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# Aboriginal Data Report for the South West LHIN Health Links

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May 2015



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## **Introduction**

This document provides a summary of known socio-demographic and health information for the Aboriginal population in Southwestern Ontario (Table 3). In addition, we describe the results of our quality appraisal of existing data, detail data limitations and provide some recommendations for moving forward with respect to ongoing health assessment and health system performance measures that will support health links in responding to service gaps for Aboriginal people in Southwestern Ontario. Finally, we have generated a comprehensive list of Aboriginal and allied health and social services and their GPS coordinates located in the South West LHIN (Appendix A).

## **Methods**

A comprehensive review of available public data, journal publications and 'grey literature' was conducted. Three online databases were searched: Medline, PubMed and PsycInfo. The search included combinations of the following keywords: Aboriginal, First Nations, Métis, Inuit, Chippewas, Oneida, Saugeen, Southwest Ontario, London, Middlesex, etc. The websites of national and regional governments and relevant health agencies were searched for grey literature, including reports, policy statements, press releases and conference proceedings. Findings were synthesized and summarized into Table 3 below.

We also contacted the Southern Ontario Aboriginal Health Access Centre and Métis Nation of Ontario to better understand existing First Nations, Métis, and urban Aboriginal health data initiatives involving the Institute of Clinical Evaluative Sciences, including their potential contribution to understanding First Nations, Métis and urban Aboriginal demographics, health determinants, health status, and health service access in Southwestern Ontario.

## **Overview of Existing Socio-Demographic and Health Information for the Aboriginal Population in Southwestern Ontario**

The main sources for existing socio-demographic and health information for the Aboriginal populations in Southwestern Ontario are from federal and local levels. The table highlights data from the 2011 National Household Survey (NHS), the 2006 Census and Aboriginal Affairs. A community health plan for Chippewas of the Thames was included in addition to 3 smaller focused studies: one treatment centre evaluation and 2 qualitative studies.

## Quality Assessment and Data Limitations

Overall, the existing data provides some understanding of the socio-demographic profile of the Aboriginal population in Southwestern Ontario. However, we can observe, based on this summary, that there are large gaps in data and knowledge, especially with respect to population based information regarding health status and health care use for the Aboriginal population in Southwestern Ontario. This represents a double standard with respect to Aboriginal compared to non-Aboriginal health assessment which is striking giving the relatively high quality health assessment and monitoring information systems that the large majority of Canadians take for granted. (Smylie & Firestone, 2015; Smylie, 2014) It also leaves health policy makers in an extremely challenging position – as it is difficult to plan, implement, and evaluate health programs and services without accurate information regarding the size of the Aboriginal population, the prevalence rates of acute and chronic illness, and the rates of use of health services.

The major quality challenge with existing Aboriginal health data is the lack of Aboriginal specific identifiers that are consistent and relevant in major health and social data sources (Table 1). This is a national challenge and not unique to Southwestern Ontario. Since the Aboriginal identification question was removed from the Census in 2006, our ability to even count the number of Aboriginal people accurately (let alone their health status and health care use) has declined.

Quality issues with the 2006 census also stem from significant undercounting of Aboriginal populations. This includes block non-participation by First Nations on-reserve communities (Statistics Canada, 2013) and an undercounting of urban Aboriginal people who are homeless, highly mobile or who have lower levels of educational achievement in written English or French. Additionally, some Aboriginal people may not participate in the census due to distrust or political disagreement with federal governmental agencies or chose not share their Aboriginal identity and/or ancestry information. (Firestone, Smylie, Maracle, Spiller, & O'Campo, 2014; Smylie, Firestone, et al., 2011) This situation has not improved with the transfer of Aboriginal identity and ancestry questions to the NHS in 2011. The response rate for the NHS in 2011 was significantly lower than that of the 2006 long form census (68.6% compared to 93.5%). (Statistics Canada, 2011)

With respect to health care utilization data, Aboriginal identification is currently not available in Canada because information regarding ethnicity and/or race is not routinely collected at point of service access (i.e. emergency room or hospital admission or primary care service rostering) as it is in other countries like the United States, Australia and New Zealand. A recognized best practice is found in New Zealand where self-identification is the recommended method of reporting ethnicity in all collections of official statistics and methods have been standardized to ensure high quality data collection and cultural security for clients being asked to self-identify. (Statistics New Zealand, 2004)

**Table 1: Aboriginal Identity Information in Primary Populations Health Data Sources, Canada**

<b>Data Source</b>	<b>Indigenous Identifier</b>
Census	No – removed in 2006
Vital Registration	On birth registration in majority of provinces and territories; on death registration in fewer provinces and territories; inconsistent terms and poor data quality
Primary Care/Hospitalization Records	No – a few provinces/territories have Indigenous identifiers on their health cards, generally not used due to poor quality of these flags
Disease Surveillance/Registries	Limited – inconsistent terms
National Health and Social Surveys	Yes on some - loss of population based sampling frame in 2006, large majority significantly underpowered in their Indigenous sampling and exclude First Nations on-reserve communities

While smaller, community-based studies do contribute to filling gaps in understanding the local Aboriginal health needs and responses, these studies are limited by the fact that they usually are restricted to existing health service users or volunteer participants and therefore do not tell us about persons who may have high needs but are not using services or volunteering for studies. As a result there are many remaining unanswered questions about barriers to health and social service use and access and the determinants of health that operate in Aboriginal peoples’ everyday lives.

Improvement of basic public health data sources is a vital and necessary step to ensuring that programs are appropriate and effective in addressing Aboriginal health status inequities. Not only are such deficiencies an infringement on Aboriginal peoples’ “right to be counted” (Setel et al., 2007), the absence of information regarding Aboriginal people reinforces and legitimizes negative and damaging stereotypes of Aboriginal people. For example, stereotypes of the “drunken Indian” serve to justify acts of racism and inequitable treatment and represents the ways in which the dominant stories in Canadian society of who Aboriginal peoples are rarely told by Aboriginal peoples themselves. (Allan & Smylie, 2014)

## Existing and Potential Contributions of Linkages to the Institute for Clinical Evaluative Sciences (ICES) Databases

Table 2 summarizes existing initiatives aiming to address gaps in Aboriginal health information by linking existing registries or cohorts of Aboriginal peoples to the holdings of the Institute for Clinical Evaluative Sciences (ICES). ICES is an independent, not for profit organization whose core business is to contribute to the effectiveness, quality, equity, and efficiency of health care and health services in Ontario. These initiatives could be particularly important in addressing the almost complete absence of population based Aboriginal health care use data as ICES holdings include regionally specific emergency room use and hospital discharge databases which have been imported from the Canadian Institutes of Health Information (CIHI). There are four existing initiatives, none of which have yet produced Aboriginal health care utilization information specific to Southwestern Ontario, but three of which have the potential to do so. The ICES linkage of the federal Indian Registrar, which is a list of all of the First Nations person in Ontario who are registered as Status Indians by the federal government according to Indian Act Legislation has the potential to produce population based health care use information for First Nations persons with status living both on and off-reserve in Southwestern Ontario. At the time of the writing of this report, the Chiefs of Ontario, the umbrella organization leading the ICES – Indian registry data project had not yet released any regionally specific data reports.

ICES data holdings also allow for the generation of prevalence estimates for chronic disease using OHIP billing codes. However, the validity of established ICES methods for generating population based chronic disease estimates for First Nations with status using the ICES – Indian registry database may be impacted by attendance at community health centres, including the Southern Ontario Aboriginal Health Access Centres (SOAHAC) as these visits do not generate OHIP billing codes.

The linkage of Aboriginal health access centre patient registries to ICES will provide important information about emergency room use and hospitalization for Aboriginal people who use the SOAHAC. Of course it will not provide information about people who do not use the SOAHAC. It may also provide some insights regarding the degree to which ICES OHIP billing-based disease prevalence estimates are impacted by SOAHAC use.

The Métis Nation of Ontario has indicated that there are not enough registered Métis in Southern Ontario to generate regional health status and health care use information using the ICES - MNO registry database.

The aim of the Our Health Counts (OHC) London study is to produce a population based cohort of urban Aboriginal people (inclusive of First Nations with and without status, Métis, and Inuit) and then link this cohort to ICES holdings. If the study achieves its target sample size of 500 adults, then it should be adequately powered to generate rates of Emergency Department (ED) access and

hospitalization specific to self-identified Aboriginal peoples living in London drawing on the ICES linkage of the study cohort. OHC London will also produce a comprehensive set of population based statistics regarding the health determinants, health status and health service needs and use drawing on the study's health survey too.

**Table 2. ICES Linkage Projects and Potential for Southwestern (SW) Ontario**

Linkages	Current data available for SW Ontario	Potential to generate data for SW Ontario	Data will be population-based
ICES – Indian registry linkage	None	Yes	Yes
ICES – Aboriginal health access centre linkage	None	Yes	No
ICES – MNO registry linkage	None	No	n/a
ICES – OHC London linkage	None	Yes	Yes

## Limitations with Existing Data can Impact Health Links

A Health Link is a new model of care where all providers in a community, including primary care, hospital and community based services, are charged with coordinating care plans at the patient level. Health Links will be designed around, and accountable for system level metrics established by the Province with an initial focus on the high-users; defined as persons who use many services (e.g., frequent ED visits, frequent admissions) as this segment of the population uses a disproportionate amount of care at a cost that is not sustainable, nor necessarily appropriate for their needs.(South West Local Health Integration Unit, 2013) As established by their terms of reference, the leadership, governance, composition and integration initiatives of the Health Links will be flexible and based on local need and population and each Health Link will work with providers to ensure that they put in place collaborative initiatives that will deliver a measurable, positive impact on patient care.(South West Local Health Integration Network, 2015)

Patients with High Care Needs in the Southwest LHIN have been defined as those who fall in to both the top 5% for number of unscheduled ED visits and the top 5% for number of non-elective hospital discharges for 2013/14. Core outcome measures for Health Links in the Southwest LHIN accordingly focus on reductions in unscheduled and non-elective emergency department visits, hospitalizations, and re-hospitalizations post-discharge from the ER or hospital.

The challenge with the focus on high users of tertiary care services and the linked success metrics around a reduction in the use of the ED and hospital is two-fold with respect to the needs of the Aboriginal population in Southwestern Ontario. Firstly, there is no Aboriginal specific data regarding emergency room use, hospitalizations and re-hospitalizations. This is because, as we pointed out

earlier, there is no existing system for identifying Aboriginal people in our health care use systems. So, we don't know what proportion of "high users" are Aboriginal and we cannot assess Aboriginal specific impact of Health Links using these metrics.

The second concern is that the "high use" focus does not tell us about the unmet health care needs of persons and populations who are under-users of hospital services. There is substantive evidence indicating that some Aboriginal individuals and/or populations may fall into this group. The first set of evidence relates to the known disproportion of premature mortality of First Nations persons in Canada compared to the general Canadian population, including premature mortality from causes that can be addressed through treatment in hospital such as suicide, cardiovascular disease, and respiratory tract infection. (Health Canada, 2009; Oliver, Peters, & Kohen, 2012; Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2009) The second set of evidence relates to documented differential access to hospital based diagnostic tests and treatment. For example, a recent study in Alberta showed that First Nations persons were less likely to receive coronary angiogram compared to non-First Nations persons within 24 hours of an acute myocardial infarction. (Bresee et al., 2014) This Indigenous/non-Indigenous differential access to urgent cardiovascular interventions has also been shown in Australia and New Zealand and is particularly concerning given the relatively high population prevalence of CVD disease among Aboriginal compared to non-Aboriginal populations. The Our Health Counts (OHC) First Nations study showed relatively high rates of ER access across levels of acuity for self-identified First Nations persons living in Hamilton compared to the general Hamilton and Ontario population, but similar hospitalization rates. (Firestone et al., 2014; Smylie, Firestone, et al., 2011) This raises questions regarding why the hospitalizations rates are not also higher, given the relatively high rates of chronic disease such as diabetes in the self-identified First Nations population (18% of adults). Unintentional bias in physician decision making regarding hospital based testing and treatments has been demonstrated in studies comparing the treatment of persons racialized as white compared to persons racialized as black and/or Hispanic in the United States. For example, a study in the United States demonstrated that Black and Latino patients were less likely to receive pain (i.e. analgesics) treatment for bone fractures in the emergency room than white patients.(Todd, Deaton, D'Adamo, & Goe, 2000) A third set of evidence relates to the substantive literature documenting both material and attitudinal barriers to accessing hospital based care (Allan & Smylie, 2014; Smylie, Firestone, et al., 2011). For example, Browne et al. examined the experiences of Aboriginal and non-Aboriginal persons accessing an inner-city emergency department and found that Aboriginal participants actively strategized on how to manage negative responses from health care providers in advance of accessing care in the emergency department. (Browne et al., 2011).

The Aboriginal Patient Journey report being prepared by Williams Consulting is an important complement to this review of health information and describes patient experiences of accessing health services in Southwest Ontario, drawing on patient interview data. Although the final report was not available at the time of writing, preliminary themes in this report support the evidence we have cited above. Experiences of attitudinal racism and the need to improve cultural security in health service encounters and setting were both identified as major issues impacting access to

health care for Aboriginal peoples in Southwestern Ontario in this report, as were unaddressed material needs, including transportation.

For Aboriginal populations in Southwestern Ontario it is therefore going to be very important for Health Links to additionally focus on better understanding and responding to the needs of hospital “under-users”. This will involve addressing barriers to accessing hospital services including lack of adequate transportation; gaps in cultural safety; and differential decision-making regarding access to hospital tests, treatment and admission by hospital staff.

**Questions for Health Links to consider:**

- What about Aboriginal individuals who don’t access the ED or who are sick and/or dying at home from potentially treatable causes?
- What kinds of services are Aboriginal people accessing and how long are people travelling to use these services? What services are they avoiding? Why?
- What are some of the key barriers to accessing care for Aboriginal people in SW Ontario?
- Where do Aboriginal people go to access services and what is the quality of this care?
- How does cultural safety compare in Aboriginal specific services compared to mainstream services?
- How can mainstream services and service providers contribute to culturally secure encounters?

## **Coordinated Care Plan in the Context of Cultural Safety**

Many Health Links are developing coordinated care planning processes that define how providers, patients and their families work together to coordinate and deliver care for Health Link patients. As outlined in the Coordinated Care user guide (Ministry of Health and Long Term Care, 2014) the following are five guiding principles to encourage the trust, use, and value of CCPs:

- i. The patient is informed of all information included in the CCP, who has access to the information and how the information is intended to be used.
- ii. Each CCP is developed with direct input from the patient. CCPs reflect patients’ stated goals, needs and preferences and are written in clear, accessible language, using patients’ own words where possible.
- iii. CCPs are accessible to patients and the circle of care in any setting where care may be delivered.
- iv. CCPs are actively used and reliably maintained according to the clinical practices established in each Health Link by all in the circle of care.
- v. CCPs are based on current evidence and use generally accepted clinical guidelines.

These principles are a very important foundation for establishing and ensuring culturally safe care, however, there are implications to be considered when providers will be asking individuals about their Aboriginal identity.

The identifiers section of the CCP will be used to, “help establish the identity of the patient by providing both basic information about him/her (e.g. name, date of birth, address, etc.) as well as other information that will help the care team understand the patient, such as his/her ethnicity, religion, marital status and living conditions.” Specifically, the patient’s self-identified ethnicity or culture will be recorded into the CCP.

While this data will be helpful for understanding health care and equity gaps, research has indicated that it is important that patients do not feel that they have to explain their identity when expressing their health care needs.(National Collaborating Centre for Aboriginal Health, 2013) This is particularly true if a health care worker is not culturally aware or adequately trained to provide a safe environment.

For Indigenous people, being able to define one’s own identity, both individually and collectively, on one’s own terms is a central part of self-determination. In Canada, self-identification is the recommended method of Indigenous identification, not only in the census, NHS and national health and social surveys, but also in vital registration, health care utilization, and disease surveillance/registry data systems. Methods that have been refined and tested in other affluent countries with minority Indigenous populations such as Australia and New Zealand provide useful exemplars.(Statistics New Zealand, n.d., 2004) It is critical that before beginning any collection of Aboriginal identity information, standards have been established and met. This will include methods and processes which allow individuals to confidentially self-identify rather than be asked by a clerk or health care provider; ensure that all staff involved in gathering self-identity data have been trained; and that high quality health information systems are in place to support this health information.

Collective Aboriginal community engagement and data sharing agreements are also needed in order to rebalance the distribution of data resources, build community-level data capacities and generate higher quality data that is more relevant and policy ready. (Smylie, Lofters, Firestone, O’Campo, & Campo, 2011) Without these protocols in place, there may be misclassification of data in addition to potential breaches of cultural safety.

## **Aboriginal Health and Human Resources in Southwestern Ontario**

The existing barriers to health care access and gaps in health information contribute to pressures and strains within Aboriginal specific health organizations and service providers. As we learned from our health equity impact analysis of Health Links in Toronto, coordinating service delivery and building and maintaining collaborative relationships between service providers requires time and

resources. Regionalized restructuring of health service delivery and funding in Ontario, first with the establishment of the LHINs and now with Health Links has dramatically increased the burden of education and liaison for Aboriginal health and social service organizations and their staff as this regionalization has increased in the number of health policy makers and organizations to liaison with. This has occurred in the context of Aboriginal health and social organizations and services that are already under-resourced and struggling to meet needs of local Aboriginal populations. Concrete and strategic investments are required to ensure that there is a rebalancing of these education and liaison responsibilities across the LHIN and Health Links so that it does not fall on already overloaded and under-resource Aboriginal health and social service representatives. (Snyder & Smylie, 2014)

There is also a need to systematically document and describe the existing human resources and service infrastructure currently available for Aboriginal health and social service delivery in South Western Ontario and begin to match these to unmet needs. In addition to supporting the training and opportunity for more Aboriginal health care professionals, which is recognized globally as a strategy to address unmet Aboriginal health service needs (Allan & Smylie, 2015) there is a need to build capacities and education among mainstream non-Aboriginal specific service providers, so that all health services and programs are accessible and culturally secure for Aboriginal clients.

## Recommendations for Moving Forward

1. The LHIN needs to support, in partnership with Aboriginal agencies, better Aboriginal data collection to ensure we can evaluate Health Links impacts and efficacy for Aboriginal people.

Core areas to include are:

- Aboriginal specific population based health service utilization data;
  - Aboriginal specific population based health status data regarding comorbidities and chronic illness; complex health needs including mental health, substance use and dual diagnosis;
  - Data regarding key social determinants of Aboriginal health including housing and income
- a. An expanded focus of Health Links to include “under-users” by developing and implementing key metrics that address unmet health needs as well as barriers and access to services. This could include measures of forgone care (ie self-reporting of delayed or forgone primary or tertiary medical care or prescription medication); measures of the extent of worsening health conditions as a result of barriers to addressing unmet health needs (ie rates of illnesses known to be prevented by screening and early and/or pro-active management such as cervical cancer, advanced breast and colorectal cancer, cardiovascular complications of diabetes) ; and tracking of access to hospital care that is known to result in a reduction premature disability/death (ie coronary angiography following acute MI).
2. Identify and address resources and capacities needed to respond to service gaps for Aboriginal people in Southwestern Ontario
    - a. Time and resources are needed to support the full engagement and action of Aboriginal service organizations and stakeholders who are already stretched to capacity.
    - b. Continue and extend cultural safety training to address institutional racism and trauma, and assess how to apply this knowledge appropriately and adequately.
    - c. Increased support and training of Aboriginal health care professionals as well as increased awareness and education for mainstream providers.
    - d. There are important unmet material needs such as transportation that need to be addressed in order to allow equitable access to services for Aboriginal people in the region

3. Develop and support synergies between health links and other research and policy initiatives that impact the SWLHIN
  - a. Our Health Counts London

OHC London will provide important population based health information that address the priority areas identified by key stakeholders describe in 1a above. This could be expanded to other areas in the SW LHIN but required time and resourcing.
  - b. Data linkages (e.g. ICES agreement with Ontario Chiefs)

This could be an important complement to the OHC London data – but will only provide information for 2/3 of the Aboriginal population that is recognized as a “Status Indian” by the federal government.
4. Work in partnership with local, regional and/or provincial Aboriginal governing bodies and health service organizations to develop a strategy for the culturally secure collection of Aboriginal identity data in vital registration and health service utilization data systems. This work needs to be guided by existing domestic and international best practices and led by Aboriginal governing and/or health service organizations.

**Table 3: Synthesis chart of known health and socio-demographic information regarding Aboriginal population in Southwestern Ontario**

	Author, Title, Year	Study Design	Population	Demographic Data	Health, Health Behaviour and Social Determinants of Health
1.	National Household Survey, Aboriginal Population Profile, <b>Southwest Middlesex (Municipality)</b> , 2013 <sup>1</sup>	Quantitative-Survey-Based on Census Sample	In 2011, 1.6% (90) of the population of Southwest Middlesex had an Aboriginal identity	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• 0-14 years: 33.3%</li> <li>• 15-24 years: 0%</li> <li>• 25-64 years: 66.7%</li> <li>• 65+ years: 0%</li> </ul> <p><b>Identity</b></p> <p>Of 90 people reporting Aboriginal identity:</p> <ul style="list-style-type: none"> <li>• First Nations: 72.2% (65)</li> <li>• Metis: 22.2% (20)</li> </ul> <p><b>Language</b></p> <ul style="list-style-type: none"> <li>• 88.9% of the Aboriginal identity population in Southwest Middlesex reported that they were able to conduct a conversation only in English or only in French</li> </ul>	
2.	National Household Survey, Aboriginal Population Profile, <b>Middlesex Centre (Township)</b> , 2013	Quantitative-Survey-Based on Census Sample	In 2011, 0.7% (110) of the population of Middlesex Centre had an Aboriginal identity	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• 0-14 years: 13.6%</li> <li>• 15-24 years: 50%</li> <li>• 25-64 years: 36.4%</li> <li>• 65+ years: 0%</li> </ul>	

<sup>1</sup> <http://www12.statcan.gc.ca/nhs-enm/2011/dp-prod/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3539005&Data=Count&SearchText=Southwest%20Middlesex&SearchType=Begins&SearchPR=01&A1=Aboriginal%20peoples&B1=All&Custom=&TABID=1>

				<p><b>Identity</b> Of 110 people reporting Aboriginal identity:</p> <ul style="list-style-type: none"> <li>• First Nations: 86.4% (95)</li> <li>• Metis: 13.6% (15)</li> </ul>	
3.	National Household Survey, Aboriginal Population Profile, <b>North Middlesex (Municipality)</b> , 2013	Quantitative-Survey-Based on Census Sample	In 2011, 0.6% (35) of the population of North Middlesex had an Aboriginal identity.	N/A	
4.	National Household Survey, Aboriginal Population Profile, <b>London</b> , 2013 <sup>2</sup>		In 2011, 1.8% (8,475) of the population of London had an Aboriginal identity	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• 0-14 years: 25%</li> <li>• 15-24 years: 18.9%</li> <li>• 25-64 years: 50.5%</li> <li>• 65+ years: 5.5%</li> </ul> <p><b>Identity</b> 1.9% (8,475) of the London population reported Aboriginal identity</p> <ul style="list-style-type: none"> <li>• First Nations: 73.1% (6,195)</li> <li>• Métis: 21.5% (1,825)</li> <li>• Inuit: 0.8% (75)</li> </ul> <p>An additional 280, or 3.3%, reported other Aboriginal identities and 100, or 1.2%, reported more than one Aboriginal identity.</p>	<p><b>Living Arrangements:</b> Family with both parents: 48.6% of Aboriginal children aged 14 and under Lone parents: 40.1% of Aboriginal children aged 14 and under</p>

<sup>2</sup> <https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/dt-td/Rp-eng.cfm?LANG=E&APATH=5&DETAIL=0&DIM=0&FL=A&FREE=0&GC=555&GID=0&GK=10&GRP=0&PID=105387&PRID=0&PTYPE=105277&S=0&SHOWALL=0&SUB=0&Temporal=2013&THEME=94&VID=0&VNAMEE=&VNAMEF=>

				<p><b>Language</b></p> <ul style="list-style-type: none"> <li>• Able to conduct a conversation in an Aboriginal language: 1.3% of the population who had an Aboriginal identity</li> <li>• Aboriginal language most frequently reported: Ojibway (45)</li> <li>• Aboriginal language as mother tongue: 0.7% of the Aboriginal identity population</li> <li>• Aboriginal language spoken at home: 0.9% of Aboriginal people</li> </ul>	
5.	National Household Survey, Aboriginal Population Profile, <b>Owen Sound</b> , 2013 <sup>3</sup>		In 2011, there were 1,020 individuals who reported an Aboriginal identity in <b>Owen Sound</b>	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• Under 25 years: 510</li> <li>• Median age: 25</li> </ul> <p><b>Identity</b></p> <ul style="list-style-type: none"> <li>• First Nations: 605</li> <li>• Métis: 390</li> </ul>	
6.	National Household Survey, Aboriginal Population Profile, <b>Stratford</b> , 2013 <sup>4</sup>		In 2011, there were 400 individuals who reported an Aboriginal identity in <b>Stratford</b>	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• Under 25 years: 165</li> <li>• Median age: 35.8</li> </ul> <p><b>Identity</b></p> <ul style="list-style-type: none"> <li>• First Nations: 290</li> <li>• Métis: 105</li> </ul>	

<sup>3</sup> <https://www12.statcan.gc.ca/nhs-enm/2011/dp-prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3542059&Data=Count&SearchText=Owen%20Sound&SearchType=Begins&SearchPR=01&A1=Aboriginal%20peoples&B1=All&Custom=&TABID=1>

<sup>4</sup> <http://www12.statcan.gc.ca/nhs-enm/2011/dp-prof/details/page.cfm?Lang=E&Geo1=CMA&Code1=553&Data=Count&SearchText=Stratford&SearchType=Begins&SearchPR=01&A1=Aboriginal%20peoples&B1=All&Custom=&TABID=1>

7.	National Household Survey, Aboriginal Population Profile, <b>Woodstock</b> , 2013 <sup>5</sup>		In 2011, there were 595 individuals who reported an Aboriginal identity in <b>Woodstock</b>	<p><b>Age</b></p> <ul style="list-style-type: none"> <li>• Under 25 years: 240</li> <li>• Median age: 31.9</li> </ul> <p><b>Identity</b></p> <ul style="list-style-type: none"> <li>• First Nations: 450</li> <li>• Métis: 130</li> </ul>	
8.	Aboriginal Population Profile: <b>Grey Bruce</b> . 2006 Census. Statistics Canada	Quantitative-Survey-Based		<p><b>Identity</b></p> <ul style="list-style-type: none"> <li>• Total Aboriginal identity population: 3,655 <ul style="list-style-type: none"> <li>2,335 North American Indian</li> <li>1,190 Métis</li> <li>20 Inuit</li> </ul> </li> <li>• Over 100 families within the Métis Nation of Ontario who reside in Grey Bruce</li> </ul> <p><b>Age</b></p> <ul style="list-style-type: none"> <li>• Median age: 31.6</li> <li>• 74% of the Aboriginal identity population is aged 15 and over</li> </ul> <p><b>Language</b></p> <ul style="list-style-type: none"> <li>• 10% knowledge of an Aboriginal language</li> </ul>	<p><b>Education</b></p> <ul style="list-style-type: none"> <li>• 36% of Aboriginal identity population reported having no degree, diploma or certificate</li> <li>• 22% of Aboriginal identity population have high school certificate or equivalent</li> <li>• 22% have College, CEGEP or other non-university certificate or diploma</li> <li>• 5.5% have a university certificate or degree</li> </ul> <p><b>Employment</b></p> <ul style="list-style-type: none"> <li>• 58.4% Employment rate</li> <li>• 11% Unemployment rate</li> <li>• Total experienced labour force 15 years and over with an Aboriginal identity: 1,715</li> <li>• Median income of the total Aboriginal identity population 15 years and over: \$14,186</li> </ul>

<sup>5</sup> <https://www12.statcan.gc.ca/nhs-enm/2011/dp-prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3532042&Data=Count&SearchText=woodstock&SearchType=Begins&SearchPR=01&A1=Aboriginal%20peoples&B1=All&Custom=&TABID=1>

8.	Aboriginal Affairs and Northern Development, First Nation profiles, updated 2015-01-23 <sup>6</sup>	Total registered population for the 5 First Nation communities in the SWLHIN		<p><b>1. Chippewas of the Thames:</b> Total registered population: 2783 % of registered population living on own reserve: 34.6%</p> <p><b>2. Saugeen</b> Total registered population: 1,810 % of registered population living on own reserve: 43.9%</p> <p><b>3. Chippewas of Nawash</b> Total registered population: 2,616 % of registered population living on own reserve: 27.5%</p> <p><b>4. Munsee-Delaware</b> Total registered population: 618 % of registered population living on own reserve: 23.9%</p> <p><b>5. Oneida Nation of the Thames</b> Total registered population: 6,010 % of registered population living on own reserve: 35.6%</p>	
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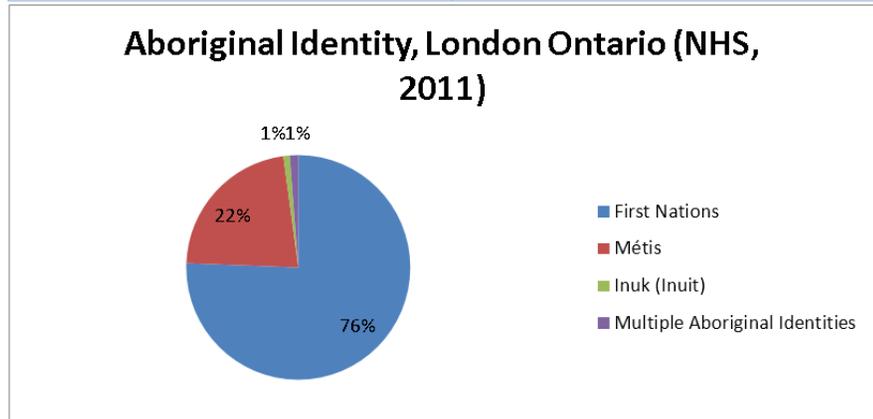
<sup>6</sup> <http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/SearchFN.aspx?lang=eng>

7.	<p><i>We Make the Path by Walking it</i>, The Chippewas of the Thames (COTT) First Nation  <i>Comprehensive Community Plan 2012 to 2022</i></p>	<p>community-based needs assessment and situation analysis</p>	<p>200 community members participated in many large and small consultations</p>	<ul style="list-style-type: none"> <li>• An estimated 80% of households are struggling with the impacts of addictions, violence, abuse and other outcomes of inter-generational trauma</li> <li>• 80% or more youth are using alcohol and/or drugs and many youth are losing their self-respect, have low morale and self-esteem, as well as low expectations for life achievements</li> <li>• Domestic violence and other types of abuse at the hands of intimate partners are still experienced by women in the community.</li> <li>• A significant number of children suffer almost daily from fear, anxiety, and emotional and/or physical abuse that is the result of bullying on the part of older, stronger children or even adults.</li> <li>• 25% of youth grow up in strong and healthy families</li> <li>• 65 to 70% of COTT people are living below the poverty line</li> <li>75% of the community's children are living in poverty</li> <li>• 25% of homes have serious mould contamination</li> <li>• By grade six-seven, many students are 2-3 grade levels behind in basic skills and academic work</li> <li>• Roughly 70% of COTT households receive all or a significant part of their income from Ontario Works</li> <li>Only about 30% of those who are able to work have jobs or are engaged in business</li> <li>• 95% of all people who are working on the Reserve have jobs with the Band</li> <li>• COTT does not have enough land to meet all its current needs, never mind those of the future</li> </ul>
9.	<p>Dell, C.A. et al. (2005). Resiliency and Holistic Inhalant Abuse Treatment. <i>Journal of Aboriginal Health</i>, 2(March), 4–12.</p>	<p>Data and case illustrations from two National Native Youth Solvent Addiction program treatment centres</p>	<p>Nimkee NupiGawagan Healing Centre (NNHC)</p>	<ul style="list-style-type: none"> <li>• Need for inner resiliency is paramount in the economic, social, psychological, and spiritual stresses faced by youth today</li> <li>• 82% of youth were not in school at the time of admission in 2001, 67% of these youth returned to school after treatment</li> </ul>

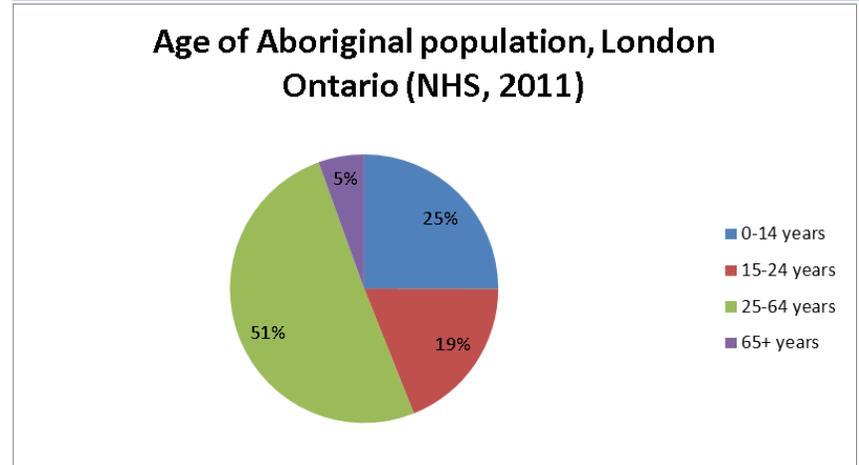
10.	Donovan, S. (2011). Challenges to and Success in Urban Aboriginal Education in Canada: a case study of the Wiingashik Secondary School. In H. A. Howard & C. Proulx (Eds.), <i>Aboriginal peoples in Canadian Cities: Transformations and continuities</i> . Waterloo: Wilfrid Laurier Press.	9 qualitative interviews with students and 2 interviews with staff	3 students from outside of Ontario, 4 affiliated with local reserves, and 2 were originally from elsewhere in Ontario		Students at Wiingashik experienced high levels of mobility Many students reported not attending school as the main reason for why they had been referred to an alternative program Students face many challenges that impede their performance at mainstream schools such as divided families, personal issues with drugs and alcohol The holistic model at Wiingashik focuses on unity, continuity and interconnectedness Overall 3 variables attributable to the school's success: 1) that it is operated in the friendship centre, 2) that it includes a cultural component, 3) that it is led by a culturally sensitive and respectful teacher
11.	Hernandez C.A. et al. (1999). A Grounded Theory Study of the Experience of Type 2 Diabetes Mellitus in First Nations Adults in Canada Diabetes in First Nations Canadians	10 qualitative interviews with First Nations adults. The study took place in a large First Nations community in Southwestern Ontario	All participants were adults, 21 years of age or older, who had Type 2 diabetes for at least 1 year and were able to understand and converse in English		Three major cognitive lifeways were found: denying, minimizing, and normalizing. <i>Denying</i> the diabetes resulted in activities such as skipping insulin or oral hypoglycemic agents. <i>Minimizing</i> involved downplaying the impact of diabetes on how one thinks, feels, one's lifestyle, and life. <i>Normalizing</i> involved asserting that one continues to live as one did prior to the diagnosis of diabetes. These characteristics were similar to those found in non-Aboriginal populations; however an additional lifeway of spirituality was also observed in this study.

**Charts and Graphs**

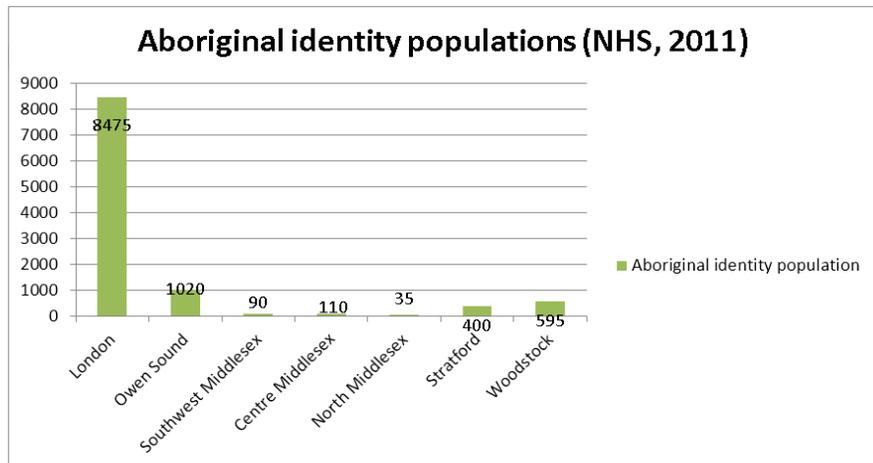
<b>First Nations</b>	<b>6,195</b>
<b>Métis</b>	<b>1,825</b>
<b>Inuk (Inuit)</b>	<b>75</b>
<b>Multiple Aboriginal identities</b>	<b>100</b>
	<b>8,195</b>



<b>Age of Aboriginal population, London Ontario (NHS 2011)</b>	
<b>0-14 years</b>	<b>25%</b>
<b>15-24 years</b>	<b>18.9%</b>
<b>25-64 years</b>	<b>50.5%</b>
<b>65+ years</b>	<b>5.5%</b>



	<b>Aboriginal identity population</b>	<b>% of total population</b>
<b>London</b>	<b>8,475</b>	<b>1.8</b>
<b>Owen Sound</b>	<b>1020</b>	<b>3.6</b>
<b>Southwest Middlesex</b>	<b>90</b>	<b>1.6</b>
<b>Centre Middlesex</b>	<b>110</b>	<b>0.7</b>
<b>North Middlesex</b>	<b>35</b>	<b>0.6</b>
<b>Stratford</b>	<b>400</b>	<b>1.4</b>
<b>Woodstock</b>	<b>595</b>	<b>1.6</b>



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## **Appendix A. GPS Coordinates for Aboriginal Service Organizations in the South West LHIN**

### **1. The Southwest Ontario Aboriginal Health Access Centre (SOAHAC)**

427 William St, London, ON N6B 3E2, Canada

Latitude: 42.988815 | Longitude: -81.234552

### **2. Southwest Ontario Aboriginal Health Access Centre - Owen Sound**

1025 2nd Ave W, Owen Sound, ON N4K 4N1, Canada

Latitude: 44.567487 | Longitude: -80.945863

### **3. The N'Amerind Friendship Centre**

184 York St, London, ON N6A 1B5, Canada

Latitude: 42.981651 | Longitude: -81.247711

### **4. KiiKeeWanNiiKaan, Southwest Regional Healing Lodge & Learning Centre**

275 Jubilee Rd, Muncey, ON N0L 1Y0, Canada

Latitude: 42.79281 | Longitude: -81.458898

### **5. M'Wikwedong Native Cultural Resource Centre**

1723 8th Avenue East, Owen Sound, ON N4K 3C2, Canada

Latitude: 44.576468 | Longitude: -80.927518

### **6. Wiingashk Centre**

260 Colborne St, London, ON N6B 2S6, Canada

Latitude: 42.981777 | Longitude: -81.23731

### **7. At^lohsa Family Violence Services**

343 Richmond St, London, ON N6A 3C2, Canada

Latitude: 42.981859 | Longitude: -81.248947

### **8. Nokee Kwe (Employment Centre)**

Dundas St, London, ON, Canada

Latitude: 42.982385 | Longitude: -81.254662

### **9. London Middlesex Counselling and Addiction Services**

20 Hillsborough Road, London, ON N6J 2E8, Canada  
Latitude: 42.946302 | Longitude: -81.261916

**10. Native Intertribal Housing Co-Op**

37 Tecumseh Avenue West, London, ON N6J 1K8, Canada  
Latitude: 42.967122 | Longitude: -81.264797

**11. First Nations Housing Co-Operative Inc.**

665 Lorne Avenue, London, ON N5W 3K4, Canada  
Latitude: 42.992543 | Longitude: -81.231055

**12. Indigenous Education Coalition**

14921 River Line, Bothwell, ON N0P 1C0, Canada  
Latitude: 42.579821 | Longitude: -81.875939

**13. Nimkee NupiGawagan Healing Centre**

936 River Rd, Caradoc, ON, Canada  
Latitude: 42.819981 | Longitude: -81.44048

**14. First Nations Centre, Fanshawe College**

Fanshawe College - London Campus 1001 Fanshawe College Boulevard, London, ON N5Y 5R6, Canada  
Latitude: 43.013919 | Longitude: -81.200929

**15. Indigenous Services Student Development Centre, Western University**

University College, Western University, 1151 Richmond St, London, ON N6A 3K7, Canada  
Latitude: 43.008629 | Longitude: -81.273276

**16. Métis Nation of Ontario - Community Wellness Program - Grey Owen Sound**

380 9th St E, Owen Sound, ON N4K, Canada  
Latitude: 44.566247 | Longitude: -80.938944

**17. Southwest Regional Cancer Program**

746 Base Line Road East #303, London, ON N6C, Canada  
Latitude: 42.96232 | Longitude: -81.227585

**18. Chippewas of Nawash Unceded First Nation**

a) Chippewas of Nawash Health Centre

Prairie Road, Mar, ON NoH 1Xo, Canada  
Latitude: 44.916542 | Longitude: -81.027966

- b) Kitaamgwedaagwad Gindaaswin Adult Learning Centre  
67 Community Centre Road, Wiarton, ON NoH 2To, Canada  
Latitude: 44.920765 | Longitude: -81.017461
- c) Chippewas of Nawash Housing  
67 Maadookii Crescent, Mar, ON NoH 1Xo, Canada  
Latitude: 44.906501 | Longitude: -81.033479
- d) Nshiime Day Care Centre  
Prairie Road, Mar, ON NoH 1Xo, Canada  
Latitude: 44.911351 | Longitude: -81.033662

**19. Saugeen First Nation**

- a) Adult Learning (SEZ)  
6493 Ontario 21, Southampton, ON NoH 2Lo, Canada  
Latitude: 44.46785 | Longitude: -81.364496
- b) Elders Facility (E'Gitzijit Endaawad)  
41 Mason Drive, Southampton, ON NoH 2Lo, Canada  
Latitude: 44.514809 | Longitude: -81.339533
- c) G'Shawdagawin Day Care  
19 Christine Street, Southampton, ON NoH 2Lo, Canada  
Latitude: 44.513828 | Longitude: -81.336971
- d) Kabaeashawin women's shelter  
24 Christine St, Southampton, ON NoH 2Lo, Canada  
Latitude: 44.514228 | Longitude: -81.337022
- e) Mino Bimaadsawin Health Centre  
57 Mason Dr, Southampton, ON NoH 2Lo, Canada  
Latitude: 44.514662 | Longitude: -81.344088

**20. Munsee-Delaware First Nation Health Centre**

289 Jubilee Road, Muncey, ON NoL 1Yo, Canada  
Latitude: 42.79281 | Longitude: -81.458898

**21. Chippewas of the Thames First Nation**

- a) Chippewas of the Thames First Nation Health Centre

Muncey, ON NoL 1Yo, Canada  
Latitude: 42.818853 | Longitude: -81.473461

b) Southwest Ontario Aboriginal Health Access Centre-Chippewas of the Thames Site

322 Chippewa Rd Muncey, ON NoL, Canada  
Latitude: 42.820147 | Longitude: -81.440304

**22. Oneida Nation of the Thames**

a) Oneida Health  
2213 Elm Avenue, Southwold, ON NoL 2Go, Canada  
Latitude: 42.818818 | Longitude: -81.409757

b) Oneida Nation of the Thames Community Development Division  
238 Oneida Rd, Southwold, ON NoL 2Go, Canada  
Latitude: 42.835199 | Longitude: -81.396143

c) Oneida Long Term Care Facility  
2229 Elm Ave, Southwold, ON NoL 2Go, Canada  
Latitude: 42.817245 | Longitude: -81.41151

d) Onyota'a:ka Family Healing Lodge  
2212 Elm Avenue, Southwold, ON NoL 2Go, Canada  
Latitude: 42.818905 | Longitude: -81.409567