Anishininiiwug Ajimoowin Animisewiinan

Mental Health and Substance Use Report

June 2024

Sioux Lookout
First Nations
Health Authority

About the Title

Anishininiiwug Ajimoowin Animisewiinan is an Oji-Cree phrase that has two translations. The literal translation is "First Nations' Stories of Hardships", or, "Hard Things in Life". The other translation is the one set within the cultural context of this report, "Stories About the Bad State We're In".

The title was selected by the Mental Health and Substance Use Steering Committee, comprised of community leadership from Sioux Lookout area First Nations. To move closer to mino bimadiziwin, the good life, we need to be able to talk about animisiwiinan, the hard things in life.

Some might be concerned that focusing on the negative paints the future of First Nations people and their health in a pessimistic light. The subject matter in this report is not polite-company conversation material. The Storytellers will tell us in this report: they are stories and statistics that we need to talk about to begin discussions about the hardships that have led to the current state of mental health and substance use among Sioux Lookout area First Nations.

— *Christian Quequish, Meno Ajimoowin Anookiwin (Knowledge Translation Specialist), Sioux Lookout First Nations Health Authority, Approaches to Community Wellbeing*

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Data Sources

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Ownership

The data in this report is owned collectively by the Sioux Lookout area First Nations with Sioux Lookout First Nations Health Authority acting as their data steward.

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A Prayer

From Elder Tom Chisel

Here, today:

We remember the very many kinds of losses and traumas our people have suffered and continue to experience.

We have lost many babies unborn, our babies who didn't survive long after birth.

We have lost babies and children through the violence of abuse and trauma from their own parents and others.

We have lost many youth who took their own lives and many more through drug overdoses.

Many youth struggle to make meaning in their lives and suffer mentally, in a society where their culture and language are ignored or demeaned.

Many youth struggle to be accepted because of their gender identity, becoming depressed and taking their lives or hurting themselves.

Many parents who have lost a baby, a child, a youth carry so much pain today.

Today, we humbly ask the Creator to give each one who suffers peace and hope. Give them the knowledge that through our collective losses, we have become resilient.

Long ago, our holy ones told us that when we are experiencing loss and grief, we are closest to the Creator's love, and are ourselves holy.

We ask that Creator gives all love and peace to become more resilient, to find peace and meaning in our lives.

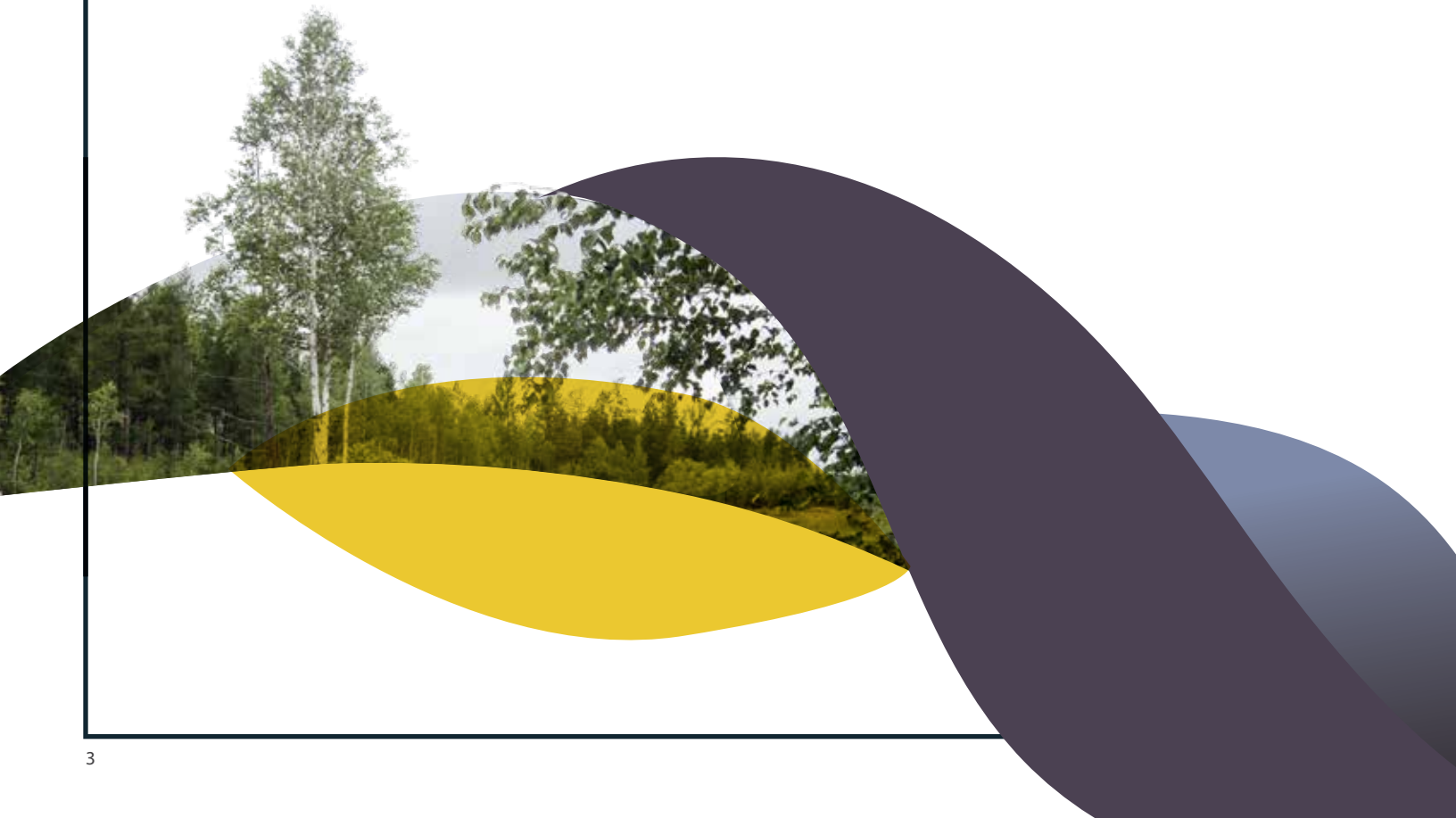
Gizhe Manido, miigwech, WIIGI ISHINAM (help us).

Stories

Patricia's Story

By Patricia Keesickquayash

> *We need to talk about it. And we need people to feel comfortable, safe, and heard when they are talking about it. There are challenges in creating those kinds of safe places in our community though.*



Patricia Keesickquayash

My Indian name is Gray Wolf Woman. I am from the Loon Clan and my protector is the Bear. I bring this stone as a symbol of my protector, and I bring this Eagle feather to give me strength and to help guide my words. Sharing my story is a part of my healing and growing. I want to share my words in a good way for my healing and for the healing of my community.

There was a time when I had frequent nightmares about a bear. No matter where I was, where I hid, the Bear would find me. I would jerk awake in the middle of the night sweating and scared. One night in my nightmare, I was running through my childhood home. The Bear was in pursuit attacking me, I ran down the hall and there was a room that I was drawn to. I knew I had to enter the room. There was an Elder, one of our traditional knowledge keepers, laying there on the bed. I picked him up and helped him out of the house. In my nightmare, he said to me, in Ojibway, "Why are you running? You don't need to be afraid, that Bear is your protector." He told me to look back and I saw that the house was on fire, and the Bear was in the house. I woke up and knew I had to go see the Elder. He was expecting my visit because he had the same dream I had. He gave me this rock and told me that the stone was a symbol of my protector, the Bear.

A Medicine Man had come to work in our community, and he was with us for quite some time. Then came the day when he knew he would not be visiting us any longer. He wanted to have a naming ceremony for me before he returned to his community. He gifted me the name 'Grey Wolf Woman'. In our language we don't have a word for 'grey', it is either black or white. So, I thought for a while, "Why grey?" An Elder I work with mentioned that I try to find balance in what I do.

I grew up in Mishkeegogamang during the 80's. When I was a young child, we moved to Bottle Hill as it was being developed. We were among the first families in that area. In the beginning it was hard. There was no running water or electricity. We hauled water. We hauled wood. After a couple of years, a pump house was built which made it a bit easier.

I am the seventh child of ten children born to my mother. My mother was only 15 years old when she was married to my father who was 33 years old. My mother did not meet him until the day she was married to him. At 15 years old you don't have much life experience and life was very hard for my mom. She was trying to learn how to be a mother.

My dad was a residential school survivor and he had expectations that made it feel like we were also experiencing residential school. He had his ways. Things had to be very immaculate, and things needed to be in place. The house had to be cleaned before he came home from work. I remember my siblings used to rush around about an hour before dad got home and they would be cleaning like crazy. Supper had to be ready when he got home. He made a black strap for our punishment. My father was an alcoholic.

Growing up, I was alone most of the time. I spent a lot of my years in the bush behind the house. I would climb trees. I would climb trees early in the morning before school. I would climb trees after school. I would sit in the trees and look across the area. I had a pretty lonely childhood, my older sisters didn't want me around.

My father was sexually abusive. My older sisters got it worse. My dad was doing that to my mom and my older sisters. From me and down to my younger siblings it kind of stopped. I was kind of a 'daddy's girl'. Nobody made me cry or gave me shit because my dad would get mad. I don't know why he protected me more than my other siblings.

But my dad still had parties at the house and drank. It was during those parties that I began experiencing sexual abuse. I was 5 years old and my dad was having one of his parties. There was a man from the neighbourhood there, and he came into my room. I was awakened in the middle of the night when my bedroom door opened, and the light from the hallway shone on my face. This drunk guy came in and knelt beside my bed and started touching me. I didn't know what to do. I just laid there. I froze. In my head, I was screaming, "No!", but I couldn't say anything. When it was happening, I didn't know how long it was. I was trying to block it out. I remember the door opening and I thought, "I'm saved! Someone is going to

help me!" It was my brother, and instead of helping me, he closed the door and I thought, "Nobody is going to help me." The drunk guy fell over when he was adjusting himself. He couldn't get back up and passed out. The next morning, I told my mom and dad what happened. The only response I got was, "Shhhh. We don't talk about that here." So, I didn't know who to tell. I still see that man in the community today.

I was introduced to solvents at an early age. There was a lot solvent abuse in the neighbourhood. I was about 8 years old the first time I got high. I just wanted to hang out with the rest of the kids, so that's how I was introduced to sniffing solvents. One evening I was heading home, and one of the boys in the neighbourhood, high out of his mind, grabbed me and molested me. He slobbered all over me. Fondled me. I could smell the glue he was sniffing. I told my brothers what happened and they didn't believe me or didn't want to listen.

Then there were the girls in the neighbourhood. One day me and the girls were playing 'house'. I was 9 years old, and she was a bit older. She was pretending to be the father of the family and I was one of the kids. I had to use the washroom and she insisted on coming with me and she had her way with me in the washroom. I told my sister and she didn't believe me. Again, nobody believed me. So, I just stopped telling people.

But I felt like people could see what happened to me. I felt ashamed. I was really shy and withdrawn. I had very low self-esteem. I was small for my age, I was slow and tiny, and kids didn't really want to play with me, or have me on their teams. As a result of my size, I used to get bullied a lot. I had a cousin, and his house was right next to where the bus dropped off the kids after school. When I got dropped off, he would notice the bullies picking on me and making me cry. He started to help me. He would come out of his house and tell the boys to leave me alone and chase them away. After a while I grew to trust him and he was like a big brother to me. He would pick me up and swing me around. He would give me chips and ice cream. I would go to him for safety and protection.

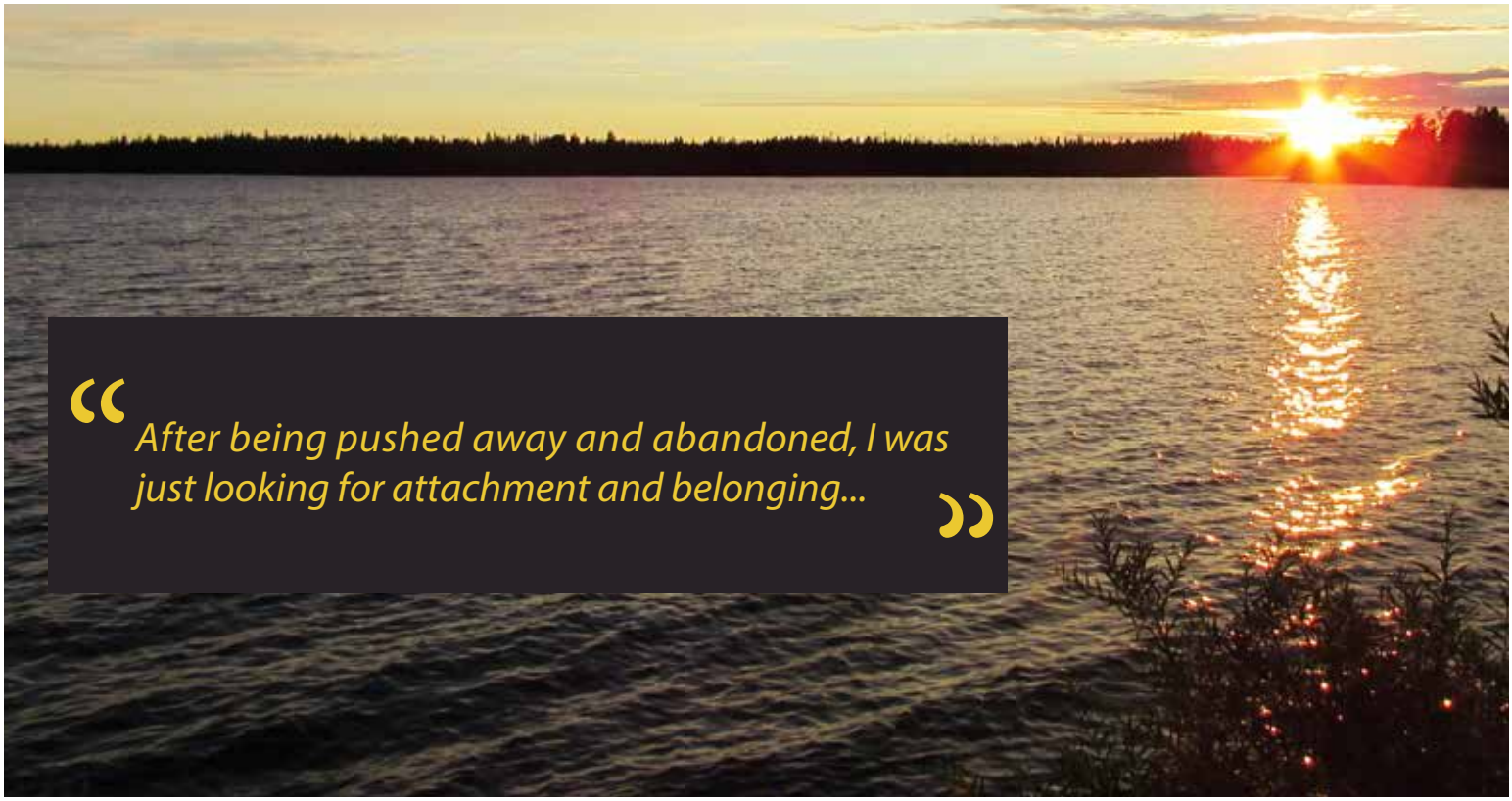
I was introduced to trauma and death when I was very young. I learned my language very early. My mom was often called upon when tragedies happened in the community. One time she was called to help clean up the highway after a car accident and there was a fatality. She would speak in the language when she got those calls, hoping we wouldn't understand, but I did. My mother would talk about the pieces of flesh, and skin, and bones, and hair that she had to pick up off the highway. Often, we would have to go with her and stay in the car while she did this. We were little and it wasn't easy to find babysitters. One day, she got one of those calls. Another fatality on the highway. It was my cousin, the one who protected me and was so kind to me. I wanted to go with her, but she wouldn't let me. She knew how close I had become to my cousin.

Alone most of the time, I focused on my schoolwork - when I wasn't up in trees. I finished elementary school when I was 11 years old. I was a little too young, and too immature to go to high school. My father let me take a year off. I went to Pelican Falls First Nations High School the following year. The high school years were fun for me. Nobody knew me.

> *"...he was sent home for break and didn't return. It wasn't until some time later that I found out he committed suicide. The boys at Pelican were sexually assaulted by the in-house counsellors and he was one of them..."*

I could be a new person, whoever I wanted to be. Nobody knew about all the sexual abuse. I had a good friend there, a boy that I liked. But things were happening in his life, and he was sent home for break and didn't return. It wasn't until some time later that I found out he committed suicide. The boys at Pelican were sexually assaulted by the in-house counsellor and he was one of them. Before he was sent home, we had a bit of an argument. I feel like I was a bit mean to him. Since learning about his suicide, I have felt bad about that all these years.

One day, when I was 15 years old, my mother left for work and never came back home. My dad was so abusive to her. He'd often come home in a drunken rage and want to fight. There was one time my mom was being beaten up



by my dad. I didn't know what to do. I wanted to help her, I wanted it to stop. I was afraid of my dad but I had to do something. Just as he was about to kick her, I threw myself in front of my mom and took the kick for her. He grabbed me and held me. And then he walked away from my mom. There was another time when he was trying to fix the truck, and he was yelling at her. She was trying to help him but he was so mad at her, even though she was trying her best to follow his instructions. He lost his temper and slammed the hood shut and jumped in the truck. She tried to run out of the way but it was winter and she slipped. My dad just backed the truck over her. I thought we killed her and she was dead. But then I saw movement and as she was getting up I felt a huge sense of relief. I wanted to cry but was too afraid.

We weren't allowed to talk about the physical and sexual abuse, and the other things that went on at home. And nobody talked about the sexual abuse and incest in the community.

My mother worked for the Children's Aid Society as the Band Family Service Worker, so people knew what she was going through. A man who owned a business in Pickle Lake helped her buy a plane ticket to Thunder Bay, and then she was gone. My mom and my sisters told the police what my dad was doing. He was arrested, found guilty, and ended up in prison for over 2 years.

After my mom left, about a week later she sent back for my three younger sisters but not me. I helped my little sisters pack and then they were gone too. I was alone. By this time we had moved and we were living on Eric Lake. It was a pretty secluded area and the closest neighbour was about a 2 kilometer walk. I was there by myself for most of the summer. It was a bit scary but some guys from the area would come and visit and hang out. I started sniffing again. We'd have solvent sniffing parties. After being pushed away and abandoned, I was just looking for attachment and belonging. They provided that for me. And there was one boy that I was close to. He would become the father of my two sons eventually.

At the end of the summer my older sister came back for me. I didn't want to go with her. I just wanted to hang out with these guys. I reluctantly moved to Thunder Bay with her and stayed with her for a while. By that time, my mom was drinking a lot and my younger sisters were missing a lot of school because of it. My mom asked me to come and live with them and I did so only because my younger sisters cried and begged me to. They were hungry, and the house was a mess.

I was in Thunder Bay for 2 years or so. During this time, my boyfriend was in jail. When he was released, I was 18 years old. He wanted me to go back to Mish with him, so I did. We were shacking up at his parents' place. He was smoking weed and drinking. I had two sons with him. Even though my partner was working, he wouldn't provide for us. I had to try to find work. He was also an Indian Residential School survivor, so it was like being with my dad all over again.

My mother always told us it was a woman's job to keep the family together and I felt that responsibility even though he was abusive towards me. I felt I had to stay and keep my family together. But I didn't want my sons to grow up seeing this. I remembered what it was like for me growing up and seeing my mom beaten up a lot of the time. But it wasn't all bad, we had a lot of good times. I was with him from the time I was 15 years old until I was 26 years old. It was when the drinking happened all the ugliness came out. During the years of abuse he broke my nose, he broke my wrist, he broke my leg. He almost killed me a couple of times. When he fought me at a party, nobody would move. Nobody said anything. Nobody helped.

He was one of those characters that everybody loved. He was the favourite brother. The favourite cousin. Everyone's favourite person. Everybody would do anything for him.

One time, I fought back.

He hit me with an empty bottle. I blocked it. He mocked me and said, "Your turn." It was just a reflex, a reaction, when I grabbed the bottle, swung it, and hit him really hard on the head. There was so much blood. I scared myself. And then he left and went to the camp for about a week. When the story went around, I got physical threats from the neighbourhood and whoever he hung out with but luckily nobody showed up.

Each time he felt bad. He'd tell me he was sorry and that it would never happen again. Over the years it got worse. His cousin told me I needed to leave, that he would kill me someday if I didn't. To me living that life was normal. It was all I knew. And leaving was going to be very complicating, very hard, very ugly. He had threatened that if I tried to take my sons he would find me and that he would kill me. I believed him. And where could I go? There was no housing in the community – I couldn't stay in the trailer we eventually moved into. It would have been very uncomfortable for me because his family and friends were close neighbours.

I moved in with my dad who was out of prison by that time. It didn't occur to me that there would be restrictions on his access to children, so my sons couldn't stay with me. They would come for visits but if I kept them too long, I was threatened with Tikinagan Child and Family Services. My biggest regret is not taking my children with me and that my sons grew up without me from the young age of 7 and 8 years old. My only coping strategy was to drink and get high.

Time went on but even in my lowest periods, my will to survive never left me. A couple of years after I left my children's father, I was trying to help myself and find work. I was offered a job as a Homecare Coordinator in my community's Health Centre. By that time I did a lot of things I'm not proud of. With my alcohol addiction, I got into a lot of trouble. I got suspended from my job for a while because I needed to find help. But nobody would offer me any help. Where do I go? Who do I see? Nobody wanted to talk to me or deal with me.

One day Donna Roundhead, may she rest in peace, called me up at home. I am forever grateful for her. She asked me if I was ready to work and I said that I was. She wanted me to attend a women's conference in Thunder Bay for a week. The condition was that I couldn't drink while there. And I said I could do that. So, I went to the conference, and it was all about colonization and Indian Residential Schools.

It was at that conference that I began to understand the reasons that my childhood had been the way it was, and I began to recognize patterns in my life. I began to understand why my dad was the way he was, and how my mom, a child bride, did the best that she could.

There was some counselling for the conference delegates in the evening and I went to see a lady who was a counsellor. I was telling her about some of the things I went through and was struggling with. She kind of talked me through my abandonment issues. And it made me realize what I needed to do to start dealing with that in a better, healthier way.

I worked with Donna in her department for some time. And we were organizing counselling for youth camps at the time. I started engaging with those counsellors more, trying to help myself, and to get more in touch with little me, the 5 year old me.

When I was a little girl, just starting kindergarten, I was given the name 'Kindergarbage' and the name stuck with me for a long time. I was told that nobody liked me, that I was nothing. I believed that all those years. So, when Donna told me one day that I had the makings of a great Health Director some day, I didn't believe her. It took me a while to build confidence. Without the guidance of Donna, and without the chance she gave me, I don't think I would be where I am today.

Eight years ago, I was offered the Health Director role at the community health centre. New in my position, I started to go through files and that was when I found notes about my family. I saw a document with my dad's name and a list of my sisters' names and it was labeled 'Incest'. It hurt seeing that. And I wondered who had been talking. When I confronted leadership no one knew of those notes or any conversations.

People in my community knew what had happened in my family but nobody had once come to ask if I needed help. Nobody wanted to talk about the sexual abuse and the incest. Nobody knew how to talk about it. My family was one of the first families that came out with it. Nobody wanted to know about it. But they looked at us, judgingly. After I found those notes, I wondered if that was why I had a hard time finding work at the beginning. There can be stigma around trauma.

When I was struggling with addiction all I wanted to do was drink to forget. Drink to be brave, drink to have courage. I drank to be someone else other than who I was when I was sober. It was all I knew. I got into this mentality where I'd say to myself, "I'm doing well. I'm ok with this."

I didn't know who to ask for help, and being stuck in addiction I didn't even want to ask for help. It wasn't until Donna picked me up and shook me and gave me that push and encouragement that I needed. So, when I think

Image created by Dale Wavy, for his wife, Patricia.

about some of the people who are struggling with addictions right now, I wonder if maybe that's all they need.

After I got the support I needed to get going in a good direction, I knew it was up to me to continue on my healing journey and discovery of who I am. The biggest thing I struggled with was opening up all the sexual abuse memories. That was the hardest for me, but it was the most important. For many years I felt shame, guilt, and regret until I realized it wasn't my fault. I accept this and I'm ok. It happened to me but it wasn't my fault. And this is mine, this is my life, I have to heal. I got this journey to walk and nobody is going to do it for me.

I just don't want anyone else to experience the abuse I did, and that my family did. But it is the reality in the community. It still happens, we hear about it. In my role, some of the stories I hear are sad and they take me back to when I was younger. We need to be able to talk about these things freely and not have people respond with comments like, "Well this is not the right time to talk about this," or, "I'm not the right person to talk to about this." People are struggling with sexual abuse. We need to talk about it. And we need people to feel comfortable, safe, and heard when they are talking about it. There are challenges in creating those kinds of safe places in our community though. There are historical family feuds that still trickle into today's relationships in the community.

And there are a lot of trust issues in the community because of these feuds. And there's a lot of gossip and lateral violence that happens in the offices. Nobody really trusts anyone.

When I started my healing journey I started to realize a lot of things. I felt unloved growing up. I felt like I wasn't good enough. Being sexually abused, I just thought my body was for sex. I didn't know what love was.

I met my current partner in 2010 and we became serious in 2014. We have been together ever since. He is the kindest soul I've ever met.

At the beginning of our relationship, I was so used to toxic behaviour and toxic relationships. I was scared of messing up our relationship but I was the one starting the fights and picking arguments. I was so used to it being that way. He would just walk away and I didn't understand why he wasn't fighting. But he was very patient with me - and kind, and supportive, and loving. He used to tell me about his growing up which was very different from mine. His dad was caring, loving, supportive, and always working, he grew up loved.

Shortly after I met my partner, I committed to counselling to work through the challenges and traumas of my life. Being on the lake, going to the land are important to my healing and staying focused. My partner and I go out to the camp often and I can be off the grid. It is important to my wellbeing to be in tune with the land. And sometimes we may have one or two drinks at camp and that is ok, I'm not messing my life up because of it.

In my past, my children's grandparents taught me how to fish, prepare ducks and geese, and how to smoke moose. So, surviving on the land isn't hard for me, and it isn't new. I like being able to provide for myself and to do those things is freedom. I wasn't able to do those things when I was younger.

So, me and my partner spend a lot of time at our camp taking care of the yard, we paddle and fish, and we go to my partner's trapline. I'm really grateful that my partner takes me out to his trapline. His trapline helped me connect to my dad about a lot of things. Dad would call me and speak in the language to ask about my weekend adventures and then he would talk about his hunting and trapping experiences. And then he would start telling me things. Part of knowing where we came from helped me understand my place in the world better.

When we were growing up we were forbidden to go to powwows and practice our traditions. It was because of my dad's time in the residential school. When my dad was in prison, he would send me these little traditional drums that he made. I have three of them in my home. He must have done some work on himself when he was in prison because when he came home he would talk about traditional practices and the Bible. He would talk about there being one Creator. He told me that I needed to be respectful to both traditional and Bible practices.

My dad passed away on the winter solstice of 2020. He was 89 years old. I knew he was sorry and that he wanted forgiveness, and that he wanted love. When we were growing up my family never hugged or said 'I love you' or had bedtime stories. When I started my healing, I wanted my dad to know that I loved him. I remember the first time I hugged him and told him I loved him. He wasn't sure how to react and he froze. But that was ok. I kept hugging him and after the fifth hug or so, he hugged me back and told me that he loved me.

Growing up on the reserve wasn't easy but I am happy now.

"....This is my life, I have to heal. I got this journey to walk and nobody is going to do it for me."

Photo by Joshua Matthews

Joshua's Story

By Joshua Matthews

> *"There's been a lot of hard nights and hard days. Sometimes when the kids are at school, I just sit on the couch all day and I wonder what the hell I'm doing. But those kids keep me on my toes. They keep me grounded."*

I miss her every day.

I remember when I first met her. She was so friendly and outgoing towards me. I wasn't used to that. Desiree would just go out of her way to come find me where I hid and just talk to me. We were becoming friends but a few weeks later she moved off the rez. She took her two boys and they moved to Sioux Lookout.

I missed her.

We lost touch for over a year and then she moved back but we didn't really talk for a few months. We were both catching a flight to Sioux Lookout and we happened to sit next to each other. The next day we had a dinner together. We sat at the restaurant together and kind of started talking slowly and getting to know each other again. On New Year's Eve, we rang in 2017 together and shared a kiss, and we fell in love.

I was amazed by her.

She loved doing her make-up. She would put her make-up on and then we would go out and get some wood. And she's out there chopping wood, stacking wood, and looking good doing it. She was funny. And she had a way of getting through to me. She found a way to me, where she understood where I came from. She was intuitive. There was just something about her that was different. I could be myself with her. I could let my guard down around her. She just took me like I am.

At the end of 2017, we had a miscarriage. We didn't realize she was pregnant. But after that happened, we knew we did want a baby together. The pregnancy was scary at first because of the miscarriage. We were so careful about everything she did. And that's when Ensley came around. Desiree was such a good mom to all of her children. She loved them so much.

Desiree had a turbulent life growing up. She went through a lot of things. She turned to substance use as a way to cope. Years before I met her, she had substance abuse issues and she was dealing with that. She would kind of get a handle on it and then there would be relapses.

We were separated when she relapsed in March 2022. I wasn't aware of the extent of it. I thought it was only marijuana that she was using. I didn't realize it was the more potent stuff that she was using again. I didn't know until I got a message that she was admitted to the clinic on the rez and that they thought it was a possible drug over-dose.

My sister went to see her in the evening, and she sent me a picture of Desiree in the bed. She did not look like the one I knew, and I was devastated. I blame myself for what happened. I was in Thunder Bay at the time, and I knew if

I had just been there, she would still be here.

She was medevaced to Sioux Lookout that night. That night, around 11:00 PM, I left Thunder Bay and drove to Sioux Lookout and arrived around 3:00 AM. I had to wait until morning to see her.

She was sedated when I finally saw her. They were running tests on her. They said they suspected an overdose and eventually tests confirmed it. They found infections in her heart and her heart was damaged. There wasn't too much they could do for her in Sioux Lookout so they sent her to Thunder Bay.

Once she got to Thunder Bay, I got to sit by her side but then they did a COVID test on her and she was positive, so they had to keep her isolated and I wasn't allowed into the room. I had to look at her through glass. They gave us a baby monitor so we could communicate. For two days she was sedated and then she was up.

I got to spend that day with her. To talk to her, and to tell her that I loved her, and I was sorry for the things we went through. I promised her that I would be there for the kids, no matter what happened, and all she needed to do was to get better. It was good. I went back the next day, and I was able to get her her favourite steeped tea and she was able to have a Pepsi. She wanted KFC too, but she wasn't allowed to have that. And she thought it was the biggest tragedy ever…she still had her humour. She was still herself. I was able to see her as I knew her, even though she was going through so much at the time. We just spent that day together.

During that time, I was talking to her mom. The doctors told us that she needed surgery and that they weren't sure if she was going to pull through. I didn't believe them. I was talking and laughing with her, we were just hanging out. I didn't say anything to Desiree when they told me that. I just didn't want to believe them.

Arrangements were made for her mom and the kids to come to Thunder Bay. They came in late that Friday night. I didn't tell Desiree just in case they didn't make it. It was getting closer to when the kids were going to arrive so, I had to tell Des that I had to take off for a little bit.
I told her I loved her and that I would be back. And that was the last time I got to speak to her.

Desiree was flown to Toronto, and I joined her as soon as I could make arrangements for our kids. The doctors kept telling me things were grim. I didn't want to believe it.

Desiree needed open heart surgery and the doctors weren't sure she would survive it, but she did. I got to see her shortly after she got out of surgery. She looked like she just came out of a car wreck. She was hooked up to all those machines. It was pretty traumatic for me to see that. But she did survive the surgery, so I decided I would take that as a win. I was grateful. The next night, I got a call from the hospital. They wanted me to come right away. Desiree's heart rate was dropping. I raced to her bedside and sat beside her. But she hung on. She hung on for three days. The doctors and nurses were surprised, and I was so happy that she was still hanging on.

It was Saturday when I had returned to my hotel room after spending the afternoon sitting next to Desiree as she laid there, hooked up to those machines. I was going to rest a bit and then head back to the hospital in the evening. But before I could make my way back, I got a call from the hospital to get there as soon as possible.

I raced back and it was different this time. There was a doctor sitting beside me and he was preparing me. They knew she was going to go…and I didn't realize I was watching her last breaths.

The doctor called Desiree's mom to tell her that her daughter was gone. I could hear my kids playing in the background. They sounded so happy. I didn't have the strength to tell them anything and I left that to their grandmother.

I stayed with Desiree for another 2 hours or so, and then somehow made my way back to the hotel. Toronto is such a busy place and as I was walking, I looked at all these people that I didn't know, and they were just going on about their lives. I wanted to be like them - not going through what I was going through.

I started drinking heavily that night, but I couldn't get drunk enough to pass out. I stayed up all night. The next morning, I felt so bad.

I was having a smoke on the balcony on the 24th floor of the Delta Chelsea. I looked down and for a couple of minutes, I thought jumping over that balcony just made sense.

I had to fight myself to get off that balcony and then I lost it. That's when I talked to her mom. The thing her mom told me was that she didn't want me to blame myself, and that she didn't blame me. She said that the day Desiree died was the day she was supposed to die. It had already

been set. It was her mom's faith that helped me get through.

After I talked to her mom, I knew I had to rely on faith. And I knew I had to get my shit together fast. But I knew that I was going to be alone for two weeks.

I was in Toronto for almost a week after I lost her, and I drank quite a bit during that time. I started getting sick of being in Toronto, so I made arrangements to get to Thunder Bay and that's where I spent the rest of my time alone.

It was so hard, and I decided that I was just going to drink. I was going to drink and grieve. I wanted to fall apart for a while. And I don't recommend doing that at all. It was destructive.

In Thunder Bay, I had the police show up a couple of times. Someone at the hotel thought someone was being hurt in my room. It was kind of funny when they showed up one night. It was about 3:00 in the morning when the police knocked on my door. My room was dark, and the police asked to come in. They were trying to figure out if I had someone in there with me. They received a report that it sounded like someone was being beaten up in my room. I said, "No, no. It was just me." And then I just lost my shit and I explained to them what was going on. They were surprisingly understanding. They spent close to a couple of hours with me just talking and I think they were trying to sober me up too. I had a good experience with the Thunder Bay Police.

And then the police came a second time to my room. The day of the viewing, I smashed my guitar on the floor, threw everything around. I was so angry. I knew that day was going to be the last day I physically saw her. It was an hour before the viewing that the cops came again. They were a different set of cops. They were pretty understanding too. I had quite a bit to drink that morning, but I wasn't to the point that I didn't know what I was doing. I was just angry more than intoxicated.

It was awful. I was just glad once I got home to the kids that I was able to get through it. Ever since then, when I came back with Desiree, I've just been with the kids. But there has been sometimes when I feel like I want a break, just be by myself. But when it happens, I get lonely for them - even though they drive me nuts sometimes.

After the funeral, I had no idea what I was going to do or how I was going to do it. I didn't know how I was going to take care of the kids. Everything felt …dark. My sister took us in. She gave us a room and that gave me time to figure things out. I'm always going to be grateful to my sister for doing that for us.

In the beginning, Tikinagan was checking up on us for the first few weeks. They just wanted to see how we were doing and how the kids were getting by. I knew that they would come around eventually, and I knew that I didn't want them, or any other agency involved. I also believed that there was no need for them to be involved. As hard as it was going to be, I knew that I could do it. I just didn't know how.

After thinking things out, I knew I didn't want to rely on other people too much. I knew that I wanted us to have our own home. I wanted to be self-sufficient and heal together. I stayed with my sister for about a year and then we moved into our new home this March. It was where our new start happened.

As much as I wanted to avoid my grief, I knew I had to face it and deal with it.

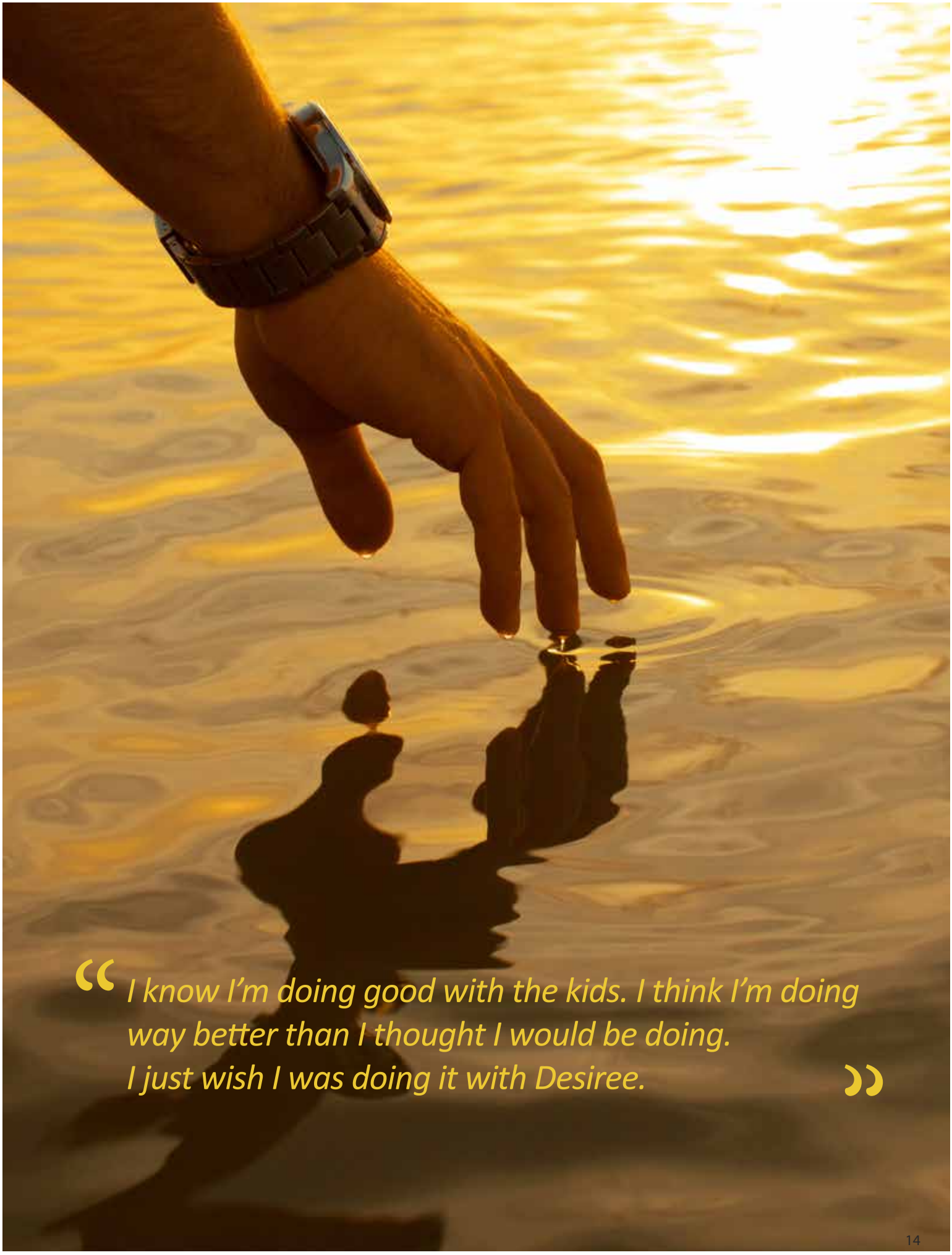
I've been speaking to a counsellor for over a year and a half now. Our sessions are done online. We speak an hour once a week or every two weeks depending on scheduling. The counselling has helped me to keep grounded. I'm able to kind of express how I'm feeling at a certain moment. Or depending on how the week went, I'm kind of able to process everything through those sessions.

I know what happened to Desiree wasn't my fault even though there are days that sometimes it feels that it was.

Sometimes I feel like I overshare too much about our life on Facebook. But the main reason I share stuff on Facebook is because I want the kids' families to know that I got them. I got these kids, and they are ok. There's been some tough days and some tough nights, and we manage to get through them somehow.

I just…I love these kids so much. I just hate that they had to lose their mom so prematurely and that they won't have that love that she had for them anymore. Ensley was just 3 years old when she lost her mom. I just hate that she is going to grow up not experiencing her mom's love.

That hurts me every single day. I'll always fall short of giving her the love that her mom would have given her. I braid Ensley's hair every day. I'm keeping that up because that's what her mom would do for her…braid her hair. I know I'm doing good with them. I think I'm doing way better than I thought I would be doing. I just wish I was doing it with Desiree.



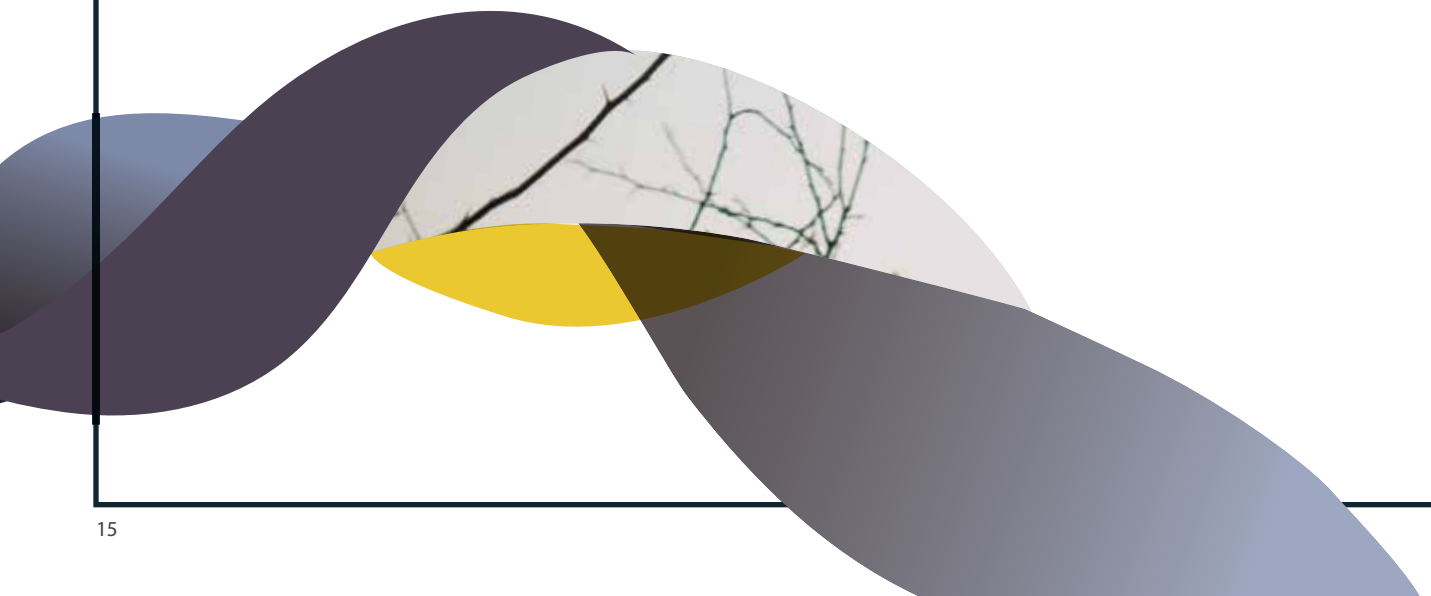
“I know I’m doing good with the kids. I think I’m doing way better than I thought I would be doing. I just wish I was doing it with Desiree.”

Carrie's Story

By Carrie Trout

"But how are you supposed to get better pretending it's not there, or that it never happened?
What if someone suffers because of your silence?

The truth needs to be told."



Carrie Trout

I acknowledge Gizhe Manitou, Aadsookanik, Dehnawehmakanug, Giizis, Nookomis Dipikuk Giizis, Nishoomis'uk, Nookimis'uk, Manitou Aki, Manitou Niipi, Manitou Noodin, Manitou Shkode, and the four directions, Waabanong, Shawanoong, Gaabi'inoong, Kiwetnoong, and to our Elders, the knowledge keepers, Lodge Carriers, the late David Herschberger, and to the many people that helped me and were instrumental in my life, and most of all to my spirit, my children, my siblings, aunts, and uncles. And my beloved grandparents and parents. Without you I would not be here. Miigwech.

I grew up in a tiny village named Canoe River, until I was 5 years old. That is where I stayed most of that time. My grandparents doted on me. I was very safe there. My grandfather passed away when I was 2 years old. When my grandfather died my sense of security was gone. I had no one to keep me safe anymore. I was with different family members while my mom and dad drank.

Life was scary when I was younger. I had seen so much violence and alcoholism. I had to learn how to hide. I slept under the house with my siblings many times. We had to hide because of the violence and there were certain individuals that we did not trust.

There was this group of young men that would come in from another community. I was terrified of them because they came in violently. They would beat up people and I know that a boy was raped. They were drunk, violent, and they sniffed gas too. They were like a gang. On the reserve you have these dogs that attack other dogs, and that's what they reminded me of.

A man that had come to our village raped a female. He was beaten up very badly. He was told if he came back again that he wouldn't leave alive. He didn't come back again. I know that these individuals went to residential school, and they were hurt too. They endured that ugliness in residential school, and now they were doing that to their own people.

My father unintentionally humiliated me at a young age. When he was drinking, he would make me stand in front of him and ask me, "Do you love me?" And then I would have to say, "Yes, I love you." He never beat us up, but his voice and his eyes were very powerful for me when he looked at me with what I thought was disapproval.

My uncle abused me when my dad was out guiding. He would tell me I was ugly and squeeze my arms until I would go limp. He enjoyed my pain. He would make me say things about myself that would hurt me deeply, and those words formed my core beliefs about myself. I would cry and tell my mother what happened, but she was too scared to do anything about it.

I started to hate men.

I was angry with God for letting me be born to get hurt all the time.

The first five years of my life were with my parents, and then for one year or so I was living in boarding homes for school.

I had to come to Sioux Lookout to board out for school. It was a culture shock for me, and I was only 6 years old. I was away from my parents for almost a year, and I was crying a lot for them. I was always fantasizing about my home in Lac Seul even though there was so much poverty, alcoholism, and abuse. It wasn't always bad. I had some good memories of swimming, sliding, harvesting moose, travelling to town, gathering, laughter, and my dad working on his machines. I still loved my parents very much. I did not care that they were that way. I still wanted to go home.

But I was very fortunate that I had my brothers, sisters, and cousins with me. We boarded with a family that ran a good home. I shared a room with my cousin, and I had my own bed. We played on the Saturday. And we got a case of pop each month- I loved that. It was a treat for me. Each day we had certain times for the TV and we would take turns watching what we wanted to. They took us places and they were really good boarding home parents.

The next school year we ended up living with two teachers. And it was a really a nice home too. Those experiences taught me a lot and introduced me to a different world. I'm very grateful for those experiences.

After one year in Sioux Lookout, I went to school in Lac Seul and attended Indian Day School. A year after, or

more, I left for Sachigo. It was hard there because they were Cree and I was Ojibway. I wasn't accepted right away. I was scared after school, terrified. Kids would want to beat me up because I was different. Eventually, the community accepted me.

I had to wear a lot of masks growing up. I never trusted anyone enough to be who I was.

In grade school I never accepted the pictures I saw of how they depicted us -there was never any story behind it. It was like these people had no feelings. There was nothing personal. I always wondered about them. I would look at my grandparents and wonder how they went from teepees to the way they were now. I always wondered why our people were drinking and why they were so angry all the time.
I wondered why my mom and my dad were fighting all the time. I wondered why we were so poor. When I went to school, I looked at those other kids and their families, and wondered why there was so much caring there. I didn't have any of that. It made me very sad. I always just thought there was something wrong with us all those years.

> *"I was on the road to self destruction. I was almost dying when I reached out for help. I finally phoned the Nodin crisis line, and that saved my life."*

I had so many questions but after a while you just come to accept that this is just the way it is.

I only made it as far as grade 8. When I was 13 years old, I met my husband. He was 4 years older than I was. I would stay with him for 18 years. I had my son when I was a teenager. We struggled on Ontario Works. I already knew that I wasn't happy. I was drinking, I felt stuck. And I didn't know why. I knew school was important. My older sister ingrained that in me and the rest of us. She told us it was our ticket out, it opened doors.

I had my daughter 4 years after my son was born. Our daughter died 10 months later because of the housing conditions we were in. The sewage was backing up. She had eczema and she got a staph infection, and she died. Within a few weeks of her passing, my third child was born, a girl. I was conflicted, my heart was conflicted. I didn't know how to process and I withdrew. I felt guilt, anger, and lost.

Her father and I were devastated. We did not know how to deal with the loss of our first baby girl and our grief. We had no accessible services, no support back in that time. We were young, and we did not know how to ask for help. We went down hill after that. It was a long spiral down. We did not plan the two children that followed the loss of my first daughter. And I don't regret them, but I wasn't ready for them. Nor was my partner. We still made the best of things. We tried to make our lives better by working. But I would always lose my job because I was really liking my alcohol.

When you are young you want to party too. I fell into that. I wanted to go out and drink and have a good time. I liked the feeling of my inhibitions melting away. All that insecurity and low self-esteem would go away, and I'd be happy, if only for a time.

Part of my behaviour was because I felt ignored by my husband, and that made me feel really bad about myself. So, I would go out there just to check to see if I was attractive on the outside- I'd have to test it out on men. I just wanted to feel wanted and special -even though I didn't like those men.

Someone wanting me made me feel good about myself but after a while that got me in trouble. The men that I was leading on would wait for me to pass out and then take advantage of me. And then I would go home knowing that it happened to me. And I'd feel really awful about myself, and I felt that I deserved it. And then it would happen again, months later.

I was on the road to self destruction. I was almost dying when I reached out for help. I finally phoned the Nodin crisis line, and that saved my life. I told the counsellor that I didn't know where to go and that I was really depressed. I told him I was DT'ing and I couldn't stop drinking. And he told me to leave, or I would die. He told me to call the women's shelter, and so I did. I took my two girls with me. My son was older, and he stayed with his dad.
So, we left. And I don't remember much of that first month. I don't even remember leaving. It was like I had a breakdown of sorts.

I dreamt about the shelter before we went there.
I remember seeing a hall and that stood out in my dream. I saw myself standing outside and smoking, and I could see the fence and the playground, and I looked up and saw the stars. That is how I was seeing myself in the dream. And then when I was actually in that moment, I remembered my dream. That said a lot to me. It told me I was where I was supposed to be. I even dreamt about the bank I would eventually work in, and I knew what it would look like before I even saw it with my eyes for the first time.

We stayed at the shelter for a while. I was starting to come to my senses, but I still wasn't ready to leave my ways behind. We got into our new home and then one month later I got drunk again. I lost my children. And then for sure I hit rock bottom.

I remember laying in my living room, crying, and not knowing what to do. I knew I had to stop drinking. When I was laying there, I was thinking about my grandparents and parents, and I was calling out to them. I felt so alone but I could still feel the Creator with me. And then I had my first epiphany, and it was profound. It was the first time I saw my parents as people, and I could see them as children who didn't have their parents too.

My parents couldn't give me something they never had. And when that understanding came, so did my forgiveness of them. I felt such a love for my parents, and for all people. I understood.

Even though I was at the shittiest point in my life, I was really happy because of that epiphany. I felt such love for my grandparents, my parents, and my children. I knew what I needed to do to get them back. The next day I was lit anew. My fire was lit again. From that moment on, and despite a lot of trial and error, I have been on my healing journey.

This epiphany allowed me to heal my relationships with my mom and my dad.

I had an estranged relationship for 15 years with my mom. I was angry at her for giving up on us. When I look back, she had no support, no guidance, no one defending her or helping her. They used child and family services and the law to fight her, and she just gave up. She just drank all those years. I know now that she loved us, and she tried. But at that time, I blamed her, hated her. When I had the realization that she couldn't give me something that she never had, that's when I began building my relationship with her. We mended our relationship, and she became my best friend.

My dad was important too. He was always there for me, even though he still drank. I know he loved me because he took me in when no one else would. He even gave me his room and built me shelves for all my clothes… I love clothes. And he always wanted to do things with me. He wanted to take me fishing and show me things about survival on the land. I think that was his way of showing me he loved me.

The losses in my life have been very challenging. I lost my daughter when she was 10 months old. My dad hung himself in 2010. My nephew who found my father also hung himself a year later. I lost my youngest daughter to a toxic drug supply in 2018. Four months later my 12 year old nephew died by suicide. In 2019, my brother shot himself. My mother had a stroke in front of my brother's casket, and then 11 days later my mother passed away. I lost my only son just a few months ago. And there have been many alcohol-related deaths among my aunts and uncles, as well as many drug and alcohol related deaths in our communities.

Each death was so hard, and I wondered if I was being punished, if their deaths were a consequence of my actions. I always wonder what would have happened if I did things differently. I have to remind myself that those paths were their journeys.

They are Spirit now, and I have to honour that.

We were going to have sharing circles in our community, but the leadership was afraid of the can of worms it would open up - the sexual abuse. They were afraid of triggering people and devastating families. I understand that. But how are you supposed to get better pretending it's not there, or that it never happened? What if someone suffers because of your silence? The truth needs to be told.

I suffer from complex Post Traumatic Stress Disorder and only recently realized this through my own awareness. I was doing the healing work but would always be taken aback by some incident which would upset me, and I'd go back to the place where I was a scared little girl again! I kept asking, "Why? Why am I stuck? Why does this keep happening to me?" My answers were in front of me, but I didn't see it until I moved further along my healing journey. Now I understand why these triggers were happening, but I needed to have the courage to explore where they were coming from. This is where I am finding my answers -in the truth.

I understand why there is so much suicide. It is clear. I know how we can fix it. The answer is within ourselves, in our culture, in the land. We have to go back to family, connection, and love- all these things we were born with before contact and the residential schools. That is what we need, and I know that it can be hard to do that.

When we suppress the truth, we keep ourselves sick. We are not going to heal if we do not have the courage to speak about what happens in our communities.

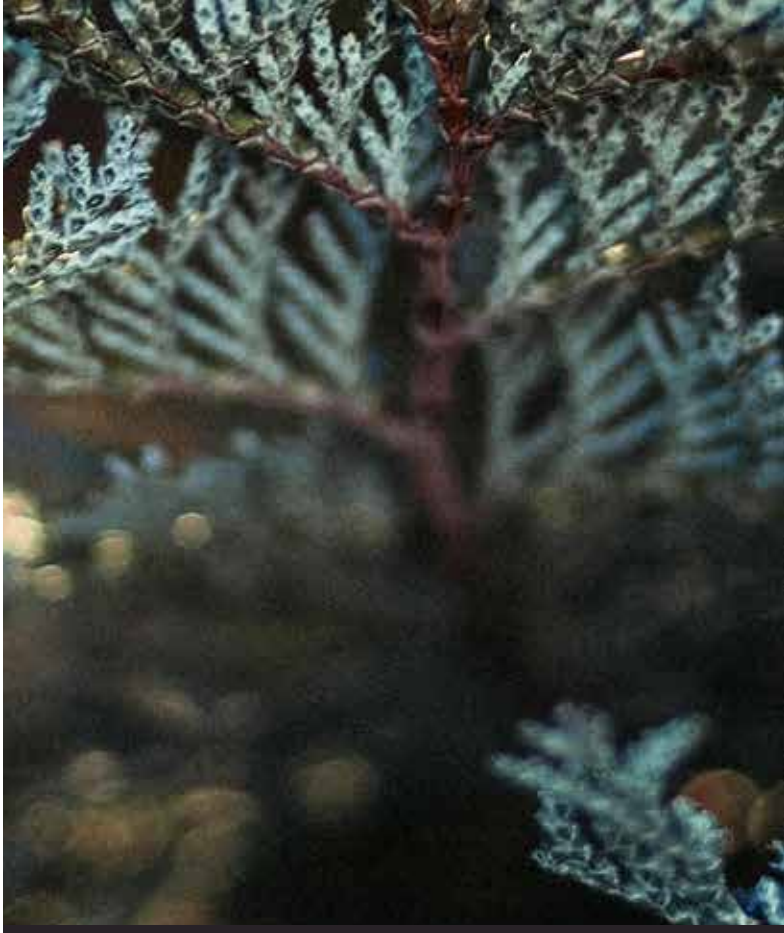
Chiefs and Councils, as well as communities, need to be ok with people sharing difficult things. By keeping secrets, especially ones you know are harmful, it hurts the person who holds the secret, and that hurt is passed down to the generations that follow.

I remember being worried about what my kids would disclose when they were going for counselling. I didn't want people to see how bad I was, my lack of parenting, my behaviour, how much I was drinking. I didn't want anyone to see it. It hurt. It was the ugly truth.

I'm guilty too. I have done many things that I am not proud of. I've hurt people. In retrospect, I could see that a lot of it came from being very angry at the world for the pain I was feeling inside me.

I had to take a good look at myself and take ownership for what I did. It was hard, it still is. But I love my kids so much that I knew I couldn't hide it anymore. That's how much I love my kids. And our leaders and our communities need to do that too.

Miigwech. Thank you for listening to my story.



"When we suppress the truth, we keep ourselves sick. We are not going to heal if we do not have the courage to speak about what happens in our communities."

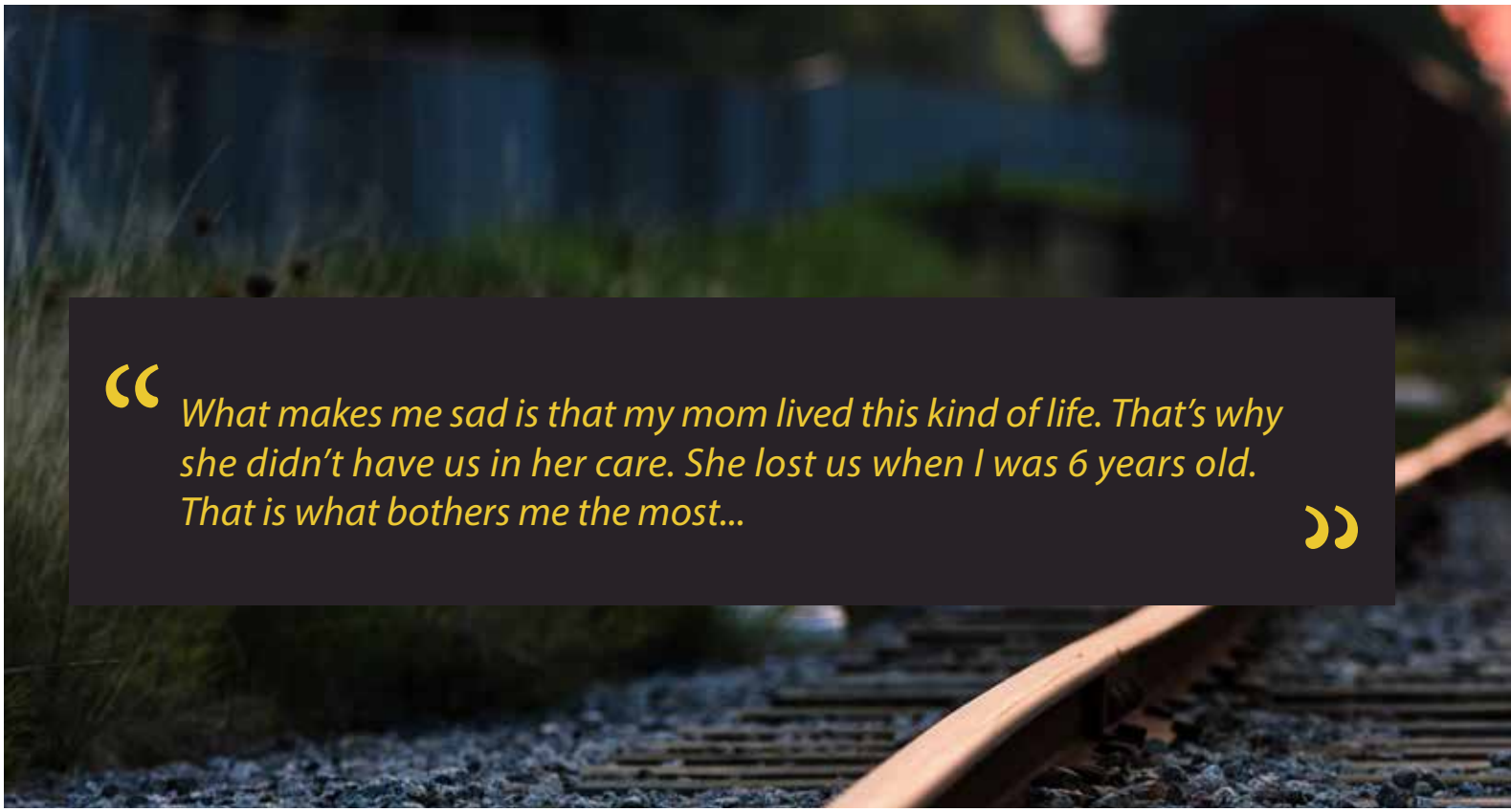
Stories from the Train Station

The forcible removal of Indigenous children from their homes during the residential school and 'Sixties Scoop' eras, and the ongoing over-representation of Indigenous children in the child welfare system today can be understood as leaving many Indigenous children, and in turn adults, experiencing cultural, communal, and spiritual forms of homelessness.

- A National Study of Indigenous Youth Homelessness in Canada, 2019

With the humidex, temperatures reached about 42°C in Sioux Lookout on June 20th, 2023. A group of 50 or so people were scattered in small clusters beneath the shade provided by the trees in front of the train station which offered only a small degree of relief from the fiery sun. They came from various Sioux Lookout area First Nations communities.

Many arrived in Sioux Lookout for different purposes though most shared the challenge of homelessness. Some people spoke about struggles with substance use, the loss of loved ones, the apprehension of their children, expulsion from community, and a legacy of trauma passed from one generation to the next. Everyone had a story, and a few people chose to share theirs.



> *What makes me sad is that my mom lived this kind of life. That's why she didn't have us in her care. She lost us when I was 6 years old. That is what bothers me the most...*

I'm Not the Same Person

I lived in Hudson but I'm from Lac Seul. I have kids in Cat Lake and Slate Falls. I took care of my kids, but some other stuff happened. My sisters are taking care of them now. I don't even feel like I'm the same person to get my kids back now. Life has changed and I don't feel like I'm the same mom anymore.

I've been homeless since I was 19 years old. I'm 30 years old now. I've gotten used to it. It's not a problem anymore.

Life is the liquor store and closing time back to the shelter. If you talk to people that's what it is - closing time - back to the shelter. Lunchtime - back to the shelter. Supper - back to the shelter. And then come back out in the morning and do it all over again. This is the life of all these people.

I want off the street but I don't know how.

I want my kids back.

I Can't Find a House, I Can't Find Work

I grew up in Fort Frances. I came to Sioux Lookout to be closer to my children. I have two kids -15 years old and 13 years old. I haven't been able to find housing and I can't find employment.

We need more housing on rez. Every reserve struggles with housing. It's just the way it is. When you are struggling in community with no-where to go, you end up leaving the reserve. And then you come here, and you still can't find housing. I don't go back to my community because I can't find housing and employment there either.

I Miss My Dad

Slate Falls has a lot of drinking. I showed up on Friday. I work about 60 hours a week at home. I see a lot of shit at home. People are drinking sanitizer.

I come to town maybe once a month. I was supposed to go back yesterday but I said 'no', 'cause I wanna drink I guess. I drink in my community sometimes but I get in trouble back home. Sometimes I become an asshole when I drink. And then if I become an asshole back home, people are calling NAPS and I end up in jail. So, I come here, raise my voice and say whatever I want and nothing happens. I can't raise my voice at home.

My dad used to work for an Indigenous organization here. He had an important position in Sioux Lookout in emergency services at one point too. My dad also had a hard life. He went to residential school. He'd drill it into my head. I'd say, "Dad, I'm sorry. I wasn't there." He kept giving me shit for it all the time. So, one time, we were drinking -there was my dad, myself, and my little brother. My dad was getting mad at my brother. My dad slapped my brother. I said, "What are you doing that for? Hit me instead." And he beat me to a pulp. But you know what? I still love him. It made us stronger I guess. My dad died on my birthday. It's only

fair right? He was there when I was born and I was there when he died. It seems right. My dad, I guess he raised me right. I've never raised my hand to any woman. I love my dad for that. I also miss him.

People Don't See Me

I've been struggling the past few days because of withdrawal. I am grieving over the death of my dad and my mom. I lost my kids through Tikinagan Child and Family Services because I don't have a roof over my head. And I don't have a stable home for them to grow up in. We have a big family and there isn't enough room for me and my kids.

Chief and Council sent me here from Sachigo because I was always outside hanging out in the bush, without a place to go to. Plus, my Suboxone was making me pass out. So, the Chief and Council were worried about me just staying outside without going anywhere. Like I'd be hanging out outside the Northern Store all day or the Healing Centre -so I could live there. I had no house to live in. It was hard to have three meals a day and to take a shower. But my kids had a place to stay which was Tikinagan.

I've been seven months in the shelter. This is the first time I've been on the streets like this. I've been on the streets for about a month now. This morning I talked to my counsellor about getting on Suboxone again and getting treatment in Kenora. We are going to Kenora to get me a house so I can look after my kids properly.

What makes me sad is that my mom lived this kind of life. That's why she didn't have us in her care. She lost us when I was 6 years old. That is what bothers me the most. My brother says, "You're just like mom." And I'll say, "Don't say that to me." So, I want to stop drinking. But it is so hard because my friends do drugs and drink.

I'm a mom. I want to get sober for my kids.

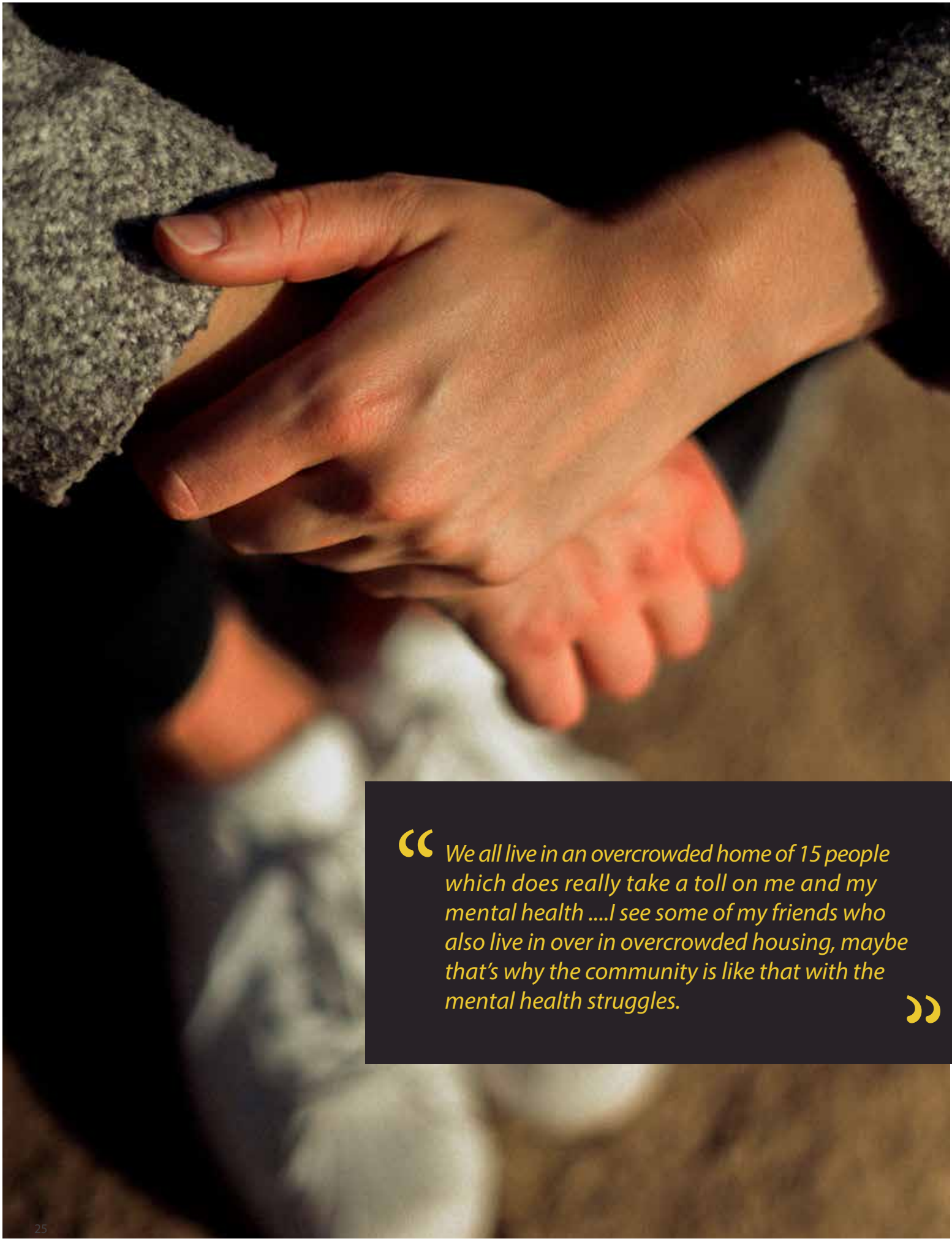
My reserve, they don't know how to support. I've been trying to go back home but I don't have a place to go to. I want them to support me and see that I'm not just out here to drink and live on the street. They know I'm a good mom but they don't support me as a parent because they know I have a past with making money from drugs and alcohol.

People don't even see that I exist.

Most of us need someone to talk to.

When I'm Lonely

When I'm feeling lonely where I live, I come uptown to socialize with my friends. I was in Saugeen, but I haven't been home in a year and a half. I had no choice. It's hard out here. Where I am living now, it's kinda easier. I was at the shelter because I had no choice but to stay there. And then, I used support from the OPP, two doctors, and the learning centre, to get letters, support letters, for where I am now. I am a registered student at the Seven Generations Education Institute!



> *We all live in an overcrowded home of 15 people which does really take a toll on me and my mental health ....I see some of my friends who also live in over in overcrowded housing, maybe that's why the community is like that with the mental health struggles.*

But when I drink, I drink with people I can trust. That don't go rowdy or start fights. That I know. And all the time I go to the drunk tank. Sleeping, waiting, eating, yelling, calling people shit, getting released, hopefully not to go back.

I haven't been back to the drunk tank since I lived in supportive housing. Its okay I guess. We get our own units. We have our lounge we share, the kitchen we share. We share the outside. And its better than the shelter. I like it over there. I've got a big bed. I've got my own sink, a couch, a microwave. You know like a hotel room? That's how it looks! I've got a mini fridge! We do our own laundry. We get an inspection every month.

I drink minimally now. Every time I was at the shelter, I was drinking every day. I need or want it at the same time. But ever since I moved over there, I have slowed down on my drinking.

I'm So Scared

It is so hard to stop. I get DTs, that's what they're called. I get psychosis and I get so scared because I am seeing and hearing things. I started drinking at 32, after my third child. I can't go back to my community. It's too hard. I get to see my kids. But I still drink because I am so scared, I feel like I can't stop. I want to get help. I feel so much shame. Like, I am the problem, and I feel lost. Being able to cut down is what better would look like.

My Family Wasn't Picked for Counselling

Weagamow has poor services. Me and my family have been trying to go to counselling and they always bumped us off, me and my family anyway. Choose Life preferred another family to go. We packed up and everything and were ready to go and then they call us and they told us, "Oh there's another family that has more urgent problems."

I finally gave up. That was like four years ago and since then I've been here, drinking. This is my fourth year out here. I've been staying in the bush, even in winter.

The shelter pissed me off.

I want to stop drinking. But I got friends here that stop me from it. There's such poor services everywhere -up north, and here too. They say you'll get help, we come out for counselling and then once you miss one appointment, they kick you out. I've been through that too.

Overcrowded Homes and Substance Use

I've been in Sioux Lookout for 3 weeks. I'm going to be here for another week or two. I'm here from Fort Hope on medical. It's been hard being here because I've been away from family for so long. I'm here with my son which helps a lot, so I don't have to be alone here. I'm glad that they approved a medical escort for me.

What can I say about home? There's a lot in the community that I see or hear, a lot of substance use and alcohol. It affects the whole family. That's how it is for my family. I live with my daughter and my other kids. We all live in an overcrowded home of 15 people which does really take a toll on me and my mental health. The overcrowding comes with a lot of stuff, I guess. There's also substance use in my home. I'm also a substance user. It's been a while since I've been using some things. Since I've been here I hardly used anything. I deal with depression. I guess that's why I tend to use- the depression among other stuff.

I see some of my friends who also live in overcrowded housing, maybe that's why the community is like that with the mental health struggles.

Message From

Chief Russell Wesley

Cat Lake First Nation

Our First Nations have been in pain for a very long time. We do have much to be proud of, and much to be grateful for, but we have a long healing journey ahead of us. Our grandparents, and their grandparents, have survived Canada's systematic attempt to destroy our culture, our language, and our families. We are still here.

We are not without our injuries however, and this report has captured the number evidence of those wounds inflicted by generations of unhealed trauma. We see that the mental health of our People continues to decline as addiction to substances continue to rise. Available services fall short of the extreme need in our region, and there continues to be wide gaps in the continuum of care for our Band members. Where there is an availability of services in community, community members responsible for service delivery are often left reeling as they grapple to manage their own grief over the extensive loss of loved ones to states of deteriorated mental health, and unnatural deaths.

When I became Chief, I quickly realized access to our own community data is an urgent priority, so that we could have a very clear understanding of community needs, and in response, develop appropriate programs for our members. Furthermore, data, such as the data in this report, strengthens our ability to lobby the provincial and federal governments for much needed resources.

Like so many, I have also experienced the pain and hardship that comes with loving someone who suffers from addiction. Though at times things seemed grim, I did not abandon my resolve to help my loved one. I was asked many times why I did not give up on her. My answer was, "Because there is still hope."

To my friends, my People, we are still here. There is still hope. We know our way forward, and we will find a healing path.

Message From

Janet Gordon

Chief Operating Officer

In 1989, the Scott McKay Bain Health Panel was established to lead a review of health services provided to the First Nations communities scattered throughout the Sioux Lookout Zone. Among their recommendations was the need to establish a health authority which would serve communities in the Sioux Lookout region, and thus the Sioux Lookout First Nation Health Authority (SLFNHA) was established.

Recent data, as well as conversations with community members, reveal that troubling matters identified in the work of the 1989 Health Panel remain unresolved and urgent in 2023. As a regional health organization, SLFNHA has heard the resounding call from all communities that conditions of poor mental health and substance use have become dire. This situation of unwellness within our First Nations communities is a legacy left behind and carried forward by oppressive and paternalistic colonial systems.

In January 2023, in service to Sioux Lookout area First Nations communities, SLFNHA's Approaches to Community Wellbeing department (ACW) began developing the following health status report which focuses upon mental health and substance use among Sioux Lookout area First Nations communities.

Through the collection of ten years of measurable data (2011-2022), and the gathering of Indigenous stories and knowledge, it is evident that the situation of distressed mental health and prolific experiences with substance use has become widespread among the Sioux Lookout area First Nations communities. Understanding our current state of mental health and substance use crisis undeniably conveys the urgency of an epidemic-level response from the provincial and federal government which is well overdue. Furthermore, on September 6th, 2023, the Chiefs in Assembly passed Resolution #23-08 Declaration of Public Health Emergency and Social Crisis to Address Mental Health and Addictions Among Sioux Lookout area First Nations.

The data analyses and findings in this report are painful and illuminate the disheartening realities in which our communities and Band members exist. Within this report we have included several stories courageously shared by our First Nations. These stories offer a greater insight and remind us that behind every number is a precious life.

Although difficult, the information shared in this report is critical for the sake of enhancing the regional knowledge base about mental health and substance use so that communities may:

1) Recognize and create ways that help First Nations Peoples live a good life;
2) Strengthen advocacy and lobbying efforts for First Nations and organizations at provincial and federal levels; and
3) Lead to the creation of First Nations defined policies that are First Nations-centred and evidence-based.

Further, this data strengthens existing First Nations' priorities, and provides supporting data for leadership to promote ongoing healing and wellness for First Nations across the region.

Miigwech to our devoted Steering Committee who drove forward this critical report.

Message From

Dr. Lloyd Douglas

Public Health Physician

Mental wellness is critically important to everyone, everywhere. While mental wellness needs are a significant First Nations public health concern, responses often fall short, remain inadequate, and continue to be overlooked within public health agendas. Sioux Lookout area First Nations communities face stark disparities in mental health and substance use issues compared to the rest of the province and Canada.

On September 6, 2023, in response to the persistent crisis in mental health and substance use, the Sioux Lookout area First Nations Chiefs-in-Assembly declared a public health emergency and social crisis to address the urgent issues facing Sioux Lookout area First Nations communities.

The risk factors contributing to mental health and substance use issues among First Nations communities can be multifaceted, including the impacts of colonial policies, intergenerational trauma, inadequate social determinants for mental health, health disparities, limited access to mental health and substance use services, persistent stigma and discrimination, shortages of mental health professionals and substance use specialists, as well as insufficient funding.

It is time for action. Advocating for sustained funding and action to address historical injustices and colonial policies are essential. Our commitment and action need to focus on addressing structural, social, and policy issues that influence mental health and addiction. Our commitment should also work towards reducing stigma and discrimination; creating First Nations racism-free environments; enhancing resilience; fostering a connection with the land and cultural revival; promoting collaborative partnerships; advocating for sustainable funding; and gaining a profound understanding of the unique context in which mental health and substance use issues persist.

I would like to thank the Sioux Lookout area First Nations Chiefs-in-Assembly, community members, the SLFNHA Board and Executive, the Mental Health and Substance Use Report Steering Committee, all partners who provided data for the development of this report, and the Report Working Group for their unwavering dedication and commitment to this cause.

Key Findings

Service Administration Log (SAL) Data: 2015 – 2020

- A total of 354,935 visits occurred in nursing stations in First Nations communities, averaging 10.4 visits per day per 1,000 population
- **Mental health and substance use was the 4th most common reason for nursing station visits**
- Among people would visited nursing stations for mental health and substance use related reason:
  - 33.5% were assessed for their substance use
  - 14.0% were assessed for anxiety
  - 12.3% were assessed for risk of suicide, self-harm, or self-injury
  - 9.7% were assessed for symptoms of schizophrenia spectrum/psychotic disorders
  - 6.8% were assessed for symptoms of mood/bipolar/depression disorders
- 65.5% of the nursing station visits related to mental health and substance use were among individuals aged 20-44 years, followed by 16.7% among individuals aged 15-19 years

Nodin Mental Health Services (MHS) Data: 2017 - 2022

- 4,938 referrals to Nodin were made between 2017 and 2022, averaging 34.1 referrals per community annually
- 10,120 clients were served, with an average of 69.8 clients per community each year
- 33,925 counselling sessions were conducted by Nodin, averaging 234.0 sessions annually per community
- The four most common reasons for referral to Nodin MHS between 2020 - 2022 included:
  - Experiences of loss and grief (454)
  - Suicide ideation/attempt (376)
  - Depression (254)
  - Alcohol/substance use (184)

*Mental health and substance use was the **4th most common reason** for nursing station visits.*

IntelliHealth Data: 2011 – 2021

- 4,574 ambulatory mental health visits occurred between 2011 and 2021, averaging 14.6 visits per community annually
- **The ambulatory visit rate for mental health increased by 168.0% between 2011 and 2021, from 9.8 visits per 1,000 population in 2011 to 26.3 visits per 1,000 population in 2021**
- 51.8% of ambulatory visits for mental health were among individuals aged 20-44 years, followed by 36.9% among individuals aged 0-19 years
- **The number of ambulatory visits for mental health by females increased by 244.0% from 107 visits in 2011 to 368 visits in 2021**
- Ambulatory visits for mental health by males increased by 95.0%, from 114 visits per 1,000 population in 2011 to 222 visits per 1,000 population in 2021
- 9,884 ambulatory visits for substance use occurred in the same time period, averaging 40.0 visits per community annually
- **Substance use ambulatory visits increased by 302.0%, from 18.2 visits per 1,000 population in 2011 to 73.2 visits per 1,000 population in 2021**
- The age group of 20-44 years made up the largest portion of ambulatory visits for substance use at 71.7%, followed by 18.0% among individuals aged 45-64 years
- Males represented 55.4% of ambulatory visits for substance use, and females represented 44.6% during the period of 2011-2021
- 848 hospitalizations for mental health and substance use occurred, with an average of 4.8 hospitalizations per 1,000 per year among individuals aged 15 years and older during the period of 2011-2021
- At 62.9%, nearly two-thirds of hospitalizations due to mental health and substance use were comprised of young people 15-24 years of age. The 15-19 age group accounted for 37.9% of hospitalizations, while the 20-24 age group accounted for 25.0% of hospitalizations for mental health and substance use

*Substance use ambulatory visits **increased by 302.0%**, from 18.2 visits per 1,000 population in 2011 to 73.2 visits per 1,000 population in 2021*

Institutes of Clinical Evaluative Sciences (ICES) Data: 2011-2021

- Rates of emergency department (ED) visits for mental health and substance use among Sioux Lookout area First Nations Band members surged from 105.9 per 1,000 population in 2011 to 244.4 per 1,000 in 2021. The 2021 rate was 14 times higher than the provincial rate of 17.4 ED visits per 1,000 population
- **ED visit rates for mental health and substance use per 1,000 population were consistently higher for males, with 248.9 visits per 1,000 population in 2021 (up from 117.8 in 2011), and for females, with 239.6 visits per 1,000 population in 2021 (up from 93.4 in 2011)**
- In 2021, the age group of 18-44 years had the highest ED visit rate at 416.9 per 1,000 population, followed by the age group of 45-60 years at 223.8
- ED visit rates for intentional self-harm and self-injury among Sioux Lookout area First Nations Band members more than doubled, from 133.2 visits per 10,000 population in 2011 to 269.9 visits per 10,000 population in 2021
- ED visit rates for intentional self-harm and self-injury were 16 times higher than the provincial rate
- **Hospitalization rates for mental health and substance use among Sioux Lookout area First Nations Band members rose from 16.2 per 1,000 population in 2011 to 31.5 per 1,000 population in 2021. Hospitalization rates were 6.1 times higher than the provincial rate of 5.2 per 1,000 population in 2021**

Office of the Chief Coroner for Ontario Data: 2011- 2021

- The average unnatural death rate for Sioux Lookout area First Nations communities was 1.6 unnatural deaths per 1,000 population, 3.2 times higher than the provincial average of 0.5 unnatural deaths per 1,000 population
- **Between 2011 and 2021, among 404 unnatural deaths in Sioux Lookout area First Nations communities, the age groups of 20-29 years and 30-39 years accounted for the highest proportions of these deaths at 20.5% and 19.1%, respectively. The 15-19 years age group accounted for 15.6% of unnatural deaths**
- 38.1% of unnatural deaths were attributed to asphyxia, and 13.1% were linked to alcohol and drug-related causes
- **Suicide by asphyxia was a significant cause of unnatural death among young people. 70.5% of the unnatural deaths among individuals aged 10-14 years were by asphyxia, and 76.2% of the unnatural deaths among individuals aged 15-19 years were by asphyxia**
- Among the 154 unnatural deaths where asphyxia was a contributing cause, 146 were determined to be suicides by hanging
- Between 2011 and 2021, the rate of suicide by hanging in Sioux Lookout area First Nations communities was 15 times higher, at 0.6 suicides per 1,000 population, than the Canadian resident's rate of 0.04 suicides per 1,000 population

SLFNHA's Approaches to Community Wellbeing's Harm Reduction Program Data: 2017-2022

- **Between 2017 and 2022, a total of 228,440 new needles were distributed to Sioux Lookout area First Nations, with an annual average of 21,756 needles distributed to Sioux Lookout area First Nations communities.**
- The total number of new needles distributed increased substantially by 127.0% from 2017 to 2022.
- During 2022 fiscal year, 192 individuals received naloxone training, and 265 naloxone kits were distributed

NAN HOPE Data: 2020-2023

- The top issues presented by clients included trauma, abuse, anxiety, depression, loneliness, stress, grief/loss, suicide, self-harm, and substance use treatment
- **Between August 2020 and May 2023, NAN HOPE assisted 1,917 individuals of which 627 were youths, and over 60% were aged 18-29**

Hospitalization rates for mental health and addictions among Sioux Lookout area First Nations Band members rose from 16.2 per 1,000 population in 2011 to 31.5 per 1,000 population in 2021. Hospitalization rates were 6.1 times higher than the provincial rate of 5.2 per 1,000 population in 2021.

Suicide by asphyxia was a significant cause of unnatural death among young people. 70.5% of the unnatural deaths among individuals aged 10-14 years were by asphyxia, and 76.2% of the unnatural deaths among individuals aged 15-19 years were by asphyxia.

Summary of Recommendations

The recommendations presented in this report are intended to improve the system of supports and services for mental health and substance use care. This will aid in preventing mental illnesses and restoring mental wellness among the Sioux Lookout area First Nations. Embracing a comprehensive approach to mental health and substance use should be grounded in building community-wide resilience, promoting mental health and mental wellness, reducing stigma, increasing awareness of mental health and substance use issues, and early identification and management of mental illnesses. For full recommendations, please see Appendix A.

The report provides specific recommendations including:

Enhanced Community-Based Mental Health and Substance Use Services: Advocate for developing and expanding a community-based healthcare system for mental wellness and substance use services within First Nations communities. This includes providing the necessary tools for delivering programs and care, ensuring that all communities have welcoming, safe, private, well-equipped, and adequately funded physical spaces. A comprehensive community-based healthcare system involves increasing the number of mental health and substance use specialists, counsellors, detoxification centres, supervised substance consumption centres, and support groups available within the community. Bridging partnerships and networks that support strong service delivery are needed. A community-based healthcare system requires support to build community capacity and awareness through program development and education in leadership. Communities require a variety of workers with clear roles who are trained and equipped with knowledge, skills, and resources to provide services that support community needs. The mental and emotional needs of community-based mental health and substance use workers must be supported within this system.

Youth-Specific and Family Support Programs: Develop and fund youth-specific mental health and substance use programs to recognize the unique challenges faced by young people and foster self-esteem through community heroes and role models. Ensure that youth have a sense of purpose, value, and connection to their families, communities, culture, language, and land. Offer support and resources to families of individuals struggling with mental health and substance use issues to help them navigate the challenges and provide a supportive environment.

Sexual Abuse Prevention and Healing Strategy: Sexual abuse in communities is not a recent epidemic and has a covert origin. It is acknowledged that sexual abuse is a fundamental result of colonialism with a history that reaches back centuries since first contact. Sexual violence specifically towards Indigenous women is contemporary, historical, systemic, and political, and is grounded in colonial violence and oppression.

Establish a diverse committee composed of representatives from: Sioux Lookout area First Nations communities and Tribal Councils, including Health Directors and leadership; and professional sectors including social, education, justice, and health to develop a regional Sexual Abuse Prevention and Healing Strategy to address incest, childhood sexual abuse, partner sexual violence, sexual assault, and sexual exploitation. Furthermore, development of a regional campaign aimed at removing shame associated with sexual abuse, and empowering people of all ages to talk about sexual abuse and to seek support for their trauma is critical for prevention, healing, and mental wellness. Moreover, it would also be valuable to mobilize trauma-informed training with specific focus on sexual abuse for First Nations organizations.

Suicide Prevention: Focus on risk identification and intervention to prevent suicide. Develop public health interventions and systems support to protect vulnerable youth. Additionally, design mental health programs targeting individuals across the lifespan, including infants, children, adolescents, youth, and adults, by promoting a healthy start to life, healthy childhood, healthy transition to adulthood, and caring for older people and Elders.

Grief and Loss Support: Provide extended and timely support to help community members cope with ongoing grief and loss, extending beyond short-term crisis intervention. Recognize the need for specialized support and strengthen community-based crisis response teams to address the mental, emotional, and spiritual needs of individuals dealing with grief and loss.

Addressing Systemic and Structural Gaps: It is essential to recognize and address the ongoing impact of colonial policies, inadequate infrastructure, staffing shortages, service delivery problems, funding limitations, and unfavorable social determinants of health. This includes advocating for policy reforms at multiple levels within the community, organization, and broader region to create more effective, equitable, and responsive care for First Nations communities. It is also critical that there is a collaborative response from both the federal and provincial governments to address the crisis of mental health and substance use through trilateral partnerships and a strategy specific to the region.

Promoting Wholistic Health Approach: Adopt a wholistic approach that recognizes the interconnection of mental, physical, emotional, and spiritual wellbeing. Promote activities that foster overall health, including revitalizing First Nations' culture and healing traditions, reconnecting with the land and land-based healing practices, and spiritual practices -whether traditional or Christian. This will foster a sense of belonging and inclusion, and encourage relationships between youth and Elders to share wisdom, knowledge, and guidance. We require a multi-disciplinary approach that is trauma informed and includes emergency care access, community first responders, and additional specialized services, which are integrated with both traditional and western approaches.

Contents

01 **Prayer from Elder Tom Chisel**

02 **Stories**

03 Patricia's Story

11 Joshua's Story

15 Carrie's Story

21 Stories from the Train Station

27 **Message from Chief Russell Wesley**

28 **Message from Janet Gordon**

30 **Message from Dr. Lloyd Douglas**

31 **Key Findings**

35 **Summary of Recommendations**

3 **Background**

4 **Setting the Context**

9 **Creating the Report**

10 Steering Committee

10 Objectives and Data Collection Methods

11 Literature Review

11 Quantitative Data Analysis

11 Primary Care Data

13 How the Quantitative Data are Presented in this Report

13 Indigenous Knowledge Gathering

15 **Limitations of the Data Sources**

17 **Beyond the Numbers**

17 Using this Report

19 **Findings**

19 Summary of Nursing Station Visits
21 Clinical Reasons for Nursing Station Visits
23 SLFNHA Nodin Mental Health Services
25 IntelliHealth Data
37 ICES Data for Mental Health and Substance Use Emergency Department Visits
43 Office of the Chief Coroner for Ontario Data
49 Mental Health and Substance Use Services
53 Discussion
59 **Cat Lake Stories and Experiences**
62 **Final Thoughts**
63 **Letter From a Son - Joshua Beardy**
65 **Appendices**
65 Appendix A: Recommendations
73 Appendix B: Model for Mental Wellbeing in Communities
74 Appendix C: Goals of the Model for Mental Wellbeing in Communities
75 **Glossary**
77 **References**

Figures and Tables

Figure 1. Summary of visits in 17 nursing stations for mental health and substance use in Sioux Lookout area First Nations, between 2015-2020 (Source: SAL data) Pg. 19

Figure 2. Proportions of the five most common mental health and substance use assessments across 17 nursing stations, between 2015-2020 (Source: SAL data) Pg. 22

Figure 3. Nodin MHS highlights 2017-2022: number of referrals to Nodin, number of unique clients seen, and total number of sessions provided (Source: Nodin MHS data) Pg. 23

Figure 4. Most common reasons for referral to Nodin MHS in fiscal years 2020-2021 and 2021-2022 (Source: Nodin MHS data) Pg. 24

.

Figure 5. Total number of sessions for four key programs of Nodin MHS, between 2017-2022 (Source: Nodin MHS data) Pg. 24

Figure 6. Ambulatory visit rate for mental health, per 1,000 population, per year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data) Pg. 25

Figure 7. Number of ambulatory visits for mental health, by year and gender, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data) Pg. 26

Figure 8. Proportions of ambulatory visits for mental health, by age group, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data) Pg. 26

Figure 9. Mental health related ambulatory visit rates, per 1,000 population, among Sioux Lookout area First Nations community members, by age and year (Source: IntelliHealth data) Pg. 27

Figure 10. Ambulatory visit rate for substance use, per 1,000 population, by year, among Sioux Lookout area First Nations' community members, between 2011-2021 (Source: IntelliHealth data) Pg. 29

Figure 11. Number of substance use-related ambulatory visits, by year and gender, among Sioux Lookout area community members, between 2011-2021 (Source: IntelliHealth data) Pg. 30

Figure 12. Proportions of substance use-related ambulatory visits, by age group, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data) Pg. 30

Figure 13. Substance use related ambulatory visit rates, per 1,000 population, by age and year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data) Pg. 31

Figure 14. Mental health and substance use-related hospitalization rate, per 1,000 population 15 years and older, by year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth Ontario Mental Health Reporting System (OMHRS) data) Pg. 33

Figure 15. Number of hospitalizations due to mental health and substance use, by year and gender, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth OMHRS data) Pg. 34

Figure 16. Hospitalization rates for mental health and substance use, per 1000 population, among Sioux Lookout area First Nations community members aged 15 years and older, between 2011-2021 (Source: IntelliHealth OMHRS data) Pg. 35

Figure 17. Proportions of hospitalizations due to mental health and substance use, by age, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth OMHRS data) Pg. 35

Figure 18. Emergency department visit rates for mental health and substance use, per 1,000 population, by region, by year, between 2011-2021 (Sources: ICES data) Pg. 37

Figure 19. ED visit rates, per 1,000 population, for mental health and substance use among Sioux Lookout area First Nations Band members, by gender, between 2011-2021 (Source: ICES data) Pg. 37

Figure 20. ED visit rates, per 1,000 people, for mental health and substance use among Sioux Lookout area First Nations Band members, by age, between 2011-2021

(Source: ICES data) Pg. 38

Figure 21. Emergency department visit rates, per 10,000 population, for intentional self-harm and self-injury, by region, by year, between 2011-2021 (Source: ICES data) Pg. 39

Figure 22. Three-year average rates of ED visits due to intentional self-harm and self-injury, per 10,000 population, by gender, between 2011-2021 (Source: ICES data) Pg. 40

Figure 23. ED visit rates per 10,000 population for intentional self-harm and self-injury, by age group, between 2011-2021 (Source: ICES data) Pg. 40

Figure 24. Hospitalization rates for mental health and substance use, per 1,000 population, by region, by year, between 2011-2021 (Source: ICES data) Pg. 41

Figure 25. 3- year mental health and substance use hospitalization rates, per 1,000 population, among Sioux Lookout area First Nations Band members, by gender, between 2011-2021 (Source: ICES data) Pg. 42

Figure 26. 3-year mental health and substance use hospitalization rates, per 1,000 population, among Sioux Lookout area First Nations Band members, by age group, between 2011-2021 (Source: ICES data) Pg. 42

Figure 27. Unnatural death rates, per 1,000 population, by year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data) Pg. 43

Figure 28. Proportions of unnatural deaths, by age group, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data) Pg. 44

Figure 29. Numbers and proportions of causes of unnatural death among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data) Pg. 45

Figure 30. Suicide rates by asphyxia-related hanging, per 1000 population, among Sioux Lookout area First Nations community members, by age, between 2011 -2021 (Source: Office of the Chief Coroner Ontario data) Pg. 46

Figure 31. Figure 31. Proportion of suicide by asphyxia-related hanging, by age, among Sioux Lookout area First Nations community members, 2011-2021 (of the 146 deaths by this cause) *Proportions of 10- and 11-year-olds were suppressed because of low numbers. (Source: Office of the Chief Coroner Ontario data)) Pg. 47

Figure 32. Number of suicides by asphyxia-related hanging, by age group and gender, among Sioux Lookout area First Nations community members, between 2011-2021(Source: Office of the Chief Coroner Ontario data) Pg. 48

Figure 33. Number of needles sent and returned by Sioux Lookout area First Nations communities, between 2017-2022 (Source: ACW Harm Reduction data) Pg. 49

Figure 34. Number of naloxone units distributed and number of community members trained by ACW to administer naloxone in the Sioux Lookout area First Nations, between 2017-2022 (Source: SLFNHA ACW Harm Reduction data) Pg. 50

Figure 35. Number of clients served by NAN Hope, within and by Tribal Council, between August 2020 – May 2023 (Source: NAN data) Pg. 51

Background

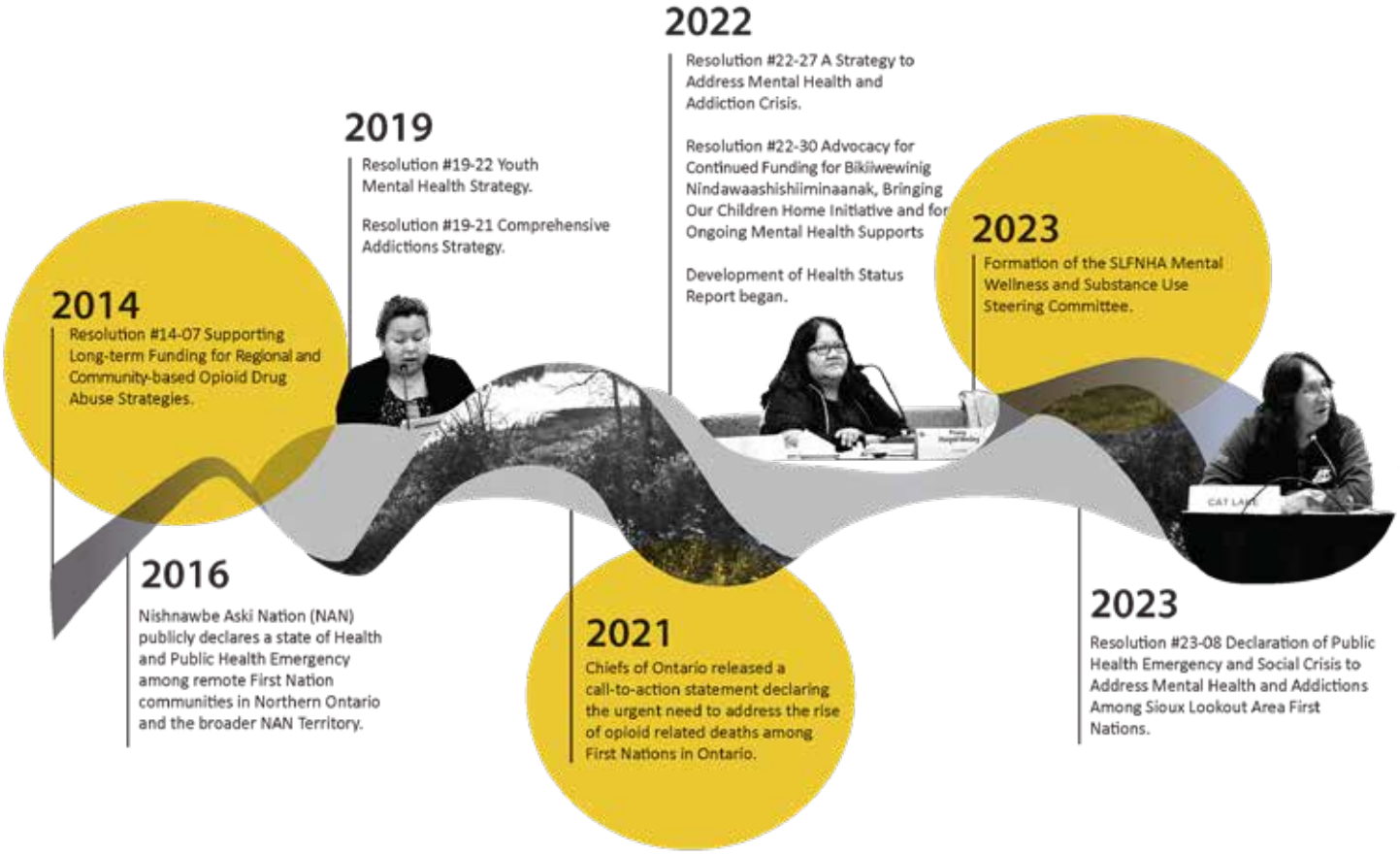
The Sioux Lookout First Nations Health Authority (SLFNHA) serves 33 First Nations communities in the Sioux Lookout region in northwestern Ontario. Directed by the leadership in these communities, SLFNHA's mission is to, "transform the health of Anishinabe people across Kiiwetinoong by providing community-led services and a strong voice for their community health needs."

Approaches to Community Wellbeing (ACW) is the public health department at SLFNHA and focuses on the prevention of illnesses and the promotion of healthy lifestyles. As a developing First Nations-governed public health system, ACW works to support the journey to lasting good health for the First Nation communities it serves.

Over many decades, Sioux Lookout area First Nations community members have faced growing mental health and substance use challenges. The situation has been described as a crisis, an epidemic, and a state of emergency. Community leaders have called for federal and provincial investments and support. While some investments have come to the region, First Nations' leaders, community members, and healthcare providers remain in continuous cycles of crisis and acute unmet needs (Sutherland, M., Marr, M. and Roberts, B., 2023).

Health status reports measure the health of a population over time, often with a focus on a specific health issue or outcome. These reports can help us to understand how big a health issue is, who the issue is affecting the most, and where geographically the problem is showing up more often.

This health status report was developed for the Sioux Lookout area First Nations and sets out to understand the state of mental health and substance use among their members. Data gathered between 2011-2021 has shown there is an urgent need to provide an epidemic-level response to address mental health and substance use challenges in communities and among community members.



Setting the Context

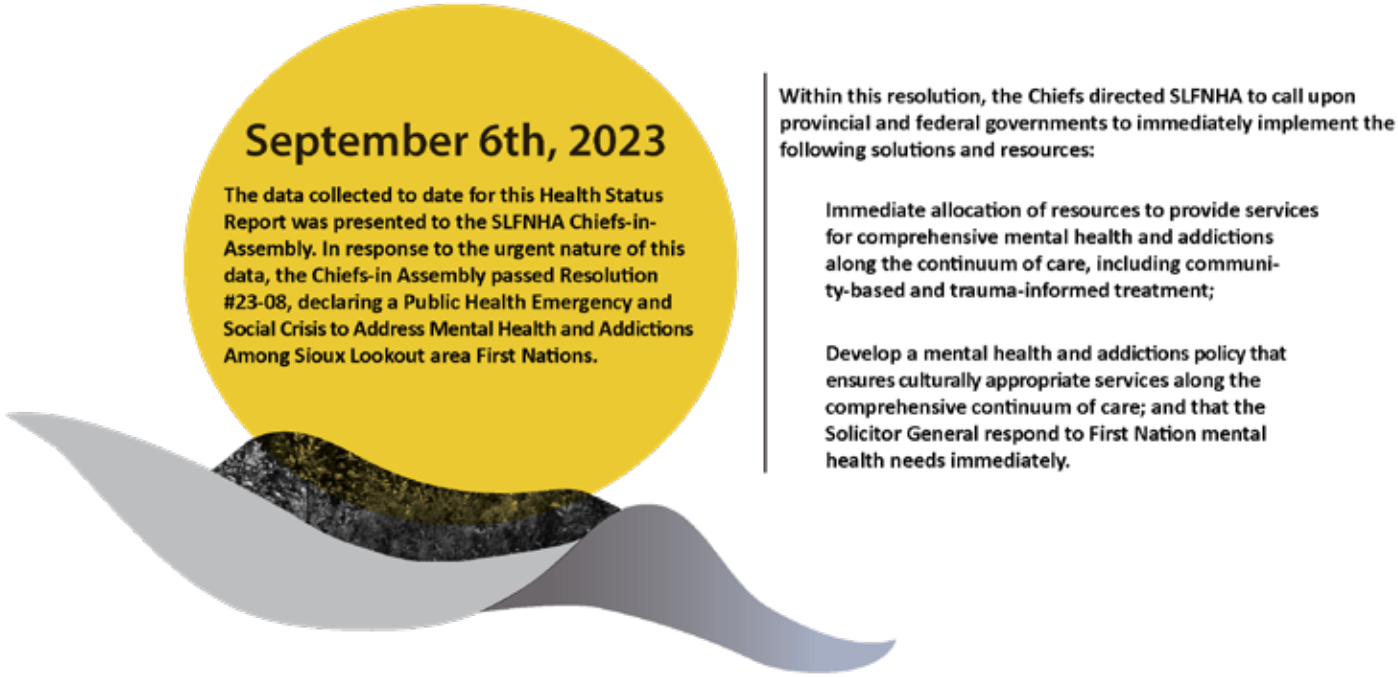
Mental wellness is a wholistic concept which recognizes the mental, physical, emotional, and spiritual aspects of a person's life. Spirituality often forms the backbone of First Nations communities. Whether it's exploring traditional ways, or Christianity, a lot of how community is formed comes down to faith and a belief that there is something greater than oneself. Believing in a higher and merciful power has the potential to ease one's mind. Spirituality is knowledge of oral traditions, teachings, values, customs, protocols, and natural and spiritual laws that are instilled and imprinted within oneself, bringing one closer to knowing who they are and that they are a sacred part of creation.

The First Nations Mental Wellness Continuum Framework, developed in partnership between the Assembly of First Nations (AFN), the Thunderbird Foundation, and Indigenous Services Canada's First Nations Inuit Health Branch, further defines mental wellness as a balance, where individuals experience:

"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 understanding of how their lives and those of their families and communities are part of creation and a rich history (Health Canada, 2015)."

Prior to colonization, First Nations societies lived a good life by their own cultures and traditions. Children were loved, nurtured, and cared for by the entire community; and there were clear and valuable roles that supported harmonious ways of life (Assembly of First Nations, 2015).

While colonialism dates back over five hundred years, the Indian Act of 1876 greatly disrupted the traditional way of life for First Nations, causing Indigenous people to experience a disconnection from their culture and traditional ways, as well as separation from their family and community. The Indian Act gave the Canadian government control over the management of all aspects of First Nations' lives, including the welfare of their children, education of their children, and the provision of health services.



The Indian Act allowed for the creation of Indian Residential Schools (IRS), Indian Day Schools, and authorized the Canadian child welfare system to remove Indigenous children from their families to be placed in non-First Nations care. It is estimated that 150,000 children attended residential schools in Canada; 200,000 attended Indian Day Schools; and between 1951 and 1984, 20,000 or more First Nations, Métis, and Inuit infants and children were taken from their families by child welfare authorities and placed for adoption in mostly non-First Nations households as part of government policies known as the 'Sixties Scoop' (University of British Columbia, June 2023).

First Nations children placed within Indian Residential Schools (IRS) experienced multiple incidents and prolonged experiences of trauma. More than 38,000 claims of sexual and physical abuse have been submitted to an independent adjudication process established to assess and compensate IRS survivors (Simpson, T.L. & Miller, W.R. , 2002). Indian Day Schools were introduced on reserves, a promise ironically fulfilled by the federal government to 'honour' Treaty commitments to provide salaries, teachers, and infrastructure within First Nations communities. Corporal punishment was enforced alongside other methods of cruel treatment. Thousands of Indian Day School class action claims in progress across Canada affirm the abusive experiences of Indian Day School students (Independent Assessment Process Oversight Committee, 2021).

The horrific abuse and trauma suffered by First Nations children and communities in northern Ontario was not isolated to residential schools and day schools. During the 1970s and 1980s, Ralph Rowe, a priest with the Anglican Synod of the Diocese of Keewatin, self-piloted into isolated First Nations communities in northern Manitoba and Ontario as a Boy Scout leader.

Ralph Rowe abused an estimated 500 young First Nations boys across northern Manitoba and Ontario (Independent

Assessment Process Oversight Committee, 2021). Listed within the Final Settlement Agreement with the Ontario Superior Court of Justice, 14 Sioux Lookout area First Nations communities are named as communities frequented by convicted pedophile, Ralph Rowe: Fort Severn First Nation; Eabametoong First Nation; Cat Lake First Nation; Slate Falls First Nation; Sachigo Lake First Nation; Kitchenuhmaykoosib Inninuwug; Kasabonika Lake First Nation; Wunnumin Lake First Nation; Kingfisher Lake First Nation; Muskrat Dam First Nation; Bearskin Lake First Nation; Wapekeka First Nation; and Weagamow Lake (Independent Assessment Process Oversight Committee, 2021).

> *"We instill in them a pronounced distaste for the native life so that they will be humiliated when reminded of their origin. When they graduate from our institutions, the children have lost everything native except their blood."*
>
> *— Bishop Vital Grandin, 1875*

In 1994, Nishnawbe Aski Nation (NAN) hosted a series of youth forums on suicide. In July of that year, NAN brought the forum to Wunnumin Lake First Nation, a community that was home to many of the young boys who had been sexually abused by Rowe. Of the sexual abuse suffered by Rowe's young victims in Wunnumin Lake, it is stated within the Youth Forum on Suicide Hearings Summary Report:

"Those who have suffered through this have spent a good deal of their energy trying to cope. Some have not survived. Some have attempted suicide seriously. Some on more than one occasion. Sexual abuse has defined the lives of many of these young men because no matter how they try to forget it, they cannot. It has affected virtually every aspect of their lives including marriage, parenting, communication at work and home, as well as relationships within the family and community" (Nishnawbe Aski Nation Inc., 1994).

A study regarding the impact of childhood sexual abuse survivors affirms that they are more likely to engage in self-harm or suicidal behavior, and that they are at a higher risk of experiencing other forms of trauma and abuse (Tricket PK, 2011). During the NAN youth forums on suicide in 1994, youth spoke about sexual abuse and incest as, "an all-too-common experience of their growing up years," and that there continued to be, "a veil of silence around the issue" (Nishnawbe Aski Nation Inc., 1994). Youth also shared that, "…stopping the sexual abuse in the community would help Youth to know their serious concerns are being dealt with" (Nishnawbe Aski Nation Inc., 1994).

The same report warned of young people who experience grief over the loss of friends and peers to suicide, and that the youth, "carry the burden of these heavy feelings and they clearly need support and help to talk about these feelings. It is important that Youth do not continue to carry guilty feelings and thoughts of 'copying' the actions of their peers" (Nishnawbe Aski Nation Inc., 1994).

First Nations populations face increased risk of suicide and suicide clusters (Tricket PK, 2011), defined as multiple suicidal behaviours or suicides that fall within an accelerated time frame, sometimes within a defined geographical area (Olson, 2013). Factors which influence suicide clusters include: the closeness of small communities whose exposure to suicide attempts are more frequently observed; and when individuals are more likely to know other individuals who attempt suicide or die by suicide (Olson, 2013). Knowing someone who has attempted or died by suicide, like a friend, family member, or community member, increases one's own risk to attempting or dying by suicide if suicide ideation is already present (Olson, 2013). Tragically, in 2017, seven First Nations girls between 12-13 years old and from reserves in northern Ontario, took their lives within a year of each other (Talaga, 2018). All were connected through reserves in northern Ontario, or care facilities off reserve (Talaga, 2018).

Data from the Office of the Chief Coroner of Ontario (OCC) showed between 2011-2021, children as young as 10 years old within the Sioux Lookout area First Nations are choosing lethal methods to attempt suicide; and that over 70% of unnatural deaths among children aged 10-19 are a result of asphyxia-related hanging.

The mental health impacts of trauma, especially when trauma occurs at an early age, may also lead to harmful substance use. Self-medication, namely through the misuse of substances is one of the methods that traumatized people use to regain emotional control, although ultimately it causes even further emotional dysregulation (Substance Abuse and Mental Health Service Administration, 2023).

In the final report of the Truth and Reconciliation Commission, many IRS survivors spoke about using substances to manage trauma. "Children who had been bullied and physically or sexually abused carried a burden of shame and anger for the rest of their lives. Overwhelmed by this legacy, many succumbed to despair and depression. Some students developed addictions as a means of coping. Countless lives were lost to alcohol and drugs". (The Truth and Reconciliation Commission of Canada, 2015).

The traumas exacted by Indian Residential Schools, Indian Day Schools, paternalistic child welfare practices, and predators like Ralph Rowe, have contributed to the overwhelming rates of mental unwellness and substance use among Sioux Lookout area First Nations. Furthermore, generations of oppressive colonial systems and an inequitable healthcare system for First Nations communities in northern Ontario have contributed to the current state of emergency that can be observed within this report.

Data demonstrating extremely high rates of emergency department use, including for self-harm and self-injury, mental health and substance use, and shocking rates of suicide among children and young adults are presented within this report.

However, within this report are also the courageous stories shared by those who have intimate knowledge of the circumstances which surround these statistics. Love and hope have compelled these Storytellers to share the truth of their challenging realities. In the face of incredible hardship and suffering, these Storytellers have found strength in faith, tradition, and loved ones. Spirituality, bravery, truth, love, and forgiveness are the lights upon their healing paths.

“Children who had been bullied and physically or sexually abused carried a burden of shame and anger for the rest of their lives. Overwhelmed by this legacy, many succumbed to despair and depression. Some students developed addictions as a means of coping. Countless lives were lost to alcohol and drugs (The Truth and Reconciliation Commission of Canada , 2015).”

Creating this Report

This report is created for the Sioux Lookout area First Nations communities. It intends to provide essential information to assist community leadership, community members, health workers, and partners to effectively address mental health, addiction, and the social crisis in the region.

Steering Committee

A Steering Committee was formed in January 2023. There were twelve voluntary First Nations community members on the Steering Committee, including Chiefs, Health Directors, and Mental Health Workers. The Steering Committee provided leadership and direction for the development of this report to the final review phase. The Steering Committee also provided guidance on the best Indigenous Knowledge Gathering methods to be used. The Steering Committee reviewed data, provided feedback on the presentation and interpretation of data findings, and conducted a full review of the draft report. Between January 2023 and November 2023, six Steering Committee meetings were held.

Objectives and Data Collection Methods

The objective of this report is to understand mental health and substance use among the Sioux Lookout area First Nations, between 2011 – 2021. To achieve this objective, three key data collection methods were used:

1. Literature review
2. Secondary quantitative data collection
3. Indigenous Knowledge Gathering, involving firsthand experiences shared by members of Sioux Lookout area First Nations communities.

The report also includes findings from SLFNHA's 2023 - *Mental Health and Addictions Review, and A Proposed Model for Community Wellbeing*. These reports describe the state of mental health and substance use services in the region, including strengths, weaknesses, and gaps. Both reports encourage the development of a community-led and First Nations governed model for wellbeing in the region.

The data in this report includes community nursing station and physician visits, as well as emergency department (ED) visits, ambulatory visits, and hospitalizations. Unnatural deaths with factors related to mental health and substance use are also presented. The data in this report supports a better understanding of how and where mental health and substance use needs have been assessed, diagnosed, and treated in the region. Where possible, each data set is further analyzed by age and gender.

Within this report, Sioux Lookout area First Nations community members have generously shared their stories and experiences of mental health and substance use. The impacts of these experiences on their lives, and the lives of their families, communities, and Nations are also explored through their unique narratives. When presented alongside the data, these voices create meaning and understanding of the lived and living experiences behind the numbers.

Literature Review

The literature review conducted included publications spanning organizational reports, community reports, and academic literature on mental health, addictions, and substance use. It also provided insights into the historical context of mental health and substance use among Indigenous Peoples and communities in northern Ontario. The literature review summarized many of the gaps within mental health and substance use programming and presented two approaches to resolving the existing crisis: 1) moving toward a culturally grounded and community-based treatment approach, and 2) innovative and meaningful pathways forward through a land-based approach.

Quantitative Data Analysis

Quantitative data collected, analyzed, and presented in this report is intended to show patterns of mental health and substance use service utilization over time, among Sioux Lookout area First Nations Band members living on and off reserve.

This report includes the analysis of comprehensive quantitative data from a number of sources including primary health care, counselling and support services, hospital system utilization, and unnatural deaths in the region.

Datasets received included individual-level data that had personal identifiers removed, as well as aggregate data in the form of reports and presentations. In the case of the individual datasets, SLFNHA staff relied on postal codes to analyze the data at community and regional levels.

Primary Care Data
Nursing Station and Physician Referrals

Service Administration Log (Sal) 2015-2020

The Service Administration Log (SAL) is where primary care services delivered by nursing staff in nursing stations and health centres across the Sioux Lookout area First Nations are recorded. Nursing stations, and the nursing services who are employed within them, are among the many First Nations health services that continue to be delivered by the Canadian government. Indigenous Services Canada (ISC), a branch of Health Canada's First Nations Inuit Health Branch (FNIHB), is responsible for the nursing staff and primary care nursing functions in all 17 of the nursing stations referenced in this report.

SAL data provides a good understanding of the health issues that community nurses respond to daily. While the nurses are not able to diagnose and treat many of the complex mental health and substance use issues that present, they are able to make assessments, and initiate referrals for more specialized care. Because of this, SAL data can be helpful to guide program planning and evaluation, such that services offered can better support the needs of the communities.

Counselling and Support Services Data

Data about specific counselling and support services delivered in the region was requested and provided by SLFNHA's Nodin Mental Health Services, SLFNHA's ACW department's Harm Reduction program, and Nishnawbe Aski Nation's Mental Health and Addictions Support Access Program (NAN Hope).

Counselling and support services data can help us understand who is accessing services most often, the types of services that are being provided, and the location of these services relative to need.

Hospital Service Utilization Data

Hospital-based data for this report was accessed through two data holders: Intelli-Health and Institute for Clinical Evaluation Services.

Institute for Clinical Evaluative Sciences (ICES) 2011-2021

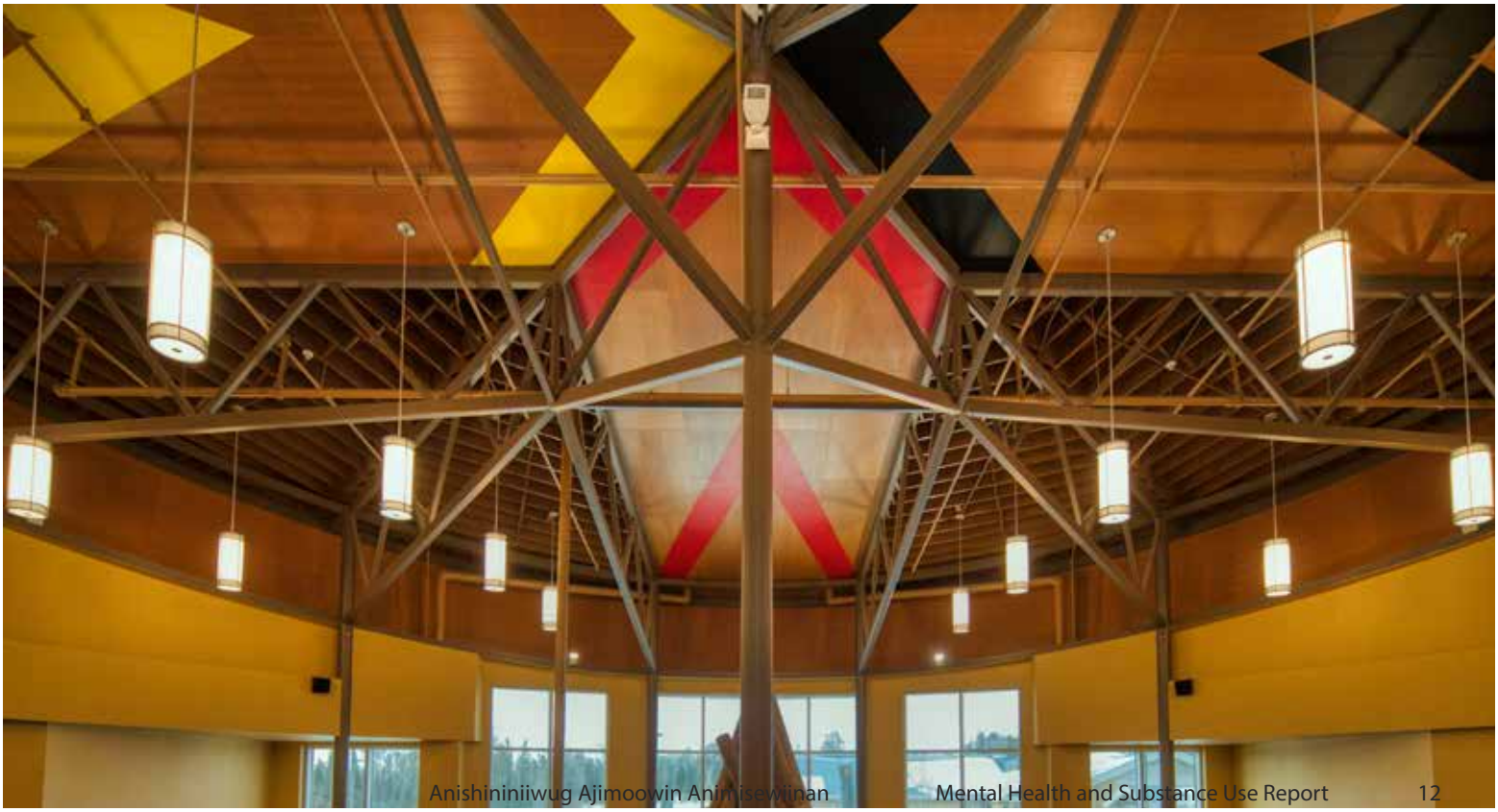
ICES, a comprehensive health system data holder in Ontario, supports health service planning, evaluation, and research using their extensive data repository and expertise. Unlike all other data holders who provided raw data to SLFNHA, ICES provided SLFNHA with the results of their own data analyses for the period 2011-2021.

ICES also applied a distinct analysis approach, analyzing health utilization patterns of Sioux Lookout First Nations Band members more broadly. ICES data analysis includes patterns of emergency department utilization and hospitalization by Sioux Lookout area First Nations Band members. The data within the ICES analysis then looks specifically at Sioux Lookout area First Nations Band members that are living in their own First Nation, or on another reserve in Ontario, as well as Sioux Lookout area First Nations Band members who are living off reserve anywhere in Ontario. The only identifier for ICES data is Band number. The intention was to stratify the data at a higher level, not community, corresponding to the concept of "no geographical boundaries". This analysis was possible through ICES's linking of health utilization data to the Indian Registry System.

Office of the Chief Coroner (OCC) 2011-2021

Unnatural death data for this report was provided by the Office of the Chief Coroner (OCC) of Ontario. OCC is responsible for the death investigations and inquests in the province, to ensure that no death is overlooked, concealed, or ignored. OCC data is used to generate recommendations to help improve public safety and prevent deaths in similar circumstances.

OCC data provided information on closed investigations for all unnatural deaths occurring within the Thunder Bay District Health Unit and the Northwestern Health Unit between January 2011- December 2021. Deaths categorized by OCC as an unnatural death include accidents, homicides, suicides, or undetermined. The number of unnatural deaths of Sioux Lookout area First Nations community members was determined using residence postal code.



How Quantitative Data are Presented in the Report

The main ways that data is presented in this report are numbers, rates, and proportions.

Numbers are used in the report to describe absolute measures for the indicators without relation to denominators.

Rates are used to describe two numbers in relation to one another. Within the report, rates are used to describe findings such as the number of health care interactions within a certain population within a certain year, or the number of people who have passed away from specific unnatural causes, such as opioid poisoning or suicide, within the population. Within this report, the populations are expressed as 1,000 people, or 10,000 people.

Proportions describe numbers as a percentage of the whole. Proportions are used frequently within the report, such as to describe the proportion, or percentage of males, compared to females who were hospitalized, or the proportion, or percentage of youth within a certain age group, who died from a specific cause.

Since the data was captured in the whole population (not study samples), to avoid misinterpretation of the findings, confidence intervals are not included as the data focuses on the entire population and not study samples. For comparison of different populations, Pearson Chi-square tests and Mantel-Haenszel tests were applied, wherever appropriate. Data analyses were performed using SAS On Demand for Academics platform.

Indigenous Knowledge Gathering

The Steering Committee considered Indigenous Knowledge Gathering as a research method in a good way. Indigenous Knowledge Gathering recognizes the unique world views of the First Nations. When statistics or numerical data is presented alongside the stories and experiences of the First Nations, greater understanding is created about the factors that have contributed to the current state of mental health and substance use in Sioux Lookout area First Nations community members

Key methods in Indigenous Knowledge Gathering included storytelling and visiting. Three individuals came forward as Storytellers for this report to share their knowledge related to mental health and substance use.

SLFNHA staff met with all three Storytellers to review the sharing process, including their self-determination, the consent process, and their continuous control over what they would share, what would be written, and what would be included within the report. These transcripts were edited for clarity and accuracy during individual sessions with each Storyteller and between four to ten review sessions were undertaken alongside the Storytellers for each story. Upon completion, informed consent on the final versions were obtained. Their stories have been written in their own words.

When statistics or numerical data is presented alongside the stories and experiences of the First Nations, greater understanding is created about the factors that have contributed to the state of mental health and substance use.

Limitations of the Data Sources

There are several limitations to consider when interpreting the results in this report.

Inconsistent time frames within datasets

When using historical, or retrospective data from secondary sources, the time frames within the datasets were varied. In the majority of datasets, the data collected included the study time period between 2011 and 2021. Data from 2022 were excluded due to incompleteness.

Data categories

Additionally, when using retrospective and secondary data, not all information could be obtained and categorized consistently. For example, based on how data was received, it was not possible to have consistent age groups between all datasets. Additionally, certain data sets include assessments of healthcare needs by healthcare providers, rather than a diagnosis of the health condition.

Underestimation of case counts

The likely underestimation of case counts is another limitation within the report. Health service utilization data in this report captures those who have accessed healthcare and is not a representation of all those in need of healthcare. It is known that service access in the Sioux Lookout area First Nations is wrought with many barriers (Sutherland et al., 2023). Therefore, the data is not representative of all people experiencing mental health and/or substance use needs or challenges in the Sioux Lookout area First Nations between 2011-2021.

Underrepresented and underestimated unnatural deaths

The analysis of unnatural deaths within this report may also be underrepresented. Unnatural death data does not include the deaths of community members who passed away in locations elsewhere in Ontario or other provinces. Likewise, the numbers of opioid-related deaths are also very likely to be underestimated. Further analysis of unnatural deaths occurring in surrounding urban communities such as Thunder Bay, Kenora, and Dryden, could provide a clearer picture of unnatural deaths due to opioid poisoning among Sioux Lookout area First Nations Band members.

Missing information on First Nations status

Missing information regarding First Nations status is an inherent limitation in all the datasets, except the nursing station data with 97.9% of individuals confirmed with First Nations status. In many data sets First Nations status is either not recorded, or is missing for a large proportion of individuals. As such, much of the data within this report looks at the health utilization patterns of the community members living in the Sioux Lookout area First Nations communi-

ties. Only ICES data could be linked to the Indian Registry System to define First Nations status, thus providing a picture of Sioux Lookout area Band members health utilization within and outside of Sioux Lookout area First Nations communities. With several communities experiencing significant backlog in their birth registrations, it is also expected that missing Registry data contributes to a further underestimation of health service activity.

Residence locations

The residence of individuals is recorded in different ways within the datasets used within the report, with the exception of the nursing station data, where the community's name is consistently clearly indicated.

ICES uses Band number, followed by residence codes, to identify the hospital utilization patterns of Sioux Lookout area First Nations Band members, on and off reserve. Interpretation of the ICES data results for Sioux Lookout area First Nations limits the ability to compare these results with the geographical data sets where residence location has been identified using postal codes. Interpretation of the community-specific data from ICES results could be even more complicated, due to Band numbers and residence codes applied, disregarding the community's geographical location. Additionally, lack of access to the raw data for ICES' analysis limited the ability to fully understand certain sources of unknown variation within results, specifically when comparing them to results from the analysis of other datasets. These variations can emerge due to differences in analysis and data collection methods.

Moreover, population numbers are well understood to be underestimated across the region, due to lags in Indian Registry System within communities. The resulting underestimated population numbers could skew rates and proportions of healthcare utilization on and off reserve within this report, as with other regional reports.

The need for further studies regarding mental health and substance use

Capturing a comprehensive picture of mental health and substance use in Sioux Lookout area First Nations requires a series of reports beyond this first volume and the companion reports by Sutherland et al. There is limited information available on the prevalence, severity, source of supply, and social impacts of substance use among First Nations. Collabaorating with the Thunderbird Partnership may create a better understanding of the burden of substance use in Sioux Lookout area First Nations through surveys. It will be pertinent to include service utilization data to community-based and community-led programs, traditional healing services, programs provided by Tribal Councils, and private psychology clinics, that are not captured in this report. It is imperative to recognize the impact and harms of interactions with the police and justice system for individuals with mental health concerns and substance use. Future volumes would include data related to individuals in custody due to mental health and substance use and harms associated with law enforcement including deaths in custody of individuals experiencing adverse mental health or substance use.

Beyond the Numbers

Numbers can be helpful for describing the size, nature, and impacts of health issues experienced across communities of people. While we share the experiences of a few community members throughout this report, we continue to acknowledge that numbers can fall short of presenting the full experience and picture of mental health and substance use in the region. A focus on statistics, rates, and numbers sometimes misses:

- Wholistic approaches: First Nations served by SLFNHA view health and wellness as connection to land, community, language, culture, ancestors, and family.
- Spirituality: Before colonization, a healthy relationship to the land was fostered in community. This formed the crux of many First Nations societies and an instinctive knowing that First Nations are a sacred part of creation, and that survival depends on environment and connection with the Creator and Mother Earth.
- Indigenous ways of knowing: Indigenous ways of knowing are valued and it is recognized that numbers sometimes take space away from the important information held in stories and oral culture. By defining health using qualitative (words) and quantitative (number) methods, we solidify the realities communities are facing and share the stories of Sioux Lookout area First Nations.
- Experience of illness: Numbers sometimes do not capture the individual, family, or community experience of illness.
- Roots of health inequity: Most of the poor health outcomes experienced by Sioux Lookout area First Nations are a direct result of colonization, assimilation policies, legislation, and systemic racism. This must be remembered and emphasized when interpreting the numbers in this report.

Using this Report

The data demonstrates the mental health and substance use service utilizations patterns among Sioux Lookout area First Nations Band members living on and off reserve. This report is a tool to guide more responsive service planning to meet community needs, and ultimately, to the creation of healthier First Nations communities.
Specifically, this report contributes to:

- Understanding the Situation: Gaining an eagle-eye view of the number and experiences of people accessing substance use and mental health services in the region.
- Planning Next Steps: Using the data to develop additional effective strategies, solutions, and interventions to address the mental health and substance use crisis in the region.
- Advocating for Support: Using the report to advocate for coordinated action and increased equitable resources and funding to achieve favourable conditions that will promote mental wellness of community members living in the Sioux Lookout area First Nations.
- Supporting Individuals: Tailoring interventions that will enable those currently facing mental health and substance use challenges to achieve their fullest mental wellness potential.

Findings: Mental Health and Substance Use Service Utilization

Summary of Nursing Station Visits

354,935 visits in **17 nursing stations** in the Sioux Lookout area First Nations

Average **3.8 visits** per person per year

Average **10.4 visits** per day per 1,000 population

Top 5 reasons for Nursing Station visits

1. Skin
2. Eyes, Nose, Mouth, and Ear
3. Musculoskeletal
4. Mental Wellness and Substance Use
5. Respiratory

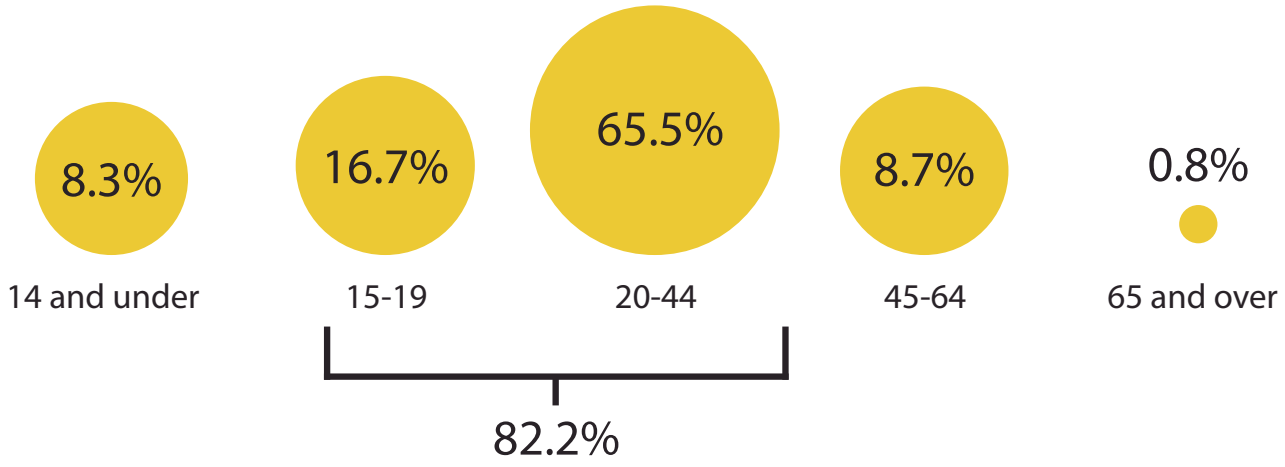
Figure 1. Summary of visits to 17 nursing stations for mental health and substance use in Sioux Lookout area First Nations, between 2015-2020 (Source: SAL data).

The original Service Administration Log data set included individual visit information from 17 nursing stations, between April 1, 2015, to November 27, 2020 (66 months). Two of the nursing stations provide services to more than one community. During this period, a total of 354,935 visits took place at 17 nursing stations.

An average of 10.4 visits per day per 1,000 population were recorded between 2015-2020. The average number of visits per person was 3.8 per year. When nursing station visits were compared, the number of visits per day per 1000 population was statistically different from one community to another over time. This variation may indicate differences in healthcare needs, or availability of and accessibility to nursing station services for different communities.

Among all individuals visiting the 17 nursing stations, 97.4% were living in the communities where service was accessed, and 97.9% had First Nations status.

Age of individuals visiting nursing stations for mental health and substance use



Most common diagnosis categories

33.5% Substance-related/addictive disorders

14.0% Anxiety disorders

12.3% Deliberate self-harm/suicide attempt

9.7% Schizophrenia spectrum/ psychotic disorders

6.8% Mood/bipolar/depression

Clinical Reasons for Nursing Station Visits

Reasons for visits, also called "encounters" in health care settings, are determined and classified by nurses, then entered into the visit records as a primary clinical reason for visit, followed by secondary and other clinical visit reasons. Mental health and substance use were among the top five primary reasons for visits, making up 8.6% of primary reasons for visits.

Although nurses working in nursing stations assess many presenting health needs, they do not make formal diagnoses. A clearer understanding of mental health and substance use concerns in communities can be presented when organizing assessment/reason for visit data into the following diagnostic categories of the DSM-5 (2017):

- Substance-related and addictive disorders
- Schizophrenia spectrum and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Trauma and stressor-related disorders
- Obsessive-compulsive and related disorders
- Personality disorders
- Deliberate self-harm

Data from one nursing station was excluded from the analysis of mental health and substance use visits, due to significant missing information. When the remaining data was analyzed, across the 16 stations, a total of 340,695 visits occurred between April 1, 2015, to November 27, 2020.

Among all reasons for nursing station visits, percentages of mental health and substance use reasons were different among each community, ranging from 5.2% to 12.5% of all visits. When analyzed for gender differences, the percentage of mental health and substance use visits by females (55.4%) was higher than males (44.6%) across the 16 nursing stations over the time period (data not shown).

The percentage of mental health and substance use visits by females (55.4%) was higher than males (44.6%) across the 16 nursing stations between April 1, 2015, to November 27, 2020.

The highest number of nursing station visits for mental health and substance use occurred in the 20-44 years age group, accounting for 65.5% of mental health and substance use related visits, while those between 15-19 years old accounted for 16.7% of such visits across all nursing stations during the 66-month period from 2015 to 2020 (Figure 1). This proportional pattern was observed in nearly all individual nursing stations.

Among those assessed for mental health and substance use conditions, the most common diagnosis categories were substance-related/addictive disorders (33.5%), followed by anxiety disorders (14.0%), deliberate self-harm/suicidal attempt (12.3%), and schizophrenia spectrum/psychotic disorders (9.7%) (Figure 2). Communities had different patterns of these diagnoses, although the specific details are not shown.

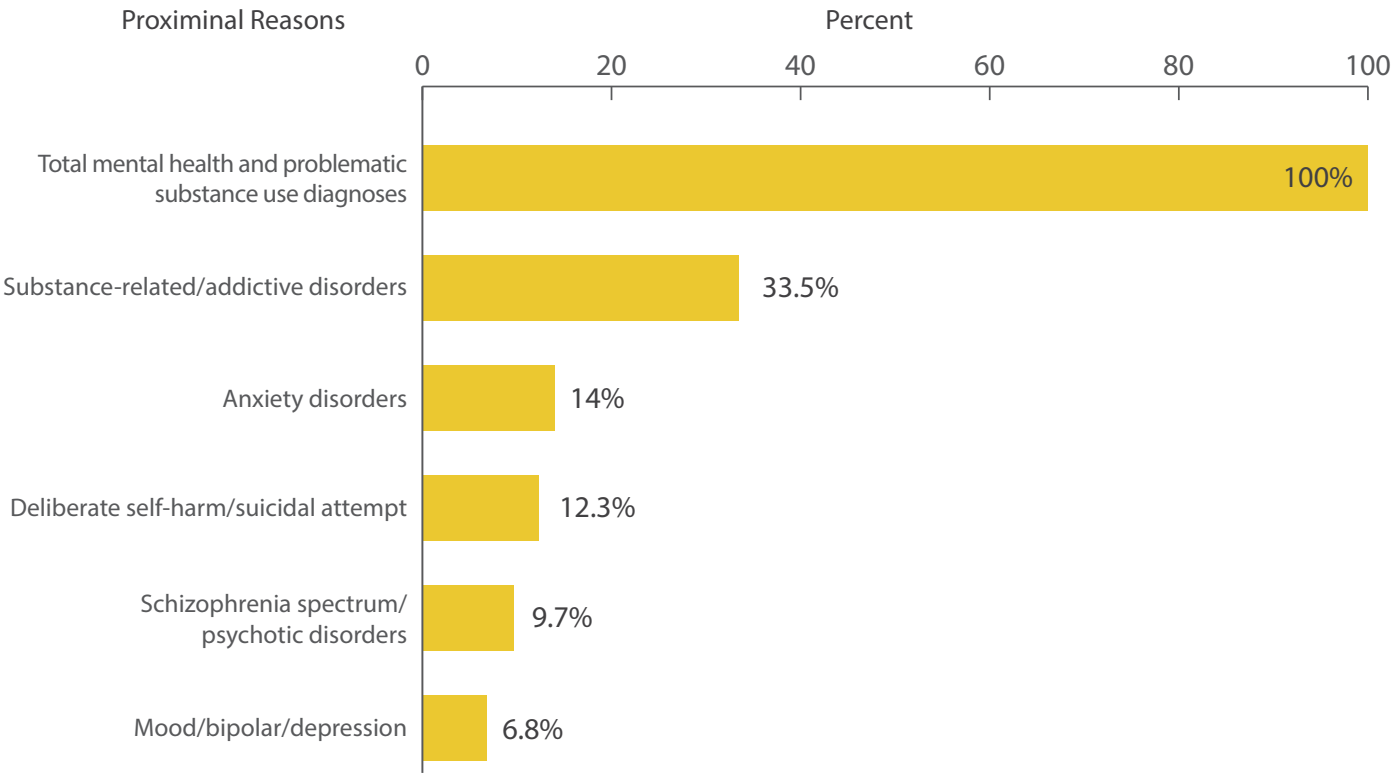


Figure 2. Proportions of the five most common mental health and substance use assessments across the 16 nursing stations, between 2015-2020 (Source: SAL data).

Between 2015 to 2020 across the community nursing stations, more women than men visited nursing stations to seek help for substance use/addictive disorders (55.3 females vs. 44.7 males per 1000 visits) and self-harm/suicidal attempts (71.9 females vs. 28.1 males per 1000 visits). However, both men and women had similar numbers of visits for anxiety disorders.

SLFNHA Nodin Mental Health Services

Nodin Mental Health Services (MHS) provides a broad range of mental health services and programs for 33 First Nations in the Sioux Lookout area. Nodin MHS services are offered within communities, remote/virtually, and on an outpatient basis in Sioux Lookout.

The figure below summarizes the number of clients with services from Nodin MHS during five fiscal years from 2017-2022. The highest numbers of services provided were observed in the 2019-2020 fiscal year.

In the fiscal year 2021-2022, there were a total of 939 referrals to Nodin MHS. Referral sources that year included those received internally from health professionals working within SLFNHA (30%), from physicians (27%), from nursing stations (18%), self-referral (17%), and from the Meno Ya Win Health Centre's Mental Health and Addictions Program (MHAP) (8%) (data not shown in graph).

In the fiscal year 2021-2022, there were a total of 939 referrals to Nodin MHS.

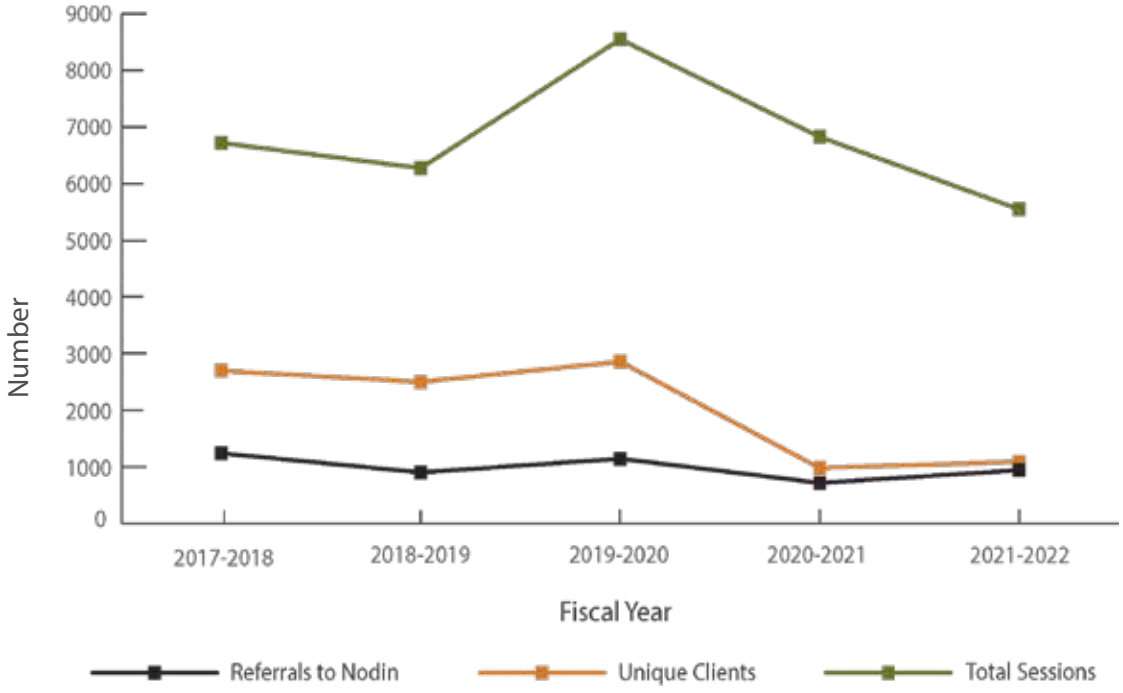


Figure 3. Nodin MHS highlights 2017-2022: number of referrals to Nodin, number of unique clients seen, and total number of sessions provided (Source: Nodin MHS data).

When reviewing the most common reasons for referral to Nodin MHS over the two-year period between 2020-2022, they included trauma/post-traumatic stress disorder (PTSD), anxiety, depression, alcohol/substance use, suicide ideation/attempt, and loss and grief (Figure 4).

The most common reason for referral to Nodin MHS between 2020 and 2022 was loss and grief.

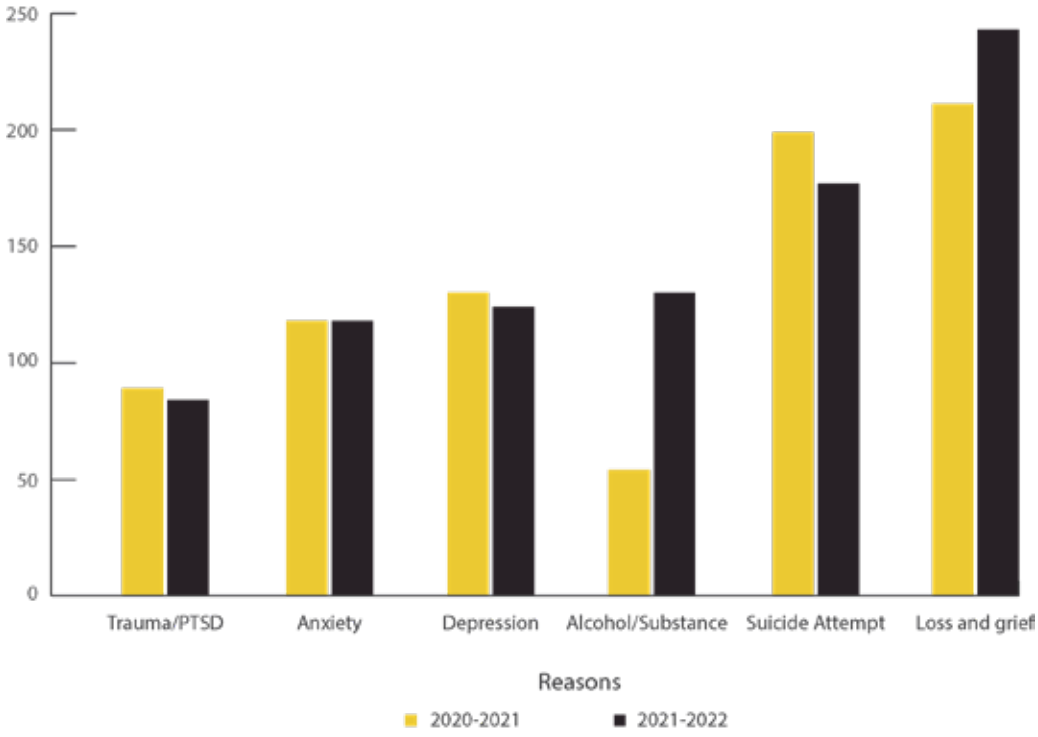


Figure 4. Most common reasons for referral to Nodin MHS in fiscal years 2020-2021 and 2021-2022 (Source: Nodin MHS data).

Among all the services and programs provided by Nodin MHS, there are four key services and programs with high number of counselling sessions: 1) Community-based mental health and addiction workers, 2) Outpatient mental health service, 3) Travelling, and 4) Youth school. Figure 5 highlights the total number of sessions for these services during five fiscal years from 2017-2022.

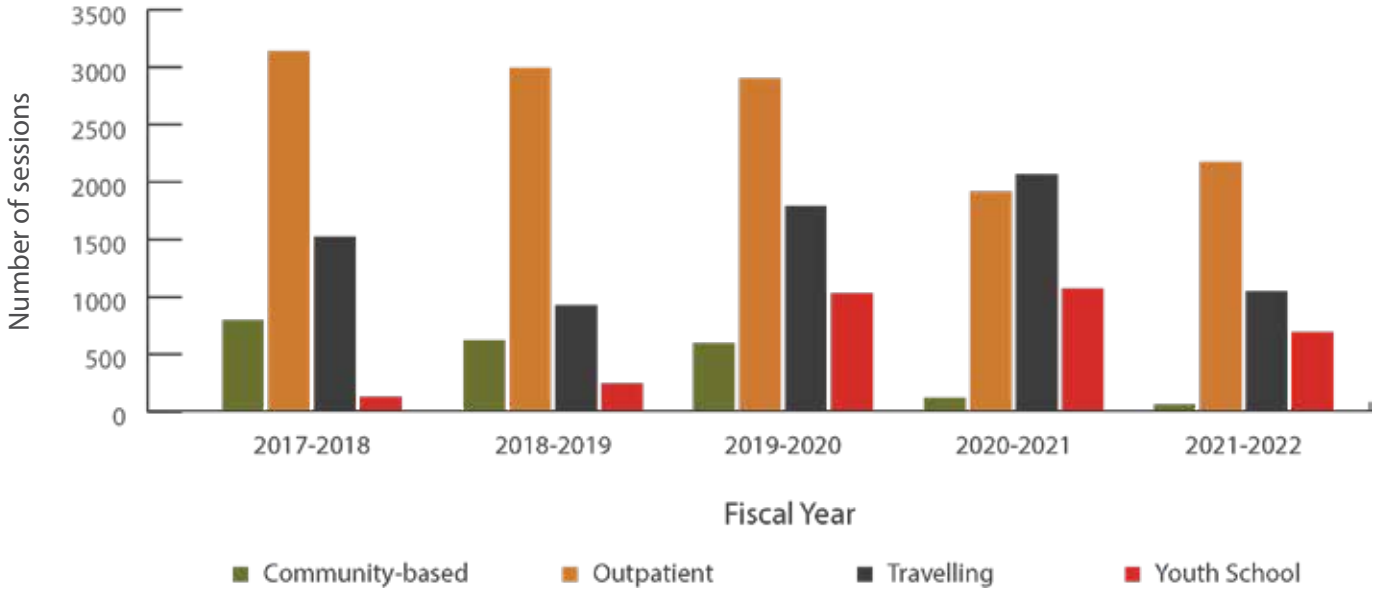


Figure 5. Total number of sessions for four key programs of Nodin MHS, between 2017-2022 (Source: Nodin MHS data).

Intellihealth Data 2011-2021

Ambulatory visits for mental health only (2011-2021)

Intellihealth data included ambulatory (hospital, outpatient) visits for mental health and substance use and hospitalizations for mental health and substance use. From 2011 to 2021, a total of 4,574 ambulatory visits were recorded for mental health among the Sioux Lookout area First Nations. Between 2011-2021, the ambulatory visit rate for mental health increased by 168%, from 9.8 visits in 2011 to 26.3 visits in 2021. The average ambulatory visit rate for mental health during the period of 2011-2021 for Sioux Lookout area First Nations community members was 18.5 per 1,000 people (reference population 2019, Figure 6).

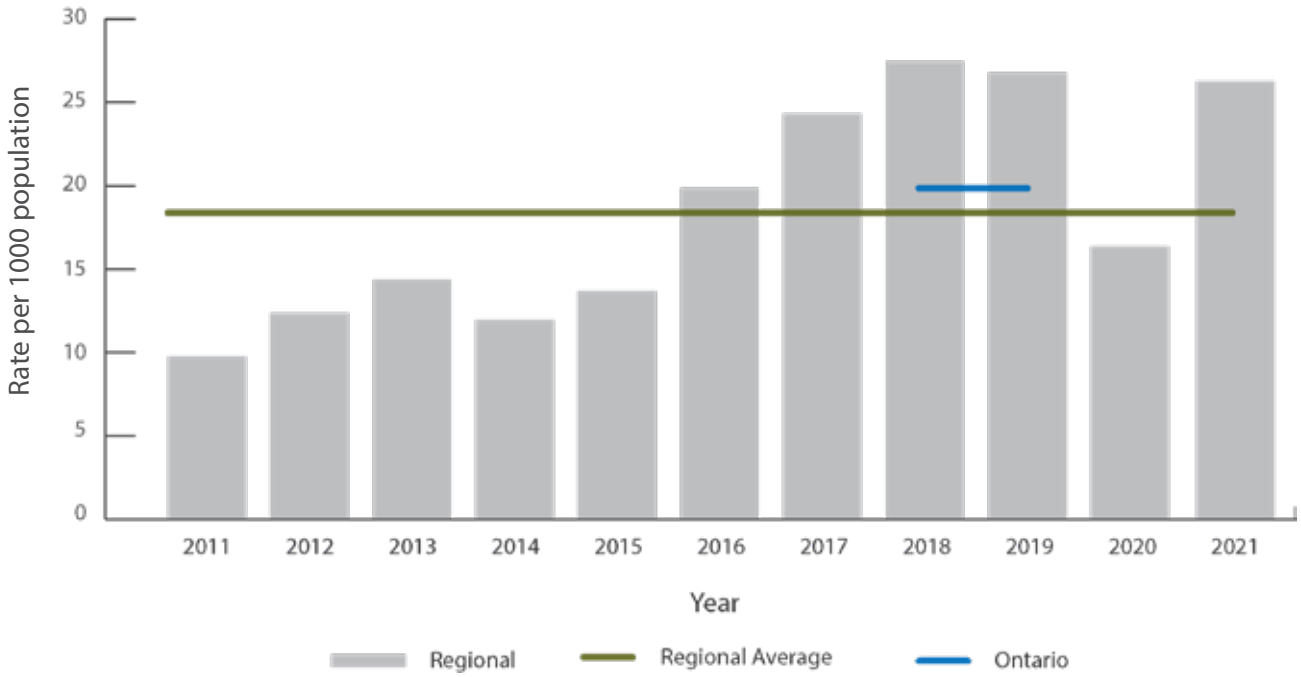


Figure 6. Ambulatory visit rate for mental health, per 1,000 population, per year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data). *Emergency department visit rate in Ontario was for both mental health and substance use in 2017.

Between 2011 and 2021, the Sioux Lookout area First Nations community member ambulatory visit rate for mental health increased by 168%, from 9.8 visits in 2011 to 26.3 visits in 2021.

Females consistently had a higher number of mental health ambulatory visits compared to males across all years. Both male and female visits for mental health increased dramatically between 2011 to 2021: female visits increased by 244%, from 107 in 2011 to 368 in 2021 and male visits increased by 95%, from 114 in 2011 to 222 in 2021 (Figure 7).

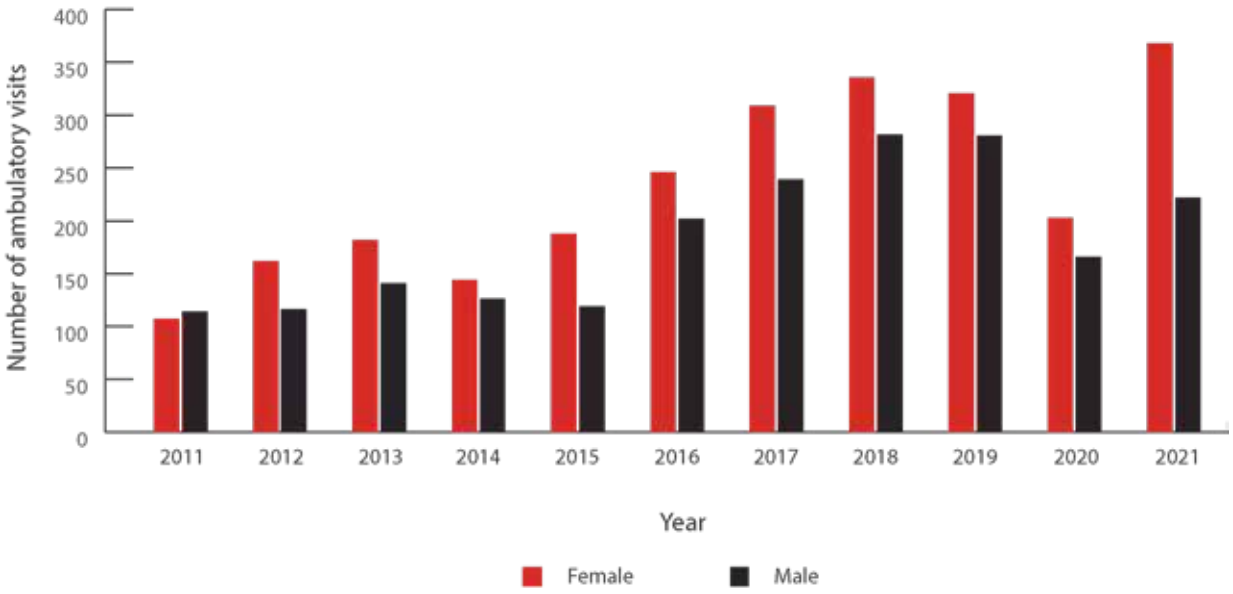


Figure 7. Number of ambulatory visits for mental health, by year and gender, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data).

Both male and female visits for mental health increased dramatically between 2011 to 2021: female visits increased by 244%, from 107 in 2011 to 368 in 2021 and male visits increased by 95%, from 114 in 2011 to 222 in 2021.

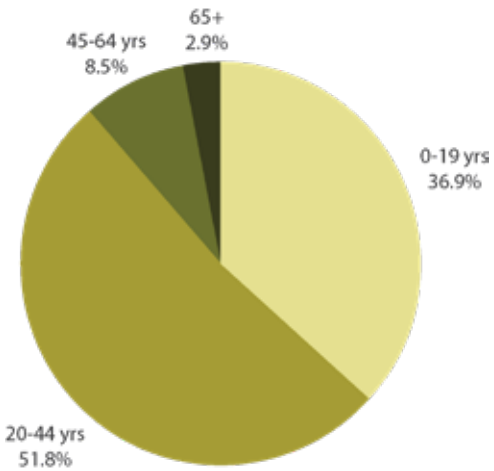


Figure 8. Proportions of ambulatory visits for mental health, by age group, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data).

Among all ambulatory visits for mental health, more than half belonged to the age group of 20-44 years old, followed by those 0-19 years old. Only a small proportion of individuals 65 years and older had visits for their mental health (Figure 8). This pattern corresponds with the pattern observed from nursing station visits data and hospitalization data.

Among all ambulatory visits for mental health, more than half belonged to the age group of 20-44 years old.

The highest rates of ambulatory visits for mental health were observed in the 20-44 age group, across all years, followed by those aged 0-19 years. Among the 20-44 age group, the rate increased 217% from 12.7 per 1,000 persons in 2011 to 40.3 per 1,000 persons in 2021. The 0-19 age group saw an 89% increase in ambulatory visit rates, from 9.6 in 2011 to 18.1 in 2021. There was a remarkably decreased rate in all age groups in 2020 (Figure 9).

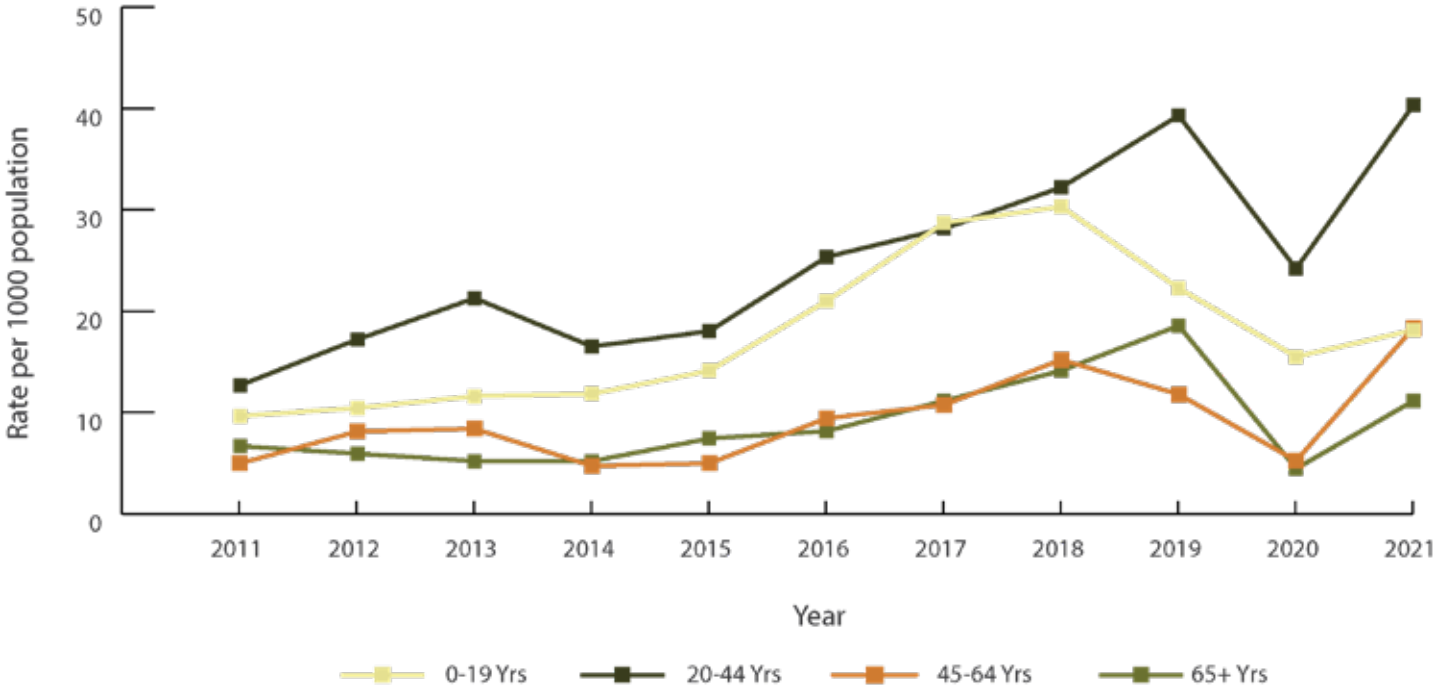


Figure 9. Mental health related ambulatory visit rates per 1,000 population among Sioux Lookout area First Nations community members by age and year (Source: IntelliHealth data).

The highest rates of ambulatory visits for mental health were observed in the 20-44 age group, across all years, followed by those aged 0-19 years.

The percentages of visits were similar for males and females among the age group 20-64 years old, however, among younger and older age groups (0-19 years old and 65+ respectively), females had higher visit percentages. Additionally, the variation between male and female mental health visits varied by community, with some communities showing more than double the number of ambulatory visits for mental health among females when compared to males (data not shown).

IntelliHealth Data 2011-2021

Ambulatory visits for substance use only (2011-2021)

From 2011 to 2021, Sioux Lookout area First Nations community members had a total of 9,884 ambulatory visits for substance use across all age groups; more than double the total of ambulatory visits across all ages for mental health. Between 2011 to 2021, the rate of ambulatory visits for substance use increased almost every year (except 2020), from a rate of 18.2 visits per 1,000 people in 2011, to 73.2 visits per 1,000 people in 2021 resulting in an overall visit increase of 302% (Figure 10).

The average ambulatory visit rate for substance use among Sioux Lookout area First Nations community members in the period of 2011-2021 (reference population as of 2019) was 40.0 per 1,000 people (Figure 10).

Comparatively, the ambulatory visit rate for both mental health and substance use combined among Sioux Lookout area First Nations community members was 58.5 per 1,000 people, a rate three times higher than Ontario's provincial mental health and substance use emergency department visit rate of 19.7 per 1,000 people in 2017.

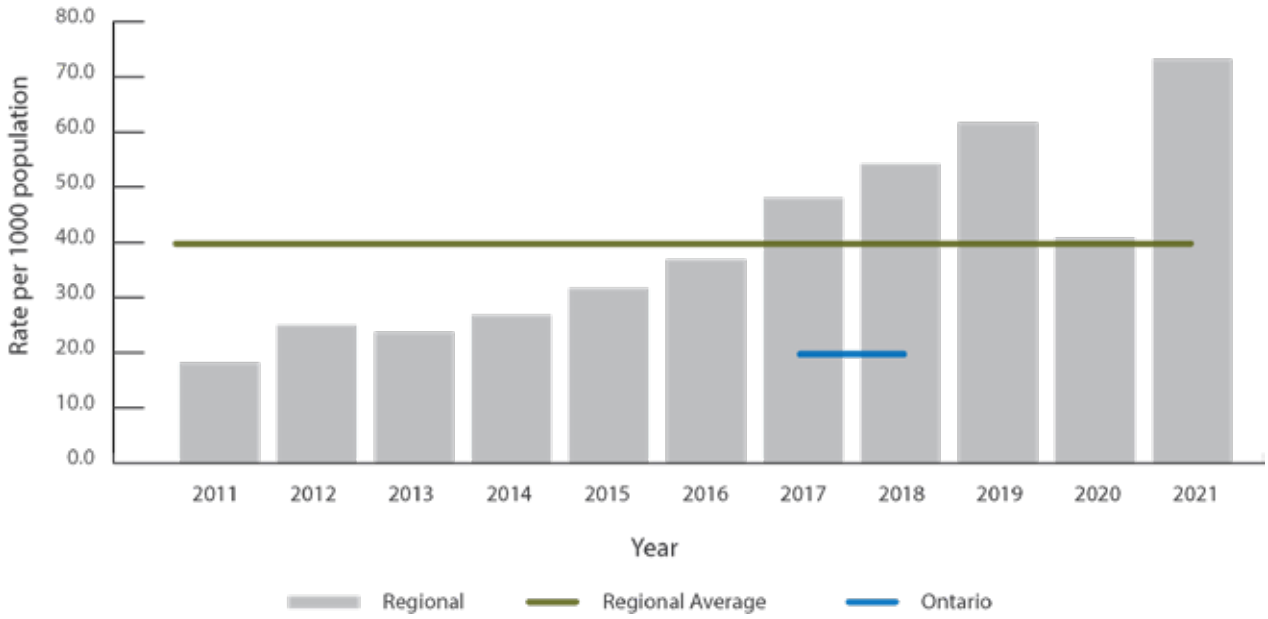


Figure 10. Ambulatory visit rate for substance use, per 1,000 population, by year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data). *Emergency department visit rate in Ontario was for both mental health and substance use in 2017.

The ambulatory visit rate for both mental health and substance use combined among Sioux Lookout area First Nations community members was 58.5 per 1,000 people, a rate three times higher than Ontario's provincial mental health and substance use emergency department visit rate of 19.7 per 1,000 people in 2017.

Males consistently had a higher number of substance use ambulatory visits than females throughout the years. Both male and female visits increased dramatically from 2011 to 2021. Males accounted for a higher percentage (55.4%) compared to females (44.6%).

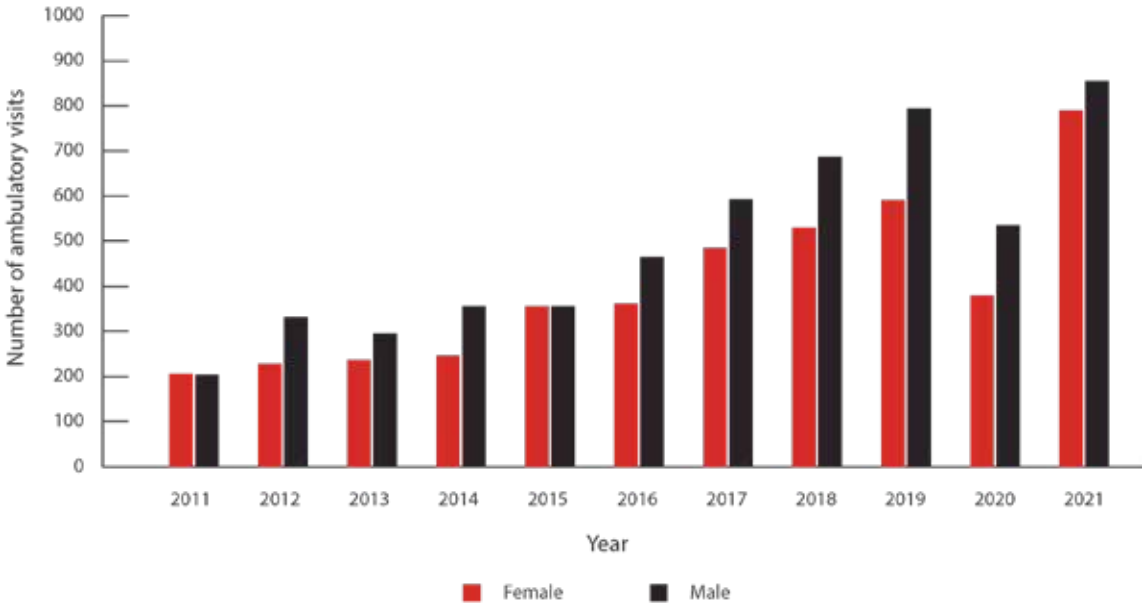
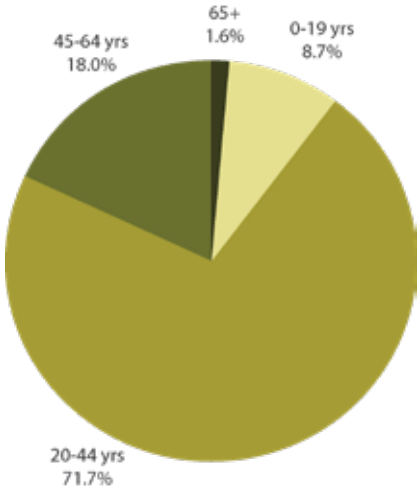


Figure 11. Number of substance use-related ambulatory visits, by year and gender, among Sioux Lookout area community members, between 2011-2021 (Source: IntelliHealth data).

Males consistently had a higher number of substance use ambulatory visits than females throughout the years. Both male and female visits increased dramatically from 2011 to 2021. Males accounted for a higher percentage (55.4%) compared to females (44.6%). In 2011, there were 206 female visits, which increased to 790 by 2021 representing a 283% increase in female ambulatory visits over 10 years. Male visits increased 319% from 204 in 2011 to 855 in 2021 (Figure 11). These percentages varied by community, with some communities having more than double the number of ambulatory visits for males compared to females (data not shown). The age group of 20-44 years old accounted for more than two-thirds of all substance use-related ambulatory visits among Sioux Lookout area First Nations community members, followed by the 45-64 years old age group (Figure 12).



The age group of 20-44 years old accounted for more than two-thirds of all substance use-related ambulatory visits among Sioux Lookout area First Nations community members.

Figure 12. Proportions of substance use-related ambulatory visits, by age group among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth data).

The highest ambulatory visit rates for substance use are observed among the 20-44 age group, across all years, followed by the 45-64 age group. Within the 20-44 age group, there was a substantial rate increase from 2011 to 2021, with the rate four times greater, from 32.1 to 132.8 per 1,000 persons. The rate increase was even more pronounced in the 45-64 age group, where rates increased by over five times from 2011 to 2021, rising from 17.3 to 92.2 per 1,000 persons (Figure 13).

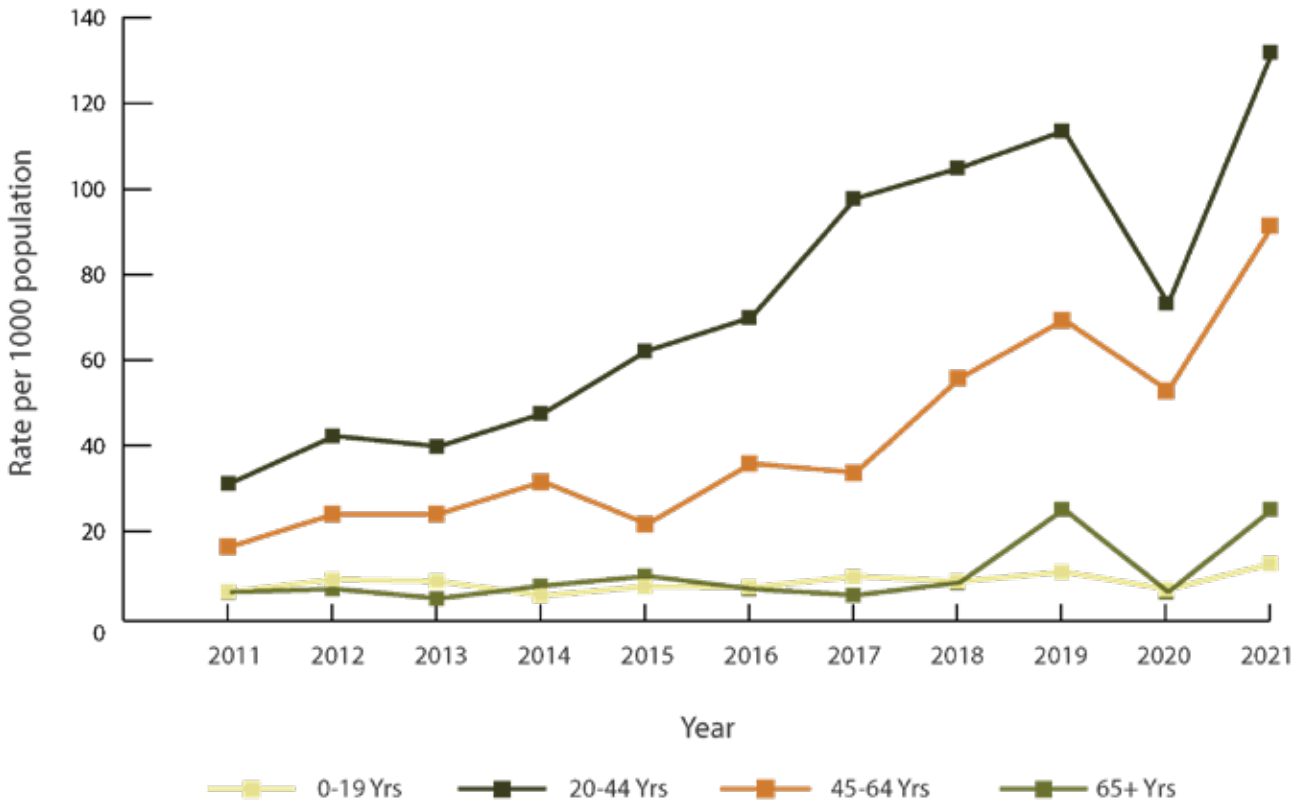


Figure 13. Substance use related ambulatory visit rates per 1,000 population, by age and year among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth).

The highest ambulatory visit rates for substance use are observed among the 20-44 age group, across all years, followed by the 45-64 age group.

IntelliHealth Data 2011-2021

Hospitalization data for mental health and substance use for adults (2011-2021)

Following a similar pattern to ambulatory visits for mental health, the rates of ambulatory visits for substance use were the highest among females aged 0-19. In all other older age groups, the higher percentages were among males (data not shown). Between 2011-2021, the Ontario Mental Health Reporting System (OMHRS) recorded a total of 848 mental health-related hospitalizations among Sioux Lookout area First Nations' community members 15 years and older. 70.1% of hospitalizations occurred in hospitals located within the Northwestern Health Unit catchment area, and 29.9 % of hospitalizations occurred within the Thunder Bay District Health Unit (data not shown).

The average hospitalization rate for people 15 years and older during the period of 2011-2021 in Sioux Lookout area First Nations (reference population as of 2019) was 4.8 per 1,000 people. In comparison, the hospitalization rate for mental wellness and substance use was 5.5 per 1,000 people in the entire Ontario population (at any ages) in 2017 (ICES Scorecard 2021), and 5.2 per 1,000 people in Canada population (15 years and older) in 2017-2019 (Public Health Agency of Canada 2021). From 2019 onwards, the annual hospitalization rates for SLFNHA service area community members 15 years and older were higher than that of Ontario and Canada for all ages (Figure 14).

From 2019 onwards, the annual hospitalization rates for SLFNHA service area community members 15 years and older were higher than that of Ontario and Canada for all ages

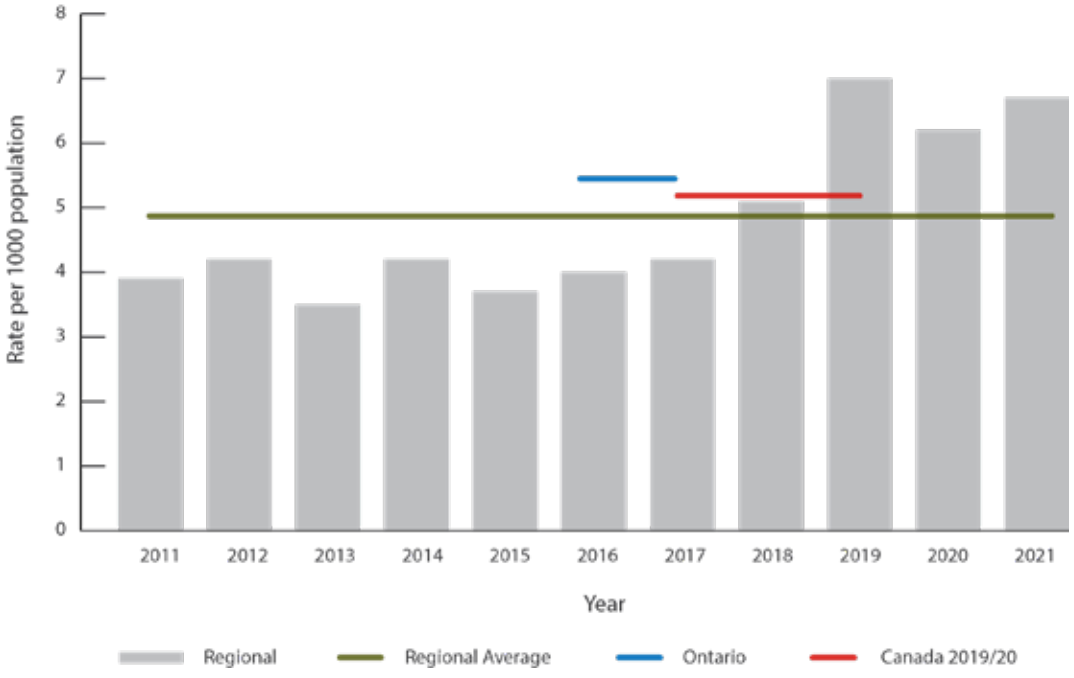


Figure 14: Mental health and substance use-related hospitalization rate per 1,000 population 15 years and older, by year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth OMHRS data).
*Hospitalization rate in Ontario and Canada was for all ages in 2017 and in 2017-2019, respectively.

Regarding all hospitalizations among SLFNHA catchment area community members aged 15 and older due to mental wellness and substance use, a slightly higher percentage for males (53.3%) in comparison to females (46.7%) during the period of 2011-2021 was observed. From 2011-2018, the numbers of hospitalizations for males were higher than that of females, however, from 2019-2021, the patterns reversed (Figure 15). These percentages varied by community. In summary, we found that females were more likely to have ambulatory visits due to mental health, but males were more likely to have ambulatory visits due to substance use and be hospitalized due to both mental health related issues/concerns and substance use.

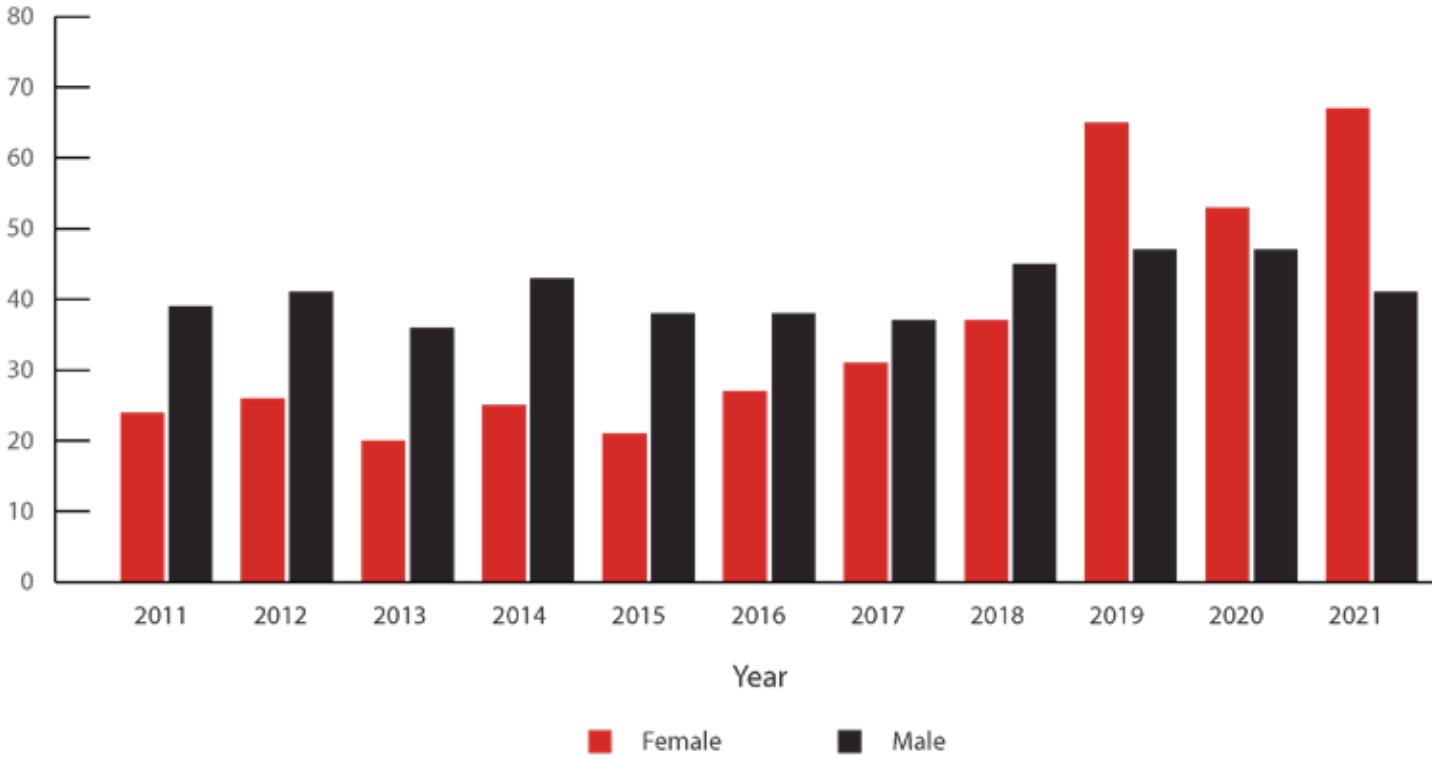


Figure 15. Number of hospitalizations due to mental health and substance use, by year and gender, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth OMHRS data).

The highest ambulatory visit rates for substance use were observed among the 20-44 age group, across all years, followed by the 45-64 age group.

The age group of 15 to 19 years had the highest rate of hospitalization for mental health and substance use from 2011-2021, followed by the 20-44 age group.

The hospitalization rates across the 15-19 years age group increased from 11.3 per 1,000 population in 2011 to 15.6 per 1,000 population in 2021. Meanwhile, the rate of hospitalizations in the 20-44 years age group nearly doubled, increasing from 3.8 per 1,000 population in 2011 to 7.4 per 1,000 population in 2021 (Figure 16). The age group of 15 to 19 years had the highest rate of hospitalization for mental health and substance use from 2011-2021, followed by the 20-44 age group. Hospitalizations for mental health and substance use were less common in the elderly.

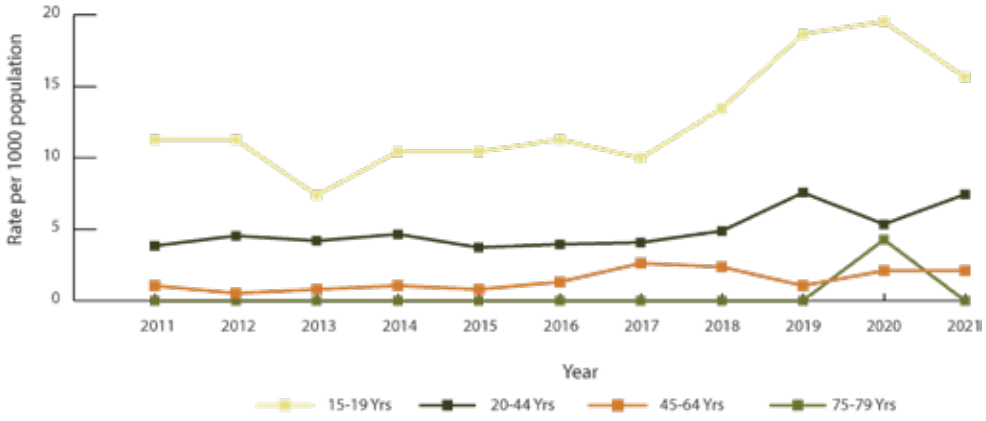


Figure 16. Hospitalization rates for mental health and substance use, per 1000 population among Sioux Lookout area First Nations community members aged 15 years and older, between 2011-2021 (Source: IntelliHealth OMHRS data).

Among all hospitalizations over the 11-year period for people 15 years and older, the largest proportions belonged to those under 24 years of age. At 62.9%, nearly two-thirds of hospitalizations due to mental health and substance use were comprised by young people 15-24 years of age (Figure 17). This pattern corresponds with the pattern observed from nursing station visits data.

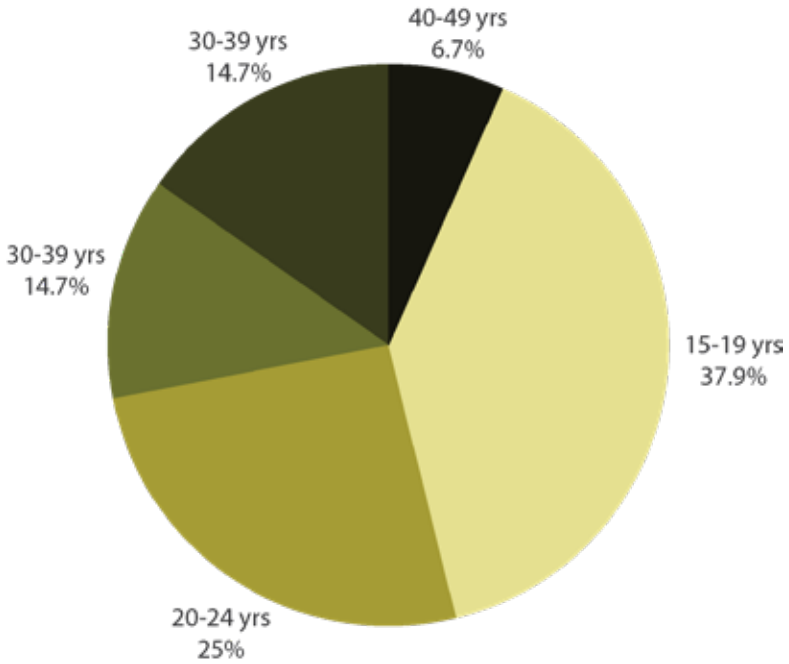
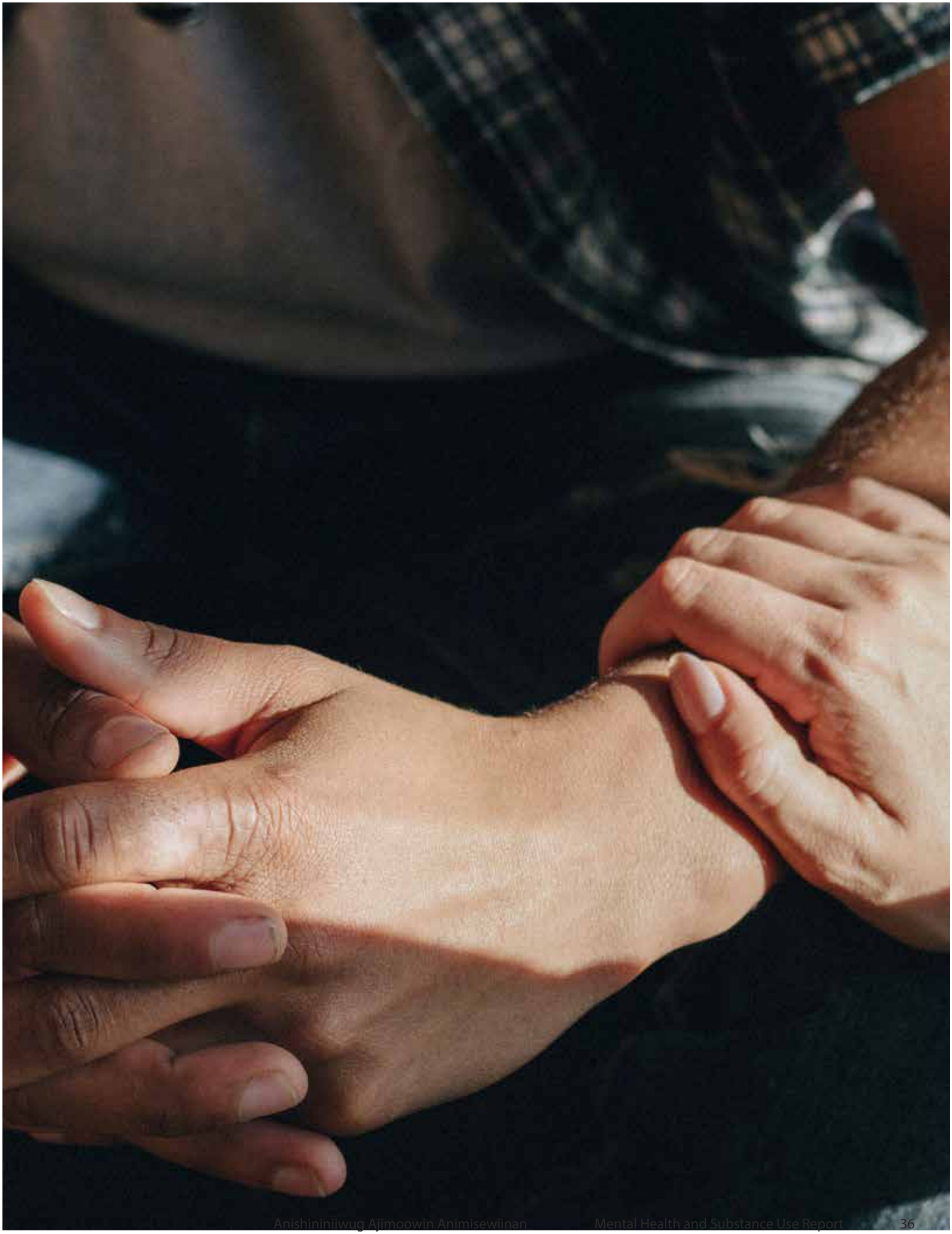


Figure 17. Proportions of hospitalizations due to mental health and substance use, by age, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: IntelliHealth OMHRS data).



ICES Emergency Department Visits

Mental health and substance use (2011-2021)

Between 2011 and 2021, the rate of emergency department visits (ED) for mental health and substance use among Sioux Lookout area First Nations Band members more than doubled, increasing from 105.9 per 1,000 population in 2011 to 244.4 per 1,000 population in 2021. In 2021, the ED rate for mental health and substance use among Sioux Lookout area First Nations Band members was a startling 14 times greater than the provincial rate of 17.4 per 1,000 population. The ED visit rate for mental health and substance use among Sioux Lookout area Band members was also much higher than rates seen in Thunder Bay District Health Unit (TBDHU), Northwestern Health Unit (NWHU), and Northern Local Health Integration Network (LHIN) Ontario (Figure 18).

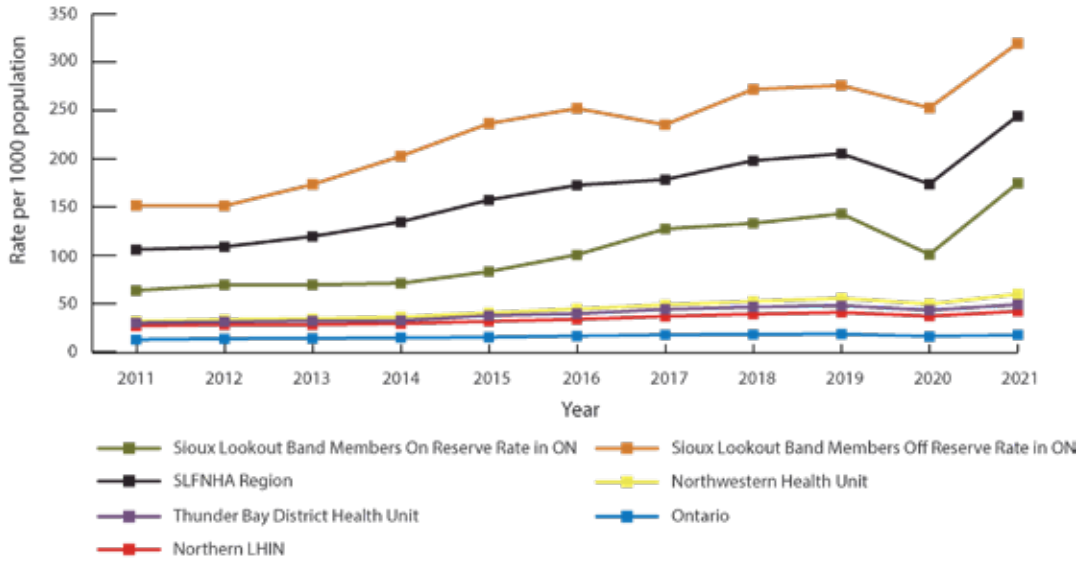


Figure 18: Emergency department visit rates for mental health and substance use per 1,000 population, by region, by year between 2011-2021 (Sources: ICES data).

*The ED rate for mental health and substance use among Sioux Lookout area First Nations Band members was a startling **14 times greater** than the provincial rate.*

From 2011 to 2021, the overall ED visit rate for mental health and substance use per 1,000 population was consistently higher for males than for females among Sioux Lookout area First Nations Band members except in 2013. The rates increased for both males and females in most years, except for 2020. For males, the rate was 117.8 per 1,000 population in 2011, and increased to 248.9 in 2021. Among females, the rate was 93.4 per 1,000 population in 2011 and rose to 239.6 in 2021 (Figure 19).

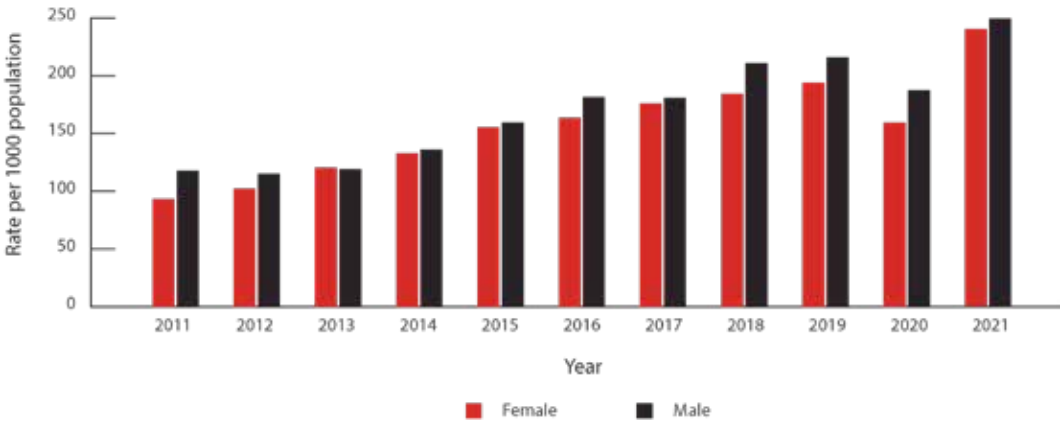
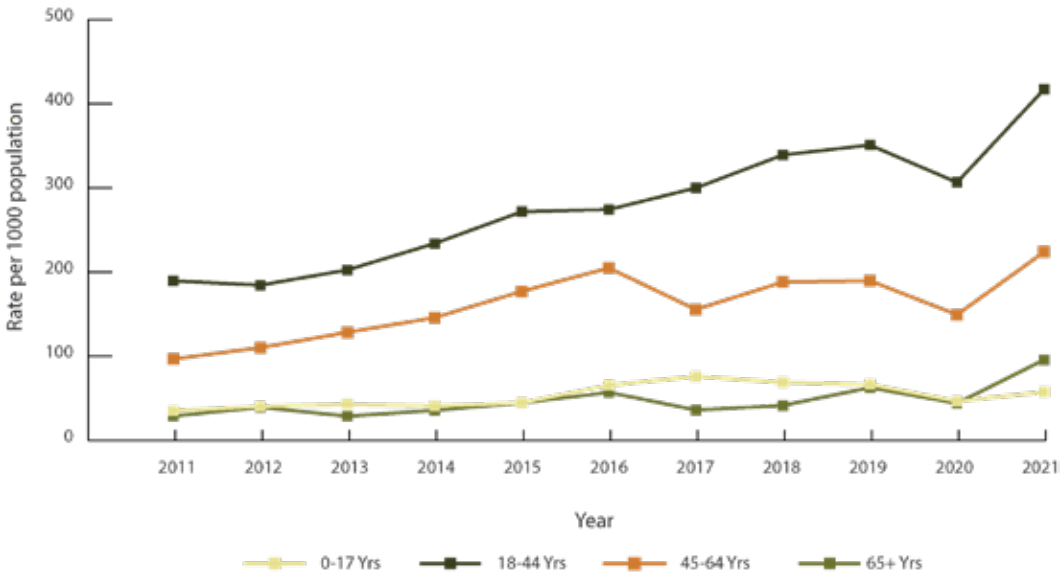


Figure 19. ED visit rates per 1,000 population for mental health and substance use among Sioux Lookout area First Nations Band members, by gender, between 2011-2021 (Source: ICES data).

The overall ED visit rate for mental health and substance use per 1,000 population was consistently higher for males than for females except in 2013.

For the entire period from 2011 to 2021, the highest rates were consistently observed in the 18-44 age group, rising from 189.2 in 2011 to 416.9 per 1,000 population in 2021 (a 120% increase). The second-highest rates were consistently seen in the 45-64 age group, with the rate increasing from 96.7 in 2011 to 223.8 per 1,000 population in 2021 (a 131% increase) (Figure 20).



For the entire period from 2011 to 2021, the highest rates of mental health and substance use ED visits were consistently observed in the 18-44 age group.

Figure 20. ED visit rates per 1,000 people for mental health and substance use among Sioux Lookout area First Nations Band members, by age, between 2011-2021 (Source: ICES data).

ICES Data

Emergency department visits for intentional self-harm and self-injury (2011-2021)

The rate of ED visits for intentional self-harm and self-injury among Sioux Lookout area First Nations Band members more than doubled from 133.2 visits per 10,000 population in 2011 to 269.9 visits per 10,000 population in 2021. Within the population of Ontario, the rate of ED visits for intentional self-harm and self-injury occurred at a rate of only 16.3 per 10,000 population in 2021. In 2021, Sioux Lookout area First Nations Band members ED visit rates for intentional self-harm and self-injury were 16 times higher than rates seen within the population of Ontario. The rates for Sioux Lookout area First Nations Band members were also much higher than rates seen within the TBDHU, NWHU, and Northern LHIN regions in Ontario (Figure 21).

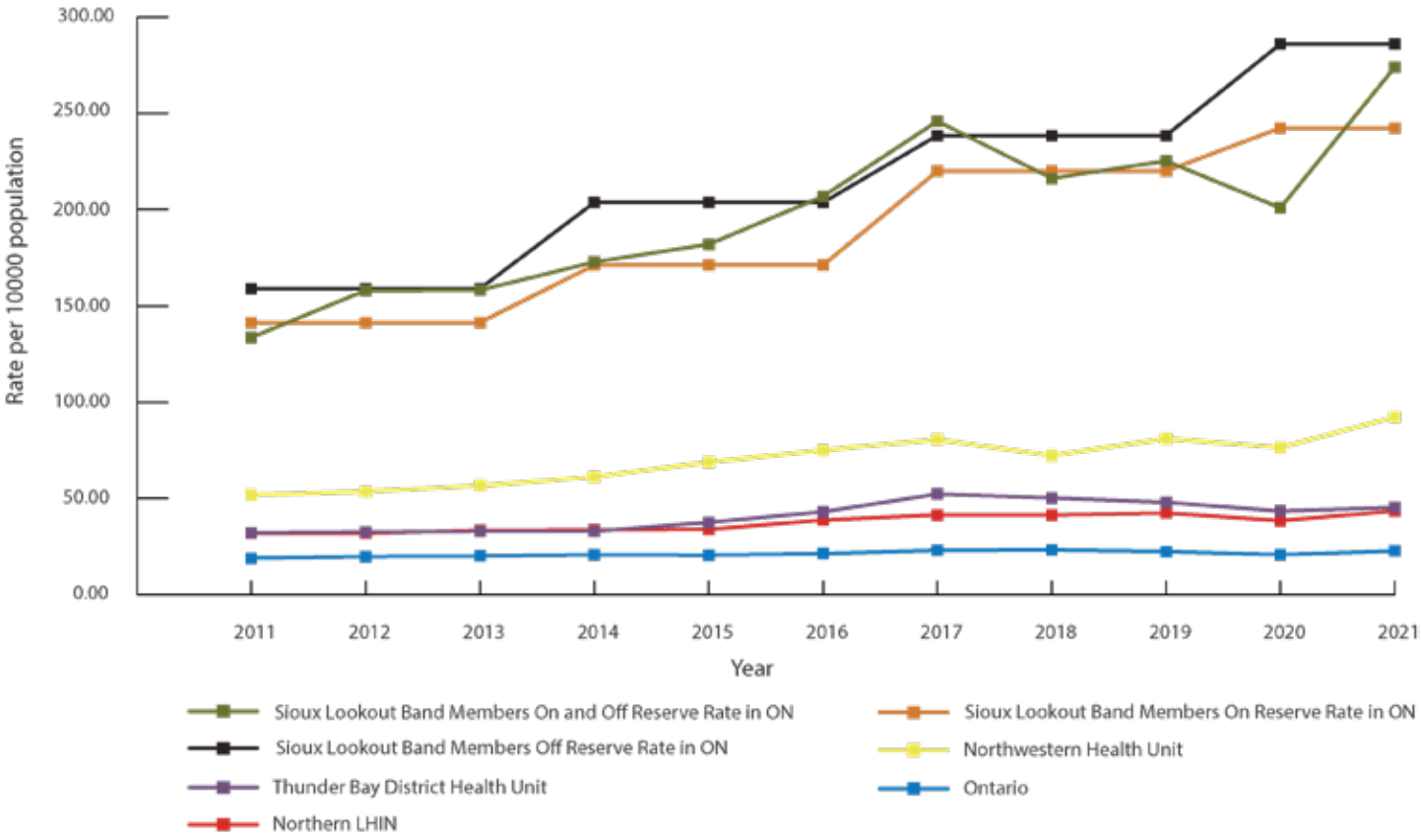


Figure 21. Emergency department visit rates, per 10,000 population for intentional self-harm and self-injury, by region, by year, between 2011-2021 (Source: ICES data).

*In 2021, Sioux Lookout area First Nations Band members emergency department visit rates for intentional self-harm and self-injury were **16 times higher** than rates seen within the population of Ontario.*

Across all years, female Band members of the Sioux Lookout area First Nations visited the emergency department due to intentional self-harm and self-injury at significantly higher rates than their male counterparts. While the variations are great across all years, in 2021 the variation was at its most pronounced, where the rate per 10,000 population for females was 413.6, compared to 121.2 for males. The visit rate for females also increased over the years 2011-2021 at a faster rate than visits by males (Figure 22).

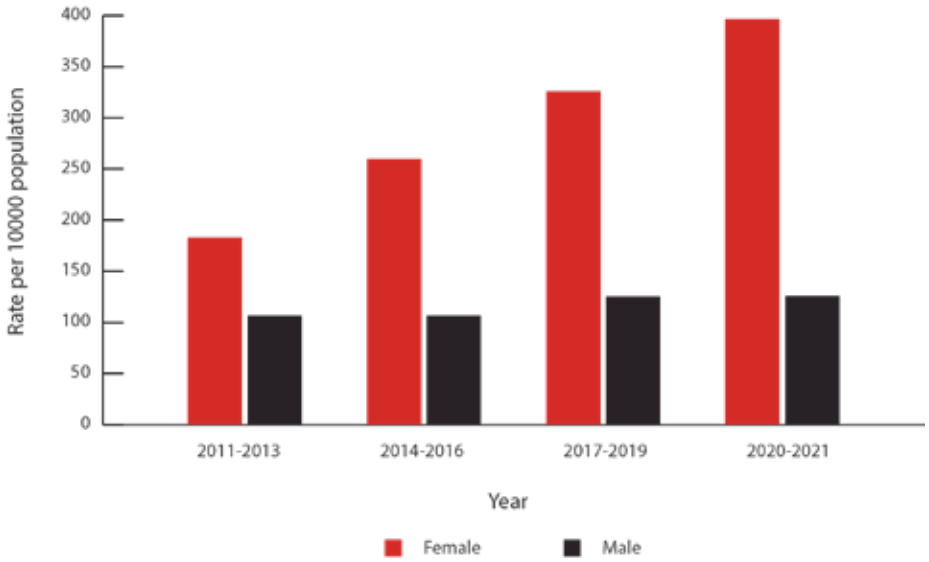


Figure 22. Three-year average rates of ED visits due to intentional self-harm and self-injury, per 10,000 population, by gender, between 2011-2021 (Source: ICES data).

Female Band members visited the emergency department due to intentional self-harm and self-injury at significantly higher rates than their male counterparts.

ED visit rates for intentional self-harm and self-injury among Sioux Lookout area First Nations Band members exhibit significant variations across all age categories. These rate differences persist from 2011 to 2021. The highest visit rates were observed among the 10-17 age group, followed by the 18-44 age group respectively.

Among the age group 10-17, ED visit rates for intentional self-harm and self-injury increased from 206.7 per 10,000 population in 2011-2013 to 378.4 in 2020-2021. Similarly, within the same time period, rates among the age group 18-44 years nearly doubled to 341.1 per 10,000 population in 2020-2021, from 177.5 in the years 2011-2013 (Figure 23).

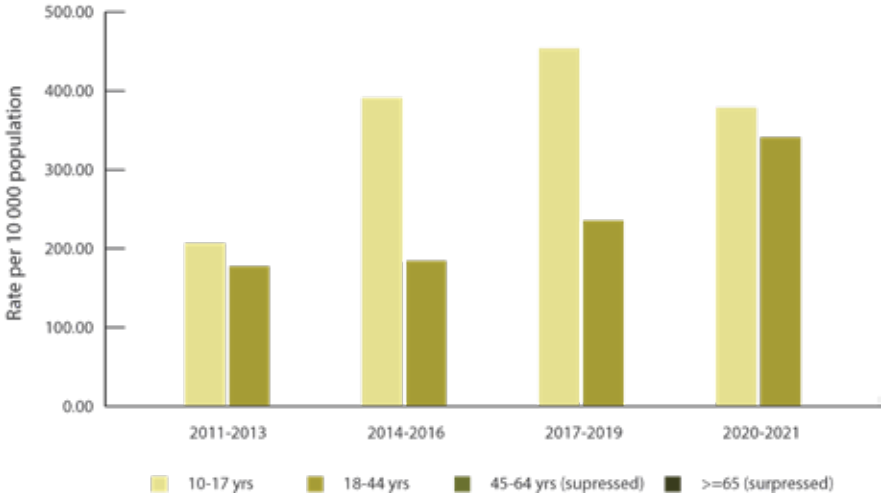


Figure 23. ED visit rates per 10,000 population for intentional self-harm and self-injury, by age group, between 2011-2021 (Source: ICES data)

Among the age group 10-17, emergency department visit rates for intentional self-harm and self-injury increased from 206.7 per 10,000 population in 2011-2013 to 378.4 in 2020-2021

ICES Data

Mental health and substance use hospitalizations (2011-2021)

Rates of hospitalization for mental health and substance use conditions among Sioux Lookout area First Nations Band members nearly doubled between 2011-2021, increasing from 16.2 per 1,000 population to 31.5 per 1,000 population.

In 2021, the mental health and substance use hospitalization rate of Sioux Lookout area First Nations Band members was six times that of the province of Ontario, with a rate of 5.2 per 1,000 population. The rate was also much higher than rates seen in the TBDHU region, the NWHU region, or within the Northern LHIN region in Ontario. Mental health and substance use hospitalization rates for Sioux Lookout area First Nations Band members living off reserve was significantly higher than on reserve members, across all years (Figure 24).

Rates of hospitalization for mental health and substance use conditions among Sioux Lookout area First Nations Band members nearly doubled between 2011-2021.

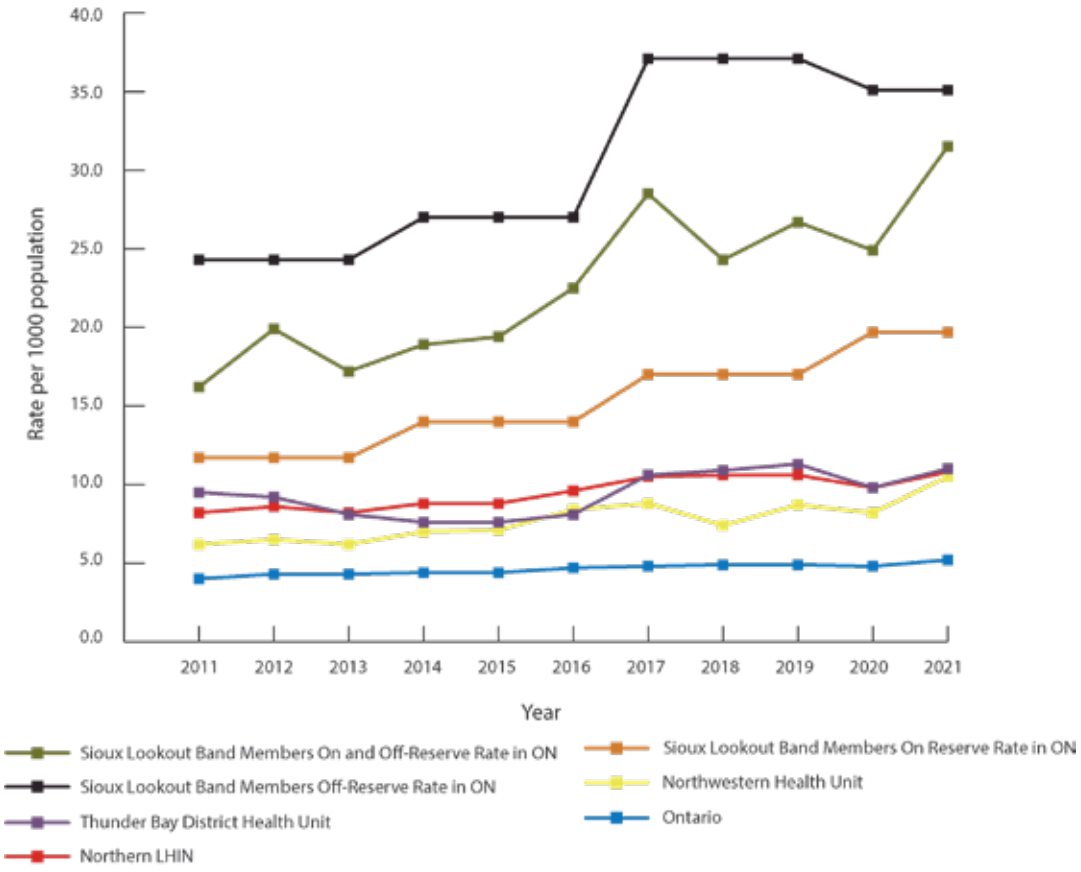
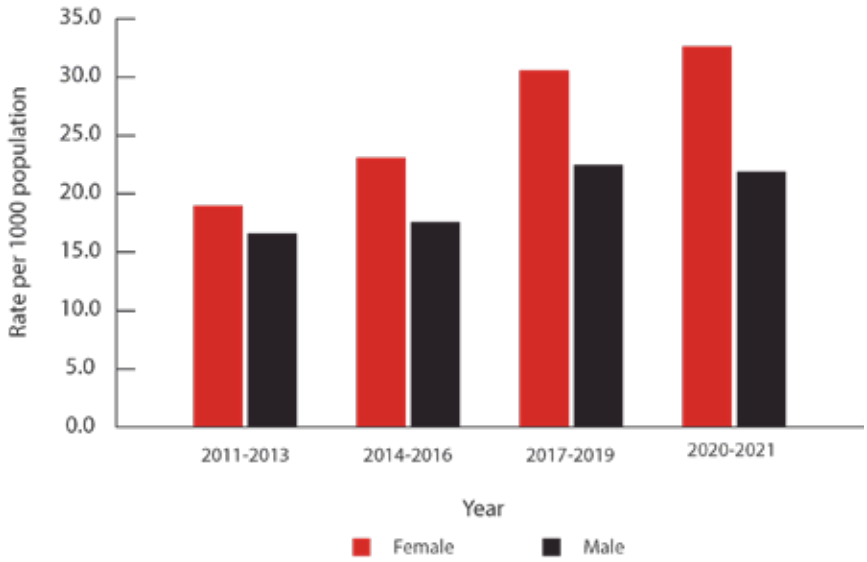


Figure 24. Hospitalization rates for mental health and substance use per 1,000 population, by region, by year, between 2011-2021 (Source: ICES data).

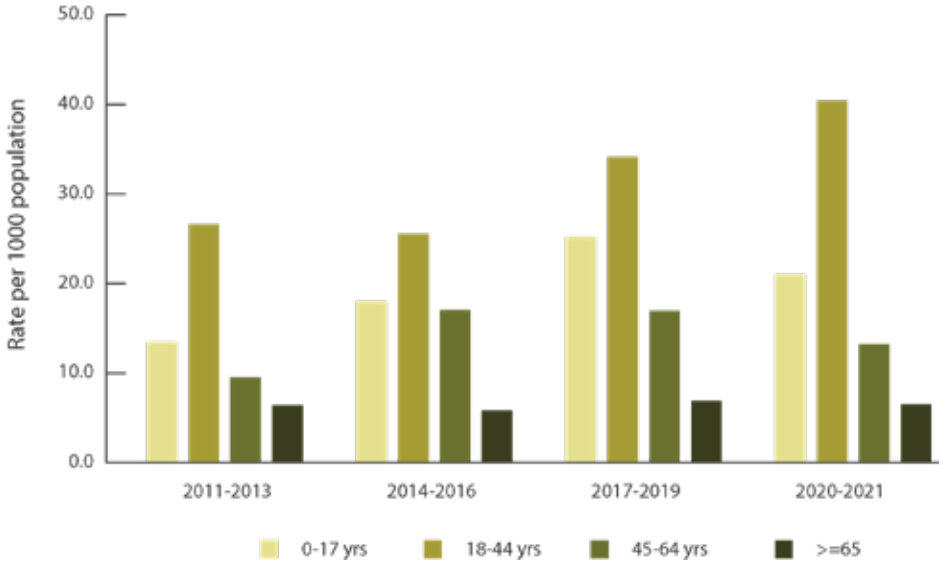
A look at the 3-year average of mental health and substance use hospitalization rates for Sioux Lookout area First Nations Band members shows that rates for females were higher than the rates of males in all year groups (2011-2021), although rates for both groups have increased over time. Data also shows that mental health and substance use hospitalization rates for females and males have increased over time, with the exception of a slight decrease seen among males between 2020-2021 (Figure 25).



Mental health and substance use hospitalization rates for females were higher than the rates of males in all year groups.

Figure 25. 3- year mental health and substance use hospitalization rates per 1,000 population among Sioux Lookout area First Nations Band members, by gender, between 2011-2021 (Source: ICES data).

Sioux Lookout area First Nations Band members 3-year average mental health and substance use hospitalization rate per 1,000 population was the highest among the age group of 18-44, followed by age group of 0-17; a trend that remained consistent across the time period. In 2021-2022 rates of hospitalization per 1,000 were 40.4 among the 18-44 age group, double the rate (21.0 per 1,000) among the 0-17 age group (Figure 26).



The 3-year average mental health and substance use hospitalization rate per 1,000 population was the highest among the age group of 18-44.

Figure 26. 3-year mental health and substance use hospitalization rates per 1,000 population among Sioux Lookout area First Nations Band members, by age group, between 2011-2021 (Source: ICES data).

Office of the Chief Coroner for Ontario Data

Unnatural deaths data (2011-2021)

The Office of the Chief Coroner (OCC) for Ontario provided the data for 2,851 unnatural deaths (accident, homicide, suicide, or undetermined) that occurred between January 2011 and December 2021. The number included all individuals who died of unnatural causes who either resided in or passed away within the TBDHU or NWHU regions. The data could be underestimated as mentioned in the Limitations section of this report .

Postal codes of the individuals who passed away were used to determine their original residence location. A total of 404 unnatural deaths were reported among Sioux Lookout area First Nations community members.

The data also showed instances where opioids were involved in unnatural deaths. Of the 357 opioid-related deaths that occurred within the TBDHU or NWHU regions during the period of 2011-2021, only 10 of these unnatural deaths were determined to be among Sioux Lookout area First Nations community members.

The average unnatural death rate among Sioux Lookout area First Nations community members during the period of 2011-2021 was 1.6 per 1,000 people, irrespective of age (reference population, 2019).

The unnatural death rate among Sioux Lookout area First Nations community members was found to be 3.2 times higher than the province of Ontario's unnatural death rate of 0.5 per 1,000 people (2011-2019), and 2.3 times higher than the rate for the Canada population of 0.7 per 1,000 people (2019-2020) (Statistical Research Department, 2022). The unnatural death rate among Sioux Lookout area First Nations community members was similar by years during the period of 2011-2021, except in 2017 (Figure 27). The unnatural death rate per 1,000 population differed by community across the Sioux Lookout area First Nations. In some communities rates were 3 times or 5 times greater than the regional average (data not shown).

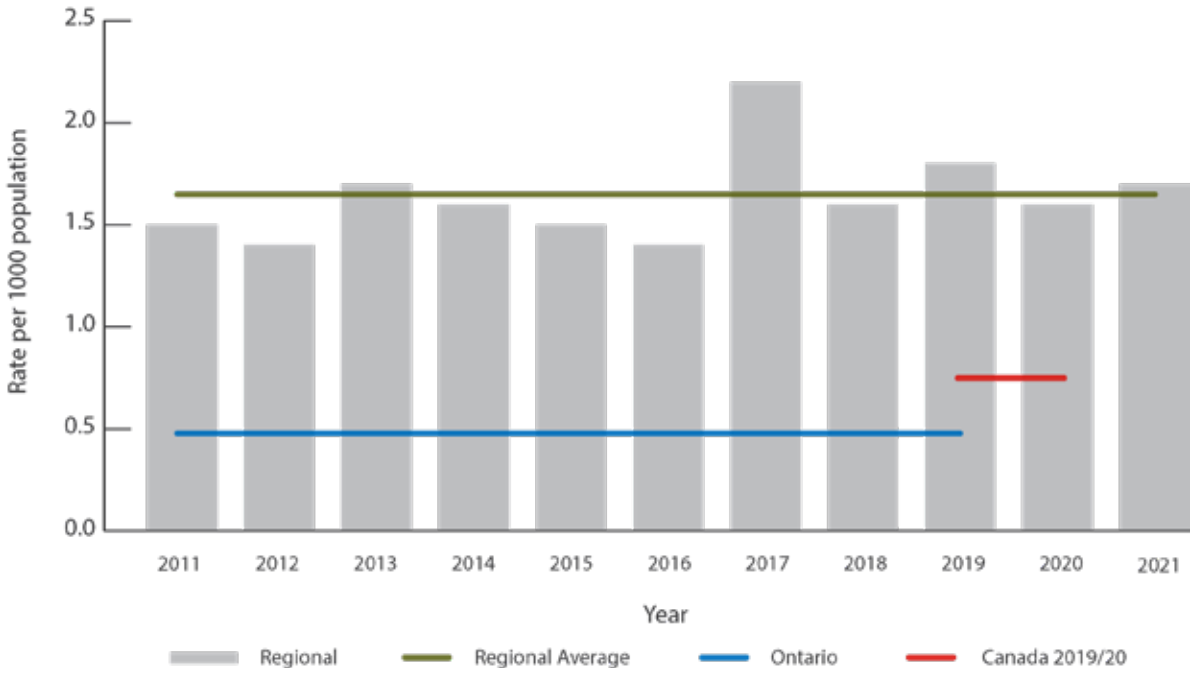


Figure 27. Unnatural death rates per 1,000 population, by year, among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data).

*The unnatural death rate among Sioux Lookout area First Nations community members was found to be **3.2 times higher** than the province of Ontario.*

Among all unnatural deaths during the 10-year period, the age groups of 20-29 years and 30-39 years accounted for the highest proportions of the unnatural deaths at 20.5% and 19.1%, respectively, followed by the 15-19 years age group that accounted for 15.6% of such deaths (Figure 28). Among the 0-4 years age group, the causes of unnatural death were a result of unexpected death in infancy, fire, vehicle collision, and drowning (data not shown).

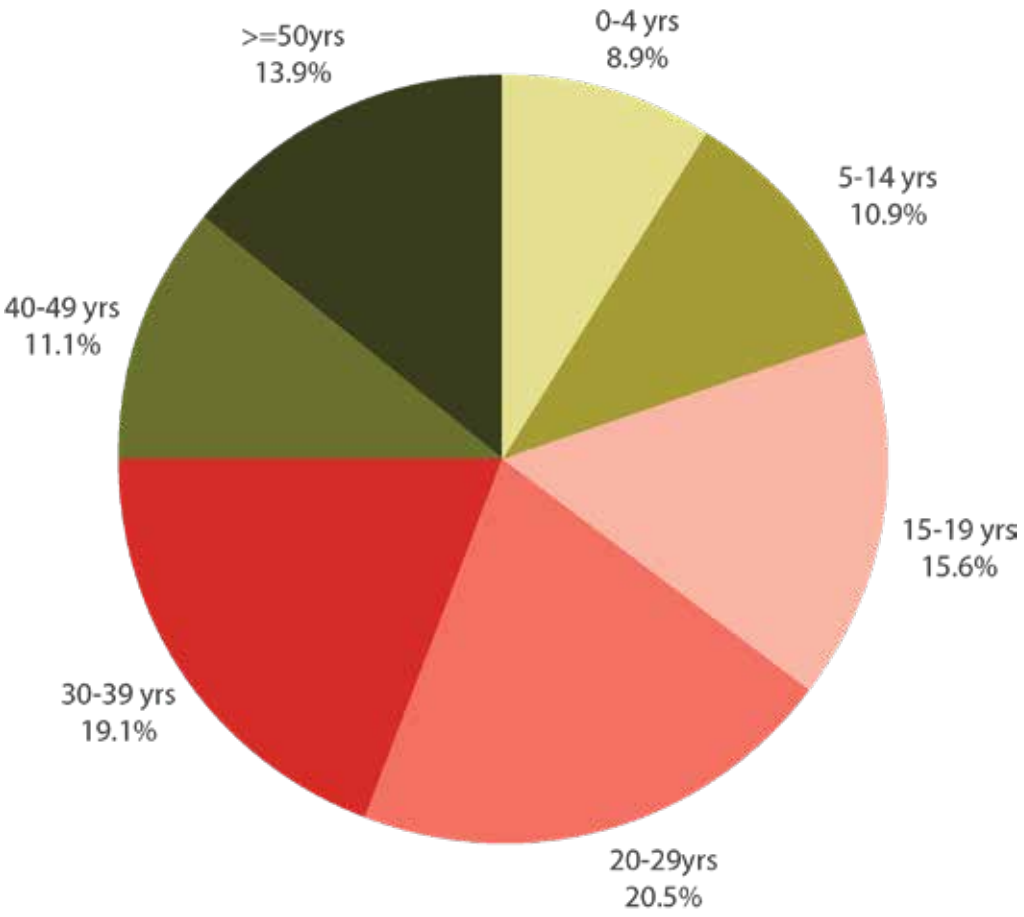


Figure 28. Proportions of unnatural deaths by age group among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data).

Sioux Lookout area First Nations community members in the age groups of 20-29 years and 30-39 years accounted for the highest proportions of unnatural deaths followed by the 15-19 years age group.

All deaths were investigated by the OCC to determine the causes most related to unnatural death. The most related causes attributed to deaths among Sioux Lookout area First Nations community members are summarized in Figure 29. Suicide by asphyxia (hanging, chest/neck compression) was determined to be the leading cause of unnatural death across the region, accounting for 38.1% of unnatural deaths, followed by substance use (alcohol, drug), which accounted for 13.1% of all deaths.

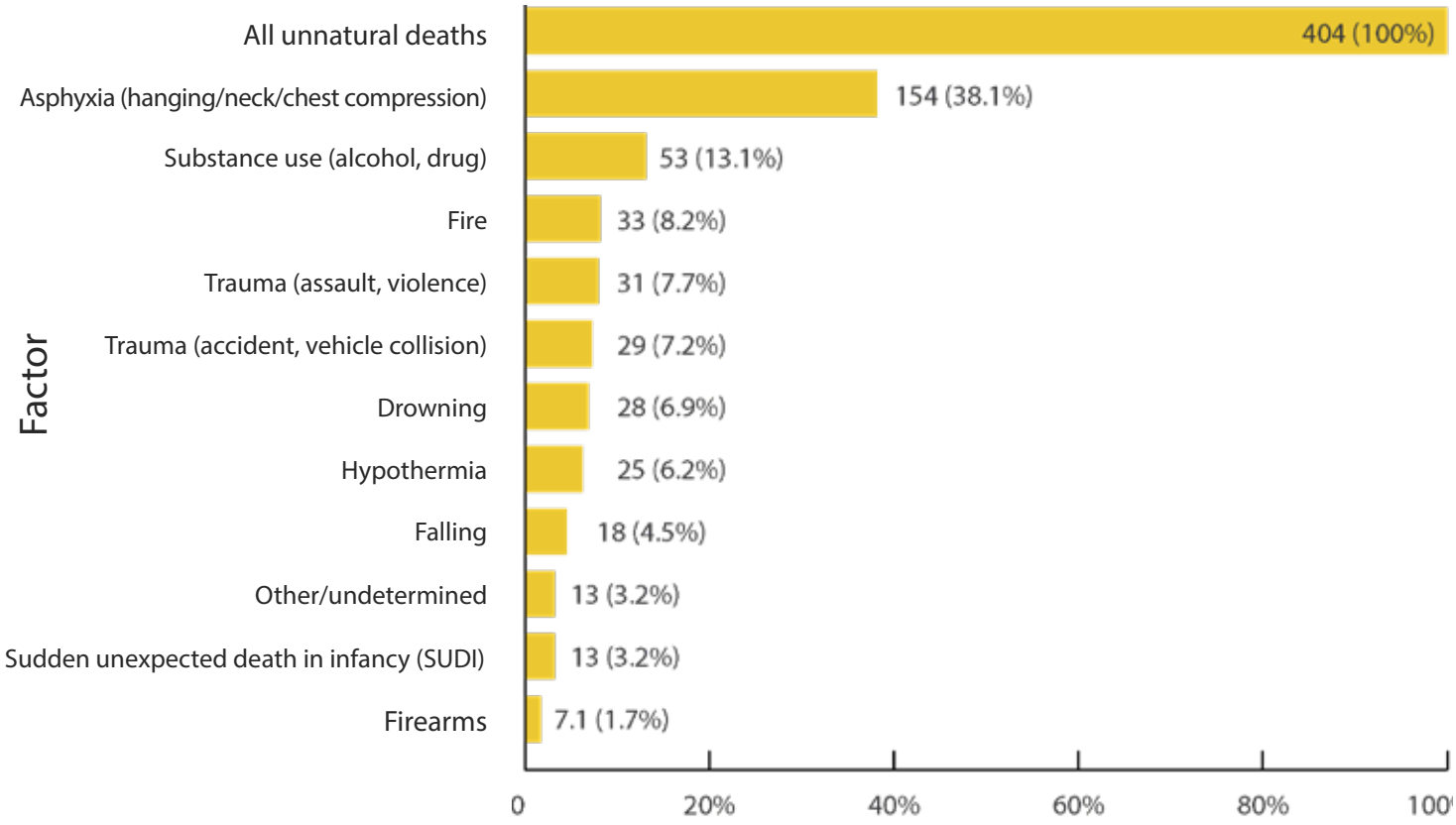


Figure 29. Numbers and proportions of causes of unnatural death among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data).

Suicide by asphyxia (hanging, chest/neck compression) was determined to be the leading cause of unnatural death across the region, accounting for 38.1% of unnatural deaths.

The rate at which individuals living in the Sioux Lookout area First Nations died by asphyxia-related suicide (0.6 per 1,000), is 15 times greater than the rate for the same cause of unnatural death among the rest of the Ontario population (0.04 per 1,000) (Office of the Chief Coroner of Ontario, 2019). Specifically, significantly higher rates of hanging related suicides were observed in younger age groups in the Sioux Lookout area First Nations communities (Figure 30).

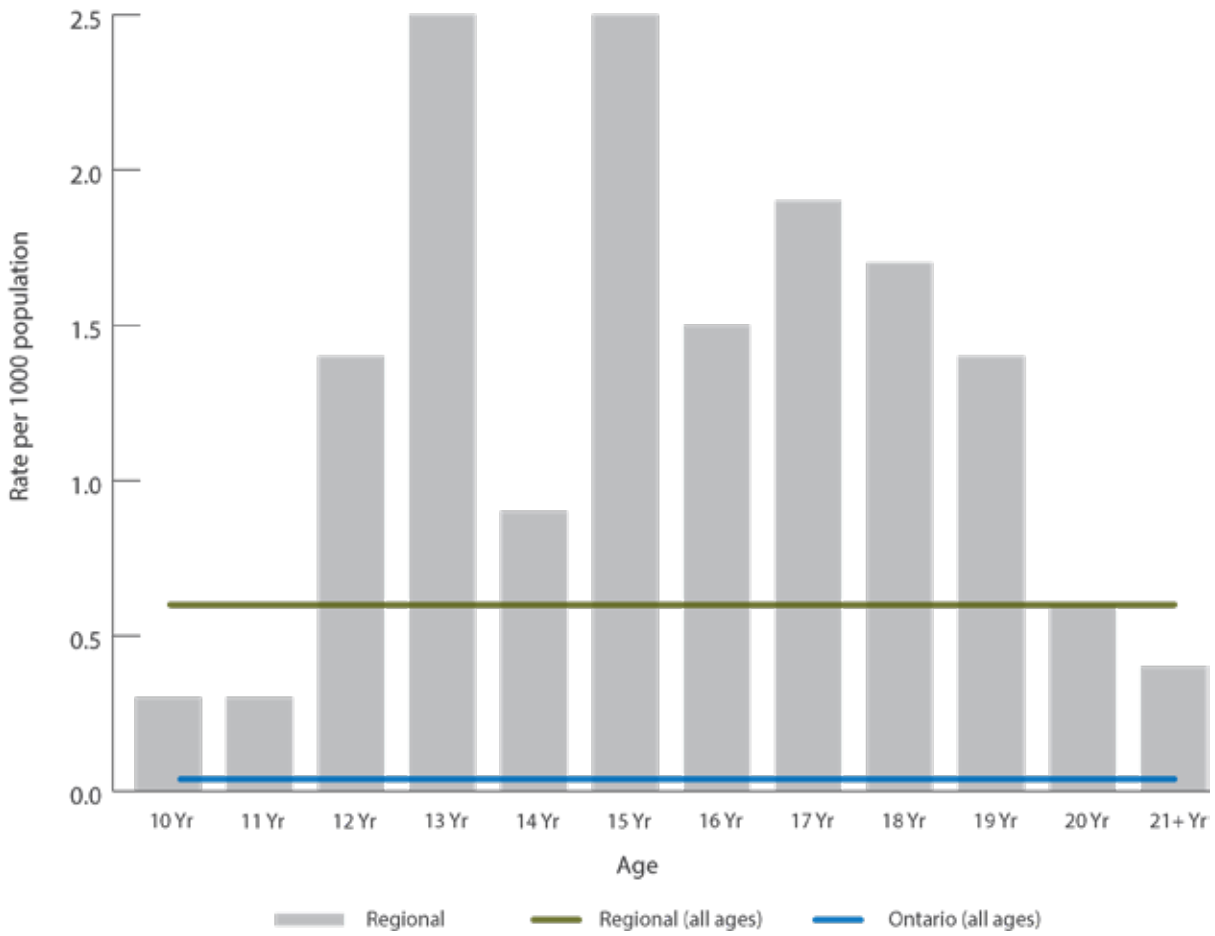


Figure 30. Suicide rates by asphyxia-related hanging per 1000 population, among Sioux Lookout area First Nations community members, by age, between 2011 -2021 (Source: Office of the Chief Coroner Ontario data).

*The rate at which individuals living in the Sioux Lookout area First Nations died by asphyxia-related suicide is **15 times greater** than the rate for the same cause of unnatural death among the rest of the Ontario population.*

Figure 31 depicts suicide by asphyxia-related hanging proportions per year in different age groups within the Sioux Lookout area First Nations over a period of 10-years (2011-2021). The analysis shows that elevated rates of suicide by asphyxia-related hanging are particularly prominent among younger age groups in the Sioux Lookout area communities.

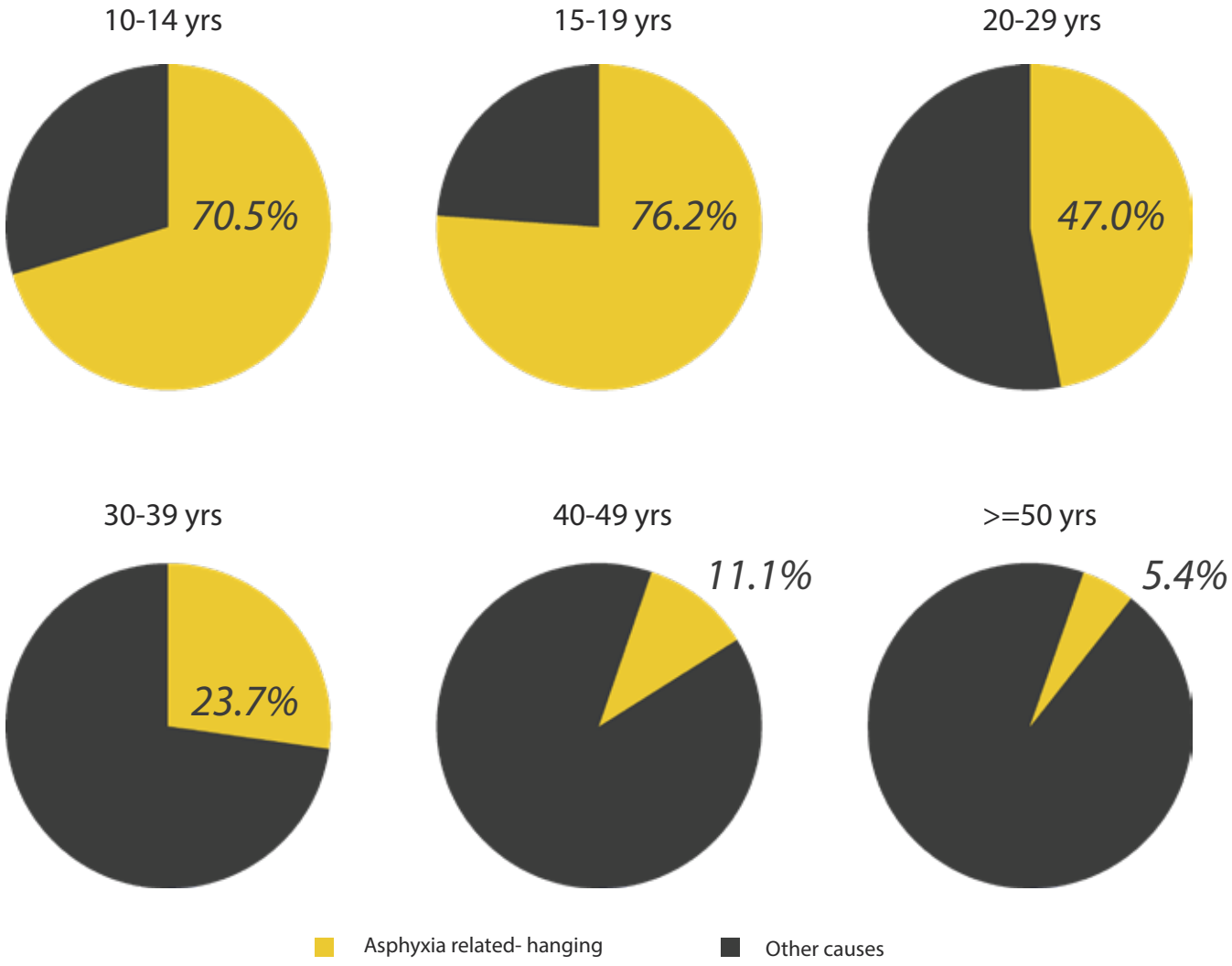


Figure 31. Proportion of suicide by asphyxia-related hanging, by age, among Sioux Lookout area First Nations community members, 2011-2021 (of the 146 deaths by this cause) *Proportions of 10- and 11-year-olds were suppressed because of low numbers (Source: OCC data).

Suicide by asphyxia (hanging, chest/neck compression) was determined to be the leading cause of unnatural death across the region, accounting for 38.1% of unnatural deaths.

Suicide by asphyxia-related hanging varied by gender across the age groups. Among the age group 10-19 years, suicide by asphyxia-related hanging was a more common cause of unnatural death among females than males, but in the 50 years and older age group, this was a more common cause of death among males. When looking more narrowly at the young age group 10-14 years, 31 suicide by asphyxia-related hanging deaths occurred between 2011-2021. Young females accounted for 74% of these tragic deaths. Among the age group of 40-49 years, numbers are suppressed due to less than 5 asphyxia related deaths (Figure 32).

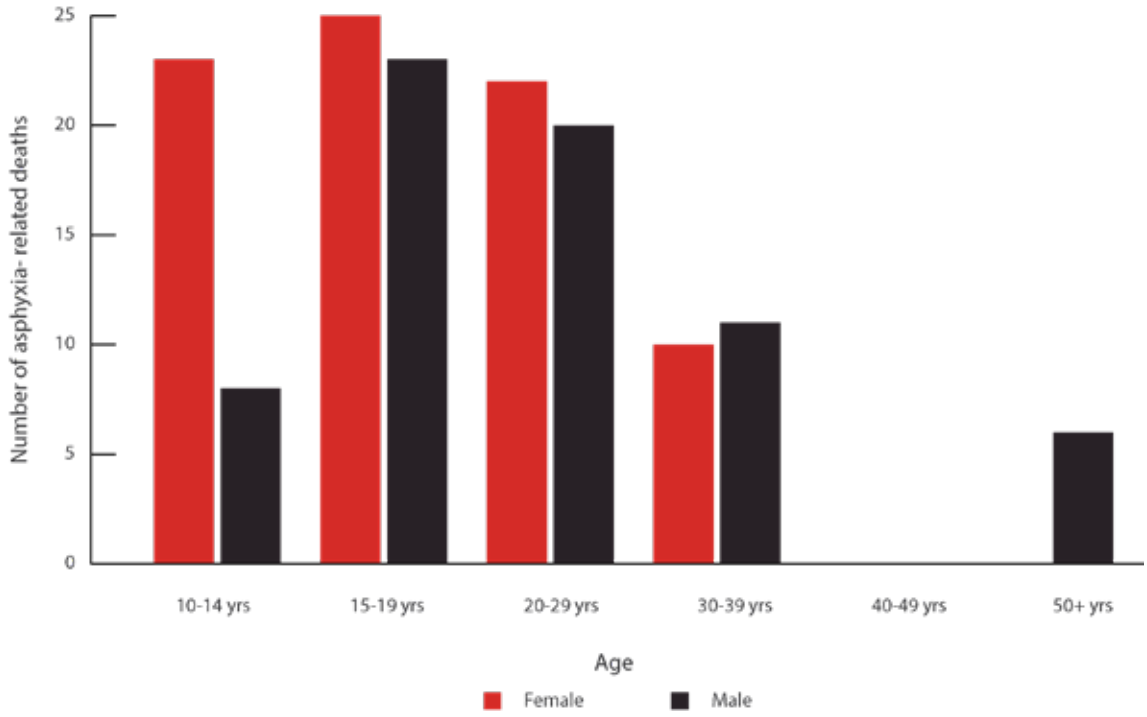


Figure 32. Number of suicides by asphyxia-related hanging, by age group and gender among Sioux Lookout area First Nations community members, between 2011-2021 (Source: Office of the Chief Coroner Ontario data).

Substance use (alcohol, drug) was the second most related cause of unnatural deaths across the Sioux Lookout area First Nations, and was the most common cause among the 30-49 years age group. Fire related accidents accounted for the third highest cause of unnatural death (especially common in 0-14 years of age). Physical trauma, including assault and violence, was the fourth most related cause of unnatural deaths, accounting for 31 deaths across the region, with more than 70% of these deaths occurring in 20-49 age group, and 70% among males (data not shown).

When looking more narrowly at the young age group of 10-14 years, 31 suicide by asphyxia-related hanging deaths occurred among this cohort between 2011-2021

Mental Health And Substance Use Services

SLFNHA Approaches to Community Wellbeing's (ACW) Harm Reduction services

SLFNHA's ACW Harm Reduction team offers a public health approach to addressing substance use. Rather than solely concentrating on encouraging individuals who use substances to quit, the harm reduction team also works with communities to minimize the adverse consequences associated with substance use.

ACW provides safer substance use equipment and naloxone to communities, supports community readiness assessments for harm reduction services, develops community hepatitis C testing campaigns, provides health promotion materials and supports communities to use them, and provides programming support, mentorship, and trainings to community-based harm reduction programs (i.e., harm reduction and suboxone programs).

From 2021-2022, ACW's Harm Reduction team distributed:

630,000 needles to 21 communities

75 biomedical waste bins to 3 communities

154 naloxone trainings to individuals

173 naloxone kits, 150 replacement medications

ACW's Needle Distribution Service (NDS) provides new needles and injection equipment as a harm reduction approach. This program ensures that substance users have access to supplies for safer drug injection, thus reducing the spread of blood-borne infections.

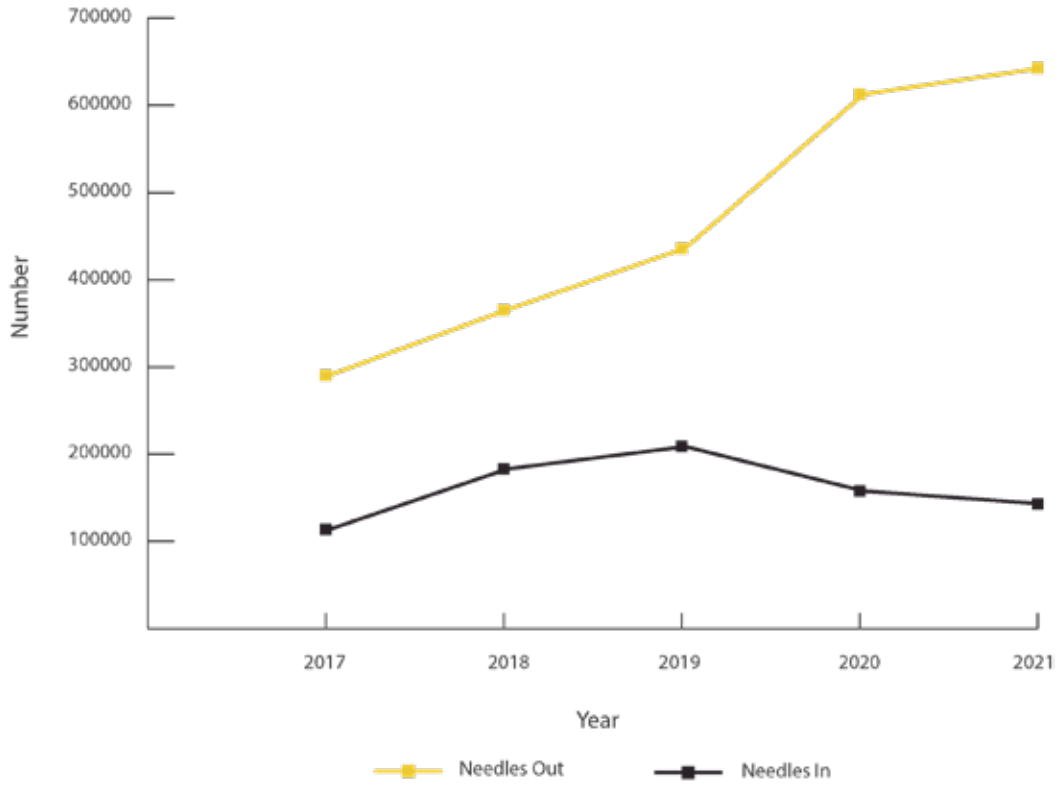


Figure 33: Number of needles sent and returned by Sioux Lookout area First Nations communities, between 2017-2022 (Source: ACW Harm Reduction Program data).

In addition to NDS, ACW's Harm Reduction team provides in-person naloxone training and naloxone kit supplies to communities. This ensures that people providing naloxone can recognize the signs of an opioid overdose and know what steps to take. Figures 34 presents data regarding distribution of naloxone kits and training to Sioux Lookout area First Nations community members during the period of 2017-2022.

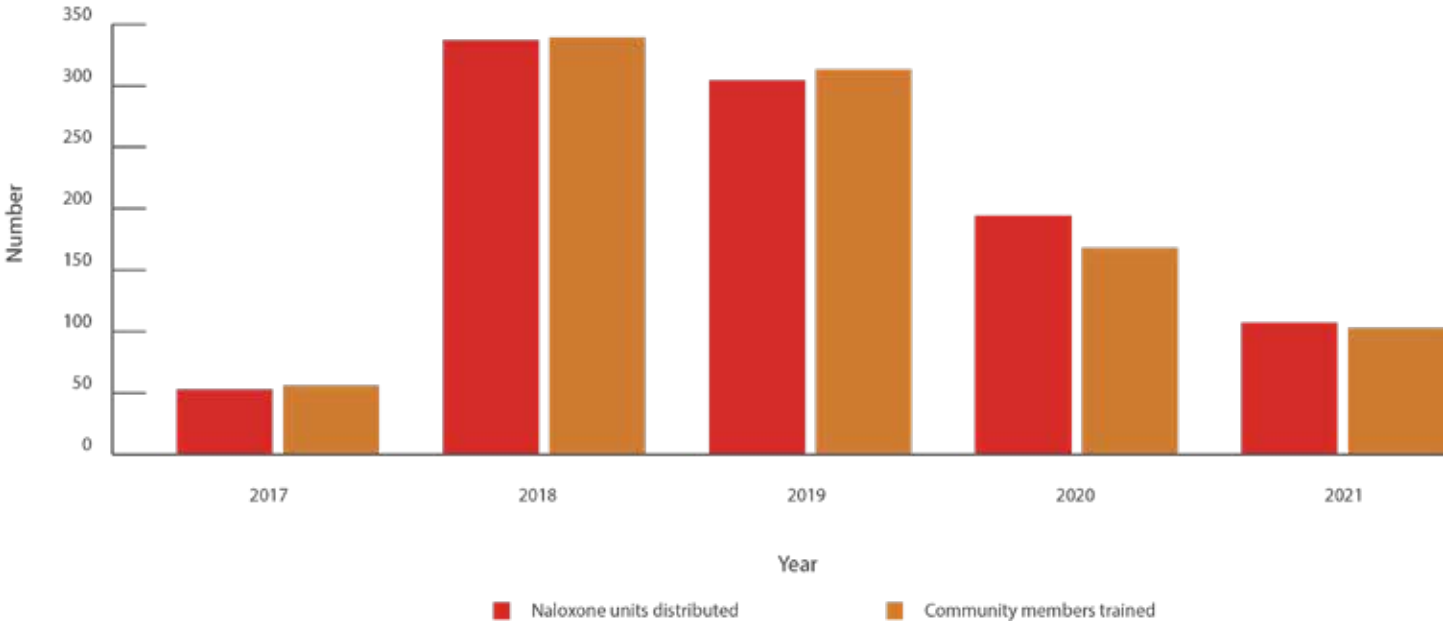


Figure 34: Number of naloxone units distributed and number of community members trained by ACW to administer naloxone in the Sioux Lookout area First Nations, between 2017-2022 (Source: SLFNHA ACW Harm Reduction program data).

Mental Health And Substance Use Services

Nishnawbe Aski Mental Health and Addictions Support Access Program (NAN Hope)

The Nishnawbe Aski Mental Health and Addictions Support Access Program (NAN Hope) provides community-driven, culturally appropriate, and timely mental health and substance use support to members of the 49 First Nations communities in the Nishnawbe Aski Nation Territory. This First Nation-led program is in response to the specific mental health needs of community members in northern Ontario.

NAN Hope services include: Rapid-Access Counselling Services; Therapeutic Modalities; and Healing Circles. Since its launch in August 2020, up to May 2023, there were 1,917 individuals who accessed NAN Hope. This includes 627 youths in which more than 60% were between 18-29 years. The top issues clients presented with: anxiety/depression/loneliness/stress; suicide/self-harm; substance use/treatment; grief/loss; and trauma/abuse. Figure 35 presents the number of clients who accessed NAN Hope during that period, within and by Sioux Lookout area First Nations Tribal Councils and independent bands.

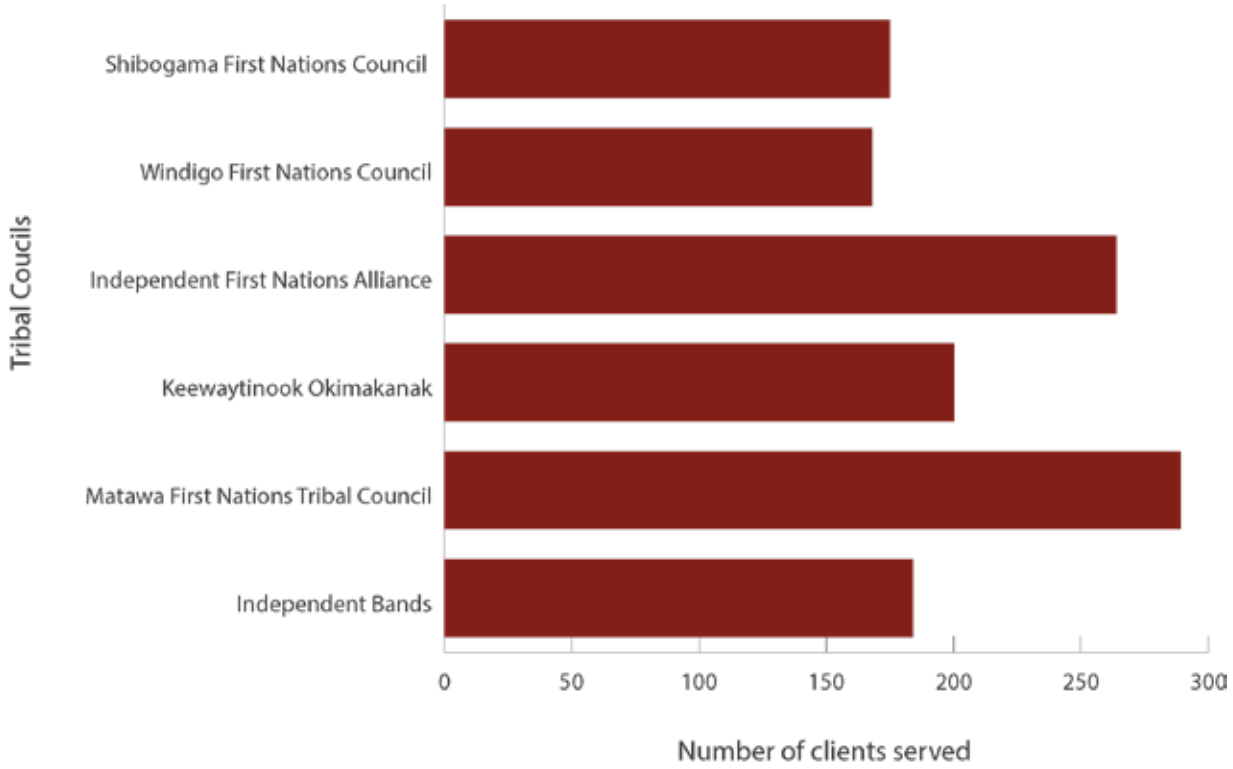
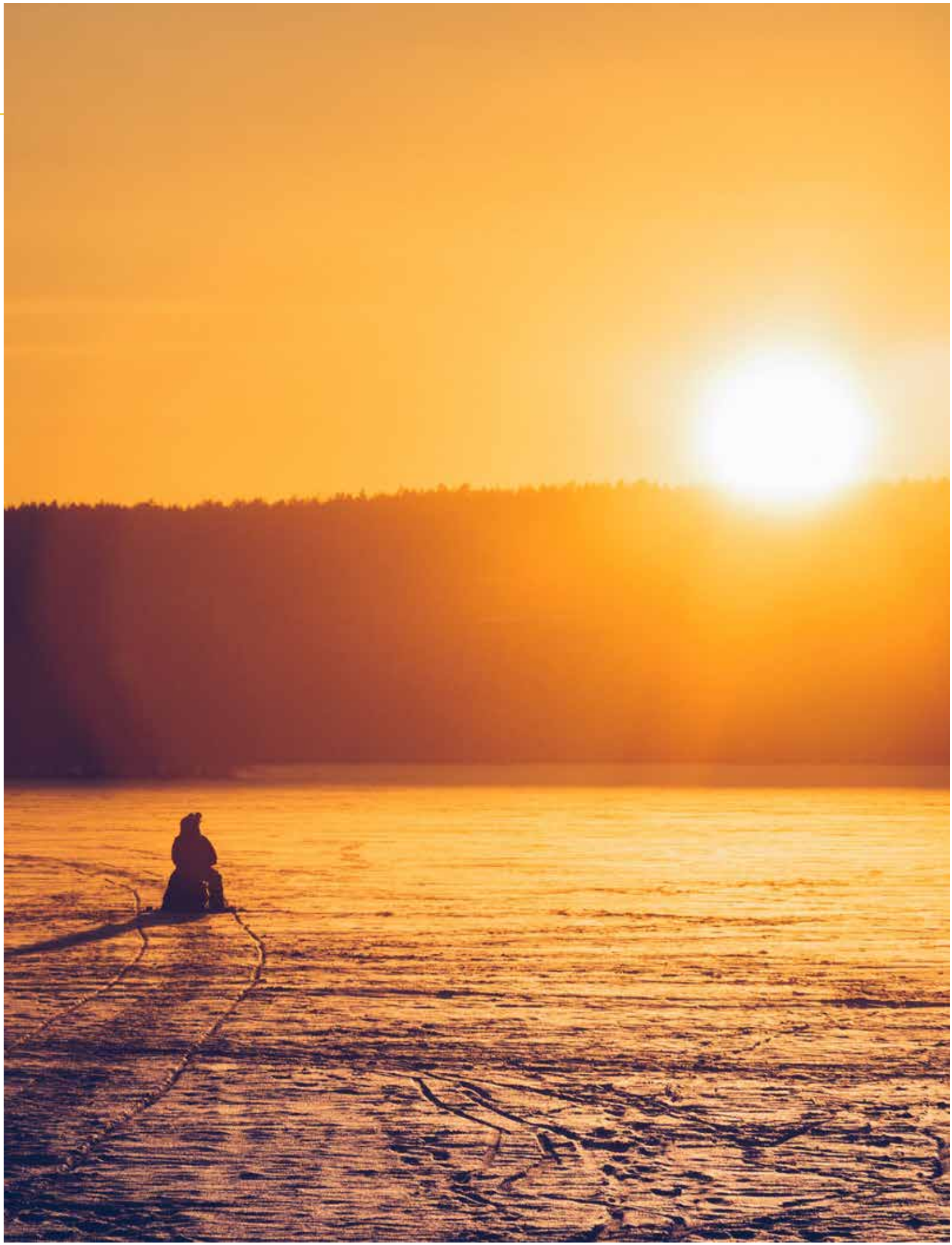


Figure 35. Number of clients served by NAN Hope between August 2020 – May 2023 (Source: NAN data).

Since its launch in August 2020, up to May 2023, there were 1,917 individuals who accessed NAN Hope.



Discussion

Significant efforts were made to obtain the datasets in this report from data custodians, following the First Nations Principles of OCAP (Ownership, Control, Access, Possession), for quantitative data collection and Indigenous Knowledge Gathering. Some datasets are unique and specific for Sioux Lookout area First Nations, such as Service Administration Log data or the Office of the Chief Coroner Ontario data.

This report documents alarming and increasing rates of mental health and substance use service utilization for Sioux Lookout area First Nations community members, especially among youth and young adults. Access to community-based mental health and substance use services is very limited and accessing services in urban centres has created additional challenges for the First Nations. Most alarming are the unnatural death rates and suicide rates among Sioux Lookout area First Nations which tremendously exceed the rates among Ontario and Canadian residents.

The Discussion Tables below provide an account of the most striking data findings, as well as discussion points to help guide the development of strategies that will support the restoration of physical, mental, emotional, and spiritual wellbeing among the communities captured in the report. For more details on the recommendations to address the needs identified in these tables, please see Appendix C. Recommendations in Appendix C and the following tables are derived from the Mental Health and Addictions Review – Final Report (Sutherland et al., 2023).

Overall Trend: Alarming and increasing rates of mental health and substance use service utilization for Sioux Lookout area First Nations community members.

Evidence	Dialogue	Strategies
SAL Nursing Station Mental health and substance use nursing station encounters were the fourth most common reason for nursing station visits. Substance use disorders were the number one reason for mental health and substance use nursing station encounters when compared to other mental health encounters.	The nursing station may be the sole community-based facility that consistently provides access to some mental health and substance use services. Community-based treatment and service options are lacking and existing services are "stretched exceedingly thin."	Enhance community-based resources to deliver substance use medicine services in community. Collaborate with regional providers, Nodin, and Tribal Councils to strengthen existing community crisis response plans.
Nodin Mental Health Services The top reason for Nodin Mental Health Services referral was loss and grief.	Crisis response teams provide short term intervention to manage an immediate crisis after tragedy.	Enhance resources to attend to community members experiencing ongoing loss and grief. Support community worker and regional provider training by including: • Land-based and cultural approaches for healing and aftercare; • Crisis intervention training in order to safely intervene when someone is in the midst of a crisis.
IntelliHealth 168% increase of the mental health ambulatory visit rate for individuals living in Sioux Lookout area First Nations. There is even a higher rate of ambulatory visits for substance use at 302%.	Lacking community-based and specialized regional mental health and substance use services may be a primary factor contributing to an increased rate of ambulatory visits for mental health. Those with complex mental health and substance use issues are often forced to leave their communities to access mental health services, which may exacerbate the challenges they are facing.	Build capacity at the community level to improve access to specialized services within the community. Support communities by assessing crisis response capabilities at the community level, building and training volunteer teams, and strengthening competencies to manage and advocate for what is needed.

Severity of Trends: We see similar alarming and increasing rates from mental health and addictions service utilization analyses of Sioux Lookout area First Nations Band members living on any reserve in Ontario or off-reserve anywhere in Ontario. In addition, there is also a widening of the disparity between Sioux Lookout area First Nations Band members and the rest of Ontario over time, with a much higher rate utilization rates than the province.

Evidence	Dialogue	Strategies
ICES For Sioux Lookout area First Nations Band members living on and off-reserve: Over the period of time captured in this report, emergency department (ED) visit rates for mental health and addictions more than doubled. The 2021 ED visit rates for mental health were 14 times higher than the provincial rate; Hospitalization rates for mental health and substance use almost doubled over the time period captured in the report. Service utilization rates were 6.1 times higher than Ontario's rate; ED visit rates for intentional self-injury and self-harm were 16 times higher than those in the Ontario population.	The rates of mental health and addictions service utilization of Sioux Lookout area First Nations Band members off-reserve are the most alarming. One might assume that those off-reserve should have greater access to specialized mental health and addictions services and would not need to go to the ED for treatment, help, or support. There are significant gaps in access to care, treatment, and support, both on and off-reserve. This is especially true for youth and young adults.	Provincial mental health and substance use services are enhanced for First Nations people whether they are on or off reserve. Address key gaps in regional services and resources related to: staffing issues, service structural issues, service delivery issues, treatment and service options, and funding issues.
Office of the Chief Coroner The average unnatural death rate for the Sioux Lookout area First Nations communities is 3.2 times higher compared to the provincial average rate. Furthermore, the rate of suicide by hanging in the Sioux Lookout area First Nations is an alarming 15 times higher compared to the Canadian resident rate. Suicide by asphyxia accounted for 38% of all unnatural deaths. **But, alarmingly suicide by asphyxia accounted for 70.5% of unnatural deaths among 10-14 year olds and 76.2% 15-19 year olds.**	The data on unnatural deaths provides insight into the disparity between the Sioux Lookout area First Nations communities and the provincial average unnatural death rates. This substantial difference raises concerns about the mental wellbeing and safety of community members.	Address underlying factors contributing to unnatural deaths and improve mental health and addiction services, crisis response intervention, and suicide prevention strategies specific to this region.

Youth And Young Adults

Dialogue	Strategies
It is worth noting that youth mental health supports are generally poorly addressed globally, but this disparity is even more pronounced for Indigenous youth in Canada. Specific action must be taken on the disproportionate mental health and substance use service utilization by young adults and youth. Youth and young adults are important to the overall wellbeing of the community. However, so many are struggling with their mental wellbeing as evidenced by their mental health and addictions service utilization. Individuals 20-44 years of age represented the largest proportion of those who presented to the nursing station with mental health and substance use issues, required substance use consultations, received referrals for psychology consultations, visited ambulatory care and emergency departments for self-injury and self-harm, and were hospitalized for mental health and substance use related reasons.	Create, maintain, and strengthen safe and supportive social spaces for youth, both on the land and within buildings and community programs. Develop a collaborative care model that connects Indigenous community and regional services to ensure youth receive services from a local or regional mental health worker they trust Focus on community healing, because youth require a community that has good internal relationships in order to experience wellness.

Underlying Key Drivers

Possible reasons for increased ambulatory mental health and addictions related health care service utilization for Sioux Lookout area First Nations Band members may include:

- A true increase in mental illness and substance use issues
- Increased awareness among community leaders, families, health care providers, and community members
- Increased help-seeking behaviors due to decreased stigma within the community
- Limited access to other community-based or primary care mental health services
- Limited access to specialized mental health and addiction services

> *"When you see how young Indigenous females are using very lethal means to die by suicide, that tells me they are feeling an extreme level of helplessness and hopelessness."*
>
> *- Lisa Bertrand, SLFNHA Approaches to Community Wellbeing Harm Reduction Manager*

Key Lessons from Indigenous Knowledge Gathering

"My parents couldn't give me something they never had. And when that understanding came, so did my forgiveness of them. I felt such a love for my parents, and for all people. I understood."

- Carrie Trout, Storyteller

The First Nations are experts in their own histories and bringing their knowledge forward to inform the data in this report was essential.

Approximately 30 one-to-one conversations occurred with Sioux Lookout area First Nations community members who lived either on reserve or off reserve. Also, by Chief's invitation, a small delegation of SLFNHA staff visited Cat Lake First Nation to share community specific data regarding information in this report, and to receive personal observations from community members regarding the situation of mental health and substance use in their community. Though each community and each person are unique, their commonalities are greater. All shared heartbreaking experiences of pervasive loss owing to oppressive colonial systems and institutions.

Many shared stories about widespread incidents of suicide and addiction; loss of children and family members; lateral violence; and harms imposed by numerous social and health inequities.

"There are a lot of young girls that self-harm. We are getting more suicide ideation and completed suicides. For a long-time we didn't have a suicide and then all of a sudden it started to become more frequent. And there are a lot of angry young men out there that go out fighting. They'll have a good time for a while and then they go fight. There are high-risk behaviours of young girls and they get caught up in the drinking and drugs, and then they get abused or taken advantage of."

-Patricia Keesickquayash, Storyteller

Some shared how stigma, fear, and shame kept their truths hidden from the light, and hidden from healing and action at community levels.

"We weren't allowed to talk about the physical and sexual abuse, and the other things that went on at home. And nobody talked about the sexual abuse and incest in the community. People are struggling with sexual abuse and other traumas. We need to talk about it. And we need people to feel comfortable, safe, and heard when they are talking about it."

- Patricia Keesickquayash, Storyteller

"When we suppress the truth, we keep ourselves sick. We are not going to heal if we do not have the courage to speak about what happens in our communities."

- Carrie Trout, Storyteller

But suffering and hardship were not the only similarities among the many different communities and people. Each person demonstrated courage in bringing forward the truth, and perseverance as they continue to relentlessly advocate for themselves and all First Nations. Those who shared their stories emphasized the need to give voice to the ongoing trauma among the First Nations, so that healing becomes the prolific experience for every First Nations person.

"For many years I felt shame, guilt, and regret until I realized it wasn't my fault. I accept this and I'm ok. It happened to me but it wasn't my fault. And this is mine, this is my life, I have to heal. I got this journey to walk and nobody is going to do it for me."

- Patricia Keesickquayash, Storyteller

Cat Lake Stories and Experiences

Responding to an invitation from Chief Russell Wesley, on May 26th, 2023 a small SLFNHA delegation shared community specific data regarding mental health and substance use findings to a gathering of approximately 30 Cat Lake First Nation members. Staff from diverse sectors of service from operational to social to economic to health, as well as leadership, came together at the Cat Lake Community Centre where they received and processed difficult information that was, for everyone, very personal and very heartbreaking.

Those who were gathered spoke emotionally of the challenging day to day reality of living in community and how those truths influenced the number data collected. In addition to struggling with resources, communities are running a deficit on information, specifically their own information. The challenge in meeting unmet needs and service gaps has been exacerbated by the inability of First Nations communities, like Cat Lake, to access their own data.

Restoring jurisdiction of First Nations data to the First Nations through the active implementation of OCAP principles will allow communities like Cat Lake to utilize their own data to develop policies that are timely and responsive to their unique needs, and increase a sense of efficacy and hope.

Cat Lake members also spoke about the children who have been removed from community and often placed in the child welfare system. Many First Nations communities, including Cat Lake, have expressed intent to enact legislation under Bill C-92, also known as "An Act respecting First Nations, Inuit and Métis children". Bill C-92 acknowledges that First Nations have a right to develop their own child and family policies and laws. However, despite a deep longing to bring children home and restore family connections, some Cat Lake members expressed a concern about a lack of services and wellness in their community.

The following are some significant captures of the heartfelt conversation that occurred that day in May.

Community Knowledge

"We have to come face to face with these problems that our community is dealing with. I know it is difficult, but we have to resolve these problems and rebuild our community. That's the number one reality. The second reality, in my role as Chief, is that I don't have data. Even though this type of information is very upsetting and triggering- I need it, SLFNHA needs it, NAN needs it. The coroners don't even have this information. So how do we begin to justify and quantify our arguments when it comes to mental health and addictions when we do not have data, information, and statistics?"

- Chief Russell Wesley

Colonized

"I remember when I was a kid, we were sleeping in the wilderness. It was 35 below zero and that is where we were sleeping- my mom, my dad, and my siblings, because that was the old way of life. That was normal for us. But through the years our culture has deteriorated- we are colonized. And that's one of the problems. My young grandkid can't speak the language. And then you have all this other stuff coming at you. The rez is like a prison. It's a prison in the mind. We are stuck on the reserve. But we have to change that mentality."

-Charles Wesley, Social Director

Suicide

"How many suicides were two-spirited people? How many were ostracized from their community? I know of one suicide because she had to leave the community. She had to leave her community, her family, nephews, nieces, uncles, aunts. But she is a human being. Those things happen. We have to come face-to-face with those values in our community. We stigmatize ourselves to a level where we are killing ourselves. These are tough things we have to come to terms with. The sooner we acknowledge that we also contribute to our own problems that better off we will be."

- Chief Russell Wesley

Trauma

"There is no support in our community. All we do is drive each other crazy at home because we don't know how to deal with this grief, my grief. And we pass this on to the kids. I struggle with mental health. And I choose to drink just to get away from my anxiety caused by all the trauma in my life and the community. It's just not me. When we deal with a suicide, or any trauma in the community, it impacts every home because we are built as a family. We were taught to love each other.

The other problem we have in community is that there is just no support. After we bury someone in the community there is the next problem we have to deal with. We don't deal with

> *"We ask for our kids to come back but we don't have the resources. If we want to bring our children back we have to be ready with the resources. I have to be brutally honest. We are going to be bringing our kids back to a dysfunctional community. We need to bring our community to an acceptable standard of community wellness where people will be happy, comfortable to live in."*
>
> *- Cat Lake Community Member*

the grief. It is constantly trauma after trauma, grief after grief. I think last year we buried 11 people. There is one every month. We don't have time to grieve. How are we as workers going to be able to teach our young people to grieve properly? We are not grieving. I have never had time to grieve with anything. I'm a mother of 9 children. I don't have time to sit down and grieve.

There is more trauma than just suicide in each household. There are different kinds of trauma that we don't want to believe happen in this community."

- Cat Lake Community Member

Resources

"We don't have resources in the community. We have no NNADAP [National Native Alcohol and Drug Addiction Program], we have no referral system. Nothing. It stops at the police station or the nursing station. Sometimes somebody is sent out and then they come back with the same old situation. When we send somebody out that we know needs help, we have no place to send these people.

We have 3 or 4 people here with very serious addiction and they need a lot of help. We don't know how to help them. I don't know how to help somebody that is high on meth. That is a real big issue here in the community -the meth addiction. All we can do is watch them and call the police. That is all we can do."

- Deputy Chief Abigail Wesley

"When I was a young person, I wouldn't go see a counsellor. There was only one counsellor that came to my house and that respected me. Some counsellors walk around and reach out to kids, and young people appreciate that. I worked with kids for 10 years, and they have a lot of issues to endure. I told programs, don't come to communities, and give them high hopes and then leave. It's not going to work if one counsellor comes once a month. You continuously need a counsellor to walk around and ask how they can help."

- Cat Lake First Nation Member

"People don't utilize their resources. The counsellors and psychologist come up here and they have basically nothing to do because people do not want to see them. I don't think it is a resource issue. I think it is a lack of commitment from people who want help. If a person wants help, there are some resources available, so I don't think it is accurate when people say that resources are not available. It is true that there are no people within the community that can work at the community level with the people. But there is out of town counselling."

- Cat Lake First Nation Member

Trying to Heal

"I go out to my trapline, and it is a process of healing. Out there is a natural law. I remember growing up in the natural law. The animals do the same thing. They never change. But here in the rez things have changed, terribly. It is not good. And we see the results of that change happening in the community over the years. We are seeing the fruits of that change now because we are not dealing with it properly. We don't have the resources. We don't have the knowledge. And we need the motivation to do stuff. We need support from outside too. Here in the community, we have to learn to work together."

- Charles Wesley, Social Director

Bringing Children Home

"Kids in urban settings have lost their connection and ties to their home. Kids that are not brought home takes a toll on the parents and grandparents. My dad mourns for that grandkid living in Thunder Bay that he has never seen once my niece died. His own grandson. My dad mourns for him. He's seven now. He's lost his grassroots tie to the community growing up in Thunder Bay."

- Cat Lake Community Member

"Our kids age out of the service, and then some of them continue on in the urban areas. Some of them just want to come home. And they don't know any family, but they have family. There are a lot of kids out there. We know this. So, once they start coming here, what are we doing to do with them? We have no services whatsoever. We have no counsellors. It is complicated."

- Deputy Chief Abigail Wesley

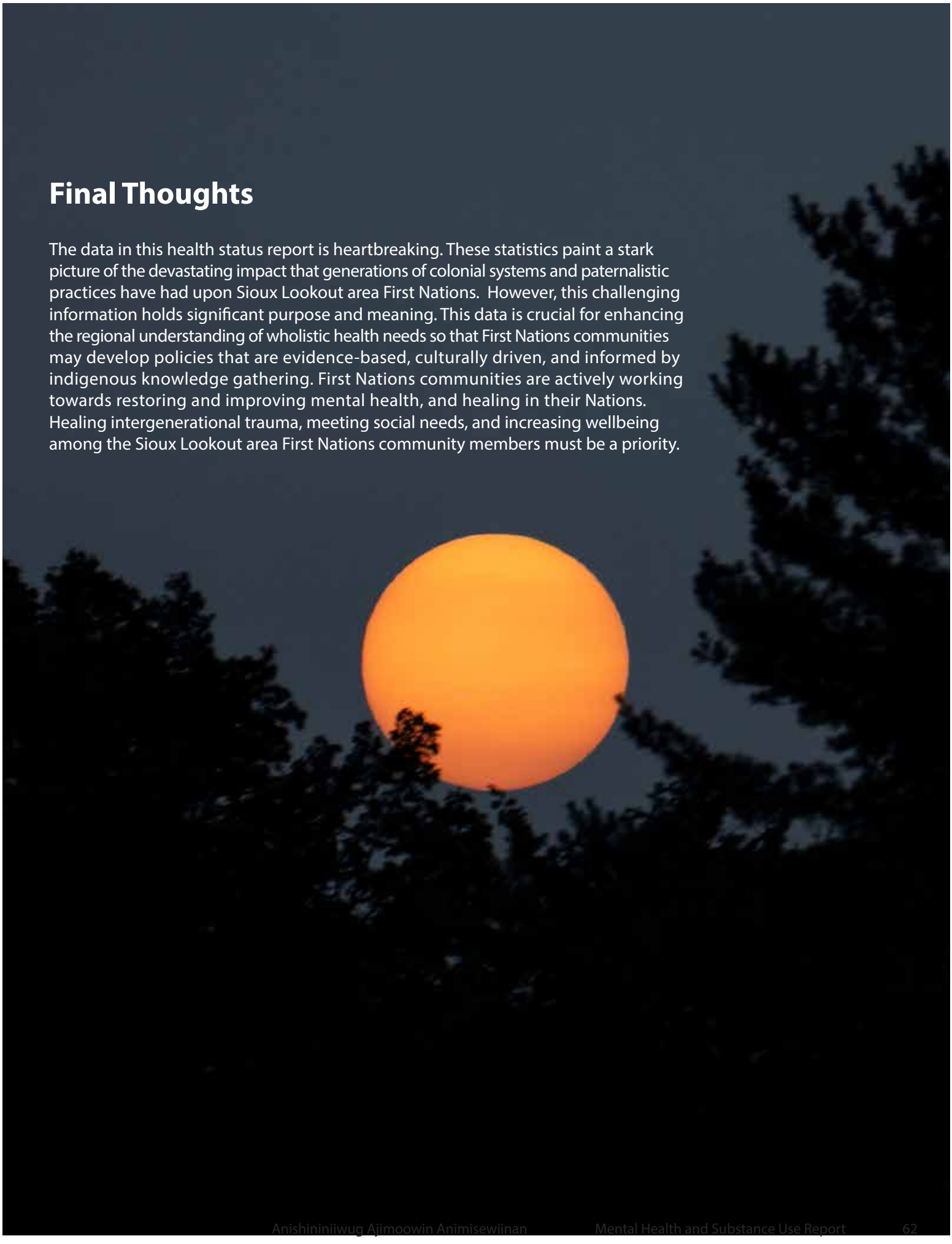
RESILIENCY

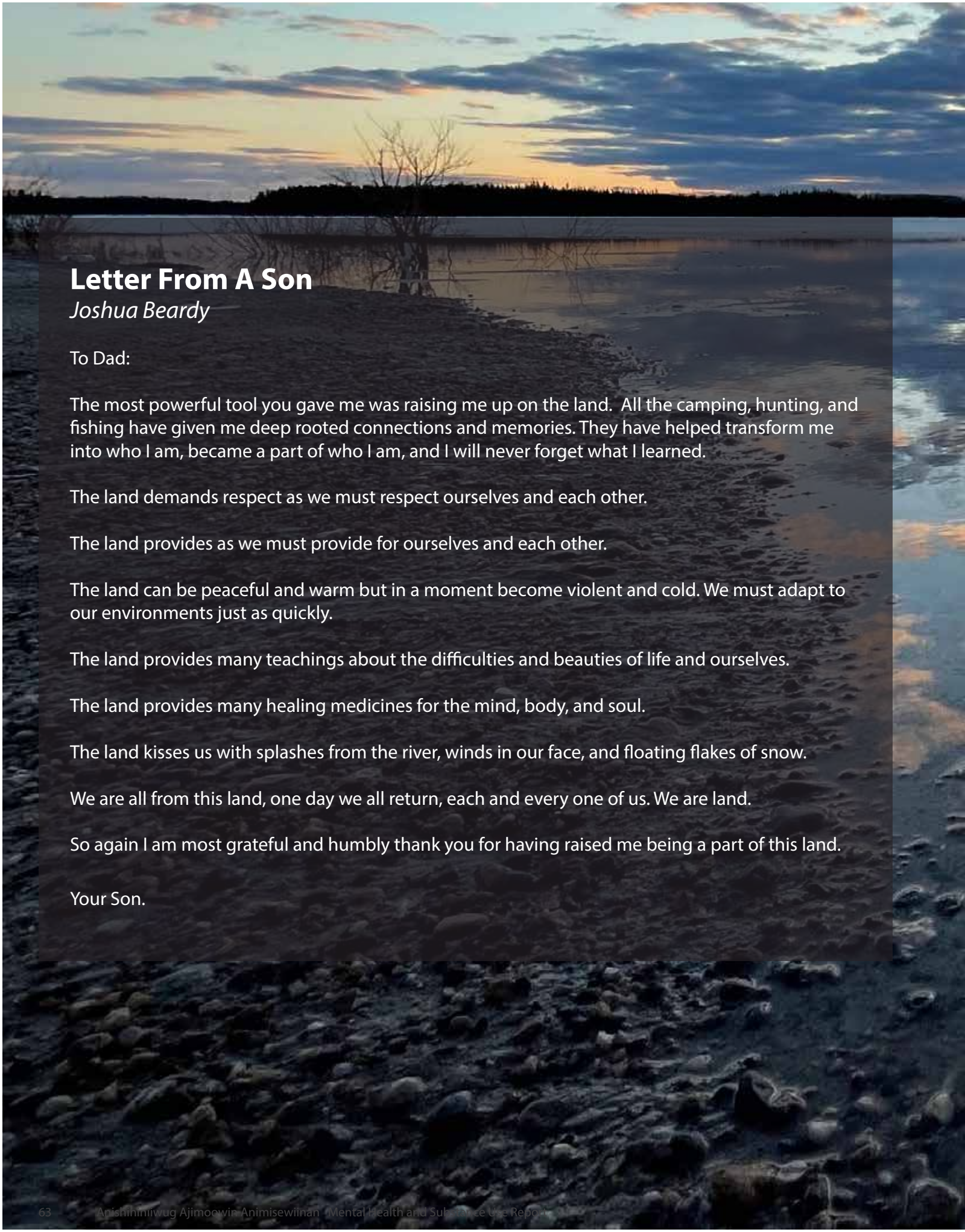
"Cat Lake has the best search team in the region. They are always called upon to help. But they never have time to grieve, yet they get up and leave to go help the people that need help. That is how passionate they are to help others. They don't have time to grieve their own traumas in their own lives, yet they suit up to leave. And we are always proud of them. I'm proud of Cat Lake just the way it is."

-Cat Lake First Nation Member

Final Thoughts

The data in this health status report is heartbreaking. These statistics paint a stark picture of the devastating impact that generations of colonial systems and paternalistic practices have had upon Sioux Lookout area First Nations. However, this challenging information holds significant purpose and meaning. This data is crucial for enhancing the regional understanding of wholistic health needs so that First Nations communities may develop policies that are evidence-based, culturally driven, and informed by indigenous knowledge gathering. First Nations communities are actively working towards restoring and improving mental health, and healing in their Nations. Healing intergenerational trauma, meeting social needs, and increasing wellbeing among the Sioux Lookout area First Nations community members must be a priority.





Letter From A Son

Joshua Beardy

To Dad:

The most powerful tool you gave me was raising me up on the land. All the camping, hunting, and fishing have given me deep rooted connections and memories. They have helped transform me into who I am, became a part of who I am, and I will never forget what I learned.

The land demands respect as we must respect ourselves and each other.

The land provides as we must provide for ourselves and each other.

The land can be peaceful and warm but in a moment become violent and cold. We must adapt to our environments just as quickly.

The land provides many teachings about the difficulties and beauties of life and ourselves.

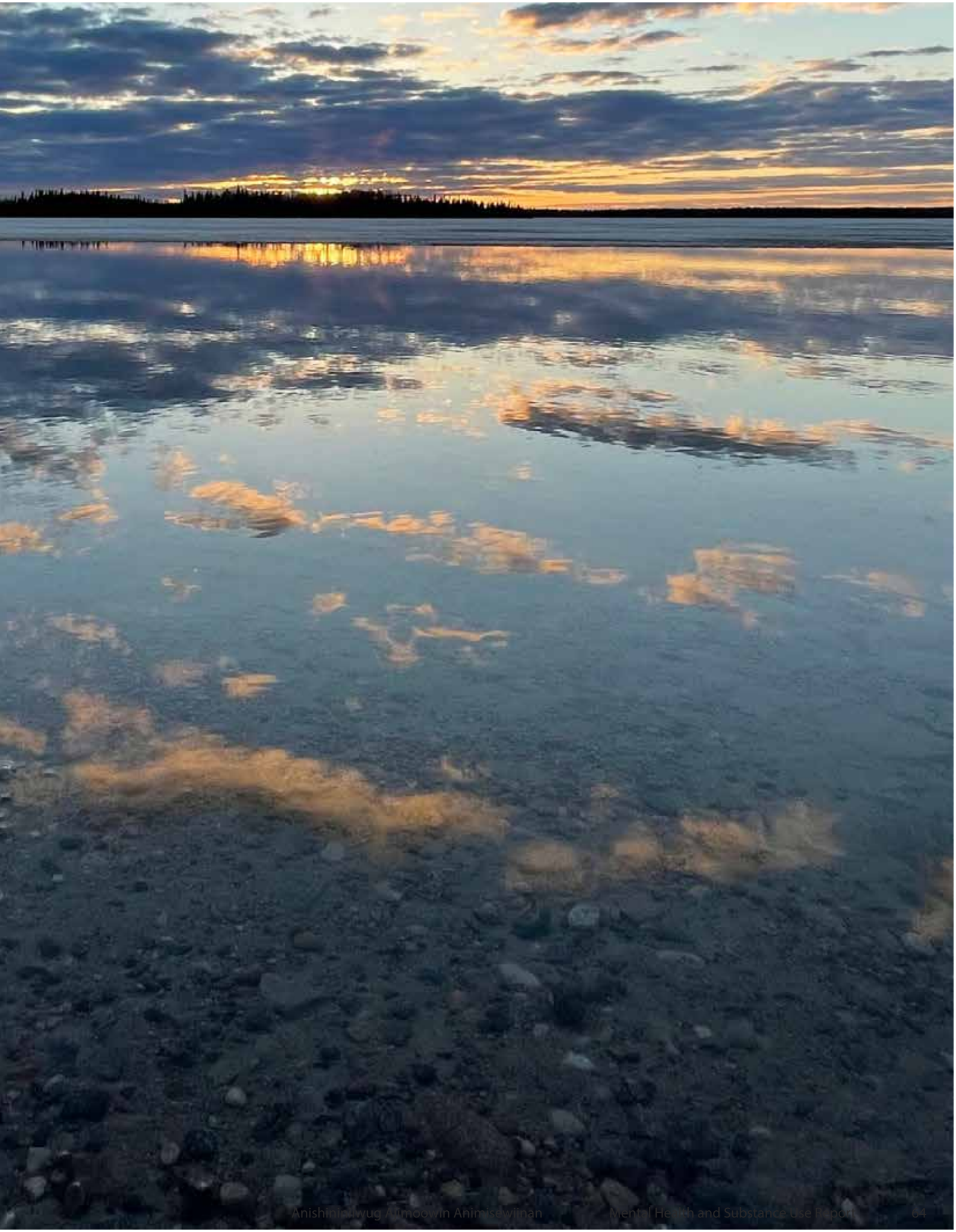
The land provides many healing medicines for the mind, body, and soul.

The land kisses us with splashes from the river, winds in our face, and floating flakes of snow.

We are all from this land, one day we all return, each and every one of us. We are land.

So again I am most grateful and humbly thank you for having raised me being a part of this land.

Your Son.



Appendices

Appendix A: Recommendations

The following key priorities for system development and recommendations are derived from the SLFNHA Mental Health and Addictions Review – Final Report (Sutherland et al., 2023). Please refer to the companion report for full details.

Priorities for System Development	Recommendations
Communications & collaboration internally	• Develop an orientation and onboarding process for new staff which builds awareness and understanding of the role of the many departments and programs at SLFNHA • Provide regular updates and promote information-sharing, both internally and with the First Nation communities and other partners
Addressing system barriers	• Develop worker job descriptions within structured team support, clinical supervision and policies such as employer supported training, and a clear path towards career progression to eventual resignation. This might entail a training program and leave policies supporting the worker to attend further education • For some workers, whose gifts or interests are in the area of local traditional or cultural wellness approaches, a plan for learning from knowledge holders, apprenticing or mentoring with healers and those with knowledge of traditional medicine or land-based healing should be developed
A regional training centre for mental health and substance use	• Invest in a regional training centre to build locally-relevant community capacity in mental health and substance use care
Community capacity-building and training	• Community worker and regional provider training needs include: o Crisis intervention training in order to safely intervene when someone is in the midst of a crisis o Mental Health First Aid First Nations o 2SLGBTQ+ needs o Care for complex needs including those diagnosed with Fetal Alcohol Spectrum Disorders (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) o Training in providing care for sexual trauma, sexual abuse (including historical abuses which happened in the region), and family violence o Ways to reduce stigma and have safe conversations and dialogues about trauma and substance misuse o Culturally appropriate and trauma-informed care to support workers to prepare for Indian Residential School trauma burden as gravesites are uncovered o Land-based and cultural approaches for healing and aftercare

Priorities for System Development	Recommendations
	o Healthy parenting skills to break the intergenerational cycle of trauma
Collaborative leadership for mental health and substance use	• Establish structured, ongoing opportunities for community engagement and collaboration amongst partners across all sectors • Continue to participate on collaborative tables with the goal of formulating processes for information sharing, coordinated outreach, and case management
Defining clear roles and responsibilities	• Ensure that any Memorandum of Understandings, care coordination plans, or service agreements, which define roles and responsibilities, are supported with adequate resources and staff capacity for implementation • Ensure that communications strategies are also developed so that system partners are aware of the proposed approach or protocol • Build evaluation and accountability measures within these implementation plans
Shared response - Meno Ya Win Mental Health and Addictions Program and Nodin Mental Health Services	• To further improve coordination and care, Mental Health and Addictions Program and Nodin should take a leadership role in working together to expand the circle of care to include other service providers in the region who are not part of the hospital or Nodin so that they are included in the coordination of care for clients • Opportunities for face- to- face networking to share information on patient needs and to collaboratively plan care needs to be reinstituted • Work to establish an in-patient secure and safe environment in the hospital for mental health and substance use care so that individuals are not sent to the hostel for accommodations
Strengthening partnerships and networking	• Strengthen partnerships through ongoing opportunities for networking and collaboration between mental health and other sectors including education, justice, policing, housing, child welfare, and others. Such opportunities may span service planning or case management for individual clients on through to shared cultural safety training opportunities and collaborative program planning

Priorities for System Development	Recommendations
Supporting system navigation and case management	• Work with communities, Tribal Councils, and key service partners to establish a community case management and services navigation system with key roles at the community-level identified • Secure funding for community case managers (clinical) and/or community navigators to support implementation of the case management system
Community support in crisis response	• Work with regional providers, Nodin, and Tribal Councils to strengthen existing community crisis response plans. This could include: o Clarifying and defining roles related to crisis response o Assessing community crisis response capabilities, building a support system at the community level, building and training volunteer teams, and building competencies to manage and advocate for what is needed o Ensuring that crisis response plans are inclusive of the full continuum from prevention through to aftercare o Situating crisis response within a fuller case management protocol o Providing resources to compensate volunteer crisis teams
Community ownership and control	• Engage with community and health leadership, Elders, and youth to devise a community mental health and substance use vision and plan • Support communities in exercising self-determination and control over their mental health programs • Advocate for culturally safe administrative structures and funding to support communities in their mental health planning and vision
Building upon community knowledge and cultural strengths	• Establish an Anishinaabe Advisory Panel comprised of knowledge holders from communities, Tribal Councils, and partner organizations to support a long-range strategy for cultural strengths-based approaches in mental health and substance use program design • Ensure cultural safety is built into workforce development and organizational structures to ensure a conducive environment is in place for the development of culturally strengths-based approaches

Priorities for System Development	Recommendations
Embracing a "two-eyed seeing" approach	• Regional visiting workers (non-Indigenous as well as Indigenous) collaborate with local First Nations community workers to assist with community engagement, cultural understanding, facilitating acceptance, and supporting interpretation. The learning should be reciprocal with both parties providing knowledge to the other in order to come up with safe and effective ways to serve the community and its members • Structure regular opportunities for knowledge sharing, collaborative training, and co-learning between community workers and other providers
Community workers as part of the circle of care	• Explore lessons, challenges, and emerging wise practices from the Community Health Workers – Diabetes Program to inform the approach and design of a task shifting model for community mental health and substance use workers • Delineate specific roles and competencies for community mental health and substance use workers. Design training curriculum and job descriptions based on these roles and competencies • Develop specific protocols for integration and inclusion of community mental health and substance use workers within the circle of care
Addressing stigma and harm reduction	• Build community capacity for awareness and leadership advocacy for a harm reduction approach • Communicate and promote the benefits of a harm reduction approach which is anchored in the primary care model of the Anishinaabe Health Plan
Information sharing and privacy	• Engage with communities and partners to discuss the development of an overall consent form for information sharing amongst partners in mental health and substance use • Conduct a community education campaign about privacy and confidentiality • Provide training and assist in developing policies and procedures for providers and community workers concerning Personal Health Information Privacy Act
Electronic medical record and documentation	• Support SLFNHA's Health Information and Information Technology team to implement a common electronic medical record for patient charting and sharing of information, service/care plans, and documentation • Engage with SLFNHA providers and staff to clarify privacy issues, consents, permissions as to what health information a counsellor can see versus what others see, and so forth • Continue working with Nodin's mental health providers to help devise and improve templates for use in Mustimuhw

Priorities for System Development	Recommendations
Supporting system navigation and case management	• Work with communities, Tribal Councils, and key service partners to establish a community case management and services navigation system with key roles at the community-level identified • Secure funding for community case managers (clinical) and/or community navigators to support implementation of the case management system
A second level service approach	• Ensure ample resources for implementation of any service improvements, including the needed space and facilities, and staffing • Advocate for wage parity across service providers and agencies
Client-centred care	• Establish a patient advisory group to include the patient voice and to inform mental health and substance use services development • Encourage and build competency in client-centred care as a focus of all service providers. Training programs are available which encompass primary care, mental health, and cultural safety • Advocate amongst funders for simpler reporting reflective of the full picture of service provision
Embedding cultural strengths into the programmatic approach	• Work with communities to identify and build a roster of knowledge holders and Elders to work with as part of the Kizhi Itwa-inan Cultural Working Group • Learn from hospital and community experiences with programs which incorporate land-based healing and cultural strengths-based approaches for mental health and substance use • Develop and implement policies with respect to program delivery so that it is appropriate to the area's Anishinabe people and respectful of diverse spiritual frameworks
Cultural safety in the organizational environment and workforce	• Establish processes for developing cultural safety in organizational policies and professional development • Clarify and co-create local, working definitions for cultural safety that fit the need and context of mental health and substance use service provision in the Sioux Lookout area • Cultural safety must be framed within an understanding of historical and societal power dynamics and the resultant health inequities and discrimination within health care interactions • It is important to situate cultural safety within the Indigenous determinants of health and the movement towards health equity

Priorities for System Development	Recommendations
	• Develop a strategy to embed cultural safety within SLFNHA organizational policies and practice. This is critically important to the culturally safe provision of traditional approaches to care • Focus on cultural safety which includes confronting and addressing internal and unconscious bias. Build reflexive practices including self-reflection and cultural humility as a professional skill set • Ensure that cultural safety is not limited to training but has accountability mechanisms to ensure it is demonstrated within and across all settings, practices, systems, structures, and policies
Cultural safety – other human resources strategies	• Provide opportunities and build accountability for engagement and learning about cultural safety in activities, onboarding, training, and professional development • Ensure cultural safety is included as a requirement for organizational accreditation and ongoing certification • Embed standards of practice which are reflective of values within the SLFNHA code of ethics and include this explicitly within performance evaluations • Systematically assess and monitor how cultural safety is being developed within the mental health/substance use workforce and within the organization • Require cultural safety training and performance monitoring for all senior supervisory staff, managers, directors, and board members
Regional land-based healing centre for land-based healing and treatment for substance use	• Stabilization: A safe, supportive environment is needed for individuals in crisis • Land-based and culturally-based programming: Once stabilized, the individual and their family may take part in a structured, month long (or longer if desired) program of land based and cultural activities • Transitional housing: Supervised transitional housing in Sioux Lookout is needed for clients and families accessing the healing centre, so that they can continue to build upon skills learned in their programing and strengthen their internal resources • Community re-integration, follow-up, and aftercare: A care plan would be developed, integrating the traditional and clinical supports needed to help the client as they return to community. This would include ongoing counseling, aftercare, and follow-up. Opportunities for education, volunteerism, or employment need to be offered at this stage

Priorities for System Development	Recommendations
Community land based healing programs	• Engage with communities and partners to develop a full treatment continuum which incorporates land-based and cultural strengths • Each of these aspects require community and partner input in order to design an appropriate framework for the necessary components and build out key logistical and operational considerations. From this preliminary design work, a service model for submission to federal and provincial funders could take shape
Community based suboxone treatment programs	**Support for program staff** • Community coordinators of Suboxone programs require integration into the circle of care • Coordinators and dispensing staff require an investment into their position to increase their knowledge about addiction and the treatment in order to support clients in a supportive role and referring role • Dispensing community staff require trauma-informed care and self-care training in order to cope with clients who may be vocally complaining and demanding • Programs need to be explicitly linked with skilled mental health and substance use workers and therapists for consultation • Substance use therapists could collaborate with physicians and with Suboxone program coordinators (i.e. dispensing staff) as well as with other substance use programs (solvent and alcohol) **Community strategies** • Community-level healing strategies are needed so that the Suboxone program is integrated within the services and programs of the community rather than operating apart. This is something that is needed so that the Suboxone program is seen as, and is, nested within a fulsome community healing or substance use treatment approach • There are differing and polarized sentiments in communities towards harm reduction in general. Community awareness, education, and dialogue is needed to reduce harmful stigma towards program participants • More community and client engagement are required around the injectable Sublocade. This may be a good option for clients who would like to seek employment or education away from the community. Communities need more information and opportunities for conversation about this option

Priorities for System Development	Recommendations

Family, land-based healing

- Some communities have included a land-based healing component using local culture and local knowledge keepers for their Suboxone program. This should be available in all programs. Cultural approaches to healing and treatment, for example, traditional counseling with knowledge keepers and Elders and spending time in traditional activities, are an important pillar of aftercare and programming. More of this is needed and the activities need to be run by local community people
- A year-long, trauma-informed, land-based program with families involving effective and age-appropriate interventions with kids and parents is needed. This land-based healing program would be an integral part of the overall approach to community healing
- Support for parents who are struggling with substance use is also needed, including parenting skills, therapeutic support, housing, conversations around contraception for those who would prefer no more children, etc.

Structural Supports

- Sustained long-term funding to support community-based Suboxone programs is needed as well as counselling and land-based aftercare programming that is also necessary
- Programs also need better infrastructure, including buildings with counselling rooms for clinical counselling since many of the clinical rooms are in trailers and the walls are too thin for confidential conversations with care providers
- Regular analysis of electronic records of Suboxone treatment statistics, tapering trends, or the level of related mental health and substance use services or traditional/cultural services for continuous quality improvement is urgently needed
- For those wishing to make a quick exit from maintenance therapy, or to bypass it altogether, there is no feasible access to a focused detoxification/withdrawal management support. If this is created in Sioux Lookout, there is a great opportunity for collaboration with partners to enhance access to wraparound care by integrating access between community programs and such a support. This relationship to the detox/Rapid Access to Addictions Medicine (RAAM) means people who are ready to receive such support have timely access. This may be a great area of focus for Nodin in the future

Appendix B: Model for Mental Wellbeing in Communities

The model below was developed within the SLFNHA Proposed Model for Community Wellbeing (June 2023) report. Please see the report for full details.

Appendix C: Goals Of The Model for Mental Wellbeing in Communities

The goals to develop a mental and addictions model were established within the SLFNHA Proposed Model for Community Wellbeing (June 2023) report. Please see the report for full details.

Glossary

ACW	The public health department of the Sioux Lookout First Nations Health Authority.
Ambulatory visits	Visits to a licensed physician in an outpatient setting that does not require an overnight stay at the hospital.
Asphyxia	A condition where there is a severe lack of oxygen supply to the body's cells and tissues, leading to potential harm or death.
Colonization	The historical and ongoing process of forced assimilation, exploitation, and genocide against Indigenous peoples in Canada.
Delirium Tremens	A severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes.
DT'ing	Referring to delirium tremens.
Emergency department visits	These visits occur in hospital emergency departments and are critical for addressing urgent medical needs ranging from injuries and sudden illnesses to severe symptoms.
Epidemic	Refers to a sudden increase in the number of cases of a disease, illness, or deviation from health above what is expected or seen as normal within a population in a specific area.
Epidemic-level response	These are recovery activities that are usually specific to an epidemic.
Harm reduction	Rather than focusing solely on abstinence, harm reduction strategies seek to reduce the risks and harms associated with substance use.
Hepatitis C	A viral infection affecting the liver caused by the hepatitis C virus (HCV).
ICES	The Institute for Clinical Evaluative Sciences is a comprehensive health system data holder in Ontario that supports health service planning, evaluation, and research using their extensive data repository and expertise.
Indian Act of 1876	The Indian Act is a Canadian federal law that governs in matters pertaining to Indian status, Bands, and Indian reserves which was designed to control and assimilate Indigenous peoples and their communities.
Indian Registry System	A database which tracks Indian registration information, Band membership, and demographic statistics.
Indigenous Knowledge Gathering	A research method that embraces Indigenous knowledge transfer and provides opportunities to learn about Indigenous ways of being, knowing, and doing.
IntelliHealth	A knowledge repository that contains clinical and administrative data from various sectors of the Ontario healthcare system.
Intergenerational trauma	This concept recognizes that the traumatic experiences of past generations due to the impacts of colonization, residential schools, the Sixties Scoop, forced assimilation, and cultural genocide can be transferred across multiple generations impacting their mental, physical, emotional, and spiritual wellbeing.
Mental health	Mental health in this context encompasses a wide range of aspects which goes beyond just the absence of mental disorders. According to the World Health Organization, it can be experienced differently and results in varying degrees of difficulty and distress for different people.

Mental wellness	A wholistic concept which takes into account one's mental, physical, emotional, and spiritual aspects of a person's life when understanding the factors that contribute to their health and wellbeing.
NAPS	An acronym for Nishnawbe Aski Police Services.
Nishnawbe Aski Police Services	A policing organization that serves 34 First Nation communities in the Nishnawbe Aski Nation Territory.
Naloxone	A medication used to rapidly reverse opioid overdose.
Nodin Mental Health Services	Supports First Nations youth, adults, and families served by the Sioux Lookout First Nations Authority in response to their social, emotional, or behavioral needs.
Nursing station	Provides the first point of contact for health services in remote First Nations communities.
OCAP	First Nations ownership, control, access, and possession of their data.
Ontario Provincial Police Services	A policing organization that serves the province of Ontario and remote First Nations communities located in Ontario.
O.P.P.	An acronym for Ontario Provincial Police Services.
Residence code	A unique 4-digit code assigned to each municipality and First Nation community in the province.
Residence location	Refers to where a person resides.
Retrospective data	Information collected from events or situations that occurred in the past (historical data).
Self-determination	Refers to the right of a people to freely determine their political status, pursue their cultural, social, and economic development, and benefit from their wealth and natural resources.
Sioux Lookout area First Nations Band members	Refers to First Nations peoples from the Sioux Lookout area recognized as being a member of a Sioux Lookout area First Nation, as defined by either the Band itself or the Indian Act.
Substance use	Refers to the consumption of psychoactive substances including drugs or alcohol.
The Office of the Chief Coroner (OCC)	Provides death inquests and investigations to ensure than no death will be ignored, concealed, or overlooked.
Tikinagan Child and Family Services	A First Nations organization established to mentor to mentor young parents, support families, and protect children.

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