



Access to Mental Healthcare in Indigenous Communities Across Canada

Research Article

Arjun Patel, MSc, McMaster University

Abstract

This paper aims to answer the question: To what extent do Indigenous communities across Canada have access to mental health care? There are significant mental health care disparities between Indigenous and non-Indigenous peoples in Canada, largely due to a legacy of colonization and marginalization. Inuit, Status Indians, non-Status Indians, and Métis people all have differing levels of access to mental health services, with the latter two groups being largely neglected in federal and provincial Indigenous health programs. Though Indigenous health is legally a federal responsibility, mental health services vary dramatically between provinces and territories.

Introduction

This topic is important to study for four reasons. First, Indigenous peoples in Canada are an extremely diverse demographic group including hundreds of ethnic groups speaking approximately 60 languages.¹ Discussions about Indigenous issues often ignore these distinctions and conflate the experiences of individuals belonging to a wide range of groups.² There is a dearth of academic literature focusing on how health access differs *between* Indigenous groups.

Second, the proportional and total number of Indigenous people in Canada is rising. Between 1996 and 2016, Indigenous Canadians grew from 2.8% of the Canadian population to 4.9%.³ These growing numbers correspond with greater demand for public services, including mental health care.

Third, Indigenous peoples have a long history of marginalization and oppression. The British and French colonial powers forcibly relocated many Indigenous peoples from their ancestral homelands, banned religious and cultural practices, and often violently enforced European hegemony.^{4,5} This was later institutionalized in the residential school system, in which children were forcibly assimilated into Western culture and forbidden from speaking their languages and practicing their religious beliefs.⁶ The concept of 'historical trauma' explains how initial trauma can create difficulty in parent-child bonding and feelings of shared grief; these then result in trauma being inherited over generations.⁷

Fourth, compared to other ethnic groups, the burden of mental illness is high in Indigenous communities.⁸ Suicide in Indigenous youth (aged 15-24) is nearly six times more prevalent than in their non-Indigenous counterparts.⁹ Substance use disorders are also prevalent, with 83% of First

Nations respondents to a 2008-2010 nationwide survey reporting drug and alcohol misuse as the most prominent barrier to their communities' wellness.¹⁰

Methods

This paper uses academic literature and gray literature, including censuses and policy documents. The health care laws applying to Indigenous people in Canada differ in two ways: by legal classification and by province or territory. In the first section, four legal categories of Indigenous peoples are compared: Inuit, Métis, Status Indians, and non-Status Indians. Each of these groups has different laws and policies affecting health care. Most of the information was collected from academic literature, government documents (e.g. Health Canada) and organizations representing Indigenous communities. From these sources, it was possible to construct an image of how access to mental health care varies by Indigenous status. Similarly, in the second section, each provincial and territorial Indigenous health policy was examined in order to assess the level of coverage.

Results

The Constitution of Canada categorizes Indigenous peoples into 3 groups: Indians (First Nations), Inuit, and Métis.¹¹ First Nations are further divided into Status Indians, who are listed in the government's Indian Register, and non-Status Indians; non-Status Indians do not enjoy the same government insurance coverage and health benefits.¹¹ The Constitution labels health care as a provincial responsibility and Indian Affairs as a federal responsibility.⁵ This creates a complication in the overlapping area of Indigenous health.⁵ In 2016, the Supreme Court of Canada ruled that health care for all Indigenous peoples was under federal jurisdiction.¹² However, Métis and non-Status Indians remain ineligible for many health



programs.

The First Nations and Inuit Health Branch (FNIHB) is a branch of Health Canada that funds health care for Status Indians and Inuit.¹³ The Non-Insured Health Benefits (NIHB) system is a FNIHB program that covers the cost of prescription psychiatric medication.¹⁴ NIHB also includes a Mental Health Counselling (MHC) service for Inuit and Status Indian patients, which involves access to registered psychologists and social workers.¹⁴ The FNIHB also includes the National Native Alcohol and Drug Abuse Program (NNADAP).¹⁵ The NNADAP funds short-term in-patient and out-patient addiction services, running 56 rehabilitation centres around Canada.¹⁵ These centres also offer traditional healing services.¹⁵

As mentioned, the above services are only available for Status Indians and Inuit. There are no federal health programs covering non-Status Indians and Métis. Consequently, their mental health coverage and services vary drastically depending on location, which is explained below.

Nine provinces and territories do not have any mental health programs for Indigenous residents: Ontario,¹⁶ Quebec,¹⁷ Manitoba,¹⁸ Saskatchewan,¹⁹ Nova Scotia,²⁰ New Brunswick,²¹ Prince Edward Island,²² Newfoundland and Labrador,²³ and Yukon.²⁴ While Inuit and Status Indian residents of these jurisdictions have access to federal FNIHB programs, Métis and non-Status Indian residents do not have any more access or coverage than their non-Indigenous counterparts. The four remaining provinces and territories do have Indigenous health programs, as detailed below.

The British Columbia Ministry of Health (MOH) works with the First Nations Health Authority (FNHA), which includes representatives from First Nations' band councils.²⁵ The MOH and FNHA cover the cost of First Nations residents receiving long-term care from psychiatrists and psychologists.²⁵ There is no equivalent program for Métis or Inuit living in British Columbia.

Alberta Health Services (AHS) has an Indigenous Health Program charged with providing culturally appropriate care to First Nations (both Status and non-Status Indians), Métis, and Inuit patients.²⁶ The AHS is advised by a Wisdom Council consisting of representatives from Albertan Indigenous groups.²⁶ Mental health care providers receive mandatory education on providing culturally sensitive care.²⁶

The Northwest Territories' Department of Health and Social Services runs the Métis Health Benefits system.²⁷ This program gives Métis residents the same health benefits that First Nations and Inuit patients receive through the federal NIHB program.²⁷

Nunavut's Department of Health includes a Health Care Plan which subsidizes airfare to centres providing specialized psychiatric treatment.²⁸ This is available to all Indigenous residents of the territory.

Discussion

There are three main research findings and corresponding policy recommendations. First, non-Status Indians and Métis are significantly underrepresented in mental health coverage. Unlike Status Indians and Inuit, they do not receive federal Indigenous health benefits. Furthermore, only three jurisdictions (British Columbia, Alberta, and Nunavut) have mental health programs for non-Status Indians. Similarly, only three jurisdictions (Alberta, the Northwest Territories, and Nunavut) have mental health programs for Métis residents. This should be rectified by expanding FNIHB coverage.

Second, Indigenous individuals are eligible for different mental health benefits depending on their legal classification and province or territory, which furthers health disparities between Indigenous groups. This supports Lavoie's (2013) recommendation that there is a need for a federal First Nations, Métis, and Inuit health policy that ensures equitable health outcomes for all Indigenous peoples.²⁹

Third, almost all government-funded Indigenous mental health programs emphasize Western medicine, apart from some exceptions, such as the NNADAP. Indigenous knowledge and healing are not covered by most programs. This refusal to acknowledge Indigenous healing is a legacy of colonialism.⁵ In order to respect Indigenous communities' autonomy, traditional healing should be included in government health programs.

REFERENCES

1. Boksa P, Joober R, Kirmayer L. Mental wellness in Canada's Aboriginal communities: Striving toward reconciliation. *J Psychiatry Neurosci* [Internet]. 2015 Nov [cited 2019 Jan 20];40(6):363-365. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4622632/> DOI: 10.1503/jpn.150309



2. Wotherspoon T, Hansen J. The “Idle No More” movement: Paradoxes of First Nations inclusion in the Canadian context. *Social Inclusion* [Internet]. 2013 Jun [cited 2019 Jan 20];1(1):21. Available from: https://www.researchgate.net/publication/273513592_The_Idle_No_More_Movement_Paradoxes_of_First_Nations_Inclusion_in_the_Canadian_Context DOI: 10.17645/si.v1i1.107
3. Statistics Canada [Internet]. Ottawa ON: Statistics Canada; 2018 Mar. First Nations people, Métis and Inuit in Canada: Diverse and growing populations; 2018 Mar [cited 2019 Jan 20]; [full page]. Available from: <https://www150.statcan.gc.ca/n1/pub/89-659-x/89-659-x2018001-eng.htm>
4. O’Fallon B, Fehren-Schmitz L. Native Americans experienced a strong population bottleneck coincident with European contact. *Proc Natl Acad Sci USA* [Internet]. 2011 Dec [cited 2019 Jan 20];108(51):20444-20448. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3251087/> DOI: 10.1073/pnas.1112563108
5. Lavoie JG, Forget E, Browne A. Caught at the crossroads: First Nations, health care, and the legacy of the Indian Act. *Pimatisiwin* [Internet]. 2010 Jan [cited 2019 Jan 20];8(1):83-100. Available from: [Caught_at_the_Crossroad_First_Nations_Health_Care_and_the_Legacy_of_the_Indian_Act_1](https://www150.statcan.gc.ca/n1/pub/89-659-x/89-659-x2010001-eng.htm)
6. Bombay A, Matheson K, Anisman H. The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcult Psychiatry* [Internet]. 2014 Jun [cited 2019 Jan 20];51(3):320-338. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232330/> DOI: 10.1177/1363461513503380
7. Wilk P, Maltby A, Cooke M. Residential schools and the effects on Indigenous health and well-being in Canada: A scoping review. *Public Health Rev* [Internet]. 2017 Mar [cited 2019 Jan 20];2(38):8. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/29450080> DOI: 10.1186/s40985-017-0055-6
8. Statistics Canada [Internet]. Ottawa ON: Statistics Canada; 2017 Feb. Census Profile, 2016 Census; 2018 May [cited 2019 Jan 20]; [full page]. Available from: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E>
9. Health Canada [Internet]. Ottawa ON: Statistics Canada; 2014 Aug. A statistical profile on the health of First Nations in Canada; 2014 Aug [cited 2019 Jan 20]; [full document]. Available from: http://publications.gc.ca/collections/collection_2014/sc-hc/H34-193-1-2014-eng.pdf
10. Registered Nurses Association of Ontario [Internet]. Toronto ON: Sullivan, L; 2013. Synopsis of First Nations substance abuse issues; 2013 [cited 2019 Jan 20]; [first page]. Available from: <https://rnao.ca/sites/rnao-ca/files/RNAO-Synopsis-of-First-Nations-Substance-Abuse-Issues-2013-26-09.pdf>
11. Indigenous and Northern Affairs Canada [Internet]. Ottawa ON: INAC; 2011 Apr. No title; 2011 Apr [cited 2019 Jan 20]; [first page]. Available from: <http://www.aadnc-aandc.gc.ca/eng/1303147522487/130314766999>
12. Métis Nation [Internet]. Ottawa ON: Pape Salter Teillet LLP; 2016 Apr. Another chapter in the pursuit of reconciliation and redress; 2016 Apr [cited 2019 Jan 20]; [second page]. Available from: <http://www.metisnation.org/media/652855/pst-llp-summary-daniels-v-canada-scc-april-19-2016.pdf>
13. Government of Canada [Internet]. Ottawa ON: FNIHB; 2013 Nov. First Nations and Inuit Health Branch; 2013 Nov [cited 2019 Jan 20]; [full document]. Available from: <https://www.canada.ca/en/indigenous-services-canada/corporate/first-nations-inuit-health-branch.html>
14. Government of Canada [Internet]. Ottawa ON: Indigenous Services Canada; 2018 Sep. First Nations and Inuit Health; 2018 Sep [cited 2019 Jan 20]; [full document]. Available from: <https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health.html>
15. Health Canada [Internet]. Ottawa ON: Health Canada; 2012 Jun. National Native Alcohol and Drug Abuse Program Treatment Centre outcome study; 2012 Jun [cited 2019 Jan 20]; [second to fifth pages]. Available from: http://publications.gc.ca/collections/collection_2018/sc-hc/H34-319-2012-eng.pdf
16. Ministry of Health and Long Term Care [Internet]. Toronto ON: MOHLTC; 2017 Aug. Ministry plans; 2017 Aug [cited 2019 Jan 20]; [full document]. Available from: <http://www.health.gov.on.ca/en/common/ministry/publications/plans/ppar17/>
17. Government of Québec [Internet]. Québec QC: QHSS; 2018 Jun. Health and social services; 2018 Jun [cited 2019 Jan 20]; [full document]. Available from: http://www.gouv.qc.ca/EN/LeQuebec/Pages/Sante_services_sociaux.aspx
18. Manitoba Health, Seniors and Active Living [Internet]. Winnipeg MB: MHSAL; n.d. Mental health and addictions; n.d. [cited 2019 Jan 20]; [first page]. Available from: <https://www.gov.mb.ca/health/mh/index.html>
19. Saskatchewan Health Authority [Internet]. Regina SK: SHA; 2018 Mar. Health; 2018 Mar [cited 2019 Jan 20]; [full document]. Available from: <https://www.saskatchewan.ca/government/government-structure/ministries/health>
20. Nova Scotia Department of Health and Wellness [Internet]. Halifax NS: NSDHW; 2017 Oct. Mental health services; 2017 Oct [cited 2019 Jan 20]; [full



- document]. Available from:
<https://novascotia.ca/dhw/mental-health/>
21. New Brunswick Department of Health [Internet]. Fredericton NB: Department of health; n.d. Health; n.d [cited 2019 Jan 20]; [pages 1-3]. Available from
 22. <http://www2.gnb.ca/content/gnb/en/departments/health/services.html>
 23. Prince Edward Island Department of Health and Wellness [Internet]. Charlottetown PE: Department of Health and Wellness; 2018. Health and Wellness; 2018 [cited 2019 Jan 20]; [full document]. Available from:
<https://www.princeedwardisland.ca/en/topic/health-and-wellness>
 24. Department of Health and Community Services [Internet]. St. John's NL: HCS; 2018 Jul. Aboriginal health; 2018 Jul [cited 2019 Jan 20]; [first page]. Available from:
<https://www.health.gov.nl.ca/health/aboriginalhealth/index.html>
 25. Yukon Health and Social Services [Internet]. Whitehorse YT: YHSS; 2018 Mar. Mental wellness and substance use services; 2018 Mar [cited 2019 Jan 20]; [first page]. Available from:
<http://www.hss.gov.yk.ca/mwsu.php>
 26. First Nations Health Authority [Internet]. Victoria BC: Ministry of Health; n.d. About the FNHA; n.d. [cited 2019 Jan 20]; [first page]. Available from:
<http://www.fnha.ca/about/fnha-overview>
 27. Alberta Health Services [Internet]. Edmonton AB. AHS; 2019. Indigenous health; 2019 [cited 2019 Jan 20]; [first page]. Available from:
<https://www.albertahealthservices.ca/info/Page11949.aspx>
 28. Northwest Territories Department of Health and Social Services [Internet]. Yellowknife NT: DHSS; n.d. Métis Health Benefits Program; n.d. [cited 2019 Jan 20]; [full document]. Available from:
<https://www.hss.gov.nt.ca/en/services/supplement-ary-health-benefits/metis-health-benefits>
 29. Nunavut Department of Health [Internet]. Iqaluit NU: Department of Health; n.d. Non Insured Health Benefits; n.d. [cited 2018 Jan 20]; [full document]. Available from:
<https://gov.nu.ca/health/information/non-insured-health-benefits>
 30. Lavoie JG. Policy silences: Why Canada needs a National First Nations, Inuit, and Métis health policy. *Int J Circumpolar Health* [Internet]. 2013 Dec [cited 2019 Jan 20];72(1):22690. Available from:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875351/> DOI: 10.3402/ijch.v72i1.22690



Calling for a Gender-Sensitive Approach to Karoshi and Overwork Disorders in Japan

Opinion Editorial

Meaghan Doner, MSc. Global Health, University Glasgow

Karoshi, which translates to “death from overwork,” is a prevalent phenomenon in Japan and much of Asia (p.278).¹ In a culture that values dedication and hard work, karoshi is responsible for 10,000 deaths each year in Japan alone.^{2,3} While it was previously considered a social issue that predominantly plagued men, almost a third of compensated mental health karoshi claims in the last five years have been awarded to women.⁴ This article examines how gender intersects with various contributing factors of overwork in Japan, suggesting that the Ministry of Health, Labour and Welfare’s focus on long work hours as the sole determinant of karoshi compensation negates the gender-specific experiences of women. Fostering gender-sensitive karoshi research improves

awareness and understanding of the ways in which women suffer from this complex phenomenon. Women’s economic empowerment is vital to reaching gender equality targets in Japan, but only possible if we strive to understand the issues that contribute to workplace gender inequality.

In 2018, Japan ranked 110th out of 149 countries on the Global Gender Gap Index: while 68% of women in Japan participate in the workforce, women make up only 13% of senior officials and managers, 10% of parliament, and 16% of ministerial positions.⁵ Previous research has outlined ways in which traditional gender roles persist in the workplace, where double-track employment systems see female workers as a