to transition client to other services) per mental health crisis over a 20 week period. Eligible billable services under the STCIMHC benefit may include:

- Initial assessment (maximum of 2 one hour sessions) performed by an enrolled provider;
- Counselling sessions on a fee-for-service basis as per Prior Approval Form (e.g. individual, family, or group counselling).

With the exception of the initial assessment, all services and modalities for the delivery of services must be prior-approved by the Health Canada regional office. Clients must access any alternate health coverage that is available to them prior to accessing the NIHB Program. They should also contact their local community organizations (health centre, friendship centre, or primary health care provider) and/or Health Canada regional office to determine if community mental health programs are available.

Exclusions

Exclusions are not benefits and are not covered under any circumstances; nor are they subject to the appeal process. Exclusions include, but are not limited to:

- Psychiatric emergencies for person(s) at risk of harm to self or others;
- Non-crisis counselling;
- Services funded by another program or agency including Health Canada’s Indian Residential School (IRS) Resolution Health Support Program (RHSP);
- Psychiatric and family physician services;
- Psychoanalysis;
- Psychoeducational assessments;
- Educational and vocational counselling;
- Substance abuse counselling/therapy;
- Life skills training;
- Early intervention programs for infants with delayed development;
- Assessment services for issues such as fetal alcohol spectrum disorder, learning disabilities and child custody;
- Expressive arts therapy;
- Hypnotherapy;
- Court-ordered assessment services to clients;
- Services which are part of, or to be used for, legal actions;
- Sex therapy; and
- Incarcerated clients.

Some of the above-noted exclusions are meant to be covered by other programs, generally provided by other FNIBH programs, other federal departments of the provinces/territories. However, as will be clear from the discussion below, existing program funding does not cover the essential basket of services identified by the First Nations Mental Wellness Continuum Framework.
Provider Eligibility

In order to bill the NIHB program, mental health providers must be previously enrolled with the program. To qualify as a NIHB STCIMHC provider, mental health providers must be registered with a legislated professional regulatory body and eligible for independent practice in the province/territory in which the service is being provided. Eligible mental health providers include psychologists and social workers with clinical counselling orientation; or mental health counsellors with education and training comparable to psychologists or social workers. In exceptional circumstances, other mental health counselling providers who do not meet these requirements may be accepted subject to the following conditions:

- There are no other mental health counselling providers enrolled with the NIHB Program in the vicinity and access to services is limited; or,
- Where there is an emergency situation such that the health and safety of the client or other persons is at immediate risk.

First Nations Mental Wellness Determinants

Over the last number of years there has been significant attention paid to articulating the unique determinants that inform First Nations health broadly, and mental health and wellness specifically. The First Nations Mental Wellness Continuum notes that, “at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment, and individual behaviour. These factors are referred to as determinants of health. They do not exist in isolation from each other; rather, their combined influence determines health status.”

First Nations health determinants include:

Community readiness, economic development, employment, environmental stewardship, gender, historical conditions and colonialism, housing, land and resources, language, heritage and strong cultural identity, legal and political equity, lifelong learning, on and off reserve, racism and discrimination, self-determination and non-dominance, social services and supports, and urban and rural.

As mentioned, understanding the functioning and impacts of colonialism is central to a fulsome understanding of First Nations wellness, particularly when it comes to mental health. Colonialism has profoundly shaped the lived experience of First Nations people in Canada from governance, economics, politics, gender relationships, spirituality, language, familial relations, and relationships to the land, among others. The most emblematic example of colonization as a determinant of health is the ongoing intergenerational impacts of the Indian Residential School experience. Simply, the dislocation from culture and identity inflicts profound wounds on individuals, families and communities. These impacts continue to be felt across the determinants of health.

3 Continuum, pg. 29.
determinants that contribute to First Nations mental health outcomes. The statistical snapshot below offers a small picture of some notable factors which contribute to First Nations health and wellness outcomes; it is by no means a comprehensive review.

A 2014 Health Canada report notes that:

- In 2006, half (50.2%) of First Nations adults in First Nations communities had not graduated from secondary school. This compares to 15.2% of the total Canadian population.
- The 2006 unemployment rate for First Nations people living in First Nations communities was nearly four times the total Canadian rate (25.0% vs. 6.4%).
- The 2005 median annual income for First Nations people in First Nations communities was less than half that of the total Canadian population ($11,210 vs. $25,767).  

The connection between housing and both mental and physical wellness is well established. It is therefore problematic that, “over one-quarter (28%) of Registered Indian households in First Nations communities fell below the standard for major repairs. This was more than 10 times the figure of 2% for non-Aboriginal households outside of First Nations communities.”  

In addition, a recent evaluation of the on-reserve housing support program conducted by Aboriginal Affairs and Northern Development Canada (AANDC) found that the rates of overcrowding on-reserve is six-times higher than that of non-Aboriginal Canadians. The First Nations Regional Health Survey (RHS) 2008/2010 found that “half of First Nations adults were living in homes with mould or mildew (50.9%), representing an increase since the previous RHS 2002/03 (44.0%).”  

Compounding the physical environment, the RHS found that “more than half (54.2%) of First Nations households were categorized as being “moderate” to “severely” food insecure.”

Disconnection from culture and language plays a profound role in the mental wellness of First Nations individuals and communities. This was one of the devastating lessons of the Indian Residential School era. The positive news is that many are reporting resurgence in cultural pride in First Nations youth as well as increased attention towards language revitalization. While these are certainly positive developments, the current state of Indigenous languages and access to culture remains a concern, particularly as it relates to mental wellness. For example:

14.5% of the Aboriginal population reported that their first language learned was an Aboriginal language. In the previous 2006 census, 18% of those who identified as Aboriginal had reported an Aboriginal language as their first language learned, and a

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6 Ibid.
8 First Nations Information Governance Centre, “First Nations Regional Health Survey,” pg. 50.
9 RHS 2008/10, pg. 81.
decade earlier, in the 1996 census, the figure was 26%. This indicates nearly a 50% drop in the fifteen years since the last residential schools closed.  

**Mental Health and Wellness: Current Status**

Addressing mental wellness concerns for First Nations remains a high priority for both the Assembly of First Nations (AFN) and the First Nations and Inuit Health Branch (FNIHB). This urgency is due to the prevalence of mental health and substance misuse rates amongst First Nations which remain unacceptably high, particularly in comparison to non-First Nations Canadians. Obtaining reliable and extensive health data for First Nations remains a challenge. In fact, it is virtually impossible to accurately measure the efficacy of FNIHB mental wellness programming in terms of improving mental health outcomes. What we do know is that mental wellness issues disproportionately impact First Nations people and communities. For example, the RHS 2008/10 found that “approximately half (50.7%) of all First Nations adults reported either moderate or high levels of psychological distress, compared to only one-in-three adults (33.5%) in the general Canadian population.” Similarly, a 2001 study found that off-reserve First Nations adults were classified as distressed and/or suffered an episode of major depression at a rate almost twice that of the Canadian population. When it comes to First Nations youth, “approximately one-third (33.8%) of female and just under one-fifth (17.2%) of male First Nations youth reported that there was a time when they felt sad, blue, or depressed for two weeks or more in a row in the previous 12 months.”

A strong indicator of the ongoing prevalence of mental wellness issues is that in 2012/2013, the second largest expenditure class for prescription drugs under the NIHB program was antidepressants, at $19.1 million annually.

**Suicide**

Suicide is considered to be a crisis by many First Nations communities. For example, the leading cause of death among First Nations people between the ages of 10 and 44 is suicide and self-injury. In fact, a 2006 Health Canada report noted that the suicide rate among the First Nations population is twice the national average. Additionally, the RHS 2008/10 revealed that “the proportion of First Nations adults who reported having attempted suicide at some point in their lifetime (13.1%) was greater than the proportion of adults in the general Canadian population who reported only having thoughts of suicide.

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11 Priorities are determined for the AFN largely by resolutions passed by Chiefs in Assembly. For a complete list of relevant mental wellness and addictions related resolutions, see Chapter Two, Appendix B.
12 RHS 2008/10, pg.197.
13 Health Canada, 2006 – the human face of mental illness, pg 164
14 RHS 2008/2010, pg. 323
15 Non-Insured Health Benefits Program - 2012/2013 Annual Report, pg 36
during their lifetime (9.1%).”\textsuperscript{17} When it comes to youth, the rates of suicidal ideation within First Nations are much higher than within the general Canadian population.\textsuperscript{18}

**Substance Use and Misuse**

There is also a close connection between mental health and substance use/misuse. This connection is reflected in the RHS 2008/10 study which found that “of First Nations youth who consumed alcohol in the 12 months prior to [the study], more than half (56%) reported frequent binge drinking (once a month or more)—a rate much higher than that observed among youth in the general Canadian population (39%).”\textsuperscript{19} It is however worth noting that the rate of abstinence from alcohol is higher in First Nations adults and youth than in the general Canadian youth population.\textsuperscript{20} The RHS 2008/10 study found that 63.6% of First Nations adults reported heavy drinking on a weekly basis.\textsuperscript{21} In addition, 36.9% of First Nations adults used illicit drugs.\textsuperscript{22}

Substance misuse also plays a contributing factor in suicide. Studies have found that:

The consumption of alcohol and other intoxicating substances is often a contributing factor to suicide for several reasons. Alcohol and other central nervous system depressants can reduce inhibitions, increase impulsivity, and intensify negative emotions (e.g. sadness, depression, anger, and anxiety). They may also decrease a person’s fear of death and an ability to imagine the consequences of their actions. Taken together with other drugs, alcohol can increase the lethality of over-the-counter and prescription medications or drugs that are often used as instruments of suicide. On occasion, people who have been drinking without serious suicidal intent may impulsively attempt suicide while intoxicated.\textsuperscript{23}

Therefore, suicide prevention requires serious consideration of the issue of substance use and misuse.

**First Nations Mental Wellness Continuum**

The First Nations Mental Wellness Continuum (the Continuum) offers a model of comprehensive First Nations mental wellness programming and services by accounting for the diverse determinants of health and within the unique political and jurisdictional context of First Nations in Canada. Beginning in 2012, the Continuum was developed by the AFN, FNIHB and First Nations mental health leaders, utilizing extensive collaboration with First Nations regions and communities themselves. It articulates a determinants model based on the specific needs and context of First Nations. The model identifies

\textsuperscript{17} RHS 2008/10, pg. 201  
\textsuperscript{18} RHS 2008/10, pg. 232  
\textsuperscript{19} RHS 2008/10, pg. 252  
\textsuperscript{20} Ibid. pg. 94, 252  
\textsuperscript{21} Ibid. pg. 98  
\textsuperscript{22} Ibid. pg. 100  
numerous determinants that can either support, or conversely, negatively impact mental wellness. These include employment, education, access to justice and adequate housing, among others. The Continuum identifies the need for a comprehensive continuum of mental wellness programs and services including “health promotion, prevention, community development and education, early identification and intervention, crisis response, coordination of care and care planning, detox, trauma-informed treatment, and, support and aftercare.”

Perhaps the most important aspect of the Continuum is the placement of culture as the foundation with the recognition that it impacts each and every element found within the model. In addition, the centrality of culture in First Nations people’s lives and the impact on mental wellness points to the profound impact of colonialism on First Nations health broadly, and mental wellness specifically.

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Federally-funded Mental Health and Addictions Programming

While federal, provincial and territorial mental wellness programs and services seek to address the mental wellness challenges faced by many First Nations communities, there are gaps between and among these services: they could be better coordinated, and are not always delivered in a culturally safe manner. A patchwork of federally funded First Nations mental health and addictions programming currently exists, though not all communities have these available and some communities do not have any of these programs:

- Brighter Futures (1992), supports a range of health promotion and illness prevention activities;
- Building Healthy Communities (1994), assists First Nations and Inuit communities to develop community-based approaches to mental health crisis management;
- The National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) (2005), seeks to reduce risk factors and promote protective factors in preventing Aboriginal youth suicide;
- The Short Term Crisis Intervention Mental Health Counselling benefit administered under the Non-Insured Health Benefits (NIHB) program, is demand driven and covers the cost of short-term professional mental health crisis counselling;
- The Indian Residential School Resolution Health Support Program (IRS RHSP) (2003), provides mental health, emotional, and cultural supports to eligible former Indian Residential School students and their families;
- The National Native Alcohol and Drug Abuse Program (NNADAP) (1982) and the National Youth Solvent Abuse Program (NYSAP) (1995), supports a national network of treatment centres as well as drug and alcohol prevention services.
- Though not a program, Health Canada also supports ten Mental Wellness Teams in seven regions across the country (Continuum, pg. 26).

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24 First Nations Mental Wellness Continuum, pg. 13.
First Nations Mental Wellness Continuum Framework

**Legend (from center to outer ring)**

- **Four Directions (outcomes)**—Hope, Belonging, Meaning, and Purpose.
- **Community**—Kinship, Clan, Elders, and Community.
- **Populations**—Infants and Children; Youth; Adults; Gender—Men, Fathers and Grandfathers; Gender—Women, Mothers and Grandmothers; Health Care Providers; Community Workers; Seniors; Two-Spirit People and LGBTQ; Families and Communities; Remote and Isolated Communities; Northern Communities; and Individuals in Transition and Away from Reserve.
- **Specific Population Needs**—Intergenerational Impacts of Colonization and Assimilation; People Involved with Care Systems and Institutional Systems; Individuals with Pre-existing Addictions; Individuals with Communicable and Chronic Diseases; Individuals with Co-occurring Mental Health and Addictions Issues; Individuals with Acute Mental Health Concerns; Crisis; and People with Unique Needs.
- **Continuum of Essential Services**—Health Promotion, Prevention, Community Development and Education, Early Identification and Intervention, Crisis Response, Coordination of Care and Care Planning, Denial, Trauma-Informed Treatment, and Support and Aftercare.
- **Partners in Implementation**—Non-governmental Organizations; Provincial and Territorial Government; Federal Government; Regional Entities; Nations; Communities; and Private Industry.
- **Indigenous Social Determinants of Health**—Environmental Stewardship; Social Services; Justice; Education and Lifelong Learning; Language, Heritage, and Culture; Urban and Rural; Land and Resources; Economic Development; Employment; Health Care; and Housing.
- **Key Themes for Mental Wellness**—Community Development, Ownership and Capacity Building; Quality Care Systems and Competent Service Delivery; Collaboration with Partners; and Enhanced Flexible Funding.
- **Culture as Foundation**—Elders, Cultural Practitioners; Kinship, Relationships; Language, Practices; Ceremonies; Knowledge; Land; and Values.
The Continuum Insights and Recommendations

As previously mentioned, the First Nations Mental Wellness Continuum was developed in partnership by FNIBH, AFN and Indigenous mental health leaders. In addition to developing a complex model for First Nations mental wellness program, the Continuum articulated a number of gaps and strengths/weaknesses in the available programs/services provided by federal/provincial/territorial governments/municipal governments. Related to accessibility, quality and system continuity, these insights are as follows:

- Many provincial and territorial services are inaccessible to those living on reserve (or in First Nations communities) due to location or other systems barriers. In order to increase access to services, more community based mental health, addiction and crisis intervention services/programs are needed to facilitate clients obtaining the service.
- Where First Nations have access to provincial and territorial services, these services are often not culturally competent or culturally safe and as such, First Nations need to have input into the services provided and who provides them to ensure their community members are receiving culturally safe services.
- Federal mental wellness programs are often delivered by community-based workers who have received some mental health training but who receive little or no clinical supervision or support.
- Some provincial and territorial service providers offering tertiary level services to First Nations communities have expressed concerns about working with and supervising community-based workers. This contributes to gaps in services and the continuity in care. Their concerns may stem from a lack of understanding about First Nations history, culture, and language.
- Similarly, cultural supports within First Nations communities are not adequately recognized by funders as a key component of mental wellness and, consequently, may be less likely to receive funding.
- There are limited human and financial resources to adequately address First Nations mental wellness needs.
- Considerable divides exist between and among jurisdictions in the delivery of mental wellness related programs and services to First Nations which results in a patchwork or absence of programs and services.
- Federal, provincial, and territorial services tend to operate separately. This lack of integration means there are gaps in the continuum as well as in the continuity of care when moving through systems.
- Both within FNIBH (nationally and regionally) and in communities, there is limited understanding of the flexibilities that already exist within current funding structures that would allow and support First Nations communities to modify programs or direct funding to address community priorities.

These recommendations relate to the NIHB mental health benefit specifically because, to a large extent, the success of the NIHB STCIMHC benefit depends on the successful functioning of allied mental wellness programs and services including those aimed at prevention and long-term care, among others. While the Continuum offers a vital framework for closing gaps in programs/services, it is at a very early
stage when it comes to implementation, however it is crucial that adequate resources exist to facilitate and sustain its implementation.
Appendix A:

INTERIM PROGRAM DIRECTIVE

MENTAL HEALTH SERVICES

PREAMBLE

The Non-Insured Health Benefits program can provide limited funding of last resort for professional mental health treatment for individuals and communities in at risk, crisis situations.

To maintain quality of care and accountability of service, Medical Services Branch, through the Non-Insured health Benefits (NIHB) program, will provide the services of mental health therapists from the disciplines of psychology, psychiatric nursing, and social work, and the services of providers under the supervision of therapists in these disciplines.

As the private therapist from these disciplines is generally working alone, without supervision or any collegial consultation, he/she must be fully qualified and currently registered/licensed with the appropriate provincial college/association to which he/she is professionally accountable. Psychologists should be registered/licensed clinical psychologists in good standing with their provincial association. Regions are encouraged to develop and maintain a list of professional mental health therapists from these allied health disciplines who are knowledgeable of the native culture and who are acceptable to the native community.

It is recognized the provincial system funds professional mental health assessment and therapy services through hospital clinics. NIHB funds should be used only for professional mental health therapy services for those situations in which early intervention, short-term therapy for at-risk, crisis situations is recommended and is not available through other MSB programs or provincially funded facilities.

The service is provided on the basis of a diagnosis and treatment plan which must be prior approved by a mental health professional, preferably a registered/licensed clinical psychologist, designated by the region.

Regions are to develop a system to prior approve treatment plans and to monitor the outcome of therapy so that they can be accountable for cost effectiveness and quality of care. It is recommended that this be done in consultation with a mental health professional.

March 1994
CHAPTER TWO

LISTENING TO CONCERNS:

AFN-FNIHB NIHB JOINT REVIEW STCIMHC BENEFIT FEEDBACK
Sources:

World Café on the STCIMHC Benefit at the AFN Mental Wellness Forum (March 2015)
Meeting Minutes from AFN Chiefs Committee on Health (CCOH)
Meeting Minutes from the National First Nations Health Technicians Network (NFNHTN)
Meeting Minutes from the AFN NIHB Caucus
Notes from the AFN NIHB Regional Roundtables, Spring 2014
Notes from the 2011 AFN Health Forum
AFN Resolutions from Chiefs in Assembly

Background

Part of the Joint Review methodology agreed to by the AFN-FNIHB Joint Review Steering Committee was to review and synthesize all existing internal documents, within our respective organizations, relevant to STCIMHC benefit, as well as provide opportunities for external engagement. The following document synthesizes a number of data sources, including meeting minutes, roundtable sessions and relevant AFN Chiefs-in-Assembly resolutions. From these, a number of recurring themes emerged. These themes centre on community capacity, program communications, cultural responsiveness, administration and operation of the benefit, the intersection with medical transportation, and access to service providers.

A number of recommendations were developed based on what was said, and the common themes that emerged. These will inform the recommendations of the AFN-FNIHB NIHB Joint Review Steering Committee; however, they should not be understood as coming from the Steering Committee itself.

Recommendations

Recommendations: Community Engagement

One common theme is the need for sustained support for community based solutions to mental health issues within First Nations communities, including meaningful engagement with communities on policy advancements or changes. The current model represents a top-down approach which replicates the paternalism of previous policy-making eras. As demonstrated by the development of the First Nations Mental Wellness Continuum Framework, First Nations themselves are best suited to know their unique needs. The need for community engagement relates to an additional recommendation found below which articulates the need for community involvement in validating the cultural competence of enrolled providers administering the STCIMHC benefit.

✓ Recommendation: Any policy changes shall include meaningful engagement with First Nations in order to ensure relevancy to their unique contexts. This may include shared leadership and decision-making with First Nations through a process designed to gather First Nations voices from across the country. Determining the appropriate level of engagement for each potential policy change should be jointly determined by the NIHB program and First Nations partners.
Recommendations: Communication of the STCIMHC Benefit

There is an identified need for information about the STCIMHC benefit to be more accessible to clients, community health professionals and the larger mental wellness community. It was clear that even basic information about the benefit itself is not widely understood. This, in part, explains the low uptake of the benefit. Technology offers the opportunity of dissemination utilizing social media and other internet platforms using plain language. For urban clients, there is an opportunity to disseminate information via networks that include Aboriginal Friendship Centres. For community members that do not have internet access, it is suggested that information about the STCIMHC benefit be disseminated through door to door notices or pamphlets, public meetings and roundtable discussions, information posters in school/band offices, community newspapers, and/or radio stations. When information is being given to community members about the health services that they are entitled to, it is strongly suggested that the language that is used is comprehensive, regional specific and in plain language. This can be achieved through the inclusion of regional First Nations in the development of materials.

✓ Recommendation: Develop a communications strategy to reflect the needs of clients and the realities of communities.

Additionally, clients have found a general lack of clarity around the program guidelines defining what constitutes a “crisis” under this program. A lack of understanding has been identified as a barrier to preventing potential clients from attempting to access the benefit.

✓ Recommendation: NIHB work with First Nations to ensure clear messaging about the benefit guidelines. In addition, ensure NIHB staff in all regions receives clear messaging on the guidelines to ensure consistency in the implementation of the guidelines between clients and across regions.

Additionally, if clients are not approved for the STCIHMC benefit, there is an identified need for resources to help them find alternative mental health supports. People with expressed mental health concerns are not well positioned to seek out treatment within a complex system that includes jurisdictional uncertainties.

✓ Recommendation: NIHB work with other programs within FNIHB, as well as other federal partners such as Aboriginal and Northern Affairs Canada (AANDC) and the Public Health Agency of Canada (PHAC), to support the implementation of the First Nations Mental Wellness Continuum to ensure adequate mental health supports across a continuum of care.

✓ Recommendation: NIHB identify contacts (or Mental Wellness navigators) within each respective region, or develop/support appropriate positions with regional First Nations, that can aid clients in navigating mental wellness programs to ensure clients obtain service in a seamless manner. Further, NIHB ensure that all staff at regional NIHB offices is aware of these contacts.
Recommendations: Cultural Responsiveness

Throughout the documentation, it has been identified that there is a significant need for greater attention to be paid to cultural needs of clients within the STCIMHC benefit. Two major concerns were repeatedly expressed; firstly, clients, communities and leadership are seeking ways to ensure traditional healing practices are supported within the benefit. Secondly, there is a need to ensure that NIHB staff and enrolled providers operate in a culturally competent and culturally safe manner.

The notion of a federal government department creating a formal process to recognize the cultural wisdom and lived experience of First Nations wellness practitioners and Elders is an exceedingly difficult task. NIHB staff is certainly not equipped, nor would it be appropriate for them to evaluate First Nations cultural knowledge. However, First Nations communities and their health leaders are well suited to make determining who can provide culturally safe services within their communities. As such, it is recommended that:

✓ **Recommendation:** Regional NIHB staff work with communities to identify key cultural leaders and mental wellness practitioners within First Nations communities who are equipped to administer traditional/cultural mental wellness counselling.

As noted above, service providers and NIHB staff need to operate in a more culturally safe and culturally competent manner, as well as understand the unique needs of First Nations, including geographic challenges and socio-economic realities, among others. As such, it is recommended that:

✓ **Recommendation:** Regional NIHB staff work with First Nations communities to identify opportunities to meet and participate in cultural awareness activities and relationship building. Where possible, this may be NIHB staff attendance at formal cultural awareness training administered by regional First Nations.

✓ **Recommendation:** That FNIHB and the AFN support the development of a First Nations led strategy, to improve accountability of service providers in delivering culturally safe and competent service.

✓ **Recommendation:** Regional NIHB staff work with First Nations communities to create a position/positions staffed by First Nations individuals with cultural knowledge that can work within the STCIMHC benefit as a resource to ensure cultural competency and cultural safety is ensured.

Recommendations: Administration and Operations

Beyond the STCIMHC benefit policy guidelines themselves, there are numerous concerns that have been highlighted related to the administration and operation of the benefit. Clients are concerned with the inconsistent application of NIHB policies. This insight runs in contrast to the program guidelines of NIHB which state:

- Benefits will be provided based on the judgment of medical professionals, consistent with the best practices of health services delivery and evidence-based standards of
Related to ensuring national consistency in the administration of NIHB benefits, it is recommended that:

✓ **Recommendation:** NIHB undertake periodic and anonymous client service testing in order to better understand client experiences and ensure national consistency in guideline interpretations.

In addition, prior to recent changes to the NIHB STCIMHC benefit, providers were required to provide NIHB with a treatment plan. Despite the change, this long standing practice has resulted in lingering feelings that NIHB is second-guessing the professional opinion of their service providers. This concern persists in many of the benefit areas including pharmacy and dental which continue to have policy analysts review the determinations of health care professionals.

✓ **Recommendation:** NIHB expand communications to service providers, community health staff and clients about recent policy changes to the STCIMHC benefit, including the change which no longer requires the submission of a treatment plan for evaluation by NIHB staff.

Another commonly-heard irritant related to benefit administration includes slow response time when it comes to receiving pre-approvals or reimbursements. The issue of pre-approvals is of particular concern for the STCIMHC benefit, as the design of the benefit is meant to respond to immediate crises. However, First Nations have communicated that crises generally do not happen during business hours, when the NIHB offices are open. Clients have also stated repeatedly that they have left voice messages with NIHB that are never returned. People in crisis need the easiest possible route to accessing services, and the failure to do so may be met with significant and devastating consequences.  

Clients are not accessing services as a result. Therefore, it is recommended that:

✓ **Recommendation:** That NIHB take measures to ensure there is someone to answer calls for STCIMHC services 24 hours per day. Client service testing can be used to ensure the service is responsive to First Nations needs and calls are being returned.

**Recommendations: Access**

**Access: Medical Transportation**

There has been a significant amount of feedback in regards to challenges in accessing the STCIMHC benefit related to the medical transportation (MT) benefit. As noted above, clients have experienced challenges in speaking with NIHB staff in order to procure medical transportation to access STCIMHC benefits. Unless it is administered by the community via contribution agreement (CA), there is very little,

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26 2006.09.06 CCOH

27 The Medical Transportation benefit will be dealt with extensively in a separate portion of the AFN-FNIHB NIHB Joint Review. However, it is necessary here to briefly articulate the interconnection between Medical Transportation and STCIMHC in order to fully explore client challenges and potential remedies.
if anything in the way of after-hours MT. In addition, First Nations living in more urban centres do not have access to MT benefits which can have the effect of limiting their access to STCIMHC service providers.

At the AFN Mental Wellness Forum in March of 2015, a First Nations MT Coordinator shared that MT applications for all benefit areas, including STCIMHC, were being rejected by the regional NIHB office during Christmas time or during sporting tournaments out of fear of abuse of medical transportation. Denying services to First Nations clients due to fear of abuse of the benefit is extremely problematic, paternalistic and dangerous. This issue has contributed to the general lack of trust between First Nations and NIHB program administrators.

Also at the intersection of MT and STCIMHC the guideline states, “travel is to the nearest appropriate health professional or health facility (when health professionals are brought into the community to provide the service, the community facility is considered the nearest appropriate facility).”  

Clients have shared that this policy is particularly challenging when it comes to STCIMHC benefit, given the very intimate and complex nature of the counsellor/client relationship, which can be particularly complex when it comes to First Nations given the legacy of colonialism and Indian Residential Schools. Perhaps more than any other benefit area, there needs to be flexibility in the administration of the MT regulations when it comes to the “nearest provider” rule.

 ✓ **Recommendation:** That the NIHB staff administering MT considers the unique needs to STCIMHC clients when making determinations related to MT predetermination requests.

### Access/ Availability of Service Providers

Despite the overall low uptake of the STCIMHC benefit, there has been significant feedback from clients and First Nations health administrators about challenges in accessing services providers enrolled in the NIHB program who are also accepting assignment. As such it is recommended that:

 ✓ **Recommendation:** NIHB maintain a publicly available real time list of STCIMHC providers currently accepting assignment.

### Continuum of Mental Wellness Programs and Services

There is a great deal of concern around the discontinuity between STCIMHC services and other mental health programs and services, whether they be provincial/territorial or federal. Programs operate in siloes and clients can be lost in the shuffle. At minimum, there is a significant challenge in ensuring follow-up when a client moves from short term crisis counselling to longer term programs. A long-term way in resolving this issue would be the full implementation of the First Nations Mental Wellness Continuum. Further, this would include the renewal of the Indian Residential School Resolution Support Program (IRS RHSP), particularly because this program is viewed by clients as more culturally responsive than the STCIMHC benefit. While it is understood that recommendations related to the First Nations Mental Wellness Continuum is beyond the scope of the AFN-FNIHB NIHB Joint Review, there are a

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28 First Nations and Inuit Health Branch, “Medical Transportation Policy Framework,” (pg. 4).
29 “Accepting assignment” refers to service providers who adhere to the fee schedules provided by NIHB and therefore do not require balance billing to clients.
30 2010.07.27.29: NFNHTN
number of ways to mitigate the challenge of siloed services in the interim. In the immediate term, it is recommended that:

- **Recommendation:** That NIHB conduct regional resource mapping to better understand the gaps within the regions and in order to better determine and explore alternate methods of service delivery.

- **Recommendation:** NIHB work with regional First Nations partners to identify areas for expansion of CAs for the administration of STCIMHC benefits in order to allow communities to better track clients and ensure continuity of care while ensuring protection of client privacy.

At the AFN Mental Wellness Forum there was significant discussion around the need for information sharing between service providers to ensure case coordination. This includes coordination with provincial/territorial systems, hospitals, as well as between mental wellness programs and services offered by the federal government. As such, it is recommended that:

- **Recommendation:** NIHB work with First Nations, as well as service provider experts, to develop a formalized system (i.e. protocols) in order to ensure clients experience coordinated care.

**Conclusion**

As directed by Chiefs in Assembly, the AFN has made mental wellness a priority for many years. Through events and processes like the NIHB Regional Roundtables, at national forums such as the 2015 Mental Wellness Forum and the 2014 NIHB Forum, and through regular accountability structures like the CCOH and NFNHTN, the AFN has garnered significant feedback on First Nations mental wellness programming broadly, and the STCIMHCC benefit specifically, as demonstrated above. This feedback and the recommendations that flow from it, leads into the following chapters which examine the results of the client and provider surveys constructed specifically for the NIHB Joint Review work on STCIMHC benefit.
Appendix B
AFN Mental Wellness Resolutions

Resolution 015/2005: Implementation of a First Nations mental health and wellness strategy with appropriate fiduciary support from the federal government
Resolution 033/2005: Strategy to address the crystal meth epidemic and other emerging addictions
Resolution 036/2005: Support for work on the problem of suicides in First Nations communities nationally
Resolution 065/2006: Securing resources for the implementation of community-based First Nations youth response teams
Resolution 74/2007: Support for First Nations War on Drug Use and Trafficking
Resolution 60/2008: Renewal of First Nations health programs
Resolution 065/2008: Adequacy and Funding of Mental Wellness and Addictions Programs
Resolution 006/2009: Suicide Intervention and Prevention; #030 First Nations Youth Suicide Prevention Requires Youth and Traditional Healers and Elders Leadership
Resolution 060/2010: Ratification of Renewed Program Framework for the National Native Alcohol and Drug Abuse Program (NNADAP) and Youth Solvent Addiction Program (YSAP)
Resolution 057/2011: Support for Akwesasne Leadership in Addressing State of Crisis Regarding Substance Abuse
Resolution 008/2012: Federal Government of Canada Failing to provide Mental Health Services; #030 Support for Embracing Life in Cowichan Tribes
Resolution 055/2012: Mental Wellness as a National Priority
Resolution 057/2012: Support of Suboxone as Medical Detoxification from Opioid Addiction
Resolution 23/2013: Pay Equity Renewal Opportunities for the National Native Alcohol and Drug Abuse Program (NNADAP) workforce in Honouring our Strengths
Resolution 030/2013: Support for a First Nations Mental Wellness Continuum Framework
Resolution 022/2014: Support for the First Nations Mental Wellness Continuum Framework
Resolution 023/2014: Pay Equity Renewal Opportunities (National Native Alcohol and Drug Abuse Program)
Resolution 041/2014: Prescription Drug Abuse Crisis in Manto Sipi Cree Nation
Resolution 026/2015: Urge the Mental Health Commission of Canada to use the First Nations Mental Wellness Continuum Framework in Development of a National Mental Health Action Plan
CHAPTER THREE

JOINT REVIEW OUTREACH:

Results of the First Nations Clients and Communities Outreach Survey

PRODUCED BY THE ASSEMBLY OF FIRST NATIONS
FOR THE AFN-FNIHB NIHB JOINT REVIEW STEERING COMMITTEE
**Respondent Profile**

A total of 94 First Nations clients and community members responded to the outreach online survey dedicated specifically for clients and communities to provide feedback about their experience, or lack thereof, with the Short-Term Crisis Intervention Mental Health Counselling (STCIMHC) Benefit. The majority of responses (57%) are from Ontario, and the second largest province of responses is British Columbia, representing 11% of respondents.

Of the total responses, more than half (62%) of respondents primarily reside off reserve, while 38% of respondents primarily reside on reserve. Furthermore, 45% of respondents reside in urban communities - less than 50 kilometers (km) from a service centre, while 24% of respondents reside in rural communities (more than 50 km from a service centre and with year round access to a road), and 30% of respondents reside in remote communities (no year round access road).

**Mental Wellness Services Beyond NIHB**

For all clients and community member respondents, the average distance to the closest primary care service (general practitioner) is 66 km. The average distance to mental health services is 57.4 km. Additionally, the average distance to a psychiatric unit is 157 km, while the average distance to crisis response services is 70 km away.

**On-Reserve**

Of the individuals that reside on-reserve, 32% of respondents indicated that there are other mental wellness programs (non-NIH) in their community, however only 24% of individuals have accessed these programs.

Of the individuals that do access non-NIH programs that are on-reserve, these programs include:

- Addictions Services
- Moose Cree Health Services
- Peetabeck Health Centre programs and services
- Traditional practitioner(s)
- Traditional Healing programs
- James Bay mental health
- Moose Cree Health Services
- Private services provided by employer for employees and their family
- Oneida Human Services Dept
- FNHA providers in region
• Brighter Futures, NAYSPS, NNADAP, Psychologist, FNIHB therapist
• Mental Health Wellness Team (NAADAP, Mental Health, Traditional Healing Coordinator)

Off-Reserve
Of the individuals that reside off-reserve, 43.5% of respondents indicated that their communities have other mental wellness programs that are not NIHB, however 36% of respondents indicated that they have not accessed these off-reserve mental wellness programs.

Of the individuals that do access non-NIHB programs that are off-reserve, these programs include:
• Timmins Hospital
• Traditional counselling, women's circle, healthy people
• Family service team
• Traditional Healing programs, one on one counselling
• Weeneebayko Area Health Authority Community Mental Health Program
• White buffalo health society
• EAP
• AA, youth programs, yoga for youth at-risk
• Psychosocial intervention services, support to residential school survivors and their families
• Victim services
• Medicine Wheel Wellness Circle at SOAHAC
• Southwest Ontario Aboriginal Health Access Centre
• Referrals from friends to individual counselling

Accessing the Short-Term Crisis Intervention Mental Health Counselling Benefit
The majority (73%) of clients and community members have never accessed the STCIMHC benefit, while only 27% of clients have accessed the benefit at some point. When asked why respondents have not accessed the STCIMHC benefit, 31% of respondents indicated that they have not needed to utilize the benefit, while 27% of individuals have never heard of the benefit and therefore could not use it. Other reasons included: lack of culturally appropriate and safe service providers, challenges in obtaining approval, and being unhappy with program guidelines.

Of the clients and community members that have accessed the STCIMHC benefit, 78% of individuals accessed the benefit within their home province or territory and the average amount of sessions utilized was eight sessions. Of the individuals that accessed the STCIMHC benefit outside their home province or territory, 69% of respondents indicated that they did not face difficulties accessing STCIMHC services, however only 26 individuals responded to this question; therefore it may not be representative of actual experiences. When asked how individuals came to access the STCIMHC benefit, 22% of individuals indicated that they gained access via social worker, 22% of individuals used a NIHB regional office, while 46% of individuals accessed the benefit through other means. Most (83%) respondents did not use medical transportation to utilize the
STCIMHC benefit, and those that did (50%), found accessing medical transportation to be somewhat difficult or very difficult.

When asked if individuals were satisfied with the number of sessions provided to them, 50% of respondents were neither satisfied nor dissatisfied, while 18% of respondents were very dissatisfied with the number of sessions provided. Additionally, when asked if individuals were satisfied with the quality of the services provided to them under the STCIMHC benefit, 32% of respondents were neither satisfied nor dissatisfied with the service they received, while 37% of individuals were either somewhat dissatisfied or very dissatisfied with the services they were provided.

Most individuals (45%) were unable to transition to other supports that met their needs once the NIHB benefit ran out and/or when the crisis situation was resolved, such as with ongoing counselling needs to facilitate recovery. These individuals indicated that they were not able to transition to other supports because they did not know how to access them. Only 15% of respondents were able to transition to other supports, while 27% of respondents indicated that there were no other supports available for them to transition into for additional support.

Clients and community members were asked if they were aware of any measures that have been taken in their region that have helped to improve access to the STCIMHC benefit or other mental health supports, however 86% of respondents did not know of any measures. Of the individuals that were aware of measures, they were listed as:

- 24 hour Emergency Medical Services (EMS) and ambulance transport to local hospital, when required
- Enahtig Mental Health Outreach in Orillia
- Development of Resource Map
- Availability through NIHB
- Support groups, a yearly mental health awareness, and seminars
- Southwestern Ontario Aboriginal Health Access Centre
- Provincially funded (Ministry of Health) Aboriginal Health Access Centres (AHAC)
- Telehealth sessions

Furthermore, 83% of respondents were not aware that the STCIMHC benefit can now be delivered through telehealth.

Below are high level recommendations related to the accessibility of the benefit. Additional details on recommendations that came from the client survey are provided from respondents verbatim in a section that follows entitled “In Their Own Words.”
✓ **Recommendation: NIHB work with First Nations to increase communication around the STCIMHC benefit overall. This may include using social media technologies, as well as direct outreach to existing and potential clients, rather than just service providers, community health centres and band councils.**

✓ **Recommendation: That specific communications be developed related to the availability of tele-mental health services.**

**Cultural Competency, Awareness, and Safety**

Clients and community members were asked if the STCIMHC benefit meets their cultural needs, and 54% of respondents felt that the benefit was not culturally safe or culturally aware.

Clients and community members provided the following reasons as to why the STCIMHC benefit does not meet their cultural needs:

- Counsellors are neither Native or aware of Inter-generational trauma from Residential Schools
- No cultural sensitive training
- Non medicinal
- Native practitioner not funded
- Therapist is non Indigenous and culturally unaware
- Not enough Indigenous counsellors
- Lack of confidentiality and anonymity in close to home paraprofessional service settings
- Those approved usually do not understand Aboriginal Culture, History, or importance of Spiritual Ceremony

What follows are high level recommendations related to the cultural appropriateness of the benefit. Additional details on recommendations that came from the client survey are provided from respondents verbatim in a section that follows entitled “In Their Own Words.”

✓ **Recommendation: That NIHB work with First Nations to develop a process which allows for the recognition of traditional healers who have established and long-standing authority within their communities.**

✓ **Recommendation: That NIHB work with First Nations to determine a process which supports existing and future providers from Western-trained programs in developing cultural safety, trauma-informed practice approaches, harm reduction skills, as well as a deep historical understanding of First Nations health, ongoing colonization, intergenerational trauma, and its effects.**

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![Does the STCIMHC benefit meet cultural needs](image-url)
In Their Own Words

In an open-ended question, clients and community members were asked to provide their feedback for changes they would like to see implemented to the STCIMHC benefit as a means to improve the benefit. The commonly reoccurring themes include the need for better dissemination and communication of the STCIMHC benefit so that clients and community members are aware of what they are entitled to under this benefit area, as well as the necessary steps required to access the benefit. The need for improved communication of the STCIMHC benefit stems from many client and community members being unaware of the existence of this particular benefit. Client and community members also raised numerous concerns about the lack of culturally appropriate and culturally safe service providers as many individuals felt that non-First Nations service providers were unaware of the unique history of First Nations people. The common recommendation from clients and community members is that NIHB should include Elders and Traditional Healers as eligible service providers under this benefit area, as well the necessity for non-First Nations service providers to be better educated and trained in cultural appropriateness. Clients and community members also raised concerns about the operation and administration of the STCIMHC benefit and feel that a more transparent and streamlined process is required, and this is significant within the context of crisis situations.

Responses have been arranged thematically and are provided verbatim below. The intention of presenting the below verbatim narratives is to highlight the imperative for First Nations voices to be included in the discussion of policy changes that directly affect First Nations people and their health. First Nations voices are valuable and valued, therefore the below narratives have not been altered.

Communication of the Benefit

- More communication to the public and First Nations/Inuit on what is available. Don't just rely on distribution of information through the First Nation's administration and service offices. Inform health providers in the service area. Use posters, newspaper ads, radio and social media.
- Publicize at urban FN community centres for off-reserve people to readily access mental health services available to them
- Better communication methods so we even know what the program is about and how we can access it
- Needs to be promoted well but only after the stigma of mental health can be removed in remote communities. This is done through primary prevention: Education
- Make people aware of it! It almost as if people in remote communities are kept in the dark about services because of NIHB wanting to save a buck. People up in remote communities are humans too and they are denied services that come easy to those down south. People are tired of being told no so they give up on trying
- More information to the community, was not aware this service was available
- Increased awareness and promotion of services
- Public education, community outreach, community clinics, broad definition of short term crisis intervention mental health counselling to learn about it
- More sharing of information with Community organizations including schools
• Community Awareness, pamphlets written in both languages English and Cree, workshops, school visits, more visible to the community
• More information and easily available on how to access it, how it works and where service may be provided
• I would like more information provided to my local Friendship Center
• More information, or awareness to isolated communities... to be able to access, make referrals and transportation costs (if covered)
• Make more clients aware in community, improve communication between services in area; provincial/federal (first nation) health programming
• More awareness and access
• Awareness. Didn't know it existed
• Information session in the remote communities
• Awareness that it is available
• Integration of promotional efforts about this short-term crisis benefit with partners - like colleges & universities where Aboriginal students may be in need and not be aware of the service
• Information on programs and services should be made available to all First Nation citizens, no matter where they reside. There should be a number to contact posted in every health centre to inquire and every doctor and nurse should be made aware of these benefits. It should be part of their training. I have no idea where to access devices because I am from the Yukon and live and Calgary and just seem to be forgotten or my needs are swept under the carpet because I do not live in the Yukon. I might as well just be non-first nation for the amount of services or benefits that I receive as a First Nation person. And you can't say move back to your community if you want benefits, because my name has been on the housing list for about 18 years and the home ownership list for over 20 years and I still have not received housing or any other benefits

Cultural Appropriateness
• Programs that support traditional healing I don't want to be handed a prescription I don't want to take pills!
• Have all approved practitioners trained in recognizing symptoms of grief and trauma from genocide....and compelled to have cultural training. As well must have appropriate trauma recovery training like EMDR for crisis relief. CBT IS horrible and makes me worse!!!!
• Cree speaking and traditional practice
• Cultural appropriate training for all workers, trauma informed service delivery
• As needed Native practitioner; more specialized services
• There needs to be more Indigenous short term crisis counsellors approved by NHIB
• More indigenous social workers and inclusion of Elder services
• Increase the number of Aboriginal MSW counsellors in all urban areas; recruit experienced Aboriginal MSW with a solid understanding of cultural safety in urban areas to act as mentors and provide supervision to others
• Providers need to be better trained and the requirements must be improved. Most have a M.Ed in counselling Psychology and their education does not prepare them to be an effective
practitioner versus a provider with a clinical social worker, M.A., or a M.Sc degrees and practicums in excess of 500 hours in accredited internship sites

- More cultural safety training for non-FNMI service providers...more FNMI workers in service organizations
- Better educated rather than trained counsellors with some solid critical cross cultural support potential without the shallow sociologically understood cultural training models like the medicine wheel and the 7 teachings that don't do the cross cultural principles very well for the transformation of clients...stop gap measures lead to more stop gap measures....need a more principled approach
- Take the foreign workers off hard to communicate on the crisis lines even councilors
- More First Nations clinicians that have the skills to provide short-term crisis intervention mental health counselling

**Operation of the Benefit & Access to the Benefit**

- Expand the services to include a broader definition of crisis
- It should be available 24 hours a day seven days a week every day of the year. Finding help on reserve is a joke, everyone passes the problems back and forth until the families of victims step in and take over themselves anyway. Family services and health centre programs are a joke and inaccessible when they are needed
- Each person needs the right kind of help that works for that person, so do your best to approve what works. People’s lives are at stake
- We should not require prior approval. If we have a letter and receipts that show proof that this was needed, we should be allowed to simply submit the receipts for reimbursement.
- It would also be beneficial to find out if retroactive reimbursement is allowed
- I don't believe that STCIMHC is beneficial as it does not meet the needs of the community. As many individuals are dealing with complex intergenerational trauma
- Accessibility and youth help. Suicide intervention
- Long-term trauma counselling
- Streamline services; access and advertise of youth mental health services
- I would like to make my own decision of whom and where to go for help....
- More telehealth centre
- Transportation is always a problem for many people
- More sessions may be helpful - more promotion of the service to make it available
- To begin with, it was easy enough for therapists to make claims for payment but when the services were off loaded to the new BC Aboriginal Health department, the new claim process became a burden and that in addition to paying only 2/3 of going therapy rates, therapists skilled in supporting Aboriginal people have chosen not to accept this form of payment for their services, leaving less knowledgeable professionals available to do this important work. So, in short, make the claim process quick and easy, and increase the rates paid to professionals. And, double the number of sessions.
- Off topic, however there are no harm reduction programs anywhere close to where we reside. Both on and off reserve. I am talking about Manitoulin Island. With increasing rates of hepC and
other blood Bourne illnesses in our area yet there is nothing being done about it. We do not have access to services that may be provided in larger centres (ex. Sudbury). However we fall under their district and jurisdiction when it comes to health care. Yet there is a huge gap in our services, does our health care act not state that all health care should be readily available to all citizens? I hope you get my point, and do something about this, I feel as though we are treated like second class citizens

- Clearer guidelines and more streamlined approval process
- Advise all in/off reserve status Indians
- More sessions, more therapists, more options for therapy (art therapy and not just talk therapy)
- Quicker response time
- Clearer, recognizable (can't find info. on the FNHB website, and equitable service under the Program for accessing Traditional Healers and Elders. The Transportation dollars provided to Healers are not equitable to what the government would pay a psychologist or psychiatrist. We must travel far or ask Healers to travel great distances with little assistance. In my opinion, the work they do is far more established among Aboriginal people than that of many Social Workers but yet they are not equally recognized
- Address high staff turnover in northern Manitoba
- Federal Services need to partner with provincial services and not operate in silos of each other. These services need to be culturally appropriate. Many FNHB service providers are not
- To always have access to counselling and not make patients pay for what the service providers may or may not be doing; we are not responsible for counsellors who double bill or abuse the system, changes made are affecting the providers whom are doing good work and making more paperwork and difficult for client to access services and longer wait time for approval of counselling sessions; also provide crisis counselling clinics so clients don’t have a long wait time, allow counsellors to see clients that maybe high-risk
- I would like the access easy for the therapist (as they are already earning less than they should) and I would prefer the number of sessions to be unlimited as mental health is a treaty right that needs to be honoured
- Transparency
- More sessions, increase the types of treatments available, increase the promotion of the program
CHAPTER FOUR

JOINT REVIEW OUTREACH:

Results of the Service Provider Outreach Survey
and External Submissions

PRODUCED BY THE ASSEMBLY OF FIRST NATIONS
FOR THE AFN-FNIHB NIHB JOINT REVIEW STEERING COMMITTEE
Service Provider Respondent Profile

A total of 130 service providers responded to the outreach online survey dedicated specifically to service providers that deliver the Short-Term Crisis Intervention Mental Health Counselling (STCIMHC) Benefit to First Nations communities and clients. The purpose of the online outreach survey is to allow for service providers to provide their feedback about their experiences with, and administration of, the STCIMHC benefit. Responses from service providers were generally dispersed amongst Ontario (28%), Alberta (24%), and a smaller portion of responses from Quebec (14%) and British Columbia (11%).

Of the total responses, 78% of respondents are registered providers with NIHB for the STCIMHC benefit. Of the 23% of respondents that are not registered providers, their reasons for not being enrolled with NIHB are as follows:

- I used to provide this service but found that there were too few sessions available to safely engage in treatment. Although this is billed as a short term intervention, it is hard to do so safely with people who tend to have child abuse in their histories. Most of my referrals had this history and came from families with intergenerational trauma. I wasn’t aware of it's existence.
- Application process was way too long and detailed - more detailed than getting registered as a psychologist.
- I have been in the past but the NIHB process run by the Federal Government is absolutely horrible and it is impossible to gain access to any funding for counselling for any First Nations person I have tried to help.
- I am unsure how to apply to be a provider.
- I tried to complete this registration, but I could never get certain questions answered and then never heard back when I called, so honestly, I gave up.

Feedback was also provided by counselling and psychotherapy professionals who, in most provinces/territories, were deemed ineligible to provide STCIMHC services following an NIHB policy change in February 2015. Now NIHB will primarily (with some rare exceptions) only enroll those mental health counselling providers registered with a provincial/territorial legislated professional regulatory body and eligible for independent practice in the province/territory in which the service is being provided. Such a professional body for counselling/psychotherapy professionals only exist in Nova Scotia, Ontario and Quebec. Further, the written submission from the Canadian Counselling and Psychotherapy Association (CCPA) notes:

In the absence of provincial regulation of the counselling/psychotherapy profession across the country, CCPA has offered for 30 years a nationally recognized certification process through which members can obtain the designation of Canadian Certified Counsellor (CCC). This designation identifies to the public those counsellors whom CCPA recognizes as achieving the national standard for counselling/psychotherapy practice in
Canada. Certification through CCPA requires a Master’s degree in counselling, psychotherapy or a counselling-related field, and an extensive supervised field practicum. Because of the variable statutory regulation of the profession across provinces and territories, CCPA has held high standards for Canada. It has an established Code of Ethics, Standards of Practice, Complaints Procedures, and a Continuing Education system.

Therefore, it has been recommended that:

- **Recommendation:** Canadian Certified Counsellors (CCCs) in provinces and territories which have not regulated the profession of counselling/psychotherapy be immediately reinstated as eligible service providers of the Short Term Crisis Intervention Mental Health Counselling benefit.

See appendix C for a full list of responses provided from service providers related to enrollment in the NIHB STCIMHC program. The full CCPA written submission can be viewed in Appendix J.

**Service to First Nations Clients and Communities**

Most (90%) of respondents do not serve a First Nations community for the STCIMHC benefit under a contribution agreement, which was described as being hired by the band/tribal council rather than individual clients billing to NIHB. The average amount of STCIMHC clients that service providers serve annually is 91 clients; there was a range from one client served annually to 3500 clients served annually. Service providers estimate that the majority (51.8%) of on-reserve clients primarily comes from urban communities (less than 50km from a service centre), 38.6% come from rural communities (more than 50 km from a service centre), 2.6% are from remote communities (no year round access road), and nearly 8% of respondents were unsure of where their on-reserve clients come from. Furthermore, 45% of service providers estimate that 75%-100% of their clients reside off-reserve. Additionally, 63% of service providers that provide service under the STCIMHC benefit also serve First Nations people through other programs, mainly the Indian Residential Schools Resolution Health Support Program (IRSRHSP).

**Experiences with administering the STCIMHC benefit**

Keeping STCIMHC benefit guidelines and administration in mind, service providers were asked how program documentation required under the STCIMHC benefit compares with other programs that they work with – 68% of respondents indicated that documentation is comparable or satisfactory to other programs, and 32% of respondents indicated that program documentation needs improvement because it is complicated, cumbersome, or time consuming. In regards to the enrollment process, 70% of respondents found the enrollment process to be comparable to other programs, while 30% of respondents found the enrollment process to be more onerous or time consuming. Half (50%) of service providers indicated that the general administration process of the STCIMCH benefit is difficult and onerous, while 50% of service providers indicated that administration processes are similar or comparable to other programs they provide service for. A significant amount of service providers (56%) found the reimbursement process to be worse in comparison to other programs as many service
providers indicate that the process is slow and inefficient. When asked about NIHB’s communication on program changes, 40% of service providers indicated that communication is very poor and often feel that changes to the STCIMHC benefit are not effectively communicated to them.

Pre-Approvals and Access
For the prior approvals process, 66% of respondents found this to be similar or comparable to other programs, while 34% of respondents found the prior approval process to be slower and more cumbersome in comparison to other programs.

Service providers were asked if it is simple/easy for them to obtain approval to treat First Nations clients under the STCIMHC benefit – 68% of service providers indicated that approval is easy. Of the 31% of service providers that did not find the approval process to be simple/easy, their reasons included difficulties with the administration aspects, such as paper work and processing times, difficulty communicating with regional staff, as well as finding the STCIMHC policy to be problematic.

Service providers were also asked how the prior approval process and client access could be improved. There was a great depth of feedback, some of which included:

- Rely more on the professional expertise of the providers. Require briefer assessments & treatment plans
- That it should be decentralized and moved out of Ottawa. They need to partner with local services. Their administration staff seems to be not only incompetent but mean-spirited.
- Train the personnel on trauma and genocide symptomology, complex grief and reactivity, shame and abandonment symptoms....
- Make the request for therapy forms simple, straightforward and based on clinical knowledge
- Limiting the time allowed to 20 weeks is unrealistic; identifying the planned end date is almost impossible. The whole idea of applying the prior approval process and limiting number of sessions to community clients does NOT make sense!

What follows are high level recommendations related to the pre-approvals process. Additional details on recommendations that came from the service providers are provided verbatim in Appendix D and E.

- **Recommendation: That NIHB work with First Nations and service providers to create timeline standards for administrative functions such as pre-approvals and payment.**

- **Recommendation: That NIHB work with service providers to utilize modern technology (online) to resolve delays in administrative processes and streamline services to clients.**

Fee Schedules
Responses indicate that generally the fee schedules of the STCIMHC benefit does not substantially impact service provider’s decision to provide service to First Nations clients under NIHB. For example, 54% of service providers indicated that the current fee schedules does not impact their decision to serve
NIHB clients. However, this does not mean that service providers are necessarily satisfied with fee schedules, but rather, that fee schedules are only part of the deliberation over serving NIHB clients.

The feedback that service providers provided is as follows:

- I serve NIHB clients on part time basis. Fee schedule is below recommended rate for registered psychologists.
- I am a privileged person and while the fees are low and I would prefer them to be the same as my lowest rate, for others I cannot see enforcing more dollar dominance and prevent access, and I know that people cannot afford extra. Those that can are far more likely to bring food, bead work, produce etc. if they wish to. I think 100 per session would be better, especially as we often need longer sessions.
- There are no other psychological services available to this population; therefore I am willing to take a lower fee.
- I service FN clients because they require assistance, I do not feel adequately compensated, and I will continue to provide service because that is the right thing to do.

These responses indicate that providers often take in NIHB clients, despite lower rates out of feelings of obligation to a high needs population. This is likely not the best way to ensure a consistent and reliable inventory of enrolled service providers. As such it is recommended that:

- Recommendation: That NIHB align regional fee schedules with the corresponding provincial/territorial professional bodies to ensure compensation is not deterring providers from serving NIHB clients.

Numerous service providers also noted that the program’s policy to not cover “no shows” is problematic, particularly given the context of crisis counselling. For example, one responded noted, “Clients often miss appointments due to crisis situations; missed appointments are not billable. Not a financially viable process.” Therefore it is recommended:

- Recommendation: That NIHB provide STCIMHC service providers with compensation, commensurate with other similar third party programs, for “no shows”.

See Appendix F for a full list of responses provided from service providers on the issue of compensation.

Jurisdictional Issues
Most (76%) service providers do not serve NIHB clients from other jurisdictions – across provincial or territorial borders – however, of the service providers that do provide service to individuals from other jurisdictions, 23.5% of service providers indicated that they have experienced challenges in serving NIHB clients from out of province/territory, their reasons are as followed:

- Currently NIHB clients must see the closest therapist to them so I cannot see clients from other provinces or territories
- Communication is POOR between provincial and federal (First Nation) health services
- Disconnection from culture, which is not replaced by local indigenous cultures which may be very different
See Appendix G for a full list of responses provided from service providers.

Continuum of Care
Perhaps the most notable results of the service provider survey centres on the relationship of the STCIMHC benefit to a mental wellness continuum of care. Most (72%) of service providers indicated that they felt that the STCIMHC benefit does not align with other mental health programs to ensure a continuum of services – for example, crisis treatment leading to long term treatment. Some of the reasons provided are as follows:

- Generally clients use this service because other services aren’t available to them. As a result, it is hard to refer the client on to other services. They develop a relationship of trust but can’t fully address issues. While crises maybe addressed, this service doesn’t allow clients to make meaningful changes to prevent further crises.
- Few referral sources available; sometimes blatant racism
- It makes no sense to transfer clients to another practitioner for long term counselling if clients cannot afford to pay for sessions.
- For a few clients 15 sessions is adequate; continuum of services is NOT ADEQUATE for those in need of long term treatment. Referring them to Cape Breton Regional Hospital Mental Health Services if a farce. Long waiting lists, even when referred at the beginning of the original sessions. The provinces mental health system fails us terribly. You may get seen one month later!

See Appendix G for a full list of verbatim responses provided from service providers on the continuum of care.

Service providers were also asked if they are able to easily transition clients to other supports that meet client’s needs once the STCIMHC benefit runs out/crisis situation is resolved (ex. ongoing counselling needs to facilitate recovery) – 82% of service providers indicated that they are not able to accomplish an easy transition. Service providers provided the following reasons for the difficulty in transitioning clients to other supports:

- Clients are not willing to switch over they like to continue with same service provider. It is a question of building trustworthy relationship.
- No, because they are not available within the community. Provincial supports off reserve often have long waitlists, even if the clients could get to them. A trip "to town" cost $50 and clients do not have adequate funds to pay
- Community based organizations are already stretched thin and tend to offer only short term models, which means that clients are bounced around and have a hard time actually resolving issues, especially trauma.

See Appendix H for a full list of verbatim responses provided from service providers on transitioning clients.
Very clearly, a large majority of service providers felt that the STCIMHC benefit does not align with a continuum of mental health/wellness services. As such, it is recommended:

- Recommendation: That NIHB work with other program areas within FNIHB, the First Nations Mental Wellness Continuum Implementation Team, as well as First Nations themselves, to ensure a continuum of mental health services for First Nations clients.

- Recommendation: That until a robust First Nations mental wellness continuum exists across the country, the NIHB program provide support for STCIMHC service providers in seeking out and transitioning clients to longer term mental wellness services.

Service providers were also asked how well they feel that the STCIMHC benefit guidelines meet their clients’ needs. The responses were varied, however, less than one-quarter (23%) of respondents felt that clients’ needs are being met through the STCIMHC benefit guidelines, while 56% of respondents felt that clients’ needs were being poorly met or very poorly met.

Service providers were also given the opportunity to provide any additional comments in regards to the benefit administration within an “other” category, their comments are as follows:

- The program is in contradiction with Health Canada’s efforts at establishing Health Centre’s on reserves.
- In Atlantic Canada approvals are completed by a physician as opposed to a clinical therapist
- Was advised that I could not advertise my NIHB provider status and only share if asked by clients. This does not help enhance access to clients.
- It is well run program
- Issue is connecting with clients that require service
- I do not think short-term crisis intervention is ever short-term with the devastation wrought on the peoples by the dominant culture and poverty and transportation for help is also an issue
- Certainly not client-centered
- Prospective clients need to be provided with list of registered service providers.
- Without a doubt, the worst Federal program I have ever dealt with
- Fee is low for psychologists only $125.00/hour
- Have always appreciated that any questions or problems were quickly resolved by a phone call
- Fees for service providers are less than the private sector
- Hard to get through to on the phone
- Forms are redundant and not user-friendly. Accessibility of the forms in PDF form....that we could download, please.
No reimbursement for no-shows and late cancellations is a major downside to this program.
Increase of 12 to 15 sessions very helpful to client
Current approval process asks for Registered Psychologist to plan for, be aware of, refer to and transition to community based mental health services that are culturally sensitive. Personal experience and reports of clients are these are either religious based, not at the level of training and regulation of Registered Psychologist and insufficient to meet the complex needs that underlie more than just the crisis of First Nations clientele. Support in providing direction on the appropriate referrals of (trained regulated mental health community based services that are culturally sensitive) is beyond the scope of the independent Registered Psychologist. These resources should be investigated and monitored by FNIBH and lists provided for registered Psychologists to transition clients to.
The new program is fine but does not allow for me to have longer session when required
Most recent changes are much more efficient in all areas above
I am very satisfied that when I ask for more sessions there has not been a problem. I only ask if the client asks and is in need.
Therapists need ID badges to show communities who they are.
Wholistic teams - naturopaths nutritionists chiropractors, Physio& massage therapists - fitness & life coaches; yoga teachers, herbalists; family reconstruction addictions councilors
They wait 3 to 4 months before I realize I’m not getting paid. It takes them that long to return paperwork at times
I feel that FN health benefits are difficult for the individual to access it is hard enough to become aware that you need help, and to have a cumbersome process is unethical.
No-Shows should have a $10. Admin fee
Client verification forms and invoice forms are redundant; they also don’t work online with windows 8.1 and cannot be saved.
Poor telephone communication in last 2 years

Additionally, service providers were asked about their awareness of recent changes to the STCIMCH benefit guidelines (respondents had the ability to select multiple answers). Most service providers were aware of guidelines that govern the standardized number of sessions and that treatment plans no longer required by NIHB for prior approval (68.6% and 66% respectively), however less than half (46%) of service providers were aware of the availability of access to counselling through telehealth. Additionally, 28% of service providers indicated that they felt that they were not aware of recent changes to STCIMCH benefit guidelines.

Areas of Improvement: Identified by Service Providers
As an additional means of obtaining feedback from service providers, the outreach survey asked service providers to identify any specific changes they would like to see implemented to the STCIMCH benefit as a means to improve this particular benefit area. Additionally, service providers were given the opportunity to provide narrative reports about their experiences with the STCIMCH through a written external submission. Service providers have valuable insight into the operation of the STCIMCH benefit as they work firsthand with the NIHB program, as well, the medical opinion of service providers is also respected, and therefore their responses are provided verbatim in Appendix J and K.

A common theme that arose from services providers’ feedback in the outreach survey as well as the external written submission is that First Nations clients need more sessions to be available to them and
that the allotment of sessions needs to be more flexible. Service providers suggest that more sessions need to be available because there is a genuine concern for the mental wellness of First Nations people. Many service providers acknowledge that First Nations people have significant histories of trauma and compounded mental health issues that requires more flexible treatment opportunities beyond the crisis situation. This is especially situated amongst the reality that service providers establish trust during initial sessions only to discontinue service with clients once treatment sessions have expired.
Appendix C

Are you a registered provider with NIHB Short Term Crisis Intervention Mental Health Counselling? – Why Not?

- I was, I have not renewed my police check so may no longer be registered.
- I have been discouraged from trying to include this as part of private practice work because the pay for this service is lower and there is not adequate compensation for clients who cancel or do not show up for sessions
- I am a Registered Psychologist and Clinical Supervisor in the Dept. of Health and Social Services, in Family and Children's Services branch of the Government of Yukon.
- I am a registered health provider with FNIHB, but I have had no clients thru NIHB since the short-term program started
- I wasn’t aware of its existence
- Sent in all documentation and never heard from anyone!!
- I was registered for years but I stopped renewing it.
- I was not aware of this. I see First Nations individuals as a psychologist under supervision with an Aboriginal Psychologist.
- Application process was way too long and detailed - more detailed than getting registered as a psychologist.
- I am unsure how to apply to be a provider.
- I used to provide this service but found that there were too few sessions available to safely engage in treatment. Although this is billed as a short term intervention, it is hard to do so safely with people who tend to have child abuse in their histories. Most of my referrals had this history and came from families with intergenerational trauma.
- I have been in the past but the NIHB process run by the Federal Government is absolutely horrible and it is impossible to gain access to any funding for counselling for any First Nations person I have tried to help.
- I tried to complete this registration, but I could never get certain questions answered and then never heard back when I called, so honestly, I gave up.
- Criteria in Canada for providing services to FN people through MSB has historically been problematic and so I just have avoided registering as a provider even though I have extensive experience working with FN. I used to provide services directly through a Tribal Council but don’t at the present time, so I will answer no to the next question. Some of my clients crossed jurisdictions but eventually that was not allowed because the provine (SK) complained. In my experience jurisdictional conflicts have always detracted from proper services to FNs.
- I was but let it lapse.
- Didn’t know about it or how to register
- I moved from Alberta, where I was a service provider for NIHB for a few years because I was able to provide the required First Nations references. In Alberta I was a psychologist with the College, but only had a Master’s degree through Loma Linda University. Once I moved to BC I was called a Registered Clinical Counsellor and could not see First Nations unless I found a psychologist to supervise me. Now that I have met the requirements to work under the banner of the College of Psychologists BC, I would be able to see First Nations clients; however, I require references from First Nations peoples to do so, and do not have that.
- Never heard of it
- I had no awareness of this resource.
- Not sure of the question, however, we have a visiting Psychologist who bills directly to Health Canada
- Community Health Nurse, (BSCN), mental health nurse as part of mental wellness team (in progress)
- My area is nursing
Appendix D
Is it simple/easy to get approval for the Short Term Crisis Intervention Mental Health Counselling benefit to treat a First Nations client utilizing NIHB? – Why/Why Not?

- Long cumbersome process
- Slow, cumbersome, many changes
- Lack of understanding of the depth of clinical issues affecting First Nations' clientele.
- It is difficult to get a response when required. Response times are slow. Even with approved sessions I have had extreme difficulty getting paid for submitted sessions to the point that I no longer will see patients through this program. It is inaccessible for clients and service providers.
- As long as one follows the provided guidelines and very helpful case examples
- Criteria are straightforward, forms easy to complete
- Not sure. Not when I cannot disclose service unless asked.
- Others have told me that due to Social Service being available on the Reserve; it is harder to get approval.
- Too much red tape, available resources, the approval process made elsewhere, limited financial assistance, do not cover out of province,
- communication is very POOR, there is no follow up and processes take forever
- Haven’t been asked to counsel for short term mental health.
- Our services are free and all costs are covered by the Government of Yukon
- Quite a few criteria have to be met for the client to qualify for treatment funding.
- I have not used the new process, but politics, changes, and the demands of the funders for NIHB made it difficult for the administrators to get funding for all that was needed.
- Sent a few emails first to generic contact from INAC website - no one seemed to know what to do. Found contact number for person in Whitehorse that covers my area. Did not hear back for months. when did hear back only sent me one email asking if I would travel - when asked her to call me about what meant about travel I never received call or email back.
- Simple, but long
- In this case the approval was very fast
- I have not had any clients under the new program. Before it was cumbersome and lengthy.
- My initial impression of the new system if positive, now that I have figured out how to fill out the form, as at first I was confusing second crisis with extension of the first.
- The system seems designed to deny or delay any reasonable access to counselling for FN people. It is disgusting.
- I couldn’t even get a straight answer to get registered, so I could not get approvals.
- Rigid around terms of the crisis or mental health concern.
- off reserve First Nation members are not familiar with services and frequently do not identify themselves as First Nations
- Straightforward
- takes a while
- I feel people get missed if they are living on reserve and do not have adequate resources on reserve; also people who are First Nations do not get services if they do not have a status number
- References from First Nations people are required.
- The turnaround between handing in the paperwork and hearing about approval is about a week.
- I have a good relationship with the approval team.
- Process is in place - follow the guideline and they report back efficiently
- Usually it is easy enough, and quick enough. But I also want to say no, because of the issue of crisis vs. long term problem. After I have seen a client for a couple of different crises, long term issues surface, and the client does not want to be shifted to other services.
- It is easy to get initial approval at this point; however, getting approval for further sessions probably not so easy.
- New forms do not allow for therapeutic experience and information to be incorporated. The therapist must fit the program time frames of the forms versus being able to use their trained therapeutic judgment on service delivery.
- I have only requested one approval in recent months. And it turned out to be smooth and easy.
- For initial approval.
- Faxing in approval and receiving a response within 10 days maximum.
- However, the time to get approval appears to be much longer than usual.
- Yes, as long as it is the client's first application for counselling. Otherwise, difficult.
- The IRS question. Hard to get birthdates and names when they affirm that a relative was an IRS survivor.
- not known at this time with the new program and lack of feedback.
- The paper work takes a lot of my time which i am not reimbursed for.
- Often clients in urgent situations, as front line psychologist, no other programs readily available.
- Faxing is not used as much so it is a taxing process. It would be nice if I could email. It's not that bad though.
- don't know.
- Have been aware.
- Somewhat more tedious and longer wait for approvals.
- I am not sure.
- Like all above MUST be a more automated method of coverage.
- a lot of paper work for clients to fill out and they get tired of the process so they stop.
- a phone call away.
- they have misinformation it has taken weeks to get answers and a client passed then I rec'd her approval.
- It can take a month.
- with the exception of the pints made in question #10
- The challenge is that the vast majority of "Short Term Crisis" clients are not indeed short term. By the time approval if in place the immediate crisis is often over and the core psychological impairments that contributed to the crisis remain and are not amenable to short term intervention.
- Ne process is much easier and streamlined.
- There are time limitations and it appears to be a onetime only counselling model.
- few rejections.
- many hurdles and when a client is in crisis and starts therapy I would not make them wait for funding approval.
- Je ne sais pas ça reste à voir avec le nouveau formulaire... Est-ce que le nouveau formulaire a pour but de diminuer les services psychologiques fournis? Seule l'expérience des prochaines années avec ce nouveau formulaire nous le dira.
- Réponses rapides.
- On ne m'a pas bien expliqué le programme.
- Compréhension et ouverture des administrateurs.
- facile en utilisant le numéro de bande.
- JUSQU'À PRÉSENT LE PROCESSUS A ÉTÉ FACILE ET ACCESSIBLE.
Appendix E

How could the prior approval process and client access be improved?

- The new procedures allowing an assessment session prior to approval is a major improvement
- Less administrative
- Rely more on the professional expertise of the providers. Require briefer assessments & treatment plans.
- Given that Health Canada has promoted the presence of Health Centres on reserves, the administrative process could be left to them to inform the community members. A small information sheet about the program could be distributed or given to community members. Also can be given by the service provider at the end of the first or second session. An example is the information sheet distributed by Health Canada’s EAP program.
- Streamlined, online, less duplication
- By having qualified clinicians approve the initial approval and extension as applicable.
- Have staff who answer phones and correspondence in a timely manner
- Make it faster.
- The new forms are a very major improvement! Much faster for me for prior approval requests; response time and reimbursement time are also much improved.
- Children in CAS care who are not receiving treatment funded by CAS should remain eligible for FNIB funding.
- Advertisements and more awareness re: programs available for clients - Modern and traditional service options – such as online counseling
- Not requiring a client/parent/guardian signature on the prior approval form. Sometimes the parent/guardian is not accessible or the signature if forgotten, yet it's on the apt. confirmation sheet
- It is simple.
- Due to disconnect with referrals, not an issue to date
- I wish the process were faster - ideally, online, but if not online then accepted by e-mail or even fax. It seems absurd to have to mail hard copies of the invoices in.
- Health Provider and client process the paper work for prior approval, Advertise the services, step by step process
- Communication between provincial and federal (first nation) is POOR - needs improvement
- Recognize that each case is not the same as next - cannot treat all first nation communities the same and expect same approach will work
- Seemed fine for me.
- OK as is
- That clients would know it is available to them.
- There are no barriers to accessing our services
- One note about FNIB access more generally - I have had several clients decline to identify themselves as IRS survivors. They explained it is a separate process & they were not anywhere near ready to tackle that aspect of their healing.
- Communication requires improvement. Appears the am staff are overworked.
- Reduce streamline billing process, Rather than paperwork make billing more of an online system
- Because I saw only a few native clients a year it was not worth the cost and time for me to keep meeting the registration requirements as a provider for NIHB (i.e., yearly police check), so I did not renew my registration and stopped seeing native clients. This was a very difficult decision and saddened me that I felt I had to do this.
• Ours has been but don't know how it is working as I have not taken on any NIHB clients recently.
• Better coordinators - checking in with clients to let them know what available and communication with providers as to process for clients to access it.
• Maybe it'll be easier if psychologist could have an authorization by phone.
• have an initial screening and referrals to other services available from the initial contact with FNHB
• The problem was registering as a provider; too much documentation was required, and the requirements were not communicated clearly at the outset. I do not understand why being registered as psychologist in Ontario was not sufficient for approval.
• Consistently, more sessions are required. There are almost no low fee counselling options in this rural area, and clients cannot afford to pay fees. Therefore, when funding ends, so does treatment. Consistently treatment ends prematurely. Having a longer term therapy option is imperative to this population.
• Not sure, as new system too new to identify possible long-term problems.
• That should be decentralized and moved out of Ottawa. They need to partner with local services. Their administration staff seems to be not only incompetent but mean-spirited.
• have enough staff to return calls/e-mails
• Train the personnel on trauma and genocide symptomology, complex grief and reactivity, shame and abandonment symptoms.... Make the request for therapy forms simple, straightforward and based on clinical knowledge (see above)
• Give access that is more flexible to client need Rural clients who can only access with limited frequency are disadvantaged by the 6 month or 20 week time limit Enrolment form does not fit the needs or service use profile of rural clients
• Providing information to a members of, First Nations
• Have not applied for funding through new approval process, but the form appears to be simple and easy to use.
• I think the recent changes made this much easier.
• quicker turn around, better billing process
• Mire advertising through cpa direct to registrants re the process
• allow First Nations people to get served if they do not have a status number and if they are on reserve and cannot get adequate services on Reserve
• I would prefer the forms all be on one page, the mailing address listed, and coloured coded between short term health and IRS
• The three references required to be a service provider would be someone who is a therapist, but not necessarily First Nations. It could be someone who is already providing service to First Nations and who might know that I am respectful of the life-ways and have knowledge of the past and present experiences of First Nations people.
• Less paperwork
• Consistent/standardized turn-around time after submitting approvals.
• Quicker approval
• Apply a minimum turnaround time
• Forms: One form for assessment approval, different form for counselling approval, another form for extensions instead of submitting same form three times
• So far, I have experienced no problems.
• Better communication with the agent receiving the request, direct communication when there are problems, phone versus e-mail.
• It is confusing when asked if there are other service providers in the community because in urban centers there always are, but who may not provide the modality the client is looking for.
Also, many of these clients would benefit from consistent, longer term therapy, and the short term model puts one in a bind in terms of what is best for the client vs. limits of the program.

- I like the system as it is. It is fairly straightforward
- After I have seen a client for a couple of different crises, long term issues surface, and the client does not want to be shifted to other services. I have been told by the approval people that I have to send these individuals to someone else, and the client refuses. This means that I end up seeing the person pro bono, or the individual does not get service. I don't believe it is right to develop a relationship with someone, often a difficult accomplishment, and then have to send the person elsewhere, to begin again, just because of the definition of crisis vs. long term.
- I believe the recent changes have been very good. It has med the prior approval process more efficient. The one form for both pgms. vey helpful to service provider.
- Limiting the time allowed to 20 weeks is unrealistic; identifying the planned end date is almost impossible. The whole idea of applying the prior approval process and limiting number of sessions to community clients does NOT make sense!
- Perhaps consultation with mental health providers that provided broader checklists from their experience of what the treatment issues are that clients present with and what they know the recommended treatment plans are, more like what are used in employee assistance programs
- I will have more comment on when we are further along in this new process
- Initially make sure I can work more hours and days with my clients and get paid before it get approval. I average two hours a session with my clients and only get paid for one hour
- Shorten the wait time to a week to ten days like it used to be
- Briefer forms, larger and more readable print. Clients currently have difficulty filling out their sections
- Consultations with service providers should have been included before the massive changes that are now in place. There is still too much uncertainty in the program.
- Clients need access to a list of approved providers. If the maximum is 15 sessions then the need for all the paperwork is not necessary. The paperwork and info pertaining to the client makes sense if approving for longer term work
- It seems to work well as it is.
- When a client come from a longer distance it makes more clinical sense to see this person for a longer time or more frequent time how to build this into the program? By that I mean for 1.5 hrs. or 2-hour sessions before they have to return and go home.
- Most recent changes are excellent
- Forms could be more user friendly
- Use the VA system that is online where I can enter data and someone emails me back with the approval.
- Promote it with practitioners?
- To possibly allow a grace period such as 2-3 sessions to start with client, until approval. The professional will have more time to complete a proper assessment and not rush to get approval, as it depends on each client’s crisis. Sometimes the client needs the service immediately depending on crisis and this will help to diminish some anxieties of the client and aid in getting through the first 48-72 hours of the crisis
- If the process was clearly defined and shared with all professional service providers, ie: nurses, it may be helpful
- Never had a problem with these processes
- I’m new to this area, I don’t have any recommendations right now, other than have an NIHN First Nation coordinator in our local lhins??
They tell me I can’t see client until I get approval. I have clients who need immediately then I’m told I won’t get paid if I do this. I told them this is why it’s called a crisis this is immediate service I should have the right to start working immediately.

Immediate approval, trust your service providers ability to make an accurate assessment or get new service providers.

I think it’s an easy process and the administration team is very fast at answering any question that could arise during the process.

If there is a crisis, a true urgent need, approval must occur almost immediately while the crisis is in place and prior to it either escalating or being over.

Unfortunately the restriction to a five month approval window is extremely limiting because clients don’t have the means to schedule weekly. In addition, we aren’t as able to serve the high number of clients requiring services due to this limitation. Therefore, we have a long waiting list for services for NIHB clients.

Client may access service more than once, as other issues/crises surface.

create an online secure web portal

Reduce information redundancy. Use less paper. Could be all on one sheet. Return to one sheet billing, rather than two.

En maintenant la demande comme avant: écrire une demande écrite décrivant la problématique afin de pouvoir discuter de l'approbation avec le psychologue responsable de Santé Canada, qui lui juge de la durée du suivi nécessaire.

Pas d'entente dans la communauté.

Faire parvenir l'acceptation et l'entente par la poste, mais signification par courriel en même temps. Diminution du temps d'attente.

Que les fournisseurs connaissent mieux le programme. Que les usagers en connaissent l'existence et les possibilités de services pour eux.

Pouvoir transmettre toute documentation par courriel.

Donner accès a plus de rencontres lorsque le lien est établi et qu'il y a une évolution significative du client.

j'AI DÉCOUVERT RÉCEMMENT CE PROGRAMME ET QUELQUES CLIENTS ONT PU EN BÉNÉFICIER. LE SERVICE ET LES FOURNISSEURS NE SONT PAS CONNUS, DONC JE N'A PAS BEAUCOUP DE RÉFÉRENCES ET J'AIME BIEN TRAVAILLER AVEC CETTE POPULATION.
Appendix F

Do the fee schedules impact your decision to serve NIHB clients?

**Fees are too low**

- The provincial psychologists association recommends 180 per hour; FNIHB only pays 130. This is a big problem for a private practitioner especially when I will never run out of clients who can pay 180. Interestingly, the RCMP and most insurance companies pay 180 and now Veterans Affairs has increased their payment to 195. Why are First Nations peoples not seen as deserving high quality care?
- Every year we should get a raise
- I serve NIHB clients on part time basis. Fee schedule is below recommended rate for registered psychologists.
- Fee is not bad although there should be periodic increases. I've been getting the same fee for 10 years
- The rates are lower than in private practice
- because it is only a fraction of the recommended fee schedule
- Fees are lower than community standards but for the few clients I am willing to accept the reduced rate.
- The rate is less than my hourly rate by 10 per hour and the length of treatment is shorter than when parents contract my services for their children
- The fees are much lower than hour set hourly rates
- I would take on more FNIHB clients if I wasn't making $50 less per hour to see them than I do with other clients.
- under rated for Psychologists
- I am a privileged person and while the fees are low and I would prefer them to be the same as my lowest rate for others I cannot see enforcing more dollar dominance and prevent access, and I know that people cannot afford extra. Those that can are far more likely to bring food, bead work, produce etc. if they wish to. I think 100 per session would be better, especially as we often need longer sessions.
- don't pay enough
- The fees paid are significantly lower than my private practice rate and significantly lower than other governmental health service plans. Here is no differentiation between fees for psychologists’ vs other mental health providers, and the fees differ from province to province.
- They do not pay psychologists enough money
- I was asked what my hourly rate was, and then I was told what I would be paid per session. I think they should post the fee schedule and not bother with asking what I charge since it does not matter anyway
- Fees do not match by far the recommended professional standards
- The fees paid for psychologists are about 1/3 of what they should be.
- Fees actually are OK but you cannot get access to approval so it is moot.
- I'm First Nations ancestry and believe in serving my people. However I know I could earn a lot more if I did not serve NIHB clients
- There has been no negotiation or change in my allowed fees in 20 years and current fees do not reflect the effects of inflation or market fee demand. As professionals we are currently subsidizing the program
- Very low fee schedules, reports are poorly paid, payment errors are difficult to correct.
- Fees always have an impact and usually are too low to cover expenses properly. Also, limiting session numbers is problematic because people sometimes need more. Everyone is different.
• Very low, only pay 60% of provincial fee. so can only serve so many to keep a practice running
• I believe the professions of service providers should reflect sufficient monetary value given the standards and regulation requirements set out by governing bodies.
• Fees are very low in comparison with those received for other clients
• As there are limits to the service I have to be conscious of how to best spend the time with client. Some clients resent having to leave service to see someone else
• fees are far below standard pay schedules which association states are fair and equitable
• For family sessions, (which are 1 1/2 hours, the highest fee of $105.00 is much too low.
• No reimbursement for no shows and late cancellations. Many clients cannot afford to pay for their no shows. This is issue is making me consider not offering services any more: it is too frustrating.
• I am not motivated to take additional NIHB clients on as the fee paid is $60.00 below the average hourly fees I charge my other clients
• It didn't before because I enjoy working with First Nation clients; however, NIHB fee schedules are not comparable to private fee schedules or insurance.
• The rates for NIHB clients have not been adjusted in many years, current rate for Registered Psychologist $130.00 per hour. Rate recommended in Alberta by Psychologist Association of Alberta $190.00 per hour. Rate paid by Veterans Service another National third party payer is $195.00 per hour. Only Child and Family Service Authority pays lower in Alberta. Only recently were service providers allowed through new forms to charge for no-show and last minute cancellations to the clients. Previously when I attempted this one time I got a stern letter from the local approvals office telling me I would be dropped from being a service provider for doing this. NIHB clientele are notorious for not attending their sessions. This is quite likely do to the lack of financial buy in they have to the process. Perhaps having a minimal buy in part for clients receiving services would not only help offset the costs but have an emotional and mental buy into the process of participating in treatment.
• Fee is too low
• Although if a client no shows too many times and we are not allowed to bill for no shows, it is more difficult to continue
• The current fees make it difficult to pay escalating office expenses.
• They are significantly lower than the accepted rate in our province
• Does not commensurate with the needs of both clients and provider. Clients often miss appointments due to crisis situations, missed appointments are not billable. Not a financially viable process.
• Cannot care for all or get proper referrals / follow ups
• No pay for no shows
• I am paid less than the going rate for my education and experience, there is no reimbursement for no shows
• As I psychologist, I am committed to work with First Nations, but take a considerable financial loss with each client I see as the FNIHB rate is close to 1/3 less that the going rate for a psychologist in my province.
• The fee is substantially less then every other federal government, provincial government and private client I see. For many of the providers with specific expertise who are busy and in high demand it is difficult to justify taking on a NIHB client at a lower rate when not only is the fee lower, but the funding is short term and the client’s needs are high. In most of these cases we take, which is out of a commitment to working with Aboriginal people, we spend an inordinate amount of pro bono time in these cases. So yes, rate is a big issue.
the fee level is 2/3 the rate of other programs and the private out of pocket rate, so I take only selected patients in specific compelling situations where I donate some time and money. I did request a boost to the fee which had declined to 50% of the going rate and it was raised to 62% of our standard office rate. Will you consider paying the rate we receive under other programs? Or are First Nations considered 2nd class?

Lower rates than what other programs pay. Frequent no-shows from high-risk clients.

FEES ARE SATISFACTORY/NOT AN ISSUE

It is better than many other programs
I treat trauma and abuse cases, and the fee is flexible, with some pro bono work.
they agreed to pay my provincial recommended amount
I see people as need arises - money is not an issue
This is a population I enjoy working with and feel a commitment to. The fee schedule is less than my private practice rate but still acceptable.
Pay is competitive
All services are covered by the Government of Yukon
The going rate for psychologists is $180 an hour. My practice was getting $130 an hour & I didn't see much of that
I have to adapt to the client needs, and it is incompatible with the CPO recommended fees.
High demand where I live I would do it no matter what cost.
There are no other psychological services available to this population, therefore I am willing to take a lower fee
while I would appreciate an increase, it is comparable other provincially funded programs in Ontario e.g. Attorney General Victims of Violent Crime programs
Somewhat. Lower than other reimbursements
I am willing to provide services for less than my usual fee ($200/hour) as I see only a few clients through FNIHB funding.
Fees are reasonable for the amount of paper work required.
In Alberta the fee was $130 which seemed adequate for the service.
They are low, but we serve them anyway
I choose to provide services despite the low fee paid because I believe in the right for NIHB clients to be able to access informed, competent and experienced service providers
It is not the fee schedule, but the fact that clients often do not show up for scheduled appointments which impacts the psychologist providing service. The counsellor loses the hour which could be provided to a different client. The attendance rate for counselling by FNIHB clients is a deterrent.
The fee of $85 per session is adequate for my needs at this time.
I want to be paid my full fee. I appreciate the fact that this program does pay appropriately.
I am a registered psychologist with CAP - the recommended rate is currently 180$ per hour. I do this work with NIHB because I have a tremendous regard and care for First Nations people.
FNIH pays lower than most other programs with only an exception of Children's Services.
Though $130 is the low end of what I charge, it is acceptable to me.
I am a social worker and the fee for service I get is more than half the fee I get in Private Practice
it's fair compensation
I personally believe in advocacy and that all people deserve the right to quality support.
My fee is $180.00 per hour; being paid $130.00 per hour limits the hours (dates and times) I am available for this work.
Fee schedule are in the range of other funding schedules
• The rate in Alberta for Psychologists is $185 the VA pays $170, this pays $130
• I'd like to provide these services. Fees are a secondary concern to me.
• Not directly affecting us, possibly our visiting Psychologist?
• no even though I have not been paid I still service the client
• I service FN clients because they require assistance, I do not feel adequately compensated, and I will continue to provide service because that is the right thing to do.
• It's a fair fee, some times over the years gets revisited and catches up with the regular fee that other organizations pay for the same service
• I take them because of the need and my interest, but many won't consider because the fee is so much lower than other programs
Appendix G

Do you feel that NIHB Short Term Crisis Intervention Mental Health Counselling aligns with other mental health programs to ensure a continuum of services (for example, crisis treatment leading to long term treatment)?

- Access to willing service providers. If the provider enrollment process is inadequate then likely inadequate access for clients
- Long term treatment is often not available in the north
- NIHB is better for the families less restrictive
- There usually is no long term treatment available.
- A competent service provider can pick up where the crisis counsellor left off.
- There are very few long term counselling options—I usually refer clients to indigenous support groups and to traditional healers but these sources do not provide individual psychotherapy.
- Very long wait lists to access free long term treatment
- There is no communication with service providers about changes in the system and the leaders need to develop a more public image that helps clients and providers connect, as well as understand the rules and expectations.
- Who is funding long term treatment? Who is funding preventive care? I don’t even know what options exist for my clients for before a crisis hits, and the options for them to get long term treatment are severely limited by their financial situations.
- Too few sessions. We had just established our relationship and we ran out of sessions. Needed to refer to MH services in the community and they did go. So stopped therapy. Disappointing
- No problems with other agencies
- It really depends in what is available which is very limited in our area
- There is no longer much access to (Medicare) funded long term treatment, other than meds, available in the community.
- If those of us in private practice had psychiatrists that would even connect with us that would be nice, however, in my area they rarely do as they seem to know better, they also don't seem to be very culturally aware. In my opinion there should be a psychiatrist available in a clinic within First nations programs, and coming out to reserves to work with people so people could get to know them our traditional medical Mental Health model flies in the face of the effects of colonization and residential schools and poverty and lack of education
- It does not have the same resources, it needs to change!
- Generally clients use this service because other services aren’t available to them. As a resulting is hard to refer the client on to other services. They develop a relationship of trust but can’t fully address issues. While crises maybe addressed, this service doesn’t allow clients to make meaningful changes to prevent further crises.
- They are always being referred out to other programs or counsellors not to a psychologist
- Long-term individual psychological treatment is very difficult to find in most cases regardless of the point of entry
- Difficult for clients to access other community programs.
- We are dealing with genocidal trauma and it is common to have multiple crisis. There needs to be a plan for long term trauma and loss recovery
- There often are no other programs or services
- Little or no community treatment & short term is not long enough
- Good relations with other publicly funded services
Longer term funded services that are satisfactory to clients are not, in my experience, readily available even in Toronto. FNIHB funding is usually the only treatment that my clients receive, even when I try to refer elsewhere. For some clients, this is adequate, but for others, funding ends at a point where additional treatment would be very helpful to the client, but is simply not available.

Availability of long term programs, in terms of their existence, geographical location, and wait times make this difficult.

Often, the client does not have access to long term treatment after the crisis treatment has been completed.

ST Counselling may meet the critical needs during a crisis; however, then the clients needs to begin with another therapist for long term counselling.

There is long term treatment?

All programs are shifting to brief therapy with an expectation of transfer to community services. The problem is that free or affordable community options do not exist.

Yes and No. Yes in that it is similar to most other program's short-term model; No in that some clients need longer term care not generally available or accessible through other mental health programs.

Few referral sources available; sometimes blatant racism

At the same time, I do not feel this service should align perfectly with others because it should be a client's right as FNI to see a FNI provider

Not enough appropriate services in region or suitable providers

Long term treatment options are not available.

Once the Short Term I. is completed, there are few other services available to the clients that address specifically trauma and multi-generational trauma, or ongoing support after the crisis is over (counselling, CLSC programs)

It makes no sense to transfer clients to another practitioner for long term counselling if clients cannot afford to pay for sessions.

For a few clients 15 sessions is adequate; continuum of services is NOT ADEQUATE for those in need of long term treatment. Referring them to Cape Breton Regional Hospital Mental Health Services if a farce. Long waiting lists, even when referred at the beginning of the original sessions. The provinces mental health system fails us terribly. You may get seen one month later!

I have been able to follow my client through her various stages of recovery

The wait for treatment in the Mental Health Clinic is very long, and not easily negotiated. If a counsellor is available within the Reserve community, the client may not want to be seen going to that office.

There are few or no long term treatment options available that are culturally competent and clinically competent and don't cost money. As well, unless clients live in or very near a larger centre, there are no long term treatment options available.

In rural areas there is a lack of mental health services, so there is often no provider to refer client to. Often my clients do not have access to transportation so they are unable to access service off reserve.

Making the precipitant to approvals for service crisis we perpetuate clients not transitioning to healthy functioning and living. I feel the new guidelines now make me inform my clients when they are actually doing the work on the initial crisis that brought them in if they are at the end of their service hours and the outlined treatment plan they must just stop coming. Clients that self-refer can decide when they are ready to stop coming. The new regulations perpetuate crisis and deal with first nations people in the same patriarchal top down mandate the communities
have complained about government doing for generations. We need to empower the clients to be actively involved in their treatment planning and maintenance of therapeutic gains rather than enter into treatment only when in crisis.

- I will be able to comment more after a period of time. I am concerned that this model may be too structured
- Many clients come to this office in crisis, attempts to have them then access complicated and limited "other" resources is almost impossible and many simply stop receiving needed services.
- The recent guidelines emphasize crisis work but the reality of working with someone for 15 sessions is that you have developed a solid trust and rapport; you know the client’s story and where they need to continue to grow and transferring them is typically unappealing to the clients.
- There are very few other affordable community resources available
- Agencies supplying free counselling by accredited social workers and psychologists are desperately overburdened. For example, Catholic Social Services currently has a very long wait list.
- The obvious goal is to place clients who are in need of assistance into second rate services that are funded by provincial government.
- Lots of other programs are going towards short term models however the reality is that there is nowhere to refer people who do not have the capacity to pay of who do not have EAP. First Nations people have experienced intergenerational trauma that is very difficult to resolve in a short term
- Clients do not often follow up with long term, the long term programs have waiting lists which are deterrents to many.
- I do not think that longer term treatment in my community is culturally sensitive.
- Given that my clients have experienced significant developmental trauma there are very few programs that meet the needs of this population. Once they establish a therapeutic alliance it would be more clinically effective to remain with the same therapist until the trauma is resolved. And then transfer to group therapy might be an option however there are a very few choices.
- Too brief / too few sessions. Difficult for clients to access other services.
- Please use qualified therapists regulated under the health act, there are many pseudo-therapists that cause more harm and I help many recover from bad therapy.
- don't know yet
- I would MAKE it work.
- Short term is too short, when we review the past multi-generational traumas that our people experienced and the lack of trusting to seek help. I believe the short term needs to be reviewed and continue to provide long term treatment.
- Nurses have only recently been added to the Mental Health team, so the process of developing a legal framework for assessments, interventions, follow-ups and documentation/reporting still need to be ironed out and standardized to provide continuity of care and facilitate the development of a therapeutic nursing plan, if necessary
- Suicidal clients sent out are only kept for 3 days where they require longer stays to be properly assessed and treated. And referred to proper long term care programs out of their community
- poor provincial mental health. many referred clients do not successfully transition to provide system
- some of my clients require more time and a lot say they do not like having "white workers" they don't trust
- Long term treatment is denied!
- Once people are comfortable with a counsellor the last thing they want is to be referred elsewhere.
- There has to be more collaboration to ensure there are no gaps.
- To my knowledge, the FNIHB programs are not very connected to other resources in the community. Linking clients with other resources is left up to the service provider and/or the client and/or their physician. There is an assumption that long-term resources are available, which in my experience is not the case. The people I serve through the Short-term crisis intervention program are vulnerable and fragile and putting them in the position of forming a therapeutic relationship with me, and then forcing them to switch programs creates major ethical and logistical issues for me, and for them. Fifteen sessions is often not sufficient to enable resolution of many crises, and the duration of a PAN is shorter than most waiting lists for other programs. I.e are
  - except for the fee
  - There is limited mechanism for long term treatment. It is unethical to begin to address challenging emotional issues that can destabilize a client when you can’t be certain if funding will be available to provide the care they need to address these issues.
  - Therapy issues for First Nation’s people are more complex than 5 months of service, particularly children. Not all clients are eligible for IRSRHS for longer term therapy. In rural areas there are limited resources available and the change in policy to only be for 5 months creates significant gaps in service.
  - There is no health board/provincial mental health resource to refer to, poor access to psychiatry, poor access to community support. None of this is NIHB system, but public mental health resources have deteriorated generally.
  - People do not want to change therapists to enter long-term treatment
  - Where is the long term treatment?
Appendix H

Are you able to easily transition clients to other supports that meet their needs once the NIHB benefit runs out/crisis situation is resolved (ex. Ongoing counselling needs to facilitate recovery?}

- No psychological services offered by the province in the north.
- Yes, but NIHB could set up ongoing counselling as well
- Integrate with other community or provincial programs - eg trauma treatment, substance use programs
- In the rural area, services are limited and other issues intervene: language barrier, systemic distrust, lack of cultural understanding, lack of understanding of historical and intergenerational trauma, lack of understanding of on-going "colonization" effects, discrimination, wait times, financial cuts in the provincial programs,
- Rural and remote locality, few other services or providers
- The public health system in Atlantic Canada is not adequately staffed to handle long-term treatment
- Few community resources available for mental health care
- Long waitlists
- As above - there are group supports available if the client is receptive, within their own communities. Long term, subsidized counselling is very hard to find for anyone in my location.
- No experience to date
- They can't afford to pay out of pocket and wait lists for gov't funded services exceed 1 year sometimes.
- Clients are not willing to switch over they like to continue with same service provider. It is a question of building trustworthy relationship.
- There are community resources, but not necessary for abuse and trauma work, but the client needs to feel comfortable to go or else they will just stop attending treatment.
- Because they can't pay out of pocket for ongoing treatment and no free services exist. Because of the lack of options for ongoing care and the lack of community-based preventive counselling, clients end up jumping from crisis to crisis with little stabilization within the system. It's mayhem for the clients, and even worse for their dependents.
- If our services are sought or referred to.
- Communication and always depends on MONEY - who pay this? who pay that?
- Not enough services available publicly and those that are available have very long waitlists.
- Lack of available services apart from private services which families can't afford
- Often clients won't go
- In Toronto we don't have enough services for First Nations people.
- Community where I live has 2-3 month waitlist for free counselling services and is only service available
- Because of poor resources of the public system.
- Lack of services available at low cost; lack of services where clients feel their confidentiality is assured; lack of resources closer to their communities.
- No other psychologists available
- The Client needs long-term 1:1 treatment, and that is NOT available elsewhere
- Availability and need for centralized transitioning.
- Client usually has bonded with me, and the transition to another therapist is difficult.
- They have no money to get other services and there are long waitlists for publicly funded services
As long as there are Native programs being funded. However over the past years most successful trauma and grief programs as well as urban support programs have lost their federal funding and closed services. Clients resent changes in care little or nothing in the community Session limit was inflexible Problems are explained in 16. above. As well, having to find other services also means disrupting an established therapeutic relationship, and having to start over with getting to know a new professional. Some clients cannot sustain treatment involvement when faced with such relationship disruption. Often there may not be community services available, or the wait times are extremely long. not often available, just get a therapeutic relationship going and they run out of funds Many community programs are short term as well. Many clients that come in through crisis intervention have complex issues that need further sessions to help them get stabilized. Clients have established rapport and trust with their Crisis Intervention counsellor and are reluctant to then transfer - if a program is available - often clients cannot pay for ongoing counseling offered by private practitioners and often the community only offers short term counseling as well. In Alberta we did not use ST Counselling - we could continue for as many sessions as needed. Not usually enough community programs to support the changes and client is required to make. There are very limited services out there. Most nonprofit services have moved to a walk-in or 6 session limit. It is inappropriate to move a high needs client to a short term service provider who is highly focused on education. Because it is difficult for some clients to abandon their current therapeutic relationship; because most do not have the funds to cover additional therapy, and those who do not, enter another short-term model, lending to a lack of continuity and impacting overall progress; because not all clients are connected or desire support from their cultural community; because clients do not always fit within another program’s definition; all these lending to limited available supports none available that are financially covered There is not always willingness from client and/or service is not always available I can refer to another indigenous First Nations provider Long term treatment options are not available. There are few/no resources to deal with the issues faced by First Nations Clients outside of the communities, (Province of Quebec/Montreal), so they are often left without support. Community based organizations are already stretched thin and tend to offer only short term models, which means that clients are bounced around and have a hard time actually resolving issues, especially trauma. I have not needed to do this to this point After I have seen a client for a couple of different crises, long term issues surface, and the client does not want to be shifted to other services. I have been told by the approval people that I have to send these individuals to someone else, and the client refuses. This means that I end up seeing the person pro bono, or the individual does not get service. I don’t believe it is right to develop a relationship with someone, often a difficult accomplishment, and then have to send the person elsewhere, to begin again, just because of the definition of crisis vs. long term. Furthermore, the wait for treatment in the Mental Health Clinic is very long, and not easily negotiated. If a counsellor is available within the Reserve community, the client may not want to be seen going to that office. NIHB short term sessions run out before clients are actually seen. Their waiting list and assessment process appears to be detrimental to the client’s mental health. As explained above, there are few, if any, longer term counselling options available.
- No, because they are not available within the community. Provincial supports off reserve often have long waitlists, even if the clients could get to them. A trip "to town" cost $50 and clients do not have adequate funds to pay.
- I am not aware of competent mental health trained programs that can provide what a Registered Psychologist can in the community. When working in an advocacy role with clients historically to assist in finding these programs as no information is provided from FNIMH I am informed they are religious, long wait lists, or poorly trained service providers.
- There is often only very limited and short term resources available and many clients are hesitant to begin again especially if related to a trauma history.
- Very few affordable services are available.
- I am not sure that clients follow through with the longer term counselling once they have started with one therapist already.
- Programs with ACCREDITED PROFESSIONALS have very long wait lists. Many of the issues these clients present are far too serious to be safely left in the hands of para-professionals.
- Services not readily accessible. Sometimes this is the only service for them.
- There is a gap in services; the clients are not willing to access these services; the continuity is lacking.
- Many people who see me require transportation paid by the band. The town I operate from has few services. It is difficult enough for people to come off the reserve to access services. They do not want to travel to Calgary to access services. FNIHB is just shuffling First Nations people off and other agencies are doing the same.
- If necessary can usually facilitate transitions however as a clinical psychologist clients usually request continuation with myself. How is
- Long waitlists; not sure about cultural competence in local agencies.
- While I have transferred clients to group therapy e.g. POP at the Grey Nuns, or the Evening Treatment Program at the University Of Alberta Hospital only some clients will match what this program is designed to offer. Plus to gain enter into this program it requires a referral from a psychiatrist.
- other counselling options are not always locally available.
- Not many other services that can meet their needs. Public services are focused more on mental health crisis stabilization only.
- No other supports will do long term. Everyone claims they only do crisis. These clients' issues are often rootin in deeper issues that they will address, given time. The approach is often much narrative and storytelling therapy to resolve issues which takes much time. They build trust and it is very hard to transfer to another therapist.
- I was a clinical supervisor of an agency in my community and I have knowledge of resources don't know.
- Once again it's the trust issues. The First Nations people were used and abused, especially when we look at residential schools experience that has impacted our people for many years and many other traumatizing issues that affected our people. So not trusting stops the client from seeking alternative support and depending on their crisis. Short term is too short when many years of abuse is present!
- I have heard of patients requiring services and follow-up support but not knowing where to go or that community health nurses are available for chronic disease management.
- Clients have difficulty in trusting their own counselling team.
- not always it's the trust issue.
- After clients engage I. The process, and are then told to go elsewhere trust, rejection and abandonment are the next issues!
- They don't want that. I respect client integrity and choice.
- The programs are not available, and once a client has formed the trusting relationship necessary to work in therapy, they are not usually wanting to then move on to have to repete the process elsewhere.
- Sometimes is hard as most local programs have very extensive waiting lists. More than 20 weeks for the most part there is a strong reluctance for access because of trust and non-aboriginal systems in place.
- The clients are too high need. Free programs often do not have the expertise of the ability to take them on. Long term funding is not easily accessible.
- There are very limited services in rural areas and on some reserves. Therefore by the time the approval window is over, there haven’t even been placed on a waiting list.
- Because of our location there are not culturally relevant services and no choice for clients.
- Nothing, no one to refer to. I see mostly people with severe mental health needs related most often to trauma, family breakdown, and substance abuse. Very difficult to find anyone to take on multi проблем clients.
- Many clients have trust/ethical issues with community based staff - often closely related
- limited long term treatment available
Appendix I

Please identify any specific changes you would like to see to the STCIMHC benefit to improve it

- Reduced paperwork for prior approval, paperwork for submitting invoices is redundant, more flexibility in planning for long term treatment.
- I would like to see our own All Nations healing hospital, cancer, hiv/aids/chrystal meth/hospice centers across Canada and 24 hour loss and grief homes that people can access to feel safe in Canada. I would like to see First Nations, Metis and Inuit counsellors get approved as Consultants and Advisors to Health Canada and the AFN. I would like to see an Elders Advisor Council and a Family and Patient Advisor Council.
- Make services available as long as client needs.
- To have the program take into account the need to integrate it into a broader and more supportive program that needs to be linked to trauma informed therapy, to trauma informed expressive arts therapy, to cultural traditions and ceremonies: healing circle, sweat lodge, storytelling, healing dances and so on. The program assumes that FN clients are ordinary Canadian citizens to be serviced likewise. However, the program has not taken into account that FN clients are displaced persons in their own country, subjects of the government, with services dependent on the goodwill of the government and according to the government’s perception of what is needed. The FN client is resilient and having to cope in a bicultural, sometimes tricultural, world. If given the resources required, which must include a return to culture, to traditions, with some obvious adaptation for current times, will see the FN client and his/her community benefit with improved emotional, physical, spiritual and mental health long term. Please note that though my services were paid by Health Canada for individual clients, I worked on the reserves with office space and secretarial services provided by the Health Centres the reserve.
- An experienced mental health clinician would understand better the needs of First Nations' clientele.
- Remove the police check for professionals who are registered members of Colleges, better leadership/training for staff so that they are efficient and helpful and responsive to clients and providers. In my experience this program seems like a sham program set up to give the appearance of action while not actually disbursing funds.
- A broader definition of crisis, a commitment to reimburse service providers within one month of receiving invoice, a comprehensive effort to make First Nation communities and agencies who serve aware of the program
- As much flexibility as possible regarding number of sessions or repeat prior approval requests, given the extreme histories of trauma for many of the First Nations clients. Would also be great to have more cultural sensitivity training opportunities and more visibility/communication amongst government supported agencies with private practitioners in the community
- Clients require a longer period of therapy given the complexity of trauma they experience make it difficult for them to benefit from shorter term treatment
- Increased communication, network engagement and share new program info. Information on how to utilize or offer new services
- Less administrative work, being able to submit our own invoices without having to fill out the provided invoice which is essentially a duplicate of the apt. confirmation document, this new process takes about 15+ hours/week to complete daily billing.
- The program should also cover first session prior approval, because we spent our professional time in the process.
- An on-line directory of service providers which is accessible to client community. Directory of service providers and resources in paper form available to client either directly or via Native social service agencies. A training course for service providers which outlines cultural issues, limitations of program and how to access treatment.
- I would love to see funding for community-based and/or preventive counselling, as well as long-term counselling so that clients can get treatment beyond the crisis. I would also love to see the per-hour payments increase so I can afford to take on more FNIHB clients.
- More sessions
- OK as is
- To receive referrals.
- Clients seem wary of the short-term nature of it, feeling as though even the title belittles the gravity and history behind their difficulties. While it is posed as one option on the continuum of services, they seem to focus on in the "short-term" part & feel insulted or not ready to work through a lifetime of difficulty in such a short time - they find it intimidating. I wonder if "immediate" might be more palatable?
- Increase visibility would be important. I spoke to different colleagues and none were aware of this program. Email from the College of Psychologist of Ontario would be a great way to inform members.
- Enrollment process for providers. Communication for providers
- As noted above-reduce paperwork; integrate forms
- Stop requiring service providers who are already meeting the requirements and registered yearly with a regulatory college (such as myself registered with the College of Psychologist of Ontario) to get time and money consuming yearly police checks. Rely on our yearly renewal with the College by checking with them to ensure we are still licensed in good standing.
- I would like to see a recognition that with all the traumas that have occurred all programs be long-term. I have seen so many generations of both white and aboriginal people that it is clear that the effects of them are far more than simple ptsd, depression, anxiety etc. Indeed working with First Nations has enhanced my life and my ability to see how to work in many different ways than my training even as a trauma specialist and psychologist would have given me. Most clients would need at least a year, most will miss appointments or forget to call, many expect a spot to be available right now or at least in a day, and providers need to be able to get some compensation for this. Clients have to sign everytime they attend and if they are getting medical transportation they have to get a slip signed so they can get gas etc. In my opinion it places them in a one down position constantly a problem that colonialization seems to have used in order to assimilate or annihilate!! We all have crises but the number of people I see with long-term historical trauma including veterans do not all respond to short-term or trauma focussed CBT attachment is crucial since the caretakers they hoped to be there for them inflict more trauma on them by not assisting them to get the help they need a repeat of many elements of early attachment traumas, and the loss of hope experienced when they see the world for what it is, but because of their trauma they see no hope and they often see only "bad".
- More allocation of funding, more sessions, on-going therapy, more follow-up funding, more specific services (i.e. Spanish-Speaking First Nations individuals).
- Clients should be informed of what available to them. Providers should be given brochures or something to give to clients and have at community events so they understand what available to them. Many clients in my area think they have to go to Yellowknife and they do not. More sessions and longer-term counseling - you can't treat trauma in a few sessions - or cover them until can get into community counseling services.
I would recommend the service not be for crisis by rather for short term therapy for up to 16 sessions. I would also recommend appropriate funding for the service to attract high quality professionals and improved procedures for confirming attendance and reimbursing professionals. I would also recommend development of further services for various aboriginal populations and further training on the importance of confidentiality and appropriate boundaries for services available in the communities. Some clients also face challenges getting to appointments because of limited finances. Improved transportation options are needed for these clients. I frequently have situations when transportation is provided but drivers do not show or bring clients at times that are not their scheduled time (particularly my IRS clients who may come from great distances). Finally, providers should also be able to bill something for missed sessions.

Pay psychologists more. These clients should not be prevented from seeing a psychologist for treatment because of low payments. Make mental health and psychological services a priority.

1. Provide all information re: registration as a provider at the start; make the process transparent
2. Simplify the provider registration (don’t ask for all kinds of documentation that is superfluous -- if one is registered as a psychologist, they already have to have insurance, relevant degrees, etc. Why require the police check?) 3. Post the fee schedule, and not ask what one wishes to charge (it saves time, and it does not matter what I ask for anyway)
4. Provide for long-term therapy if needed, since appropriate follow-up (beyond the crises) may not be available anywhere
5. Acknowledge receipt of submissions by provider or applicant, acknowledge receipt of invoices.

Prospective clients need to be provided with a list of registered service providers in the area. Also, centralized directories or referral services to receive assistance from other community programs.

To emphasize, I strongly believe that a long-term psychological treatment option is essential to meet the mental health needs of this population.

I find it strange that the new form seemingly does not have any place to indicate the nature of the crisis. One of my clients really needs long term, as for him it is one crisis after another, at least these past two years.

Increase the number of sessions available to at least what is available for veterans with VAC pensioned conditions - 24 sessions per year.

Start over.

See suggestions above. And create a long term recovery plan that is available for recovery from cultural genocide.

Differentiate services for isolated reserves and individuals from those whose access to urban centres and services is great. Pay psychologists more appropriately, allow local band input into needs and tweaking of services, allow easier access to assessments that can open the door to other services.

1. Increase fee schedule 2. Reimburse for written reports 3. Stream-line payment, especially when errors occur.

This survey is mostly designed for people currently registered with the system, so I can't answer a lot of questions here. When I think of becoming a registered provider for FN services, I think "hassle." FN people should be able to go to any licensed and qualified mental health service provider in Canada and have coverage for that without government vetting of providers, which just costs more money and limits access further. Short-term crisis intervention sounds like a band aid for historic, chronic, and ongoing trauma related to colonization and residential school sequelae. It's getting ridiculous that short-term and prevention programs keep being offered to people who have long-term, chronic, and intergenerational problems. You can't fix a long-term
crisis with short-term, bandaid solutions. You can't do prevention when the problem has already occurred. I wish everyone would recognize this, commit to real program solutions, and stop jerking FN people, kids, and families around. These kinds of short-term stop gaps will never address the deep and unfathomable pain I have seen in the eyes of a foster child who has been punted from home to home or program to program. Get real.

- Less restrictive criteria for acceptance. For example my work involves Neuropsychological Evaluations these include concussions, head injury, neurological diseases and dementia screening. These groups are excluded.
- When I was a provider (a couple of years ago), direct contact with the program was often challenging b/c of limited staff availability. More staffing would probably be very useful.
- Would be very helpful if unused sessions in one 6-month approval period could be utilized at a later time. A number of clients attend sporadically, but still benefit, even from widely spaced appointments. Having to reapply for approval every six months is somewhat onerous for me, and I have to explain to clients that approval is uncertain even if a number of appointments from the initial approval were unused. Would also be helpful to know whether and in what circumstances additional sessions can be approved, and, for an individual who has accessed funding in past, how soon that person can again access funding.
- Ease of direct billing for client and provider. More info to potential providers
- Being able to access additional sessions - much like the Indian Residential school counseling process -
- To consider an appeal process for exceptional circumstances
- I would like to see the STCIMHC to be replaced by less restrictive model which would include individual, couple and family therapy along with group therapy offered by qualified therapists.
- Clients usually need more support than the 15 sessions that are approved in a year.
- We need to have a service that values the unique needs of FIHB clients. They have high levels of trauma, addiction, etc and difficulty trusting institutional service providers. We need a system that allows the FNIB workers and the psychotherapist to work together to ensure an appropriate service is provided. I don't like to keep people in therapy for long periods of time but my clients often go off, live with growth and come back - not in crisis - but in need of support to prevent crisis, I don't think the current program respects this process. I am also offended that art therapy and hypnotherapy are disallowed as interventions. that should be upto the therapist. Similarly we often have to chose between individual and family counselling - clients often need both.
- Would like to see an option for additional/extended coverage beyond that of transitioning client to alternate mental health supports.
- Opportunity for on-going treatment from the same therapist due to difficulty of referral
- Make it more well-known for counsellors in private practice to participate.
- There are occasions when short term becomes long term and the best treatment approach is to continue service - some consideration for same.
- Forms as previously mentioned, also allow scanned materials instead of faxed documentations for approvals, reimbursements and eliminate the approval for travel forms for providers
- Recognition of the poor attendance by clients and compensation, in some fashion, for missed appointments. 2. Recognition that long term treatment options are not available.
- One the "Short Term Crisis" has been dealt with, if that is possible in 15-20 sessions, a we are dealing with multiple traumas, Heath Canada should be setting up Comprehensive resources for First Nations Clients, in urban settings, off reserve, and should be assisting the therapists in the setting up of after-counselling service plans, a time consuming and very frustrating endeavour. Clinical opinion on the short term intervention for severe trauma clients. It is like putting out a
burning bush in a forest fire. It is this psychologist's opinion that when you address the crisis with so few sessions, no real trauma work is done, the sessions are spent mainly creating safety/a trust relationship with the client. The client can experience the briefness of the therapy as an indicator that their deeper issues cannot be resolved, leaving the client feeling powerless. Food for thought. We need more First Nation Sensitive resources, after the crisis sessions are complete....Such as the no longer existing Native Healing Foundation......

- Allow for a longer term model that actually serves the needs of clients, and cover no shows and late cancellations.
- Make the fees paid to psychologists accord with the fee schedules set by each of the provincial professional bodies (i.e. in Alberta the College Of Ab Psychologists)
- I don't mind determining long term vs crisis at the beginning of a therapeutic relationship, but after a while, when the relationship is formed, I think a client should be able to continue with me instead of being referred elsewhere if/when the issues become long term. It can take a long time to develop trust, and that is lost when a referral has to be made to community resources.
- When a client is in treatment via NIHB Short Term counselling program, there should be a system in place to fast track this client into appropriate provincial services. First service provider is at times left juggling between what is needed for client and access to appropriate mental health services. Thank you for asking us.
- Short term crisis intervention is not useful with First Nation clients who have extensive trauma, and that is most of them. They may or may not be motivated to work on that but if they are it is definitely not a short term process and definitely not one that can be transitioned to another provider, even if one can be found. Relationship is extremely important so transitioning clients to another program is highly disruptive to the client's therapy. This is especially important in communities where the therapist may have been in the community for many years and has a good relationship with members of the community. Many clients seek therapy only because of that and would otherwise not reach out. The short term crisis model may work acceptably with most off-reserve FN clients; however, it makes absolutely no sense to implement it in a community when the therapist is contracted to provide services to the community. Together with mental health therapy, these services include providing workshops and education to community members, consultations with other professionals, and support to mandated clients (child welfare, court system). None of these are allowed under the new guidelines. Clearly the new guidelines were designed by someone who has little or no knowledge of how a community or reserve makes use of mental health services.
- I am a contracted therapist to two First Nations. I am paid a flat fee to provide services to the communities. The benefits of this are that I am part of the health care team on reserve. Relationships are developed with community members. This allows me to provide psychological services that are long term and preventative, as opposed to only crisis intervention. I work closely with other agencies on reserve and get referrals from many of them. The recent need to fill out prior approval forms, is another unnecessary administrative hurdle. In the past I was able to see anyone who wished to access help, and to provide preventative care when the opportunity arose.
- Let's review this again in 3-4 months and see what the strengths and challenges of the program are at that point in time.
- Short term crisis intervention can only be successful with trauma specific issues if there is an available longer term resource for them to move to. This is often seen in follow up resources for addictions. Unfortunately for many trauma victims there does not exist other options outside of their benefits, if they have no employment or are already dealing with issues of poverty or
violence. The only long term resources available are if there are issues related to substance abuse or addictions.

- More hours at our sessions to facilitate stabilization. More pay. The ability to increase our pay scale. The ability to work to facilitate ongoing healing for trauma and grief.
- I don't believe the counselling services should be restricted to short term crisis work. There are too few, affordable, good quality programs available that meet their needs. Also, the needs of this population group are very high. If the government was serious about providing adequate services, this restriction would not be there.
- Again, lessening the approval time would help. I also do not think the clients understand the crisis model of the benefit, they often want to start into much longer work than the crisis would dictate; perhaps more education around that would help or allow the clients to continue with the maximum sessions, so make it something short term crisis and short term therapy counselling.
- Clients need to be given more counselling sessions. Also, the forms are very difficult for our clients to read (the print is small and information is very dense on each form).
- Easier payment info with IRS vs STCIMHC. Shorter name for STCIMHC.
- Inform the providers what is the overall goal (to reduce expenditures to the federal government??). Where does the program stand in relation to Medicine Chest and Treaty??
- It is very rare for people to engage in long term therapy without taking a break in between chunks of work. I would suggest getting rid of caps and extension requests. It makes sense for people who are actually doing longer term work to take a break in therapy of 4 to 6 months or use their other entitlements such as EAP, insurance, or fee for service. Or perhaps the Bands could pay for counselling for part of the session. We should make it easy and convenient for First Nations people to access supports.
- How can telehealth be billed since a confirmation sheet is required?
- Increase payments to line up with everyone else in the province who want to see a registered psychologist.
- 1. Ability to see clients longer than 1 hour when required. 2. An increase in fee from 130 to 160.
- 3. Payment for no-shows. 4. My partner and I have worked with the Native population for over 25 years; we are unable to include Registered Psychologists, who has worked under our supervision. I would like to see a system to bring them on board so they could also provide Psychological Services. I would be interested in talking with someone about a more inclusive Mental Health Program so that after the short-term aspect of the program there would be options like, Group Therapy, Group Therapy, Marital & Family Therapy and Therapy for the children.
- Increased number of sessions.
- More sessions approved; 1.5 hour sessions approved. These clients often like to tell stories that link to their therapeutic goal and help them but it takes time and often 1 hour is rushed for these clients.
- Reduce the intake process, online portal instead of fax, online billing. :)
- Is there a site where service users can access service provider information?
- Let me know about it. I have been looking for ways to serve the FN community. Thank you.
- Go back to the way it was and also adding a list of Psychologists accepted to provide services with Health Canada. At times accessing psychological services in English is difficult near our communities therefore we need to access services in the Montreal area. But many Psychologists are in private services which is not accepted by Health Canada, which makes it more difficult to access services.
- 1- Nurses involved on the teams 2-Standardised documentation of all assessments, interventions, treatment plans and evaluations 3-Improved inter-collaborative practice 4-Improved access to English language services in Quebec 5-Affordable access to psychology
- Therapists require more time in community in order to make a difference and to impact one’s life.
- An formal long term treatment program that meets the needs of these clients
- Pay time mandatory 4 to 6 week payment and if not with interest. Able to work with clients immediately with no repercussions of being told I won’t be paid. Paperwork done properly accountability to what they have done wrong or what they haven't done. More aboriginal people in this unit. I really don't think they "get" our issues. a colleague toured this unit she stated not one native person this is very wrong!
- Revamp the program, talk to individuals who have utilized service and get their feedback. Improve this service people need it!
- cover one no show for each client so that the counsellor can inform the client that they can no longer see them or that there is only one chance to miss.
- I believe there are flaws that require attention which I will speak to in written submission.
- Fund longer term intervention as it used to; 2. pay the going rate for the professions the program uses; 3. make the paperwork so that forms can be downloaded and computerized to facilitate efficiency and accuracy (as used to be possible); 4. the two different invoicing forms ask for the same information in different orders which makes them confusing and creates great potential for errors.
- There needs to be a recognition that most of the clients, at least who have been referred to me and my practice, have significant deficit areas, typically in the area of trauma and come with major disruptive behaviour difficulties - substance abuse, domestic abuse, violence, sexual offending behaviour. As well their histories of trauma are often profound. The idea that short term intervention to patch up a symptomatic crisis is helpful and not have a mechanism for attending to the core issues contributing to the problems occurring in their lives is problematic. My practice stopped providing services to this program over a decade ago as we felt we could not appropriately attend to the client needs in a professional responsible manner. Over the years we have had numerous inquire from clients, agencies and requests to take clients funded through NIHB. Recently we have opened the door to this as an option again, but continue to find the same challenges that resulted in us deciding not to provide these services in the past
- Longer length of approvals; acceptance of individuals who may have professional credentials (ie., CCC) but not provincially regulated; streamline the billing paperwork to decrease redundancy in forms; inform providers of changes in programs with enough notice to meet the demand rather than making immediate changes with programs and providers that negatively impact clients. Rural areas don't have many professionals that meet the criteria for FNIH and the demand is high. Ultimately, it creates more suffering for the clients.
- -access to sessions more than once as different crises arise. Consideration given to clients who may not fit with the other mental health option (only one person in my area).
- I'd like to see a second tier of people to refer to for specialised services, i.e. easy access to psychiatry for medication, and community support mental health nursing. I see some of this having developed for health issues like diabetes, why not mental health?
- 15 - 20 sessions over a 20 week term is only feasible for urban settings, where clients are seen once a week. My clients require 1-2 days for travel and only book 1 - 2 times per month. Require different schedule, such as fitting for once per month. Many clients experience multiple crises, such as multiple family deaths over a 5 month period. This program does not address that. Difficult to separate info on a "per crisis" basis.
As an Occupational therapist, providing equipment and supports to First Nations clients, I am completely unaware of this service. I wish NIHB were more transparent with respect to the services available to my clients. What’s IRS-RHSW? I’m completely unaware of this term and would have liked to have it spelled out. Also, the survey speaks to on-reserve/off-reserve services. Here in Yukon we do not have reserves, so I was unsure how to answer these questions.

Remove the hurdles...people in crisis are not always able to keep regular weekly session...remove time limit on use of sessions...speed up approval process...extend number of sessions to meet the need...I could go on forever. I am very passionate about First Nation work...I wish the government would support this work...this is the most inefficient agency I have ever dealt with in my 45 years of being a therapist. I worked 2 days a week last year doing NIHB work and made $5,000...it felt like any reason to disqualify a claim was used. I am worn down by the bureaucratic inefficiency. It seems to me that Canada still continues to look like they are 'helping' when in fact they are breaking promises.

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Appendix J

External Written Submissions

Kahnawake Shakotiia’takehnhas Community Services (KSCS)
Submitted by: Kathy Jacobs Horn
Manager Support Services

Subject: Non-insured Health Benefits – Short term Crisis Intervention Mental Health Counseling (NIHB/STCIMHC)

Kahnawà:ke Shakotiia’takehnhas Community Services (KSCS) is a full spectrum social services delivery agency, was established in 1987 for the Kanien’kehà:ka (Mohawk) community of Kahnawà:ke. Its mandate from the MCK was “to coordinate all programs and provide quality services in the areas of Alcohol and Drug Abuse Prevention, Social Services and Community Health”. Since that time, six (6) other related programs were brought under the KSCS structure and the organization has grown to over 175 staff members.

The KSCS Vision is... KSCS strives for a strong collective future for Kahnawà:ke by promoting and supporting a healthy family unit.

The KSCS Mission is... To encourage and support a healthy lifestyle by engaging with the community through activities that strengthen our KSCS values of peace, respect and responsibility with the collaboration of all organizations of Kahnawà:ke.

KSCS has proven itself to be successful...

In 2015, KSCS provides a full set of quality client services, including essential services, to support the individual and family needs at every life stage of Kahnawà:konon. The client services are grouped into four (4) service delivery teams:

1. **Prevention Services that offered:** Primary Prevention Services, Secondary Prevention Services and a specific Family and Wellness Centre. Each of these program areas have several related programs and/or activities.

2. **Support Services that Offered:** Intake Services, Addictions Response Services, Youth Protection Services, Youth Criminal Justice Assistance Services, Foster Care and Case Aide Services, Emergency Response Services, including “on-call and Psychological Services – (NIHB/STCIMHC)

3. **Assisted Living Services for elders and special people:** Family Support and Resources (community outreach and service delivery), Young Adults Program (social integration programs), Independent Living Centre (13 bed residential facility), and direct Clinical Supervision.

4. **Home and Community Care Services:** Adult and Elders’ Support Services and Programs, Home Care Services, Home Care Nursing, Turtle Bay Elders’ Lodge (25 beds residential facility).
KSCS also possesses a full set of organizational competencies, policies, processes and tools to support the work of the four delivery teams. These staff services include:

1. Human Resources, which also comprises Communications and IT;
2. Organization Development Strategies (ODS), a group of OD consultants who also provide services for fees to other First Nation organizations;
3. Financial and Administrative Services, including Environmental Health Services (EHS).

KSCS is also an active member of Onkwata’karitáhtshera, Kahnawà:ke’s Health Authority. Onkwata’karitáhtshera is responsible to oversee the Community’s Health Plan; therefore KSCS’ strategic goals and objectives must be alignment with the Community Health Plan. One of the main priorities identified in both the Community Health Plan and the KSCS Strategic Plan is Mental Wellness.

In recent months, we have been planning our 2016-2019 KSCS Strategic Plan. One of the key objectives of this plan is:

- assess our needs for effective and efficient psychological services and implement an upgraded capability, including people and processes, to address the priority needs in mental wellness.

Outline: NIHB benefit to be discussed

Non-insured Health Benefits – Short term Crisis Intervention Mental Health Counseling (NIHB/STCIMHC)”

Broad topic area (i.e. Suitability of benefit, administration, access, etc.)

Kahnawake’s partnership with Health Canada in relation to psychological services has been long standing ever since we took over the direct management of the service; through the “Non-insured Health Benefits – Short term Crisis Intervention Mental Health Counseling (NIHB/STCIMHC)” agreement that we have with Health Canada. We have received tremendous support from Health Canada throughout the years and we are very appreciative. Although elements of the service delivery are challenging, we are very happy with the arrangement, as we believe we have been able to provide:

- a higher quality of psychological support for a large percentage of community members;
- have been able to extend our annual budget as much as possible by including client contributions;
- instituted STCIMHC as “payer of last resort” when clients have psychological health benefits in their private and employment group plans (at a very reasonable cost to Health Canada in comparison to other communities); and
- have been able to institute greater quality control in the services being delivered.
Outline: Issues/challenges with the topic area.

Before I go into detail of the issues and challenges, I want to reiterate the system so you understand the context of the situation.

When all cases come in to KSCS, we provide basic screening and assessment to ensure we are utilizing the full extent of our community services (as per Section 5.3.c of the NIHB/STCIMHC agreement). This may include non-psychological mental health counseling services, addictions response services and traditional Kanien’kéha’ka counseling activities (including sweat lodge, traditional medicines and ceremonies). If further psychological support is recommended and warranted, the worker will refer them to our psychological services department, where they are assigned to an in-house psychologist to do one of 2 things;

1. They would personally conduct a psychological assessment, develop a service plan, locate an appropriate therapist, refer the client to them, ensure all contracts are prepared, provide coordination and communication for the on-going therapy, coordinate approval for extensions of service, ensure proper closure to the file is conducted and ensure that all recording in our files is maintained.

2. Our psychologist will immediately refer the client to a therapist to conduct a psychologist assessment with the expectation that the assessing psychologist would recommend a service plan (and carry out therapy themselves), or recommend an alternate therapist. Our psychologist would make the final determination and then support the on-going therapy as outlined above.

KSCS currently has *approximately 140* active psychological cases. As mentioned, most of these cases are currently referred out to various service providers who are delivering on-going therapy. This amount of administrative work on behalf of our staff psychologist represents a significant investment in time and expertise. In addition, although of secondary importance to the individual client situation, our staff psychologist also sit on various multi-disciplinary committees, acts as a resource during community crisis situations (as per section 4.3 of the NIHB/STCIMHC agreement), and regularly advise our staff members regarding psychological services for a large variety of issues. Given this, they provide a significant avenue to gain access to advice and guidance.

In reviewing our agreement with Health Canada, and wanting to remain in good standing, one of our top challenges in the last 3 years was to secure an in-house staff psychologist to fulfill the agreement as outlined, due to a staff departure. When we made the agreement with Health Canada to take over our NIHB/STCIMHC, we agreed to cover the cost of the actual staff psychologist. FNIH agreed to provide the direct funding for the NIHB/STCIMHC, and we have negotiated an amount to support that. The challenge is that it is no longer makes sense to cover the costs associated with a staff psychologist outside of the NIHB/STCIMHC budget.

Mental Wellness has consistently been identified as the number one health related challenge in most First Nation communities, yet the NIHB/STCIMHC program is not organized to make actual efforts to change this fact. By providing only short term service, as well as crisis services, and on top of this, not
providing psychological coordination of services (i.e. the use of a staff psychologist) is ineffective to create long term positive change.

Outline: Current challenges:

1. There are NO other avenues for our community (or most First Nations community for that matter) to seek to receive mental health services in the provincial system, given that the provincial system unequivocally states that do not provide the service to our population, nor do they provide the service in English in our region.

2. We currently have, and anticipate more, long term, severe and persistent mental health clients that do not fit into the agreement guidelines of the NIHB/STCIMHC, or the Residential Health Support Professional Counselling Program guidelines. These clients have long term, deep rooted, persistent mental health conditions that need to be monitored through ongoing therapy which reaches far beyond the usual 12 to 20 sessions that are provided in the NIHB/STCIMHC agreement. We consider this a major concern and challenge.

3. When a problem is only addressed once it becomes a “crisis” is unrealistic to effect change because a client seeking professional assistance in order to avoid crisis is actually in more of a prepared state for actual change to take place. These are actual the ideal candidates for therapy.

4. Given the complexity of a community trying to address their mental health issues, coupled with active addiction challenges, it is vital that community health dollars also take into account hiring professionals to coordinate services, particular for large populations (for example like Kahnawà:ke or for groups of communities/Nations). Finding other funding sources to cover these costs is not always possible and inappropriate given that it then reduces the amount of community dollars for those programs.

Outline: Your ideal scenario related to the issue.

Ideally, we believe the NIHB/STCIMHC should function in a multi-disciplinary environment whereby social services, 1st line services, addiction response services all function within a single team. The FNIH program of NIHB/STCIMHC should allow for flexibility in administering the services given a community’s particular situation (i.e. “short term vs longer term” “prevention vs crisis”), and should also allow for these funds to also be spent on staffing as well. If Health Canada truly intends on supporting First Nation communities’ efforts at changing their situation, real investment can be achieved, particularly if focused in the right areas. With the right investment, a community, group of communities, or Nations, can hire a staff psychologist to administer the program, support clinical discussion and evaluation, build capacity, extend budget, and provide better quality control directly at the front line where it matters most.

We would be happy to discuss our ideas in more detail and look forward to hearing the results of the review. You can contact me for further information at 45-632-6880, or contact our Executive Director, Derek Montour, at the same telephone number.
Canadian Counselling and Psychotherapy Association

AFN-FNIHB NIHB Joint Review Steering Committee
jointreview@afn.ca

September 22, 2015

Re: Written Submission for the NIHB Joint Review

NIHB Benefit to be discussed

Short Term Crisis Intervention Mental Health Counselling Benefit

Broad Topic Area

Recent change to the approved provider list which resulted in the removal of fully qualified professional counsellors/psychotherapists thereby significantly reducing the number of providers available and exacerbating access issues for Indigenous peoples in need of this benefit.

Issues/Challenges with the Topic Area

As of February 2015, Health Canada's NIHB Program and Indian Residential Schools Resolution Health Support Program (IRS RHSP) initiated a nationally standardized process to enroll mental health counselling providers across Canada. Health Canada will now enroll only those mental health counselling providers registered with a legislated professional regulatory body and eligible for independent practice in the province/territory in which the service is being provided. Consequently, it appears Canadian Certified Counsellors in provinces where the profession has not been regulated (i.e. all but NS, ON, QC) are now excluded as providers of the short term crisis intervention mental health counselling benefit.

In the absence of provincial regulation of the counselling/psychotherapy profession across the country, CCPA has offered for 30 years a nationally recognized certification process through which members can obtain the designation of Canadian Certified Counsellor (CCC). This designation identifies to the public those counsellors whom CCPA recognizes as achieving the national standard for counselling/psychotherapy practice in Canada. Certification through CCPA requires a Master’s degree in counselling, psychotherapy or a counselling-related field, and an extensive supervised field practicum. Because of the variable statutory regulation of the profession across provinces and territories, CCPA has held high standards for Canada. It has an established Code of Ethics, Standards of Practice, Complaints Procedures, and a Continuing Education system.

Indigenous mental health practice has emerged as a distinct field within the mental health profession, combining Indigenous healing approaches with Western-based therapeutic approaches. CCPA values and promotes this distinction and the importance of culturally-safe practice. Through the Indigenous Circle Chapter of CCPA, support and resources are provided to Indigenous and non-Indigenous counsellors/psychotherapists working on the front lines. Circle members have the opportunity to network, share effective practices, access relevant professional development opportunities, and contribute to the evolution of this distinct field within mental health.

As a national association, we continue to strive to find ways to help meet the needs of Indigenous peoples in Canada in the area of wholistic health and wellbeing. We understand the principles of balance and
interconnectedness that inform Indigenous mental health practice, involving the mental, physical, emotional, and spiritual aspects of individuals and communities. The Indigenous Director position on our national Board of Directors ensures that Indigenous issues are addressed in all policy and program decisions. Our second CCPA issues paper (currently under development) focuses on the urgent need to increase and improve mental health services for Indigenous peoples in Canada.

Given our collective body of work specific to Indigenous mental health and the rigour of our national certification program, CCPA is confident in requesting the reinstatement of Canadian Certified Counsellors as approved providers of the NIHB counselling benefit.

Our Ideal Scenario Related to the Issue

CCPA strongly recommends that Canadian Certified Counsellors (CCCs) in provinces and territories which have not regulated the profession of counselling/psychotherapy be immediately reinstated as eligible service providers of the Short Term Crisis Intervention Mental Health Counselling benefit. By reinstating Canadian Certified Counsellors (CCCs) as approved providers, the Government of Canada would help ensure appropriate access to mental health counselling services for Indigenous peoples.

For Further Information

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Thank you/Merci/Meegwetch

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About
The Canadian Psychological Association (CPA) is the national association for the science, practice and education of psychology in Canada. There are approximately 18,000 psychologists registered to practice in Canada. This makes psychologists the largest, regulated, specialized mental health care providers in the country. Their scope of practice across public and private sectors includes the psychological assessment and diagnosis of mental disorders and cognitive functioning, the development and evaluation of treatment protocols and programs, the delivery of psychological treatments, and research.

CPA appreciates the opportunity to provide recommendations to the Assembly of First Nations and the Health Canada’s First Nations and Inuit Health Branch for the joint review of the Non-Insured Health Benefits Program. The focus of this submission is on the short term crisis intervention mental health counselling benefit.

1) Barriers to access for First Nations clients and communities

The program is set up to help individuals address crisis situations by providing immediate psychological and emotional care to individuals in significant distress when no other mental health services are available.

There are conditions and requirements of eligibility which, within a complex system, may pose significant barriers to accessing care. Navigating these barriers is made even more problematic by users’ acute state of distress. For example, a client must first demonstrate that there are no other funded programs or services available to them. In a system, or set of systems which completely or incompletely cover mental health services, it can be challenging to demonstrate that no alternate care is indeed available.

The number one challenge identified by First Nations communities is substance abuse. Substance use and abuse is concomitant with mental disorders. According to the CAMH, “30 per cent of people diagnosed with a mental health disorder will also have a substance use disorder at some time in their lives. This is close to twice the rate found in people who do not have a lifetime history of a mental health disorder”. Given the concomitance of mental disorders and substance abuse, it is hugely problematic that persons in crisis who may be experiencing problems related to substance use and abuse do not qualify for substance abuse counselling/therapy under the NIHB program.

It is also problematic that assessment services are not covered by the program – particularly those that may be related to detecting developmental or learning programs. Similarly, the fact that treatment for developmental delay or learning disabilities is not covered is also problematic. Return on investment is greatest when the mental health problems of children and youth are assessed and treated. Mental health crisis may be precipitated by a range of biological, social and psychological conditions. An assessment is critical for an accurate diagnosis. The 15 sessions permitted by the NIHB or IRS RHSP programs will be more effectively spent if they followed from an appropriate assessment and diagnosis of presenting problems.

Fifteen sessions, with a possible extension of 5 sessions, as permitted by the NIHB or IRS RHSP is not always long enough to adequately deal with mental health crisis and its underlying problems.

Psychotherapy outcome research by the APA Task Force on Evidence-Based Practice (2006) and Harnett,
Donovan, and Lambert (2010) demonstrate that 85% of clients show reliable improvement after 21 sessions, and recommend that psychotherapy is most effective at 21 to 25 sessions for sustainable change.

Recommendations:

- Provide assistance to otherwise eligible service users so they can determine if any publicly funded services exists as a condition of their eligibility for NIHB services.
- Permit users to access service for a situational crisis even if their mental health condition includes a concomitant substance abuse disorder.
- Cover the cost of assessment to help ensure that the treatment provided is based on a complete and evidence-based understanding of a user’s presenting problem.
- Cover the cost of 20 sessions with a possible extension of 5 additional sessions.

2) Administration issues

A psychologist wishing to serve clients must first enroll and get prior approval. The psychologist must then ensure that a number of conditions are met on behalf of their client. Some may find that the system is too complex, hard to navigate and unsure if reimbursement for the services provided will be possible.

In terms of compensation, in some jurisdictions, rates are lower than the rates set by the Provincial and Territorial associations of psychology. No reimbursement is provided for missed appointments.

The Guide articulates that eligible practitioners include “psychologists and social workers with clinical counselling orientation”. The term clinical counselling is not particularly meaningful to the practice of psychology. Further, psychologist is a protected title through registration. We recommend instead that the requirement read “psychologists and social workers registered to provide clinical or counselling services”. The Guide also allows for mental health counsellors with education and training comparable to psychologists or social workers. We recommend instead that it read “mental health counsellors with appropriate training and/or credentialing” which would render the provision which follows unnecessary.

A provider either is a regulated health professional or not. Allowing for comparable training from an unregulated provider makes sense in terms of broadening the pool of providers available to those in need of services. However, permitting the provision of service from a provider who is unregulated and has no appropriate or comparable training is not likely to yield accountable service or public protection.

Recommendations:

- Those Federal government departments which enter into contracts for service from registered psychologists pay at least the recommended rate set by the provincial and territorial association of psychology in the jurisdiction in which the service is delivered.
- Missed appointments with a psychologist cost that practitioner at least 50 minutes of clinical time with no opportunity to fill that time with other remunerated work. It is common practice that psychologists invoice patients for missed sessions unless a certain period of notice has been given (e.g. 24 to 48 hours). Recommend that providers receive some kind of remuneration for appointments cancelled without notice.
• Limit providers to those practitioners who are registered to provide clinical or counselling services and/or unregulated practitioners with demonstrable appropriate training.

3) Promising practices or approaches that have helped to improve benefit delivery or client access to the benefit.

As mentioned in the Guide, the provision of culturally competent care is critical to the delivery of effective services. Further, developments in tele-mental health allow those living in remote communities access to care they might not otherwise receive. This means of service delivery may afford First Nations persons better access to needed care.

NIHB and IRS RHSP have developed guidelines and procedures for a limited provision of mental health services through telehealth. We are pleased that the mental health counselling providers must meet the standards and code of ethics of their respective legislated regulatory bodies and Provincial/Territorial regulations in the provision of mental health services through telehealth, including client privacy and confidentiality.

We wanted to make this committee aware that the CPA has draft ethical guidelines for psychologists providing psychological services. The guidelines are derived from the ethical principles and values of the *Canadian Code of Ethics for Psychologists* (CPA, 2000), which provides an ethical framework and standards for the professional activities of all members of the Canadian Psychological Association, or of members of other bodies that endorse or have adopted this code. However, the guidelines address issues that are unique to the use of electronic media; they do not duplicate relevant standards in the *Code*. As such, the guidelines should be used in conjunction with the most recent version of the *Code*. Each guideline is referenced with one or more Ethical Values used in the *Code*.

**Recommendations:**

- Develop an online workshop on cultural competency for all mental health providers.
- Work with CPA to develop continuing education workshops that would enhance the cultural competency of psychologists and other providers to work with First Nations persons.
- Work with CPA to explore the application of tele-mental health services.

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i The number one challenge identified by First Nations communities is substance abuse

ii [http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/concurrent_substance_use_and_mental_health_disorders_information_guide/Pages/what_are_cd_infoguide.aspx](http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/concurrent_substance_use_and_mental_health_disorders_information_guide/Pages/what_are_cd_infoguide.aspx)

iii [http://www.cpa.ca/docs/File/Position/CPAbriefSSCommitteeNov2011FINAL.pdf](http://www.cpa.ca/docs/File/Position/CPAbriefSSCommitteeNov2011FINAL.pdf)