Expanding and Building our Partnerships to Improve Access

Health Canada ~ Health Services Integration Fund (HSIF) Project

Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Québec

Final Research Report

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By:
Amy Chamberlin, M.A.

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Onkwata'karitáhtshera

and

Coalition of English-speaking First Nations Communities in Québec

(CESFNCQ)

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Cover design: Doug Lahache, KSCS Communications

Layout: Marie David, KSCS Communications

HSIF Steering Committee Members

Back Row (left to right): Jimmy Peter Einish, Joyce Bonspiel-Nelson, David McLaren
Missing: Monique Raymond

Front Row (left to right): Robin Decontie, Donna Metallic, Rheena Diabo, Eleanor Pollock

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1. INTRODUCTION

1.1 Foreword

The project "Expanding and Building our Partnerships to Improve Access" is a three-year project that started in 2012 with funding from Health Canada's Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera; an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montréal).

The goal of the project was to establish a coalition among English-speaking First Nations Communities in Québec (CESFNCQ) in order to expose and improve access to health and social services in federal and provincial systems. The Coalition is comprised of four nations – Naskapi, Mi'gmaq, Mohawk, and Algonquin, from eight First Nations communities: Kawawachikamach, Gesgapegiag, Listuguj, Kanesatake, Kahnawake Eagle Village First Nation / Kipawa, Kitigan Zibi, and Timiskaming. The communities are located in different geographical areas (remote, rural and urban).

In April of 2012, the English-speaking First Nations communities began working together to address access issues. The Coalition, made up of directors and key individuals from First Nations health and social services organizations, identified that there is a lack of existing health, social and related services accessible for First Nations in the English language: as such, English-speaking First Nations do not have the same level of access to services as that of the mainstream Québec population.

In Québec, English-speaking First Nations communities face many challenges when attempting to access services from the federal and provincial systems. There are obstacles because of language, and for First Nations there are access issues resulting from historical and social injustices. Generally speaking, underlying issues such as poverty, coupled with the intergenerational effects of colonization and residential schools, continues to affect the health and wellness of Aboriginal peoples.[1] Furthermore, numerous studies and reports have raised concerns about the health concerns facing Aboriginal People. For example, John O'Neil et al. assert that: "Aboriginal Peoples bear a disproportionate burden of illness in Canada"; the authors argue that community well-being is fundamentally linked with 'self-governance' in terms of both the administration of services and the health and well-being of Aboriginal population.[2] As such, access to, and making decisions about, health and social services is critical in order to begin addressing the many pressing health and social concerns prevalent in First Nations communities.

In working towards solutions to mitigate the 'disproportionate burden of illness' carried by Aboriginal Peoples, the Coalition of English-speaking First Nations of Québec oversaw a one-year research project. The overarching objectives of the project were to:

i) Create a portrait of the specific issues and challenges facing First Nations when accessing health and social services in English; and

ii) Identify strategies that English-speaking First Nations communities have in place, or would recommend, on how to improve access to those services.

While each First Nation community has its own distinct needs, the Coalition enables First Nations to work together, and to come before the government with one strong voice.[3] The research is part of an ongoing effort to improve English-speaking First Nations access to health and social services from provincial and federal systems. Participants' comments are included throughout the report to capture their perspectives—challenges, positive experiences, and proposed solutions —with respect to accessing health and social services.

1.2 Mandate and purpose of the research

The mandate for the research was to document a portrait of the situation for English-speaking First Nations people when accessing health and social services in English from federal and provincial systems. The Coalition oversaw the direction of the research, and Organizational

1 *Health Council of Canada. Empathy, dignity and respect: Creating cultural safety for Aboriginal people in urban health care*. Toronto: Health Council of Canada, 2012: 4. PDF file.

2 O'Neil, John, et al. "*Community Healing and Aboriginal Self-Government." Aboriginal Self-Government in Canada*. 2nd ed. Ed. John Hylton. Saskatoon: Purich, 1999: 139–142. Print.

3 Coalition of English-speaking First Nations Communities in Québec (CESFNCQ). "HSIF Project Launch." Québec City, 28 Jan. 2013. Research Meeting.

Development Services (ODS) provided management support for the project.[4]

The purpose of the research was to expose and identify:

- Access issues and challenges facing English-speaking First Nations
- Strategies and solutions to mitigate access issues and challenges

1.3 Health Canada: mitigating gaps in health

In recent years, Health Canada has taken steps to mitigate access issues for First Nations. For example, in 2004, Health Canada launched the Aboriginal Health Transition Fund (AHTF), which supported projects that addressed "the gap in health status between Aboriginal and non-Aboriginal Canadians by improving access to existing health services."[5] In the province of Québec, Aboriginal communities engaged in AHTF projects, helping to raise awareness and understanding about the barriers and constraints that Aboriginal Peoples face when accessing health and social services.[6]

Then, in 2010, Health Canada announced another similar initiative: the Health Services Integration Fund (HSIF). This initiative also addresses the challenges that Aboriginal Peoples face when accessing health care services. Specifically, the HSIF is a multi-year initiative geared to support collaborative planning involving multi communities and projects in order to meet the health care needs of First Nations, Inuit and Métis.[7] This research initiative was funded under the HSIF initiative; the research builds upon previous work and projects addressing access issues and gaps, including, but not limited to, the AHTF projects.

1.4 Scope and limitations

In November of 2012, the Coalition engaged a research consultant to design and to conduct the research. The intent of the research was to seek out the perspectives of English-speaking First Nations community resources (key informants working in First Nations Health and Social Services community organizations) and First Nations community members (i.e. Elders (or their caretakers), parents with young children, and individuals with chronic health conditions).

This research also included the perspectives of key informants who had been involved in previous Aboriginal Health Transition Fund (AHTF) projects to uncover best practices that could foster lasting and sustainable strategies to improve access.[8] The communities of Eagle Village, Listuguj, Gesgapegiag, Kanesatake and Kahnawake conducted AHTF projects to address various barriers when accessing services.[9] (Appendix A: AHTF Projects of Coalition Communities).

Following the review of the draft research report, the Coalition requested that 'additional preliminary research' on a specific access issue facing English-speaking First Nations.

Focus groups, interviews, and questionnaires were conducted to seek out the perspectives of First Nations, and to document a portrait of the situation. Participants were asked about their experiences when accessing health and social services from the provincial and federal systems. The research questions focused on the following areas: general access issues, issues related to language and culture, as well as positive experiences when accessing services. Furthermore, participants were asked about solutions they have in place, or would recommend, towards improving access.

The answers to the questions varied; nevertheless, the research demonstrates that English-speaking First Nations—in remote, rural and urban areas—face obstacles because of language when attempting to access health and social services.

Some of the limitations of this research:

- Time Constraints – Availability of the project partners to contribute to the various aspects of the research;
- Accessing Information – Working through the various protocols (written and unwritten) about how best to conduct research with and for First Nations

4 Organizational Development Services (ODS) is a First Nation consulting/training business within Kahnawake Shakotiia'takehnhas Community Services (KSCS).

5 Canada. Health Canada. First Nations and Inuit Health Branch. "*Improving Access to Health Services - First Nations and Inuit Health Canada*." Health Canada. 2 Oct. 2013. Web. Oct. 2013.

6 First Nations of Québec and Labrador Health and Social Services Commission. *Compendium of Projects: Aboriginal Health Transition Fund*. FNQLHSSC, 2011: 9. Print.

7 Canada. Health Canada. First Nations and Inuit Health Branch. "*Health Services Integration Fund*." Health Canada. 4 Feb. 2013. Web. Feb. 2013.

8 The AHTF projects (2004 -2010) addressed barriers when accessing services (for example, English language servi.e. cultural appropriateness, and jurisdictional issues), and also identified strategies to improve access (i.e. fostering formal and informal linkages between Aboriginal health care service providers and provincial service providers) Compendium of Projects.

9 Interviews were conducted with key informants engaged in projects in Gesgapegiag, Listuguj, Kahnawake, and Kanesatake. It was not possible to access data related to Eagle Village's AHTF project.

communities. Most of the research conducted 'at a distance' (video or teleconferencing), thus, the researcher worked closely with communities to ensure that data collection was consistent; and,

- Data Collection – Ensuring that data (perspectives) was gathered equally (breadth and depth) from each of the participating communities.

1.5 Data collection

- All data was collected by the researcher, or by research liaison assistants, from the eight participating communities over a five-month period from March 12–July 24, 2013.

- Additional Research was conducted from Oct. 4–Oct. 11, 2013. This research was preliminary only, and was conducted in a short time frame. It is likely that more communities would have participated given more time to conduct the research.

- In all, a total of 130 participants took part (the majority of participants were First Nations, and a small number of non-Native individuals who either work(ed) or live in the First Nations' communities took part in the research.)

    - *Focus groups*: A total of 14 focus groups (semi-structured) were conducted (ten with community resources and four with community members.)

    - *Interviews:* A total of 19 individual interviews (semi-structured) were conducted (six with key informants involved with Aboriginal Health Transition Fund (AHTF) projects; nine key informants (health and social services), and four with First Nation community members.)

    - Follow up research (questionnaires): Three (3) key informants completed 'Follow Up Questionnaires' as part of this research.

Research findings

Generally, First Nations spoke about long wait times at hospitals, difficulties travelling because of poor road conditions or lack of public transportation. Some participants described access issues resulting from jurisdictional issues—corridors of services, provincial boundaries, and a lack of clarity between federal and provincial authorities. As articulated by a First Nations community member: "People are bounced back and forth between the hospitals…[The boundary] divides the population and influences when they are willing to go to the hospital." Participants expressed their frustration when attempting to access English-language service, while others spoke about challenges because of a lack of understanding and awareness about their culture, history and health needs as First Nations. There were also positive stories about "compassionate" and "culturally sensitive" nurses, doctors, and social workers—those who went above and beyond to make certain that individuals received the services that they needed.

Participants described the strategies they use to overcome obstacles when accessing services. For example, some organizations have worked in partnership with provincial institutions and have successfully drafted agreements and protocols for the delivery of English-language services. While other First Nations stated that: "[we] rely on bilingual colleagues" to translate documents or place phone calls to mitigate language issues.

Finally, throughout the research process there were questions raised. For instance: How does the provincial health system work? Can First Nations access services from the network? Are individuals able to choose where they access services? What are the responsibilities of the federal and provincial government when delivering health care to First Nations? And, can we request health and social services in English?

2. METHODOLOGY

2.1 Goal and objectives

The goal of the research was to seek out the perspectives of English-speaking First Nations people when accessing health services and social services from the federal and provincial systems in English.

The research objectives:

- *Expose challenges* – Identify the specific issues and challenges that the First Nations communities face when accessing health services and social services in English from federal and provincial systems.

- *Explore strategies* – Share and explore strategies (best practices) utilized by First Nations to address the challenges of accessing English-language health services and social services from the province. Explore how these (and other) strategies may work in First Nation communities when accessing health and social services. Finally, determine how these strategies can be sustained in the long term.

2.2 Research approach

This project used an action-research approach to document the perspectives of English-speaking First Nations. Action research (or participatory research) is a way of conducting research that allows participants to be directly involved in the research process—determining questions, gathering data, reflection, and deciding on a course of action.[10]

The researcher worked with the members of the Coalition to identify questions, and decide on the best ways to gather information from the communities. Community support was critical to the research, and key individuals from each community assisted in bringing people together to participate in the focus groups and interviews.

2.3 Activities

The activities involved in the research project included:

- Review the Access Project proposal prepared by the HSIF Coalition.

- Scan reports and relevant materials regarding accessing health services and social services for English-speaking population of Québec.

- Scan reports from Aboriginal Health Transition Projects (AHTF) undertaken by the First Nations partners.

- Attend project meetings as required.

- Develop and test research tools (i.e. consent forms and research questions).

- Work with First Nations communities to set up a list of potential participants from the participating First Nations communities (community resource people and community members).

- Conduct focus groups and interviews.

- Transcribe focus group and interviews.

- Analyze information received.

- Draft research report.

- Review draft research report, and conduct any additional research.

- Submit final research report.

10 Chilisa, Bagele. *Indigenous Research Methodologies*. California: Sage, 2012: 226–227. Print.

2.4 Methods

The research methods were as follows:

Research Design – Develop an appropriate research methodology; develop research questions/tools; test research tools to ensure that methods are relevant and appropriate for the First Nations communities.

Literature Scan – Gather documents and reports related to accessing English-language health services and social services from provincial institutions; review Aboriginal Health Transition Fund (AHTF) reports from the participating communities.

Data Collection – Work with Coalition and Project Managers to prepare a schedule for the data collection. Work with local HSIF Research Liaisons to gather information from First Nations communities (focus groups and interviews).

Analysis – Compile, organize, transcribe, and review the data collected through the focus groups and interview processes.

Share findings – finalize research report.

3. BACKGROUND

3.1 Aboriginal health legislation and policy environment

In Canada, health and social services for Aboriginal Peoples fall under the responsibility of both federal and provincial governments. Over the years, what has emerged for Aboriginal Peoples is described in The Aboriginal Health Legislation and Policy Framework in Canada as a 'complex patchwork of policies, legislation and relationships' among the federal, provincial and Aboriginal governments. Generally speaking, the lack of clarity over jurisdictional responsibilities has negatively impacted Aboriginal Peoples access to "appropriate and responsive" health care.[11] Also, when federal and provincial governments have met and negotiated without First Nations at the table, the resulting decisions did not favorably impact First Nation communities. Throughout this research, in various ways, members of the English-speaking First Nations Communities in Québec (CESFNCQ) asserted that: there is a lack of understanding about their capacity and competency; there are assumptions about First Nations' abilities to manage; and as a result some English-speaking First Nations fear the upcoming 2014 negotiations between the federal and provincial governments.[12]

To understand the present situation, the lack of clarity over jurisdictional responsibilities as well as the 'fear of negotiations', there is a need to critically examine how the policies and legislation have evolved over the years. In 1979, the federal government brought forward the Three Pillars / Indian Health Policy. According to Health Canada, this policy stems from the unique relationship between Aboriginal Peoples and the federal government. In their analysis, O'Neil et al., reiterate the three pillars for health identified within this policy in this way: (**1**) restore Aboriginal health through community development, (**2**) reaffirm the traditional relationship of Aboriginal peoples with the federal government, and (**3**) strengthen the relationships among the components of the health care system (including provincial and private medical services). This health policy for Aboriginal Peoples required a shift; that is, the Three Pillars policy provided a foundation upon which First Nations and Inuit could deliver their own community health services.[13] (Although some communities had already assumed control over health and social services, as well as community health nursing.)

From the early 1980s, Aboriginal communities have gained more control over health and social services in their communities through the devolution of programs from the federal government. Over the last few decades, First Nations communities have taken over the delivery of programs and services such as: National Native Alcohol and Drug Abuse Program (NNADAP) and the Community Health Representative Programs (CHRs). As well, the federal government established the Non-Insured Health Benefits Program (NIHB) to provide funding for some health services that were not covered by either provincial or third party resources.[14]

The various community-control initiatives have promoted the self-government of health services for Aboriginal people.[15] For example, the Kateri Memorial Hospital Centre (KMHC) in Kahnawake, established in 1955, today provides curative and preventative services as a result of a "nation-to-nation" arrangement between Kahnawake and the Government of Québec.[16] Today, many communities are actively engaged in identifying health and social needs of their communities and developing their plans accordingly.[17]

While it is true that communities are administering and delivering more services through federal transfers and agreements; nevertheless, there remain questions, and frustration, about whether or not the programs "are truly responsive to Aboriginal community needs".[18] The criticism to gaining administrative control is that Aboriginal communities are not fully in control of the planning, implementing and evaluation of health and social services intended for their communities.

11 National Collaborating Centre for Aboriginal Health (NCCAH). *The Aboriginal Health Legislation and Policy Framework in Canada*. British Columbia: U Northern British Columbia, 2011: 1–3. PDF file. [*Synopsis of Looking for Aboriginal Health in Legislation and Policies: 1970 to 2008*, by Josee Lavoie et. al.]

12 CESFNCQ. Steering Committee Meeting. September 2013. Review of Research Report.

13 O'Neil, John, et al.: 137.

14 Ibid: 139–142.

15 Ibid: 139.

16 Hospital services have existed in Kahnawake since the early 1900s. In 1955, the Mohawk Council of Kahnawake took over the hospital services. In 1970, the Kateri Memorial Hospital Centre ("the clinic") opened its doors. In 1973, the Ministère des Affaires Sociales du Québec designated the community clinic as a "hospital centre". Since that time the Kateri has received funding "on the same basis as other hospitals in the Province of Québec". (Macaulay, Ann C. "*The History of Successful Community Operated Health Services in Kahnawake, Québec*." Canadian Family Physician 34 (1988). PDF file.)

17 CESFNCQ. Steering Committee Meeting. Montréal, May 29, 2013. Preliminary Research Presentation.

18 O'Neil, et al.: 140.

Despite the changes to legislation, and subsequent transfer agreements, the access issues remain. To this point, the First Nations Regional Health Survey (2008/10), reveals that just under 40% (38.6%) of First Nations adults felt that they had less access to health services than that of the general Canadian population.[19] For English-speaking First Nations people in Québec the obstacle of language magnifies access issues.

Kitigan Zibi, Algonquin | Anishinabeg

There is a lack of access to specialized services in English. Speech therapy for children is another place the language barrier creates obstacles…I think if you're accessing any provincial service, I don't know too many that are in English. For those who are disabled trying to access services, there's nobody in English.

Finally, as stated within *The Aboriginal Health Legislation and Policy Framework in Canada* there is a growing awareness that Aboriginal communities are "better positioned to identify their own health priorities and to manage delivery in their own communities."[20] With this in mind, to improve access to health and social services—and to adequately address the 'complex patchwork of policies, legislation and relationships' that has emerged—Aboriginal communities and organizations need to have an active role in responding to, developing, and shaping policies and relationships with the federal and provincial governments. As the Coalition put it, Aboriginal communities and organizations want the opportunity to meaningfully respond, through a clear consultation process, to policies, which may impact their access to health and social services from federal and provincial institutions.[21]

3.2 Government responsibilities

First Nations may access health services and social services from both the federal and provincial governments. Yet, depending on whether or not the First Nation community has entered into agreements with the province of Québec, there are different conditions for the delivery and funding of health and social services. The following section summarizes information from the *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit)— Frame of Reference*. This reference document was put forward by the Ministère de la Santé et des Services sociaux (MSSS) for communities that are 'not under agreement', as well as those 'under agreement'.[22]

- The Coalition communities that are 'not under agreement' include: Gesgapegiag, Listuguj, Kahnawake, Kanesatake, Kitigan Zibi, Eagle Village/Kipawa, and Timiskaming.

- The Coalition community that is 'under agreement' includes: The Naskapi Nation of Kawawachikamach (Northeastern Québec Agreement signed in 1978).

a. Health and social services provided in communities 'not under agreement'

- Program development and the organization of health services and social services are the responsibility of Aboriginal authorities or federal government, depending on whether or not the community has taken charge of service delivery.[23]

- Funding of health services and social services provided in the communities is the responsibility of the federal government, except for the medical care covered by the Régie de l'assurance maladie du Québec. (Note: The Kateri Memorial Hospital of Kahnawake is funded by Québec).

- Community Health and Environmental Health Services.

- Generally, the health services provided in Aboriginal communities focus on "*promoting health and preventing disease*" (front-line services).

- Addictions and mental health.

19 First Nations Information Governance Centre. First Nations Regional Health Survey (RHS) *Phase 2 (2008/10) National Report on Adults, Youth and Children Living in First Nations Communities*. Ottawa: First Nations Governance Centre, 2012: 69. PDF file.

20 *The Aboriginal Health Legislation and Policy Framework in Canada* : 5.

21 CESFNCQ. Steering Committee Meeting. Montréal, May 29, 2013. Preliminary Research Presentation.

22 Québec. Ministère de la Santé et des Services sociaux (MSSS). *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit) – Frame of Reference*. Quebec, 2007. PDF file.

23 With respect to the Coalition communities, the following have not yet taken charge of health service delivery: Kanesatake, Eagle Village/Kipawa, and Temiscaming. With respect to social servi.e. Kanesatake and Temiscaming have not taken charge of the delivery (*Delivery and Funding of Health Services and Social Services for Aboriginal People: 9–10.*)

- Health Canada funds a program of non-insured health services.[24]

- Health Canada funds six alcohol and drug treatment centres for Aboriginal people, five of which are for adults, while one is for youth.[25]

- Social Services – A series of programs are funded by Indian Affairs and Northern Affairs Canada. Services are provided in the following areas: child, family and adult services, child and adult placement, home assistance, family violence prevention and the integration of people with disabilities.

- Indian Affairs funds a certain number of safe homes for women and children who are victims of family violence, residential centres for people with decreasing independence who require less than two and half hours of care per day, group homes for people in difficulty, and foster care.

- The facilities that provide health and social services in Aboriginal communities 'not under agreement' are not regarded as institutions of the Québec network.

b. Health and social services provided in the communities 'under agreement':

- Québec assumes responsibility for the funding of the health and social services provided in the Aboriginal communities under Agreement with the province (Cree, Inuit and Naskapi).

- Québec is responsible for funding non-insured health services for communities under agreement.

- The Naskapi community of Kawawachikamach has its own CLSC, which is under the authority of the Côte-Nord (Region 09) health and social services agency.

3.3 Québec's Network

In Québec, health services and social services fall under one administrative authority, the Ministère de la Santé et des Services sociaux (MSSS), which is regulated by An Act Respecting Health Services and Social Services (Chapter S-4.2). Generally, according to the MSSS, its objective is to: "maintain, improve and restore the health and well-being of the population by making a set of health services and social services accessible…"[26]

In early 2000, the Government of Québec set about changing its delivery of health and social services for its population. At that time, the government established a commission with a mandate to hold public consultations to discuss issues facing the health and social services system and to propose solutions for the future.[27] Although these consultations were held across Québec, there are questions as to the extent that English-speaking Quebecers engaged in discussions. For instance, in "What Future for English-language health and social services in Quebec?" James Carter argues that from 1994–2003, two major events changed the "political and administrative" context for the implementation of right to services **i**) "Radical transformation of the health and social services system; and **ii**.) Government sanctioning of the introduction of language politics into the delivery of services in English."[28] Both the transformation of the health services (i.e. networks) and the 'sanctioning of language politics' affected access to service for English-language speakers, including First Nations people seeking services in the English language.

In their discussions about the restructuring of the health and social services network, members of the Coalition spoke about the Government of Québec's lack of consultation with First Nations during the restructuring of the health and social services system—and more specifically, the detrimental impact that the restructuring had on community members' ability to access to services in English.[29]

24 The NIHB program provides services such as: prescription drugs, vision care, dental care, medical supplies and equipment, medical transportation, and crisis intervention. (Canada and First Nations. Health Canada and Assembly of First Nations' (AFN). *Your Health Benefits: A Guide for First Nations to Access Non-Insured Health Benefits*. Ottawa, 2011. PDF file.). Therefore, because First Nations people and Inuit are covered under the NIHB, they are "not covered by Québec's basic prescription drug insurance plan under the Regulation respecting the basic prescription insurance plan (c.A-29.01,r.2)". (*Delivery and Funding of Health Services and Social Services for Aboriginal People:* 11).

25 There are six alcohol and drug treatment centres, four of which are located in Coalition communities: the Wanaki Center in Kitigan Zibi; the Mawiomi Treatment Services in Gesgapegiag; the Onen'To:Kon Treatment Services in Kanesatake; and the Walgwan Centre in Gesgapegiag (for youth). The other two centres are located in La Tuque and Sept-Îles, respectively (*Delivery and Funding of Health Services and Social Services for Aboriginal People*: 8).

26 Québec. MSSS. *The Québec Health and Social Services System – in brief.* Quebec, 2008: 3. PDF file.

27 Québec. MSSS. *Report and Recommendations: Emerging Solution*. Quebec, 2001. Commission of study on health and social services. PDF file.

28 Carter, James. "*What Future for English-language health and social services in Quebec?*" [Community Health and Social Services Network (CHSSN)] *The Vitality of English-speaking Communities of Quebec: From Decline to Revival*. Ed. R.Y. Bourhis. Montréal: CEETUM, U de Montréal, 2008: 4. PDF file.

29 CESFNCQ. Steering Committee Meeting. Research Meetings. Nov. 2012–Sept. 2013.

By 2004, the Government of Québec had reformed its health care system by introducing local service networks. According to the MSSS, the corridors of service were intended to ensure that all members of the population would be able to easily access services. In setting up the networks, the goal of the Ministry was to make certain that those who are most vulnerable: "people suffering from mental illnesses, health problems or chronic illness, those nearing the end of life, frail seniors and troubled youth" would be able to easily access services.[30] Furthermore, according to the Québec Ministry, the system is intended to "welcome the user", determine the individual's needs and "guide him toward an effective service."[31] In his analysis of the network system, Carter asserts that each of the local services networks has assigned designated corridors—"in order to facilitate access of the population of each of the territories to ultra-specialized services."[32] In sum, the corridors were intended to make certain that all members of the population could easily access both general and specialized health services and social services.

Generally speaking, however, the corridors have impacted English-speakers' access to English-language services in part because individuals' 'freedom to choose' the institution for services is restricted. The restructuring changed the manner by which organizations deliver their services, and consequently how individuals access services was impacted. As stated by Carter, "institutions within a network must concentrate on meeting the needs of the populations within their assigned zones (population responsibilities)."[33]

For the English-speaking population, and in particular for English-speaking First Nations, the new 'corridors of service' are presenting challenges when seeking out services (specialized and general) in English. This research exposed some of the challenges for English-speaking users when navigating the system if the services they need fall outside of their designated zone or corridor of service. "We are being refused and redirected to a corridor that does not have or offer the service in English," stated one participant.

Kanesatake Mohawk|Kanien'keha':ka,

Now they say that if you are not from that region you cannot access those services. I have had children caught waiting months [to receive services at a hospital in a different region] only to hear, 'No, we will not give you English services here…Sometimes having to go through a committee first…I have seen delays of a year-and-a-half to two-years trying to get speech language pathology assessments done. Really challenging.

As well, the needs of the population are supposed to be considered in the planning and delivery of programs and services. The Québec Ministry, as stated by Carter, "encourages the participation of English-speaking communities at the institutional level to ensure that their needs are taken into account in the planning and delivery of services."[34] However, there are challenges for English-speaking First Nations communities to participate in the planning not only because of language obstacles, but also because there is a lack of awareness of First Nations communities by mainstream society. In sum, although all members are supposed to navigate the system from general to specialized services; the ease by they are able to navigate is questionable.

For English-speaking First Nations, navigating the system would require involvement at all levels of management—at the local, regional and central level; and in all areas—policy direction, coordination and organization of services.

30 Québec. MSSS. "*Local Services Networks and Health and Social Services Centres*." Santé et des Services sociaux, Québec. 2013. Web. Feb. 2013.

31 Québec. MSSS. "*Local Services Networks and Health and Social Services Centres*." Santé et des Services sociaux, Québec 2013. Web. Feb. 2013.

32 Carter. 97.

33 Carter. 98.

34 Ibid: 99.

Table 1. List of the governance structure of the health and social network

Governance Management Level	Function
Central	Ministère de la Sante et des Services sociaux (MSSS) establishes policy direction (health and social services) and assesses the services of the network (planning, funding, allocating financial resources, follow up and evaluation).[35] * Fourteen organizations (Advisory Boards) report to the Minister of Health and Social Services (Note: *Among these organizations is the Provincial Committee on the provision of health services and social services in English.*)
Regional	Health and social services agencies *coordinate and organize the services* in their respective territories. *There are a total of 18 regional administrative authorities.
Local	Local health and social services *networks deliver services* to the population of a territory. *Corridors of Service: There are ninety-five (95) local service networks, known as health and social service centres (CSSS).[36]

3.4 Access Programs

In Québec, there are programs in place to make certain that the English-speaking population can access services in English. Notably, in 1999, the Québec Government adopted English-language service plans (these Access Programs are described in section 3.6).[37] Although the Access programs were in place, there continued to be issues and challenges for the English-speaking population to access health and social services. In 2005, the Community Health and Social Services Network (CHSSN) commissioned a polling firm to survey English-speaking persons across Québec on a range of issues related to community vitality.[38]

A few years later, in 2008, the Government of Canada launched the Road Map for Canada's Linguistic Duality. Through the Road Map, Health Canada funded initiatives to improve access to health and social services in English.[39] At that time, the CHSSN was requested by Health Canada to produce a report outlining the health and social services' priorities for English-speaking communities for the years 2013–2018. Subsequently, the Québec Community Groups Network (QCGN) was commissioned to conduct research. Their research report, The Health and Social Service Priorities of Québec's English-speaking Population 2013–2018, draws on the findings from the 2005 survey, and also from the researchers' consultations with English-speaking communities across Québec.[40] Some First Nations communities were included in the consultation process, and in fact the report confirms that:

> *First Nations communities and their members experience many of the same obstacles to access as do other English-speaking citizens, but some obstacles are experienced more intensely as a result of language and cultural differences, socio-economic disadvantages, and racism.*[41]

As indicated in the passage above, First Nations and Québec citizens face similar obstacles when accessing services because of language; however, as affirmed by Québec Community Groups Network, First Nations' experiences of obstacles resulting from language are "more intense" because of "cultural differences, socio-economic disadvantages, and racism."

Although the QCGN's consultations intentionally sought to include English-speaking First Nations' perspectives, nevertheless, the findings do not fully capture the issues and challenges facing First Nations. For instance, the demographics in the report refer to English-speaking Quebecers as a whole, and do not specifically refer to the First Nations population. Consequently, it would be difficult to draw out Québec's 'population responsibilities' for English-speaking First Nations without an understanding of their specific demographics and community profiles.

In addition, the questions used in the consultations focused on the programs and services delivered by the MSSS: First Nations participants would have had limited opportunity to fully voice the access challenges and issues they face outside of those

35 Information in this table from: Québec. MSSS. "*Local Services Networks and Health and Social Services Centres*." Santé et des Services sociaux, Québec 2013. Web. Feb. 2013

36 The CSSSs were established in 2004 by merging local community centres (CLSCS), residential and long-term care centres (CHSLDs), and generalized and specialized centres (CHSGSs). (Ibid.)

37 Carter: 94.

38 Ibid: 94.

39 *Community Health And Social Services Network*. 2012. CHSSN. Web. Feb. 2013

40 Quebec Community Groups Network. *The Health and Social Service Priorities of Quebec's English-speaking Population 2013–2018 – A Document Based on a consultation of member's of Quebec's English-speaking population*. [Quebec], May 2012. PDF file.

41 *The Health and Social Service Priorities of Quebec's English-speaking Population 2013–2018*: 52

jurisdictional areas. Given that First Nations fall under the authority of both federal and provincial governments, therefore when it comes to determining priorities for health services and social services, any consultation process would need to take into account issues and challenges that First Nations faces when accessing services from both federal and provincial systems.

3.5 Québec's Health Services and Social Services Act

Listuguj, Mi'gmaq

When my son went in for surgery on his lungs, everybody spoke French, when he went for his operation no one came and talked to me in English. I was sitting there, getting angry and nervous. Finally, a nurse came over and explained everything to me in English. She stayed with me, and I said 'My God, I love you!'

In Québec, the health and social services system is regulated by An Act Respecting Health Services and Social Services (Chapter S-4.2).[42] The Act provides guidelines for the delivery of health services and social services, recognizing the right of English-speaking persons to receive health and social services in the English language. (Appendix B: Excerpts – Health and Social Services Act.) In addition, the Act stipulates the need to consider the distinct characteristics of the population it is intending to service. Throughout the research, participants (both community members and community resources workers) raised the issue and asked questions about their cultural and linguistic rights when accessing health and social services from the province.

The following section summarizes information from the *Frame of reference for the implementation of programs of access to health and social services in the English language for the English-speaking population*, a reference document produced by the Ministère de la Santé et des Services sociaux (MSSS).[43] The *Frame of reference* specifies information about language legislation and Access programs for English-speaking persons in Québec.

Right to Access Health and Social Services in English in Québec

- English-speaking persons in Québec have a right to receive health and social services in English at **designated institutions.**
    - In Québec, there are a total of 42 institutions (of approximately 200 public institutions in Québec), which are designated to make health services and social services accessible in the English language. (*As per Article 29.1 of the Charter of the French Language and under Québec's Health and Social Services Act (Article 508.)*
    - The majority (29 of 42) of the designated institutions are located in the administrative region of Montréal (06).
- English-speaking persons may access programs and services in English, which are listed in a region's Access Program (**Indicated Services**) (*Québec's Health and Social Services Act, Article 15*).
- Agencies are responsible to develop an **Access Program** outlining the services and programs that are available in English at various institutions.
    - These programs are to be revised every three years. The Access Programs are intended to reflect the diverse needs and characteristics of the population for whom the program is intended.
    - The Access Programs are developed by the agencies, in collaboration with institutions and English-speaking representatives of their respective regions.
    - Once developed, the Access Program is tabled with the Minister of Health and Social Services and approved by the Government (*Québec's Health and Social Services Act, Article 348*).
- At the **regional level**, there is a committee responsible for the regional access programs. The agencies must seek the opinions of the regional committee

42 *An Act Respecting Health Services and Social Services (chapter S-4.2). Éditeur officiel du Québec 2013* Québec. Web. Feb. 2013 The language legislation that forms the backdrop to the delivery of programs and services in English includes: the federal government's Official Languages Act (passed in 1969), which "recognizes French and English as the official languages of Canada" (bilingualism); and Québec's language policy, Official Language Act, S.Q. 1974 (known as Bill 22) and the Charter of the French Language, 1977 (known as Bill 101). For a legal and political legislative context of the legislative guarantees for English language health services, see: Silver, Richard. "*The Right to English Health and Social Services in Québec: A Legal and Political Analysis*." McGill L.J. 45 (2000): 681–755. PDF file.

43 Québec. MSSS.. Quebec, 2006. PDF file; Québec. MSSS. "*Access Programs for services in the English language*." Santé et des Services sociaux, Québec. 11 Oct. 2013. Web. 11 Oct. 2013.

when developing their access program (Québec's Health and Social Services Act, Article 510).

- At the **central level** (provincial) the *Comité provincial pour la prestation des services de santé et des services sociaux en langue anglaise* advises the Government with respect to the approval of the access programs of each region. (Québec's Health and Social Services Act, Article 509).

3.6 First Nations Rights

As well, participants asked about their rights, as Aboriginal People, to access health and social services from provincial institutions. The following information is from the MSSS' *Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit)—Frame of Reference*;

- Aboriginal people are covered by the Health Insurance Act (c. A–29) and the Hospital Insurance Act (c.A–28);

- Aboriginal people, "regardless of where they live in Québec, are entitled to equal access to the health services and social services of the Québec network, like all Quebecers.

    - Although entitled to 'equal access' like 'all Quebecers', there are access issues resulting from language for English-speaking clientele.

    - First Nations' members may access health services and social services that are available in their own communities.

- Thus, First Nations may access services from either First Nations' health and social services organizations or from provincial institutions of Québec's network (*such as CLSCs (local community service centres), hospitals, etc*).

Kawawachikamach, | Naskapi

People need to be informed about what are their rights. Here [in the North] they think it's a privilege, not a right, to have health care. [We need] to be more informed. It's also a communication thing [First Nations] don't have enough information forwarded to them.

4. COMMUNITY PROFILES

At many of the focus group sessions, participants spoke about the importance of respect: Respect for 'who we are as First Nations'; as well as respect and awareness about First Nations' history, culture and languages.

4.1 First Nations communities in Québec

- In the province of Québec, there are eleven Aboriginal nations (including First Nations and Inuit); there is a total of forty-one First Nations communities in the province, and fifteen Inuit communities.[44]

- The total Aboriginal population (First Nations and Inuit) in the province of Québec is 98,731 (with 69,900 residents and 26,667 non-residents).

- Approximately 64.5 % of the total Aboriginal population (and an estimated (71% of the community/ resident population) either speaks English, or English is the first official language spoken after their own Traditional language.[45]

First Nations who took part in this research spoke about the need for more awareness and understanding of the distinct and diverse histories, culture, languages and demographics of their respective Nations developing policies for health services and social services.

4.2 Coalition communities

The English-speaking Coalition of First Nations' Communities of Québec is comprised of four nations: Naskapi, Mi'gmaq, Mohawk and Algonquin; from eight First Nations communities: Kawawachikamach Naskapi Nation, Gesgapegiag, Listuguj, Kanesatake, Kahnawake, Eagle Village First Nation / Kipawa, Kitigan Zibi, and Timiscaming. The communities are located throughout the province of Québec in urban, rural and remote geographic areas. The First Nations that currently comprise the Coalition are situated within six of Québec's eighteen public health regions, including: Outaouais, Abitibi-Témiscamingue, Côte-Nord, Gaspésie-Îles-de-la-Madeleine, Laurentides, Montérégie.

a.) Languages

For the majority of the Coalition communities, English has either become the predominant language spoken, or it is the main language in which business is conducted. (For instance, in Kawawachikamach, the majority of community members speak their traditional language of Naskapi; for some this is their only language, while others also speak English and a small percentage speak French).[46] Although in many Aboriginal communities (First Nations and Inuit), English has become the predominate language spoken, still there are many speakers, and learners, of the respective nations' traditional languages. Furthermore, for many Aboriginal communities, as indicated by participants, the priority is to retain the traditional language first, and French after. Indeed, studies confirm that the "protection" and "enhancement" of Aboriginal heritage and language is vital to processes of decolonization and empowerment.[47] In comparison, for the mainstream English population whose mother tongue is English, there is a high rate of bilingualism (English and French), which has increased steadily since 1991.[48]

44 Québec. Secretariat aux affaires autochtones. "*Aboriginal Population in Quebec*." [Aboriginal Affairs and Northern Development Canada, Indian Régieter, December 31, 2012.] Québec. 27 May 2012.Web. March 2013.

45 Approximate figure based upon information about First Nations and Inuit communities (languages spoken): *Canada. Aboriginal Affairs and Northern Development Canada. "Welcome to the First Nations Profiles." Aboriginal Affairs and Northern Development Canada*. 16 Jan. 2013. Web. Oct. 2013; and with data from Statistics Canada, 2012 "*Aboriginal Population in Quebec*." Author's note: Further research is needed to obtain an accurate figure for the languages spoken by Aboriginal Peoples of Québec.

46 Des Roches, Michel. *Portrait demographique et sociosanitaire de la population*. CLSC Naskapi. Janvier 2005: 1. PDF file.

47 Taylor, Donald et al., "*Aboriginal Languages in Quebec Fighting Linguicide with Bilingual Education*." Diversité urbaine (2008): 69–89. PDF file.

48 Canada. Parliament. House of Commons. Standing Senate Committee on Official Languages. *The Vitality of Québec's English-Speaking Communities: From Myth to Reality*. Ottawa: Senate of Canada, 2011: 7. PDF file.

b.) Age Structure

Aboriginal communities across Canada have a fast growing and younger population than that of the overall Canadian population. Aboriginal communities have a far greater younger population because of the high birth rate and a lower overall life expectancy.[49] Likewise, in Québec, the median age for the First Nations population is 31 years of age, while the median age for the non-Aboriginal population is 41 years of age.[50] With regards to the mainstream English-speaking population in Québec, the population is ageing; the number of people under the age of 35 has decreased significantly over the past 35 years.[51]

c.) Nations

Naskapi

The Naskapi of Kawawachikamach live within the northern region of Québec on the Québec–Labrador border. Surrounded by "rocks, trees, and water," the community is situated just fifty kilometers south of the tundra line. The name Kawawachikamach means "the winding river."[52] Today, many Naskapi continue aspects of their traditional way of life and culture. The main language spoken is Naskapi, and similar to other northern communities many Naskapi People rely on subsistence hunting, fishing, and trapping for a large part of their food supply, and for many raw materials. Harvesting is at the heart of Naskapi spirituality.[53] Kawawachikamach is the most northern community that is part of the Coalition of English-speaking First Nations Communities in Québec.

Mi'gmaq

The homeland of the Mi'gmaq nation is called Mi'gma'gi. The territory is made up of seven districts, which encompass what we know today as the Atlantic Provinces, the Gaspé Peninsula and parts of Québec, parts of Newfoundland and Labrador, and the northern part of Maine.[54] There are three Mi'gmaq communities in Québec of which two are members of the Coalition: Listuguj and Gesgapegiag.

Mohawk | Kanien'kehá:ka

The Mohawk (Kanien'kehá:ka) have a rich, vibrant, and unique heritage. Kanien'kehá:ka is one of six Indigenous nations that make up the Six Nations (Iroquois) Confederacy (also called the Haudenosaunee). The traditional homelands of the Haudenosaunee extended over a vast territory, encompassing much of present-day northeastern North America. As a confederacy of six nations, the Haudenosaunee were joined together under an alliance and form of governance known as the Great Law of Peace. The Kanien'kehá:ka Nation is comprised of eight communities, located in Québec, Ontario, and New York State.[55] The Mohawk communities of Kanesatake and Kahnawake are part of the Coalition.

Algonquin | Anishinabeg

Algonquin, or Anishinabeg, which means 'the people' or 'first people', have lived on Turtle Island for thousands of years. A strong element of the Anishinabeg belief system is respect; every animal, every plant, every stone, is part of the circle of life.[56] There are nine Algonquin communities in province of Québec of which three are members of the Coalition: Eagle Village/ Kipawa, Kitigan Zibi, and Timiskaming.

49 Adelson, Naomi. "*The Embodiment of Inequity, Health Disparities in Aboriginal Canada*." Canadian Journal of Public Health. 96 (2005): 49. PDF file

50 Canada. Statistics Canada. National Household Survey, 2011. "*Median age for First Nations and non-Aboriginal population, provinces and territories, 2011*." Statistics Canada. 2 May 2013. Web. March 2013.

51 *The Vitality of Québec's English-Speaking Communities: From Myth to Reality*: 7

52 McGill University, Culture & Mental Health Research Unit. "*Naskapi Nation of Kawawachikamach (Quebec) | ICIHRP Roots of Resilience Project - McGill University*." McGill. 13 May 2011. Web. Dec. 2012.

53 Naskapi Nation of Kawawachikamach. "*Overview [The Nation and the People]." Our Community*. n.d. Web. Dec. 2012.

54 Mi'gmawei Mawiomi Secretariat. *Nm'tginen Memnaq Ejiglignmuetueg gis na Naqtmueg. Listuguj: Mi'gmawei Mawiomi Secretariat, 2007*. Print.

55 Mohawk Council of Kahnawá:ke. "*Tsi Nitiohtón:ne Oká:ra (History of Kahnawá:ke)*." Mohawk Council of Kahnawá:ke. 3 Seskehkó:wa 2013. Web. Oct. 2013.

56 Doerfler, Jill, Niigaanwewidam James Sinclair, and Heidi Kiiwetinepinesiik Sark. *Centering Anishinaabeg Studies – Understanding the World Through Stories*. Winnipeg: U of Manitoba, 2013. Print.

d.) First Nations Communities

Table 2. Community Profiles – Location, Population, and Administrative Regions			
Community	Location	Population	Administrative Region
Kawawachikamach	Kawawachikamach is situated at the south end of Lake Matemace, about 16 kilometers northeast of the town of Schefferville on the Québec-Labrador border.	Total population of 1,170 persons (with 857 living in the community and 313 living outside of the community.)[57]	La Côte-Nord (09), Remote
Gesgapegiag	Gesgapegiag is located on the southern Gaspé coast, on the north shore of the Cascapedia Bay (about 45 kilometers west of Bonaventure).	Total population 1,412 (with 672 living within and 740 living outside of the community).	La Gaspésie-Iles-de-la-Madeleine (11), Rural
Listuguj	Listuguj is located in the southwestern part of the Gaspé Peninsula. Surrounded by the Appalachian Mountains, the community is situated on the northern banks of the Restigouche River, across from the province of New Brunswick *(Border community with New Brunswick).*	Total population 3,672 (with 2,086 living within and 1,586 living outside of the community).	La Gaspésie-Iles-de-la-Madeleine (11), Rural
Kahnawake	Kahnawake is located on the South Shore of the St. Lawrence River, 10 kilometers southwest of the city of Montréal.	Total population 10,336 (with 7,745 living within and 2,591 living outside of the community).	Montérégie (16), Urban
Kanesatake	Kanesatake is situated approximately 60 kilometers north-west of Montréal, on the banks of the Rivière des Outaouais (Ottawa River).	Total population 2,321 (with 1,383 living within and 938 living outside of the community).	Laurentides (15), Rural
Kitigan Zibi	The Kitigan Zibi Anishinabeg community is situated just outside the municipality of Maniwaki. The community is 130 kilometers north of Gatineau/Ottawa. It is bound on the north by Riviere de l'Aigle and Riviere Desert *(Border community with Ontario).*	Total population 3,021 (with 1,593 living within and 1,428 living outside of the community).	L'outaouais (07), Rural
Eagle Village | Kipawa	Eagle Village First Nation is located 10 kilometers west of Temiscaming, on the bank of Lake Kipawa *(Border community with Ontario).*	Total population 951 (with 276 living within and 675 living outside of the community).	Abitibi-Témiscamingue (08), Rural
Timiskaming First Nation	Timiskaming First Nation is located at the head of Lake Temiskaming, approximately 600 km from Ottawa *(Border community with Ontario).*	Total population 1,923 (with 641 living within and 1,285 living outside of the community).	Abitibi-Témiscamingue (08), Rural

57 Information for this table from: Quebec. Secretariat aux affaires autochtones. "*Aboriginal Population in Quebec*." [Aboriginal Affairs and Northern Development Canada, Indian Régieter, December 31, 2012.] Quebec. 27 May 2012.Web. March 2013.

5. FINDINGS

5.1 Overview

The goal of this research was to document a portrait of English-speaking First Nations when accessing English-language services from provincial and federal systems. In addition, the research sought to document solutions to these challenges. To seek out the perspectives of English-speaking First Nations, focus groups and interviews were conducted with two main groups: First Nations community resources (front line workers from both health and social services) and First Nations community members (Elders, caregivers, parents with young children, and individuals with chronic conditions). (Appendix C: Table. Focus Groups, Interviews Held, and Questionnaires.)

In the winter of 2012, research tools (research questions and consent forms) were developed, reviewed by the Coalition, and then tested with First Nations' front line workers.[58] (Appendix D: 'Interview Guide for Aboriginal Health Transition Fund (AHTF)'; Appendix E: HSIF Focus Group and Interview Guide). Coalition members identified a research liaison from their respective communities who assisted with the data gathering. In some communities, the research liaison set up the focus groups or interviews, while in other communities the liaison facilitated the sessions and gathered the data.

The researcher (or research liaison) conducted the focus groups and interviews on site or with video conferencing/telephone. The focus group sessions and interviews were recorded; the audio was transcribed, or there was a note taker present. Participants who were unable to attend the focus group session or interview had the option to reply to the research questions in written format. The sessions were held in English, with the exception of the community of Kawawachikamach, which held its focus group in Naskapi and English. The research was explained to participants, and consent was obtained either by group consensus or by having the participants sign consent forms at the beginning of each session. Each focus group session lasted from two to three hours, while interviews were generally thirty minutes in length. The names of provincial institutions were not included in the report; however, the locations of the institutions are included, if mentioned by the participants. The names of the communities are included; however, individuals are not mentioned by name to ensure confidentiality. Finally, following the review of the draft research report, a questionnaire was developed to gather additional information (preliminary research) about a specific access issue that was identified by the Coalition (Appendix F: Questionnaire – Transportation and Lodging).

5.2 Exposing issues and challenges

a.) Key access issues and challenges

The following is a compilation of the **key access issues and challenges** identified by participants. The access issues are listed in order of priority, and any issues common to both groups (health and social services' workers and community members) are marked with an asterisk(*).

First Nations Community Resources

- Access to specialized services in English.
- Documentation and information in English.*
    - Key areas: patient records/medical charts, training information, assessment tools, websites, government sites, updates for immunization protocols, ambulance forms, information to understand provincial legislation or new policies in the areas of health and social services.
- Training in English (including supporting documents).
- Cultural discrimination / lack of cultural sensitivity.*
- Communication – language barriers.*
- Jurisdictional issues: provincial borders, corridors of service, and Federal/Provincial responsibilities for First Nations.
- Access to general services, in either French or English.

58 Research methodology and tools were reviewed by the Coalition at the project launch. Québec City, January 28, 2013. Research tools were tested by the researcher with front line workers of health services and social services agencies in Listuguj on February 6, 2013.

First Nations Community Members

- Long wait times for services, and even longer wait for services in English.
- Emergency services (emergency room and dispatch).
- Documentation and information in English.*
- Communication – language barriers.*
- Cultural discrimination / lack of cultural sensitivity*
- Attitudes and perceptions (fear, anxiety, and not being understood because of language and culture).
- Funding (lack of clarity about who is responsible for First Nations: Provincial or Federal authorities).
- Quality of services in English (i.e. assessments, discharge from provincial institutions).

The key access issues identified by each participating First Nation community are included in Appendix G of this report.

b.) Compilation of data

The data collected from the focus groups and interviews was compiled and organized into four broad areas:

i.) General Access Issues and Challenges

ii.) Issues Resulting from Language

iii.) Issues Related to Culture

iv.) Positive Experiences

The research data was analyzed to determine which issues and challenges are common among all the communities, as well those issues that are shared by some members of the Coalition because of their geographic location—remote, rural or urban.

The findings for each individual First Nation community are included in Appendix H of this report.

i.) General access issues and challenges

Common issues identified by all First Nations Communities

- **First Nations lack information and knowledge about where and how to access services from the provincial network**. The responses varied among participants. In rural areas, some participants were unaware that they could access services from provincial institutions (i.e. CLSCs), while others (rural and urban) reported not knowing where to access services (in particular English-language services) in Québec.

- **Concerns about quality of care.** In remote areas, participants reported that 'errors are being made' with medication and clients' appointment; in urban and rural areas, participants reported that quality of care was a matter of 'luck of the draw', depending on the individual staff and/or institution.

  - *There was a case where there was an error in medication. The names [of clients] were the same, but the medication was sent to the wrong house. (Kawawachikamach)*

  - *When you call you get bounced around and end up in a department you don't even want. One member tried to get his address corrected and couldn't manage to do it. He also had a problem in that his file was confused with his son's, which could have resulted in a significant accident. I don't trust those guys, I have to be pretty damn sick to go there [hospital] (Gesgapegiag).*

- **Perceptions and beliefs when accessing services from provincial institutions.** Participants were reluctant to access services from provincial institutions (hospitals, CLSCs, etc.) because of negative perceptions about the quality of care. Community members spoke about their 'fears' and 'anxiety' around accessing services from the province.

- **Long wait times to access services (specialists, testing).**

- **Ageing population.** Participants described the difficulties that elderly people have communicating with specialists and asking questions about their health needs. Others described the difficulty that elderly clients have to navigate and find services at hospitals because of age-related issues.

- **Travel.** Mixed responses from participants. For those in remote and rural areas there are challenges because of distance (lack of good roads), while participants from urban areas reported difficulties because of a lack of public transportation available to access services at institutions within their corridor of service. Participants reported issues associated with funding

for travel through Health Canada's Non-Insured Health Benefits (NIHB).

- **Government cutbacks in funding to health services.** Participants reported that government cutbacks (provincial and federal), generally speaking, are impacting health and social services: fewer services, and First Nations community organizations need to make up the gap in services.

- **Two-tiered health care.** Participants reported that for clients, there is an "emerging 'two tiered health care system' and that 'for a fee' individuals can 'buy their way to quicker services.'" (public health vs. private care).

Remote & Rural Areas (general access issues)

- **Distance to access services (travel).**

- **Lack of general and specialized health and social services in either English or French**.

- **Difficult to find a family doctor in Québec.**

- **Lack of access to medical equipment in the area** (i.e., dialysis equipment, wheelchair, walkers, etc.).

- **Transportation and lodging.** Challenges for those from rural and remote areas when traveling to urban areas for medical reasons (general access issue and language).

    - Based on preliminary research (questionnaires), participants are 'somewhat satisfied' with the transportation and lodging services.

    - Some participants noted that language is an issue with the transportation; clients are frustrated in that the drivers do not speak enough English for comprehension purposes.

    - Participants expressed concerns with the lodging; specifically: lack of choice with respect to lodging; there are "mix-ups" with the accommodations; the accommodation process (making reservations with the third party service provider) is "complicated"; and participants expressed concern about the safety of boarding homes.

    - Key informants indicated that First Nations organizations are subsidizing the cost for alternative accommodations. Recommended that communities should be able to run the program (transportation and lodging) based on their own needs, and with adequate funding to support the services required.

    - *Lodging is the big problem. People don't feel comfortable in someone else's home where they speak a different language. They should have a choice of where they would like to stay.*

ii.) English language access issues

Common issues among all First Nations communities.

- **Language barriers (communicating) – Doctors and specialists more likely to be bilingual, less so for nurses, front line workers, and reception.**

    - *Sometimes nurses yell if people can't understand French, as if speaking louder would help! (Gesgapegiag)*

    - *Mental Health Services: If the person walks into a place and they're getting the impression that this person doesn't really understand them, they'll ask 'why am I going there?' It's hard enough to get them to go to counseling. They won't go back. They won't open up, they won't talk. You have to have someone who is fluent…you want to be comfortable that what you are saying is being interpreted in the way and meaning of what you are saying. (Listuguj)*

    - *Some of the doctors speak English. For my son, his doctor speaks English, but it's the receptionists who are difficult. They only speak French. I get my mother to call because I cannot speak French, and whenever we go to the hospitals, I get my mother to come along for the same reasons. (Eagle Village | Kipawa)*

    - *If I am sick, it is already scary enough and if I have a nurse/doctor telling me what is wrong and I don't understand what they are saying, it further affects me—I may not understand the diagnosis and service plan. (Kahnawake)*

Calling provincial institutions is difficult because of language barriers.

- *If you have to call CLSCs after 4 P.M. or on weekends, it's French. They want to know why you are calling, and I myself am not totally bilingual, but I try to give them the information, it's hard because of the language. (Kitigan Zibi)*

- **Documentation from the province is mainly in French.** *Participants highlighted*: Information from Professional Orders (Ordre des travailleurs sociaux et des therapeutes conjugaux et familiaux du Québec (OTSTCFQ); signage; information from the province; reports, assessments and discharge papers; invitation letters from the province (including invites to meetings about 'English Access' programs); Medical Alerts, Protocols and Medical Information; and Training Information—lack of access to English materials.

  - *A lot of information that we get is always in French, and to try to get it in English it's hard; difficult to obtain information in English, even from organizations that deem themselves bilingual; lack funding to translate documents, materials or forms: If you want to translate it yourself you can, but do you realize how expensive that is?! Long wait period when requesting province to translate documents. (Listuguj)*

  - *Some templates (i.e. for 'Home and Community Care') are sent to First Nations' community organizations in English, however, the instructions may be 100% in French. Ambulance forms—the forms are all in French, but all of the first responders have adapted and learned to use them. They might not specifically be able to translate what things mean, but they could tell you what box they need to tick off for something like respiratory problems. They get the sense of what it all means, and make do. (Kahnawake)*

  - *We do have basic little hand-outs for [clients] that [the province] provides for us in English. But say a mother requires some information about the PIQ [Protocole d'immunisation du Québec] and the only information I can draw from is outdated from the older translation, I don't know how old the information is—maybe five years old. It's not right and downright dangerous. (Kitigan Zibi)*

- **Tracking clients' information is difficult because of language barriers**. Participants described obstacles because clients' information may be charted in French, which then requires translation for English-speaking community resource workers. However, in some communities nurses (community health centres) track community members' information in English (homecare stats, vaccines. reports).

- **Translation services are limited: lack of funding and treatment can be delayed while waiting for translations.**

  - *The Agence de la santé has provided a translator on site at the hospital, and I believe it's four days a week within office hours. So, unless you time your sickness within those office hours, there's going to be some issues. (Eagle Village | Kipawa)*

- **Limited access to training in English in Québec.**

  - *Courses are mainly offered in French. We need to go to Ontario for training in English. If we get our training from out-of-province, it may not be accepted by Québec and the information (guidelines, recommendations, procedures) may be different between provinces. (Timiskaming)*

  - *It can be difficult to receive training from a worker who is not fully bilingual; It's frustrating when you're trying to learn something while struggling to understand what the instructor is saying. (Timiskaming)*

- **Lack of access to health and social services in English.** In remote and rural areas, participants reported difficulty accessing both general and specialized services, while in urban areas there were obstacles accessing specialized services. Many participants from across the regions spoke about difficulties accessing: speech language therapy, mental health services, audiologists, and services for individuals (in particular youth) with physical and developmental challenges (i.e., autism, learning disabilities).

  - *Access to services for families with special needs is very difficult. First Nation Health Centre brought in services from New Brunswick for autistic child because [there is] none in the area. Services in English for children with Down's syndrome are very limited, even off reserve. (Gesgapegiag)*

  - *The services provided to the students by the CSSS in the school are lacking. Because our students aren't capable of receiving services in French, then a lot of services are pulled back…It's not*

uncommon for parents to just up and leave the province altogether because the services they get for their special needs child in English is not acceptable—long delays and quality of service is not there. (Eagle Village | Kipawa)

- *With Ontario doctors refusing our patients, we need to find a place to send them, calling one hospital, another, a third hospital, a fourth, to get names of doctors, and because they are not locals and can only be here once a month, you send referrals and they get lost. Sometimes I find it very difficult to know where to refer a patient because they change—I have names of psychologists, psychiatrists, and they are not there anymore and you need to do this research all over again. (Timiskaming)*

- **Limited access to mental health services in English.**

  - *The mental health issues are more impacted by the language barrier. Clients need assistance with translating personal information for them to obtain services. (Kanesatake)*

  - *Waiting lists everywhere: patients are leaving hospitals, yet no psychiatrists available for these mental health patients. Discharge from hospitals is an issue (strain on family/community). Limited options for psychologists in English. Assessments—limited pool for conducting assessments (non-insured, psychiatrist services). Report provided in French and organization needs to pay to have assessment translated, increases the cost of doing an assessment. (Kahnawake)*

- **Limited detoxification services and treatment services in English.** (Jurisdictional issues, provincial boundaries, funding, and long waiting lists.)

  - *First Nations organizations are sending clients to New Brunswick and Nova Scotia for detoxification services. However, despite having service agreements, some provincial institutions are only accepting referrals from Québec after their own clientele has been served. (Gesgapegiag)*

  - *[Our] Community has paid out considerably to send a few members to private clinics in Québec for English services (approximately $75,000 invested one year by the community to send three people from the community to long-term private clinics for English services in the province of Québec). (Kitigan Zibi)*

- **Corridors of Service. The provincial network (corridors) can present obstacles for individuals seeking services in English.** Participants reported delays in assessments and treatment (i.e., for speech language pathology). Others reported challenges for any type of mental health services in English if sent to closest hospital (by ambulance). In urban areas, participants commented that travel is also an issue because of provincial corridors: clients must travel farther, and with less public transportation available to them, in order to access services in their own corridor. In border and remote communities, participants reported that they are being encouraged to "stay in the province of Québec," even if they need to travel farther—but within the province—to access services.

  - *The corridors of service have been changed for people living on the South Shore. Access to hospitals in Montréal is restricted, clients being referred back to South Shore. More and more we are being delegated to the South Shore for services, which are almost all French. The "State of the Art" medical services are on the island and we are being shut out because of our postal code address. (Kahnawake)*

  - *There's a constant stress in that the provincial government wants to keep everything in the region…we wouldn't have any problem staying in Québec, if they could provide those services in English. There's pressure on us to stay within Québec [rather than going out-of-province]. However, because of the language issue we end up further and further away from our communities. It's a big circle. (Eagle Village | Kipawa)*

- **Emergency Services. General access issues and obstacles because of language and culture**. In remote areas, there are challenges for community members to access emergency services. In rural and remote areas, participants reported that in addition to access issues and language obstacles, the emergency response time is 'even slower' in First Nations' communities. In urban areas, participants reported issues with emergency services, for example documentation of ambulance forms available in French only, and reported that there is a lack of employment opportunities and training opportunities for English-speaking individuals (paramedics).

  - *If you live in the city and you dial 911, that ambulance will be there at your doorstep. Why isn't it the same here in the northern region? (Kawawachikamach)*

- *I've gone on emergency calls in an ambulance, and the ambulance driver and the one working on the patient, they speak French…that's been a big barrier. (Kanesatake)*

- *I think we've lost lives because of it. Because of waiting, and longer delays: the ambulance driver spending 10 or 15 minutes just trying to find the road in the community. (Kitigan Zibi)*

- **Ageing population.** General concern expressed among all communities that elderly First Nations' community members are not seeking services from the province. There are obstacles associated with ageing, language, and cultural issues.

  - *A lot of Elders don't go to the doctors if they have pain. In the end they may have something very serious. And, they are not comfortable going to CLSC because of the language…If you trust where you are going you will go and get help, but if you don't trust where you are going you won't go to get help. (Kawawachikamach)*

- **Judicial. Issue**s with language where social services interfaces with the Department of Youth Protection and the provincial court system. There are limited services available in English in remote and rural areas. In urban areas, the main issue for judicial services is with the translation of documents (quality of translation, cost).

  - *It's confusing in the courts because there is so much back and forth, the facts get lost in translation…Using an interpreter also raises the problem of confidentiality and privacy for the client. (Gesgapegiag)*

- **Long wait times for services in English**. Participants report having to wait longer to get services because of language barriers (speech language therapy, rehabilitation services, mental health services, for example).

Critical Care. Participants spoke about issues because of language while at provincial hospitals with family members who were in 'critical care'. In remote and rural areas, the issue of having an escort was identified as a challenge, while in urban areas participants said that institutions cannot always ensure that a bilingual worker will be available for those in critical care.

  - *Once surgery and diagnosis is finished and the person is in critical care, then you need to be able to communicate with people who are assessing you to determine if you are passing benchmarks or deteriorating. It's that lack of confidence that community members feel that people will not understand them and communicate their needs in very vulnerable situations. The hospital is not always able to ensure that bilingual people will be available. (Kahnawake)*

- **Perceptions and beliefs influence whether or not individuals will seek out services from provincial institutions.** Participants reported that they felt they were being discriminated against because they are English-speaking. Some participants reported that individuals avoid using hospital services because of language barriers: language is interfering with quality of care when seeking services from provincial institutions.

- **Employment and hiring**. Participants from all regions reported that there is a lack of opportunity for First Nations who cannot speak French, even within organizations of English-speaking First Nations' communities.

Remote & Rural Areas (language barriers)

- **Medication and Prescriptions.** In remote areas, participants reported obstacles receiving information, in writing, in English (e.g., how to take medication, possible side effects).

- **Crisis Situations**. Participants reported a lack of services in English for women/children/families in crisis situations (e.g., violence, sexual abuse).

Rural & Urban Areas (language barriers)

- **Provincial boundaries** are presenting barriers to individuals seeking English language services out of province (e.g., denial of services such as treatment services and mental health), and issues with funding when seeking services from out of province.

  - *People are bounced back and forth between the hospitals in New Brunswick and Québec depending on the issues; [The boundary] divides the population and influences when they are willing to go to the hospital. (Listuguj)*

- **Provincial databases and software are mainly available in French.** In both rural and urban areas participants reported that the 'French only' databases available in health services and social services are presenting obstacles in the workplace for First Nations' community organizations.

- *They've tried to make [the database] available to First Nations communities in Québec, but it is still not available in English. To keep up with the standard of delivery and tracking of data, in comparison with the rest of the province, we have to wait until that database is available to us. (Kitigan Zibi)*

- **Liaising and networking with provincial institutions**. Participants spoke about the difficulty liaising and networking because of language barriers.

- **Negotiating English-language services and placements for adults and children with severe special needs is difficult**. There are challenges because of limited services, and transferring to a different region is difficult (corridors of service and issues with funding). Although there are agencies that serve the Anglophone communities, participants from urban areas reported that English-speaking First Nations are not the top priority.

- **Provincial Help Lines**. Participants reported obstacles when accessing services from provincial help line numbers because of language. Community workers reported that they rely on out of province lines or US lines. Participants from urban areas were more familiar with Info Santé in comparison to those from rural or remote areas.

  - *The Elder abuse, the hotline number is very difficult to access for a lot of community members. We've always come back to that same question 'When an Elder is being abused, who do they call?' Where do they go? Because when they try to access that 1-800 number, it's all French. (Listuguj)*

Urban Areas (language barriers)

- **Youth seeking services in English**. Teens may require additional support (i.e. transportation, information). Participants reported that youth (generally speaking) do not seek out services.

- **Medical vehicles (ambulances)**. In urban areas, participants reported obstacles because of language. *English-speaking communities need to make certain that the writing inside of the ambulance is in English and not solely in French.*

- **Support Services/ Resources**. Participants reported difficulty accessing programming, support services and resources for health and social issues, in English.

iii.) Access issues related to culture (Aboriginal)

Common Issues among all First Nations Communities

- **Provincial legislation creating barriers for English-speaking First Nations' communities.**

  - Language Legislation (Proposed Bill 14). Participants spoke about the difficulty of striking a balance between the workers' rights to speak French in the workplace and clients' rights to receive services in English. For First Nations, there are additional issues because many felt that their rights as First Nations (cultural and linguistic) are not being respected.

  - *Many community members believe that nurses can speak English but many simply do not want to, "they want you to speak French." Québec's new language policy [Bill 14] is creating even more problems. (Gesgapegiag)*

  - Bill 21: Obstacles to recruit and retain English-speaking professionals to work in English-speaking communities; professionals (nurses and social workers) may work in communities on 'conditional basis' only. Required to be part of the Professional Order, however, documents, meetings, and training are available in French only.

  - Bill 49, Act for Family Resources (language issues and governance). In addition to issues with language, there are also issues because First Nations were not consulted about the proposed changes.

  - *The new system for Foster Care placements does not take into account First Nations culture, spirituality, sense of identity of the child and community. (Kahnawake)*

  - *Lack of understanding of First Nations communities' service delivery capacity, the province and even in some cases, the feds don't know what we are doing. (Kahnawake)*

- **First Nations' health needs and priorities are not being met. Community organizations reported that they are 'going beyond their mandates' to make up for the gaps in services.**

  - Participants reported that it is difficult for First Nations to access services despite being included in the population count for the region (Note: In remote area, a priority issue identified was ambulance/emergency services.)

  - Case management / Translation Services—Participants (First Nations health care workers) reported that they are spending a lot of time and energy on case management, primarily because of language issues (referrals, booking appointments, and follow up). Funding is not available for translation services (translating documents, placing phone calls). Thus, staff members at First Nations organizations who are bilingual, and willing to go above and beyond their own responsibilities, fill this need for their clientele.

- **Funding. Reported a lack of adequate funding for First Nations' health and social services, and obstacles accessing funds because of language.**

  - First Nations' organizations are expected to provide more services, with the same level of funding (i.e., lack of funding for translation services).

  - Proposals – The perception is that language is an issue when submitting proposals to government to access funding for projects (funding/project proposals need to be submitted in French).

  - *First Nations' health and social issues are well-known, there is a lack of funding to implement lasting solutions. (Kitigan Zibi)*

- **Non-Insured Health Benefits (NIHB). Obstacles when accessing services.**

  - Lack of clarity and information about what is covered and what is not covered through NIHB. Participants reported that community members are 'caught paying bills' for health services due to the lack of clarity.

  - Obstacles accessing payment for services (i.e., medication) under the Non-Insured Health Benefits (NIHB) program. Participants may need to pay out of pocket, and then wait for reimbursement from Health Canada.

  - Not all medications are covered under NIHB, in particular for palliative care patients.

  - Participants reported that there is a lot of paper work involved for clients, and not all service providers will accept NIHB.

  - Participants reported inequities in what is covered under the NIHB in comparison to provincial programs geared for individuals who are receiving social assistance.

  - Limited Coverage for Mental Health Services through NIHB.

  - *For an Elder that goes in and wants to get their eyes done, there's a little bit of a barrier, wondering, 'Do they pay for the drops at the optometrist?' Is it reimbursable? They don't tell them enough about that information; They go to pharmacies, and the pharmacists say, 'it's not covered.' If a person doesn't have money to pay, they may not receive their medication. (Kanesatake)*

  - *There is a growing issue of "delay of care" due to the decision to centralize the bureaucratic program approval process in Ottawa, it is worsening the situation. (Kahnawake)*

- **Jurisdictional overlap between federal and provincial governments creating barriers when accessing services.**

  - First Nations have access to health and social services from both federal and provincial governments, however participants reported that there is a lack information and clarity about who is responsible for what services (delivery of services and funding), which affects access to services.

  - Participants reported that there is a lack of services for physically handicapped persons due to disputes over fiduciary responsibilities.

- **Consultation and engagement health planning is insufficient.**
    - Participants reported that the province is not conducting meaningful consultation with English-speaking population, including First Nations, about changes to health policies. (i.e., Québec's changes to computerized system for health records).
    - Participants reported that there are difficulties for English-speaking First Nations communities to fully participate in health planning and decision-making with the province: linguistic obstacles and lack of accommodation of First Nations health priorities.
- **Communication between First Nations and provincial organizations/institutions – gaps in discharge.**
    - First Nations community members reported that patient's confidentiality is not being maintained in the communications between the hospital and the community health services (not satisfied with quality of services).
    - Lack of communication between institutions (First Nations and provincial) when clients are discharged.
    - Language is an obstacle because the discharge summaries are all in French.
- **First Nations Rights are not being respected.**
    - Participants commented that community members are "being taken advantage of" if they don't speak French. Client's rights are being violated because "*workers [at provincial institutions] talk about you, but you don't know what they are saying.*" *(Kawawachikamach)*
    - Some First Nations are not aware that they have a right to access services from provincial institutions: participants reported a lack of information about how and where First Nations can access services from the province.
    - First Nations reported that it was difficult to make formal complaints to provincial institutions—some participants stated that they were 'afraid to rock the boat', and others were not familiar with complaint processes. Bilingual participants reported assisting English-speaking First Nations to lodge their complaint in writing.
    - *Not only the Naskapi, but all Native people are facing racism. There is an attitude of colonization…We have to be fighting all the time for rights that are already given to everyone else. But we have to fight for them every day. We don't have the right to be informed. We don't have any respect given to us for who we are and what we are. (Kawawachikamach)*
- **Discrimination and lack of cultural sensitivity.**
    - Participants spoke about their frustration with the lack of cultural understanding and awareness about Aboriginal history, culture and social context. In remote and rural areas, many participants spoke about a lack of respect for their culture and "feeling judged" by provincial workers. Some reported that, or their clients, have experienced "discrimination and cultural stereotyping" when seeking services from provincial institutions.
    - Double discrimination—as English speaking persons, and as Native people.
    - *There are still some people out there who look at you and treat you differently because of the colour of your skin. (Eagle Village | Kipawa)*
- **Language and culture**
    - Participants from all communities (rural, remote and urban) spoke about issues with language and culture. Some said it was 'unjust' to expect First Nations community members to have to learn/speak French, given that some First Nations have already lost their language once, learning English.
    - *There was a loss of language once, and [Aboriginal languages] were replaced with English, they cannot expect you to change your language again. (Kahnawake)*
    - *Provincial institutions and specialists lack knowledge and awareness about First Nations culture and history. There is a lack of understanding…there is a lack of understanding about ceremony. (Listuguj)*

- **Ageing Population**

    - There are challenges for Elders because of linguistic issues and challenges related to health issues associated with ageing. Reported that many Elders are 'falling through the cracks.'

    - Elders who need nursing home care face obstacles because of language, which may trigger 'reliving residential school experiences.'

    - *They fall through the cracks a lot, because when you talk about Elders…first of all their first language is Mohawk. They always have someone with them to help. Okay, this is the first time they are going alone, so you ask them what they need to do and they say, 'I don't know. They just gave me this paper,' so if nobody is going to help them, how are they ever going to be diagnosed with cancer? Because they didn't know what to do with that paper." (Kanesatake).*

- **Detoxification and treatment services**. Participants spoke about the lack of culturally and linguistically appropriate care for First Nations when seeking services for detoxification and treatment (rehabilitation) from the province. Participants spoke about the gap between detoxification and treatment services.

- **Escort/liaison services**. Participants reported that clients who need assistance because of language are not able to access 'escort/liaison' services (primarily available for elderly population).

- **Medical Transportation**

    - Lack of funding for medical transportation (generally speaking). Funding for transportation is not always available when accessing services 'out of province' or in a different corridor of service (which clients need if seeking out English-language or culturally appropriate services).

    - Some reported that the transportation services are not always available in English. When traveling from rural to urban areas, participants described being unable to communicate with drivers resulting in 'missed appointments'.

    - *[Elder's experience, translated from Naskapi into English]: Our Elder spoke about the escort that was needed. His son had a small surgery, a small bypass. He was going to have an escort, but at that time he was not provided with one because there were no funds for an escort (Kawawachikamach).*

Remote areas

- Training in the community for students in health field can be problematic (i.e., intern doctors, social work programs). Participants reported obstacles because of language barriers and a lack of respect for cultural protocols.

- Language and Culture (Naskapi, English and French)—lack of respect, awareness and understanding about First Nations history and culture.

iv.) Positive Experiences

At the focus group sessions and in the interviews, participants spoke about positive experiences when accessing services from the province. The following is a compilation of comments from the First Nations communities in remote, rural, and urban areas:

- **Projects that bring together the federal, provincial and First Nations – positive outcomes.**

    - First Nations are building connections and relationships with local provincial institutions through joint projects.

    - There is an increased awareness among community members that First Nations may access services from the provincial CLSCs.

- **Agreements between First Nations organizations and provincial institutions are improving access to services.**

    - Agreements have resulted in increased access for First Nations in some areas (i.e., mental health).

    - Agreements between First Nations organizations and provincial institutions have allowed for the inclusion of cultural practices.

    - Mental health services (suicide prevention): Hospitals are making efforts to accommodate English-speaking workers from First Nations' community organizations.

- Building relations—Hospital is reaching out to First Nations community during crisis situations.

- **Quality of care. Some participants reported being satisfied with the quality of care received while at provincial institutions.**

  - Participants described compassionate nurses, willing to speak English with patients when undergoing surgery.

  - Some participants reported that they are satisfied with the quality of care and services at provincial institutions: some hospitals described as "excellent" and "culturally sensitive."

  - Staff at provincial institutions described as "understanding", and "willing" to provide services in English. Other participants reported that emergency service providers spoke English and were "attentive" and "caring."

  - One participant spoke positively about a CLSC social worker who assisted a mother to access rehabilitation services in English, from out of province, for a youth who is severely autistic.

  - Staff at CLSC are helpful—assisting individuals (knowing where, how, what is required).

  - Efficient services from local CLSC: when making an appointment, the CLSC provided the client with a date and time when they would call, all communication was in English.

  - RAMQ services: Very helpful and efficient.

- **Some participants reported that wait times for services have not been too long.**

- **Services are available in English at some provincial institutions, including hospitals and CLSCs.**

  - When able to access services in English, participants spoke positively about the quality of services available to them. In the larger urban centres, there were "usually no problems" finding someone who speaks English.

  - There are hospitals in Québec (in larger urban areas such as Montréal) where the services in English are good. Sometimes, clients may be afraid about getting around, because it's all French, and when they come back, they always say, 'You know, it's not too bad. There was always someone around to help us out.'

  - Some staff people try to speak English or provide English documents.

  - Participants commented on the need for a positive attitude and a willingness to work together.

  - If they know that you speak English, some of the support staff [at hospitals] will speak to you in English. Another participant at the session commented on the importance of "cooperation and both parties being willing to communicate using each other's language." (Listuguj).

  - Doctors at provincial hospitals are encouraging English-speaking clients to access services from the province.

- **Availability of English language documents.**

  - Participants reported that the documentation and information is available from pharmacists in English (rural and urban areas).

  - Participants described positive results when provincial institution sent invitation letters in English to community members about breast cancer screening; observed an increase in the number of community members who went for screening.

- **Resources and Networking**

  - Participants reported that the Health Canada representative (regional office) is very helpful in giving direction for finding English regional services.

  - Support services for certain chronic conditions are available in English from community organizations (urban areas).

5.3 Strategies and solutions

a. Strategies in place

Participants were asked about the **strategies that they have in place** to address obstacles when accessing services; the following is a compilation of their responses:

- Relationship building
    - First Nations are networking and researching to find out what services are available in English.
    - Building on relationship with the Agency and working with their openness to help (key contacts persons) and showcase best practices, including cultural teachings.
    - Professionals are visiting First Nations' community (information sessions), and in turn "gain understanding of the communities needs and priorities."
- Agreements and policies
    - First Nations are entering into agreements with provincial institutions; for example, liaison positions to assist clients overcome barriers because of language and culture.
    - Policies have been established between First Nations and provincial institutions, which protect cultural practices (for example, there are policies in place at some provincial hospitals for birth practices following Mohawk cultural practices, established through the Aboriginal Health Transition Fund (Kanesatake)).
    - Urban Areas: First Nations have entered into special agreements to receive services from other administrative regions; however, participants report that such agreements are becoming more difficult to enter.
- Protocols between institutions
    - Rural Area: Protocols between agencies (provincial hospital and First Nation organizations) about the delivery of services for First Nations clients (for example, Mental Health Protocol and Speech Language Therapy protocol were developed in rural areas to provide services to Anglophone and First Nations clientele).
    - Referral Tool established between First Nation organization and some provincial institutions (in English).
    - Letters sent to provincial hospitals with procedures when discharging clients.
- Accessing services in English from other jurisdictions
    - Participants reported seeking services (primary care, family doctors, and specialized services) from other corridors of service in Québec and also from out-of-province (primarily, New Brunswick, Ontario and also Nova Scotia); also, some clients are seeking services in the U.S.
- Accessing services in English from private institutions
    - Participants reported that First Nations organizations and/or individuals are paying for private services in English in Québec (i.e., mental health services, detoxification/rehabilitation, and also developmental needs for youth).
- Complaints process
    - Clients are encouraged to make formal complaints about discrimination (language or cultural), ("squeaky wheel").
    - First Nations organizations are sometimes asked to write up formal complaints for clients (translator services required.)
    - First Nations' organizations set up meetings with provincial institutions to address issues/complaints.
- Training in English
    - First Nations request simultaneous translation at training.
    - Seek training in English from out of province.

- First Nations of Québec and Labrador Health and Social Services Commission (FNQL-HSSC) has offered English training for health and social services.

- Translation services
  - Bilingual staff translate documents or place phone calls for co-workers.
  - Staff translate for clients (assist clients to fill out forms that are in French).
  - First Nations need to cover the cost to translate documents; some translation services are provided by FNQLHSSC.
  - Family members who are bilingual will take patients to their appointments and help with translation (i.e., grandchildren will accompany grandparents).
  - Bilingual family members place calls for patients (general inquiries or to book appointments).
  - Organizations report promoting the use of French: "You do get better reception if you go in with a good attitude"; "Using my ability to speak in both languages has opened doors" (Kahnawake).

- Advocate and escorts
  - First Nations organizations report that they spend a lot of time being an advocate and support for clients to help them get the treatment and services they need.
  - Elders (55+) can have an escort included with transport.
  - Community members are volunteering at hospitals—visiting patients, and helping people to get around.

- Discrimination and cultural sensitivity
  - First Nations offer awareness training and workshops for service providers, both First Nations and provincial; with a changeover of staff, need to check if the training plan is being implemented.
  - Work with universities to develop 'Cultural Awareness and Sensitivity' training for those studying health and social services.
  - To enhance cultural awareness, participants spoke "Being assertive and knowing your rights"; "Perseverance"; and "Being creative and culture-based."

- Emergency services / crisis situations
  - Participants reported taking a bilingual family member with them when accessing emergency services.
  - Urban area: Paramedics reported that "try to put someone on each shift who is bilingual."
  - Rural Areas, some border communities: During crisis situations, community organizations seek English-language services from shelters out of province.

- Transportation
  - First Nations are providing transportation services for clients who need to travel to access services (because the service is not available locally or to obtain the service in English).

- Information and awareness
  - Search on various websites to find information to print out materials.
  - Request materials in English from the province (in writing and calling).
  - Documentation (i.e., pamphlets with information about health conditions) are obtained from out-of-province.
  - Information about medication is available in English from pharmacies.
  - Doctors and specialists, some of whom are from out of province, deliver workshops and presentations in the community in English.

- Rural Areas: Specialists are delivering presentations in English in communities through videoconferencing and webinars (networking with local organizations in the delivery of online presentations).

b. Proposed solutions

Participants were asked about any **solutions**, which could improve access and expand partnerships; the following is a compilation of their responses:

- Leadership and vision
  - Develop a concrete strategic plan outlining how English-speaking First Nations can gain access to services in English.
  - Establish a 'Health and Social Services' forum or body to share information about accessing services from the province.
  - Political leadership is needed. "Chief and Council need to address the health sector at the Table with the province."
- Relationship building
  - Collaboration between First Nations service providers and provincial agencies is needed (share information for contacts, work together, 'think tank'.)
  - Form partnerships with provincial and local institutions.
  - First Nations need to have a seat on Advisory Boards.
  - Cooperate with local not-for-profit organizations in place for Anglophone communities to overcome access barriers (networking and collaboration).
  - Establish partnerships with universities: internship opportunities in First Nations communities.
- Agreements and policies
  - Periodically review agreements and policies between First Nations and provincial institutions to ensure proper implementation.
  - Suggested that First Nations establish a code at provincial institutions if clients require services in English.
  - Improve relationship at the local level with CLSCs, hospitals (need consistent policies for services such as occupational therapy, specialized nursing, IVs/VAC, dressings/support.)
  - Need to have tripartite agreements with First nations, provincial and federal governments (political will required)—address jurisdictional responsibilities and gaps in services.
- Access to services in English – priority areas
  - Ensure that First Nations can access services geared for their own health care needs and priorities (i.e., detoxification, mental health services, developmental needs for youth, care for Elders) First Nations population is young and English services are needed to meet their health care needs.
  - Crisis situations: When services are needed immediately, funding needs to be made available to access services in English from private institutions.
  - Private Clinics: Long-term funding for services at private clinics.
  - Corridors of Service: English-speaking clients need access to services at English-speaking hospitals and from English-speaking health care providers, rather than accept the Corridor of Service.
  - Provincial Boundaries: Need to ensure that English-speaking residents of Québec can continue to access services in English from other provinces (if unavailable in Québec).
  - Referral and follow up: Address how doctors/hospitals work with clients, directly and/or through First Nations health centre (privacy issues and quality of care).

- Telephone reception services—Option to speak with an English-speaking agent.
- Ageing population: Support for Elders is needed.

- Rights and Responsibilities – English language and Aboriginal Rights
  - Information about language policies and legislation is needed (i.e., Health and Social Services Act) to access services in English.
  - Bilingual staff at provincial institutions: *Provincial agencies receive per-capita funding to provide services to First Nations communities, therefore they should ensure that there's at least one person on staff who is bilingual.*
  - Advocate for English-speaking services for First Nations communities.

- Aboriginal culture and traditional languages
  - Health field needs to recognize Aboriginal Peoples cultural practices and languages. For First Nations who are speakers, services need to be made available in the language. *"We need to work in our language. We could provide services to our Elders. Because our Elders are not in the picture. They need to be put in the picture for the health services even if it's from the provincial government," Naskapi Nation.*
  - Visibility of First Nations: Provincial institutions need to have First Nations' designs and pictures visible in the buildings to encourage Aboriginal Peoples to access services from the province.
  - Respect: When outsiders work in the community, they need to respect the people—respect their language, culture, and health needs.

- Training and employment
  - Training for trainers (increase the number of English-speaking trainers.)
  - More training opportunities (health and social services) in English.
  - Recruit Aboriginal professionals to work in the communities in the areas of health and social services. It is very important to have Native people with university degrees working in the community.
  - Promote bilingualism (i.e., through training opportunities for staff).
  - Remote Areas: Incentives for (local) Aboriginal workers to work in the community (i.e., lodging, rented vehicles, outing allowance).

- Address discrimination and improve cultural sensitivity
  - Cultural Awareness workshops and updates for staff at First Nations and provincial institutions.
  - Orientation sessions with various health professionals/organizations about First Nations culture and services available in the communities.
  - There needs to be respect for culture, traditional ways, and First Nations languages in the delivery of health and social services.

- Complaints process
  - Establish a process to gather and address complaints from clients (related to language and culture).
  - Track access issues.
  - Identify possible long-term effects if change does not happen and services are not accessible.

- Translation services

- Funding required for translation.
- Identify and prioritize which documents to translate into English.
- Referral Forms—Need to indicate the client's primary language.

- Liaison and support services
  - Liaison person for English-speaking clientele (phone calls, fill out forms, and help to navigate through the provincial network).
  - Escort/Support Person (translation and to navigate provincial institutions).
  - *There's this big building, and we're at the building, and there's no door. At least with an Aboriginal liaison there would be a door, and they could say, 'Go see this person… To have someone on hand to understand and translate like that would fix a lot of the problems that we are facing." (Kitigan Zibi)*

- Information and awareness
  - Share information about where and how to access English-language services from provincial institutions in Québec (i.e., create a list of bilingual service providers (issue: high turnover rate).
  - Share information using different methods (i.e., newsletters, radio, website, posters, presentations, and workshops).
  - Telemedicine: Access to video conferencing for specialized services.
  - Address First Nations perceptions and beliefs about accessing services from provincial institutions.

6. CONCLUSION

This research was conducted to expose issues and challenges that English-speaking First Nations face when accessing services from provincial and federal systems. The conversation began in the east, in the Mi'gmaq communities of Gesgapegiag and Listuguj; then information was gathered from Mohawk territory in the communities of Kahnawake and Kanesatake; then west, in the Algonquin communities of Timiskaming First Nation, Kitigan Zibi, and Eagle Village | Kipawa; the research concluded in the north, in the Naskapi Nation of Kawawachikamach.

The data collection took place over a period of five months, from March 12 until July 24, 2013. Additional Research was conducted from October 4–October 11, 2013. (The follow up research was preliminary only, and was conducted in a short time frame. It is anticipated that more communities would have participated had there been sufficient time to conduct the research.)

A total of one hundred and thirty participants took part in this research (key informants from health and social services, as well as community members); fourteen focus group sessions were held, involving all eight of the participating communities; and a total of nineteen interviews were conducted. Finally, at the conclusion of the research, each community had the opportunity to complete a questionnaire in order to gather additional research; a total of three communities completed questionnaires, involving an equal number of key informants.

A common theme among the many focus group sessions and interviews was the recognition and awareness about "the difficulty and the need" to strike a balance between workers' rights to speak French in the workplace, and clients' rights to receive services in English. As well, First Nations participants spoke about the pressing need for more information about where and how to access services in English. *"We have the right to access services in a language that we can understand, and in the province in which we live,"* said one participant.

Many of the participants spoke about the 'double discrimination' that they face: as English-speaking individuals, and also as First Nations. Language and culture are closely connected; participants spoke about the need to break down barriers between provincial, federal, and First Nations' organizations, and to build relationships based on respect. In the words of an individual who took part in this research, *"First Nations need to consider how important it is for their partners to properly understand their history and culture, and to be able to perform in a culturally competent way when providing services."*

In rural, urban and remote areas from six of the province's administrative regions, the issues and challenges were discussed, exposing common issues.

The following are the key priority areas with respect to accessing services for English-speaking First Nations:

- Communication—language barriers when communicating with workers.
- Jurisdictional issues: Provincial borders, corridors of service, and Federal/Provincial responsibilities for First Nations.
- Access to documentation and information in English.
- Cultural discrimination and lack of cultural sensitivity.
- Attitudes and perceptions (fear, anxiety that there will be a lack of understanding because of language and culture).
- Access to specialized services in English (*rural and remote areas: lack of access to general services and services in English).
- Long wait times for services, and even longer wait for services in English.
- Lack of availability of training in English in Québec.
- Emergency / Crisis services (emergency room and dispatch).
- Funding (lack of funding for services such as translation and liaison workers).
- Dissatisfied with the quality of services in English.

This research was conducted to create a portrait of access challenges when accessing services. The research exposed the challenges facing English-speaking First Nations when accessing

health and social services from provincial and federal systems; the research also identified solutions to those challenges.

Over the course of this research, participants from the various First Nations communities spoke about the challenges that they face, as well as the strategies either in place or recommended to improve access to English-language services. In general, common among all the communities, was the perspective that English speaking First Nations need to be actively involved and engaged in the assessing, planning and delivery of services at all levels with non-governmental organizations and networks; with the province (local, regional, and central); and with the federal government. Similarly, as expressed by the Coalition of English-speaking First Nations of Québec, *"If First Nations are not being adequately consulted, and if communities are not represented at the Tables, then decisions should not be made on behalf of First Nations."* Simply put, *"First Nations need to be at the Table."*

The research is intended to contribute to English-speaking First Nations' long-term vision of expanding and building partnerships to improve their access to health and social services from provincial and federal systems. Because of First Nations unique relationship with both governments—federal and provincial, there is a need for a tripartite initiative to be used to address the challenges noted in this report. Reflecting back to the principles of the Three Pillar Policy: that is, restoring health through community development; reaffirming the traditional relationship of Aboriginal Peoples with the federal government; and strengthening the relationships among the components of the health care system, change will be possible. Those who participated in this research recognize that English-speaking First Nations face difficulties, in particular stemming from language issues, when accessing services from provincial and federal systems. Despite the challenges, many English-speaking First Nations voiced their commitment to seek lasting solutions that will lead to community health and wellness.

7. RECOMMENDATIONS

1. **Expand and build partnerships with federal and provincial partners**

    - Develop protocols when working with both levels of government (federal and provincial) to mitigate jurisdictional gaps for First Nations when accessing services.

    - Establish and foster relationships with provincial institutions (local, regional and central levels). English-speaking First Nations need to be meaningfully involved in the planning and delivery of services to ensure that the needs of English-speaking First Nations are being responded to appropriately and effectively.

    - Meet regularly with partners to discuss concerns and challenges.

2. **Develop a strategic plan that reflects the linguistic and cultural needs and priorities of English-speaking First Nations to improve access to services.**

    - Identify the legislation and policies (e.g., Québec's Act for health and social services. Three Pillars / Indian Health Policy), which could contribute to developing lasting strategies that meet the linguistic and cultural needs of First Nations.

    - Address the 'issues, challenges and strategies' facing English-speaking First Nations.

    - Establish formal mechanisms to track access issues and challenges in First Nations' communities (that is, continue to identify the emerging issues, challenges, and solutions by and for English-speaking First Nations).

3. **Establish protocols and agreements with provincial institutions based on the needs and priorities of English-speaking First Nations.**

    - Formal mechanisms are needed to ensure a continuity of understanding and communication between First Nations and provincial organizations – at the program delivery level (i.e., regular meetings, committees, roundtable discussions, etc.)

    - Evaluate protocols and agreements between First Nations and the province to ensure proper implementation (identify other gaps or challenges in the implementation strategy).

4. **Collaborate and network with non-governmental organizations and networks to improve access to services for English-speaking people in Québec.**

5. **Integrate First Nations history and culture into the planning and delivery of services – foster cultural sensitivity.**

    - Cultural awareness workshops help to bridge gaps of understanding.

    - Identify any misconceptions that may create obstacles for First Nations when accessing services from provincial institutions.

6. **Share information and raise awareness about services (including English-language services), which are available for First Nations from provincial and federal systems.**

    - First Nations' organizations and provincial institutions need accurate information about the programs and services available at their partners' institutions.

    - Provide information about how and where First Nations can access services from the province.

7. **Long-term funding is required to build and expand partnerships to effectively address access issues and challenges.**

    - Transfer Payments: The federal and provincial governments need to be able to meet the cultural and linguist needs of First Nations to

improve access to health and social services from provincial and federal systems.

8. **Formalize the Coalition to enable English-speaking First Nations to address their unique linguistic and cultural needs in order to improve access to services from provincial and federal systems.**

    - Representative of the Coalition to sit on the Provincial Committee for the delivery of health and social services in the English language to ensure that English-speaking First Nations' access issues are addressed appropriately.

APPENDIXES

Appendix A: Table. Coalition's Aboriginal Health Transition Fund (AHTF) Projects

First Nation Community	Organization	Project Title(s)
Gesgapegiag	Gesgapegiag Health and Community Services	1.) Improved access to detoxification services adapted to the needs of the Gesgapegiag and Listuguj communities. 2.) Development of a plan for continuity of services between the Centre de Santé et des services sociaux de la Baie-des-Chaleurs and the Gesgapegiag Health and Community Services.
Listuguj	Listuguj Community Health Services	1.) Improving Access to Health Care Services: Listuguj, Québec and New Brunswick Collaborative Development.
Kahnawake	Kahnawake Shakotiia'takenhas Community Services	1.) Exploring Partnerships—AHTF Integration Project—Onkwata'karitashera.
Kanesatake	Kanesatake Health Center Inc.	1.) Assessing, Enhancing and Integrating Health Services for Kanesatake. 2.) Cultural Adaptation of Pre-Hospital, in-Hospital and Post-Hospital Services and Liaison for Kanesatake.
Eagle Village - Kipawa	Eagle Village Health Center	1.) Miwijiwa Minomatisiwin: project focusing on improving the health care and follow-up among the members of the Eagle Village First Nation community (MM).

Appendix B: Excerpts – Health and Social Services Act

Table. Excerpts from 'An Act Respecting Health and Social Services' Chapter S-4.1, which refer to both language and culture:	
OBJECTIVE OF THE ACT	Article 1: Services are to "maintain and improve" an individual's physical, mental and social capacity to carry out their roles in their community. Article 2: Services are to be provided on continuous basis to meet the physical, mental and social needs of individuals, families **and groups.** Each region's distinctive characteristics must be taken into account (geographical, **linguistic,** sociocultural, **ethnocultural** and socioeconomic). Article 3: The user must be treated with "courtesy, fairness, and understanding" and in a way that respects his "dignity, autonomy, needs and safety"; the user is to be encouraged to play "an active role" in the care and services that concern him; the user is to be provided with information to use services appropriately.

RIGHTS OF USERS	Article 4: To be informed about health and social services available in his community. Article 5: To receive continuous care in a personalized and safe manner. Article 6: To choose the professional or institutions from whom or which he wishes to receive health services or social services. Article 9: When receiving care of any nature, his consent must be given. Article 10: Every user is entitled to participate in any decision making affecting his state of health or welfare. Article 15: E**nglish-speaking persons have the right to receive health and social services in English,** keeping in mind the resources (human and financial) that are available and the regional 'Access program.'
USER'S RECORDS	Article 19: When an institution transfers a user to another institution, a summary of their information must be provided to the institution taking charge within 72 hours after the transfer. Article 24: At the request of the user, an institution must send a copy, summary or extract of the user's record as soon as possible to another institution or professional.
EXAMINATION OF COMPLAINTS	Article 29: The board of directors of every institution must make a by-law to establish a complaint examination procedure. Article 30: A local service quality and complaints commissioner must be appointed by the board of directors of every institution. Article 33: The complaint commissioner shall distribute information to increase understanding of the **rights and obligations of users and the code of ethics.**
ASSISTANCE BY COMMUNITY ORGANIZATIONS	Article 76.6: When a user wishes to address a complaint, the community organizations involved must collaborate in providing any assistance and support requested by a user.
GENERAL PROVISIONS	Article 80: The mission of a local community service centre is to offer "health and social services of a preventative or curative nature and rehabilitation or reintegration services **to the population of the territory served by it.**"
LOCAL HEALTH AND SOCIAL SERVICES NETWORK AND LOCAL AUTHORITY	Article 99.3: The purpose of establishing the network is to foster "greater sense of responsibility" among providers of the network and to ensure that the people in the territory have "continuous access to a broad range of general, specialized and superspecialized health services and social services." Article 99.5: The local authority is responsible to identify: "the social and health needs and the **distinctive characteristics of the population.**", "Supply services required given the **needs and the particular characteristics of the population.**" Article 99.8: The local authority must use different methods of informing and consulting the public in order to involve people in the organization of services and determine their level of satisfaction.

FUNCTIONS	Article 100: The function of the institution is to ensure provision of safe, continuous and accessible health or social services which **respects the rights and spiritual needs of individuals**…respond to the needs of the various population groups…**elicit and facilitate the cooperation with other key players (including community organizations**). Article 101: Every institution must: i.) receive any person who needs services and assess his needs; ii.) **provide the required health and social service directly or from another institution** with whom it has entered a service agreement; iii) ensure that services are "continuous and complementary" with those provided by other institutions and resources of the region, **and that services are organized in a way that reflects the needs of the population it serves**; iv) refer persons to whom it cannot provide certain services to another institution or body that provides them. 108: An institution may enter into an agreement with another institution: for the provision of certain health services required by the user of the institution.
BOARDS OF DIRECTORS OF PUBLIC INSTITUTIONS	Article 129: The board of directors is composed of persons who are elected, designated, appointed or co-opted (**including two independent persons** elected by the public in an election). Article 130: The board of directors must be made up of an equal number of men and women. Article 138: Selection of board members must ensure a "better representation of the territory and **better sociocultural, ethnocultural, linguistic and demographic representation** of the population served by the institutions. Article 171: Board of directors shall establish strategies focusing on the populations to be served… and taking into account the **distinctive geographical, linguistic, sociocultural and socioeconomic** characteristics of the users and of the human and financial recourse of the institution.
HEALTH AND SOCIAL SERVICE AGENCIES (Regional Institutions)	Article 339: The Government shall establish an agency for each region. Article 340: Each agency shall: prepare a multi-year strategic plan; ensure mechanisms for referral and coordination between institutions; develop information and management tools adapted to the **distinctive characteristics** of those institutions; develop a mechanism to **protect the users and for user rights advocacy.** Article 343: Agency shall ensure implementation of a mechanism for public participation (i.e., users' committees). Article 346: Agency shall: i.) ensure that information on health of the population is up to date and accessible and ii.) identify the needs of the population (for its multi-year strategic plan). Article 348: Agency shall collaborate with institutions to **develop a program of access to health and social services in the English language for the English-speaking population of its area**…or develop jointly with other agencies of another region (taking into account the human, financial and material resources of the region). Program must be approved by the Government and revised at least every three years. Article 349: Each agency must, with bodies representing cultural communities and the institutions of the region, facilitate accessibility to health and social services in a manner, which is **respectful of the characteristics of those cultural communities.**
BOARD OF DIRECTORS (Regional Agencies)	Article 397.3: When appointing board members, the Minister must take into account representation of various parts of the territory of the agency, the sectors of activity and the **sociocultural, linguistic and demographic groups**, as well as the different age groups.

ADMINISTRATION OF THIS ACT	Article 508: The Government shall designate (from among the institutions recognized under section 29.1 of the Charter of the French language (chapter C-11)) **those institutions, which are required to make health services and social services accessible in the English language to English-speaking persons.** Article 509: The Government shall provide for the formation of a **provincial committee** advising the Government on: i.) dispensing of health and social services in the English language; ii.) approval, evaluation and modification of each access program developed by an agency. Article 510: The Government shall provide for the formation of a **regional committee** that shall: advise the agency about the access programs developed by the agency; ii.) evaluate and suggest modifications to access programs.

Data Collection

The data collection for this research took place over a period of five months, from March 12 until July 24, 2013. Additional research was conducted in a short time frame, from Oct. 4–Oct. 11, 2013. This research was preliminary only, and was conducted in a short time frame. It is anticipated that more communities would have participated had there been sufficient time to conduct the research.

- A total of 130 participants took part in this research. Total participants: 130 individuals (100 community resources (health and social services and AHTF key informants) and 30 community members.
- Target Groups – Community resources in Health and Social Services; Community Members (Elders and/or their caregivers; parents with young children; and individuals with people with chronic health conditions, both men and women); Key informants (Aboriginal Health Transition Fund project—AHTF), community resources and community members.
- Focus group sessions: 14 focus groups: 10 with community resources and 4 with community members.
- Interviews: 19 interviews – (6 with key informants involved with AHTF projects; 9 key informants (health and social services); and 4 with First Nation community members.)
- Questionnaires: Three key informants completed 'Follow Up Questionnaires' as part of this research.

Appendix C: Table. Focus Groups, Interviews & Questionnaires

First Nation Cmmunity	Region and Administrative Zone	Data Collection	Target Groups	Number of Sessions	Number of Participants	Total
Gesgapegiag	Rural La Gaspésie-Iles-de-la-Madeleine (11)	Focus Groups	Health and Social Services	1	6	2 focus groups
			Community Members	1	8	1 interview
		Interviews	Key Informant (AHTF)	1	1	*1 Questionnaire*
		Questionnaire	Health and Social Service	1	1	*16 Individuals*

Listuguj	Rural Border La Gaspésie-Iles-de-la-Madeleine (11)	Focus Groups	Health Services Social Services Community Members	1 1 1	8 5 8	3 focus groups 2 interviews *1 Questionnaire*
		Interviews Questionnaire	Key Informant (AHTF) & Key Informant (Health Services) Key Informant	1 1 1	1 1 1	*24 Individuals*
Kahnawake	Urban Montérégie (16)	Focus Groups	Health Services and Social Services	1 1	5 7	2 focus groups 11 interviews
		Interviews	Key Informants (AHTF) Key Informants (Community Resources)	3 8	3 10	*25 Individuals*
Kanesatake	Rural Laurentides (15)	Focus Groups	Health and Social Services	1	10	1 focus group
		Interviews	Key Informant (AHTF) Key Informants (community members)	1 4	1 4	5 interviews *15 Individuals*
Kitigan Zibi	Rural Border L'outaouais (07)	Focus Groups Questionnaire	Health and Social Services Community Members Key Informant	1 1 1	13 4 1	2 focus groups *1 Questionnaire* *18 Individuals*
Eagle Village - Kipawa	Rural Border Abitibi-Témis-camingue (08)	Focus Groups	Health and Social Services Community Members	1 1	8 6	2 focus groups *14 Individuals*
Timiskaming	Rural Border L'Abitibi-Témis-camingue (08)	Focus Group	Health Services	1	9	1 focus group *9 Individuals*
Kawawa-chikamach	Isolated La Côte-Nord (09)	Focus Group	Health and Social Services and community members	1	9	*1 focus group* *9 Individuals*
				TOTAL	**130 participants**	**14 focus groups** **19 interviews** **3 questionnaires (follow up reearch)**

Appendix D: Interview Guide for Aboriginal Health Transition Fund (AHTF)

ABOUT THE RESEARCH

The project *Expanding and Building our Partnerships to Improve Access*, is a multi-year project that will operate from 2012-2015, with funding from Health Canada's Health Services Integration Fund (HSIF). The project is sponsored by Onkwata'karitáhtshera, which is an agency that oversees health and social services in Kahnawake (a Mohawk community on the south shore of Montréal).

The goal of the project is to formally establish a Coalition. Currently, there are eight First Nations communities involved. The Coalition of English-speaking First Nation Communities in Québec (CESFNCQ) is comprised of the following communities: Eagle Village First Nation, Listuguj, Gesgapegiag, Kitigan Zibi, Kawawachikamach, Kanesatake, Timiskaming and Kahnawake.

One of the Coalition's objectives is to address the challenges faced by First Nation communities in the province of Québec with respect to accessing health and social services in English.

As part of this work, the Coalition is overseeing a one-year research project. The goals of the research are to create a portrait of the situation by documenting:

- The challenges and issues that First Nations face when accessing health and social services in English in the province of Québec.
- The strategies and solutions needed to address the challenges of accessing services in English.

The results of the research will be shared at a forum with the First Nation communities, and their federal and provincial partners.

An independent research consultant has been mandated to conduct research for the HSIF Access Project. **As part of the research, interviews are being conducted to seek out information about the successful strategies that English-speaking First Nations communities developed through previous Aboriginal Health Transition Fund (AHTF) initiative.**

We will be contacting you to make arrangements to conduct a telephone interview using the following questions. If you are interested, please read through the questions, and complete the consent form at the end of the questionnaire. Thank you.

Should you have any questions about the HSIF Access Research contact:

Project Management Team	Project Researcher:
Dale Jacobs Winnifred Taylor	Amy Chamberlin, M.A. Listuguj, Québec
Organizational Development Services (ODS) Kahnawake, Québec	

AHTF – Interview Questions

Part 1 Questions on Challenges, Issues and Goals

To start, I would like to learn more about the project that your community developed through the Aboriginal Health Transition Fund (AHTF) initiative:

1. Generally, can you describe your community's AHTF project?
2. What gaps were you trying to address? (In particular, any access issues related to language).
3. What were the main activities that your organization undertook through this project to accomplish your end goal? Please provide examples.
4. What were you hoping to accomplish or realize through the project?

Part 2 Questions on Outcomes

We would like to hear more about what resulted from the project.

1. Can you tell me about any changes or outcomes that may have resulted because of this project?
2. Did you identify other gaps or needs, particularly related to language, from this project. Please provide examples.

Part 3 Questions on Long Term Impact

The following questions address the long-term impact of the project and what happened after the project initiative came to a close.

1. After the AHTF project came to a close, did the initiative continue in any way? Please describe what has been happening.

2. From your perspective, how can the solutions developed through the AHTF projects be sustained over the long term? What is needed to make sure the strategy has a lasting impact?

3. In your view, how might other First Nations communities benefit from the strategies or solutions that your community developed to address access issues? Describe the lessons learned.

Part 4 Closing

1. Are there any other comments that you would like to make?

Thank you for your time.

CONSENT FORM

Community: _____

TITLE OF AHTF PROJECT(S): _____

_____

_____

CONTACT PERSON: _____

PLEASE CHOOSE:

We accept to have a telephone interview based on the 'Interview Questions'_____

We do not accept to have a telephone interview based on the preceding questions _____

We will prepare answers to the questions and email our responses _____

LIST OF PARTICIPANTS FOR TELEPHONE INTERVIEW:

NAME	ORGANIZATION	CONTACT INFORMATION	AHTF PROJECT (If more than one project is listed above)
1.			
2.			
3.			
4.			

Thank you

Appendix E: HSIF Focus Group and Interview Guide

EXPANDING AND BUILDING OUR PARTNERSHIPS TO IMPROVE ACCESS
Health Services Integration Fund (HSIF) Project

FIRST NATIONS – FOCUS GROUP

1. Welcome and Opening Prayer

2. Roundtable Introductions

3. Introduce HSIF Research and Purpose of the Focus Group (Consent Forms)

4. Group Discussion – Sharing Experiences

   HEALTH BREAK

5. Group Activity – Challenges and Issues (Group List and Top Access Issues)

6. Roundtable Discussion – Where do we go from here?

7. Closing

CONSENT FORM

I, _____, (your name) voluntarily agree to participate in the research for the project *Expanding and Building our Partnerships to Improve Access*. This project is funded under Health Canada's Health Services Integration Fund (HSIF) and sponsored by Onkwata'karitáhtshera, a health and social services agency of Kahnawake.

I understand that the research is being conducted by Amy Chamberlin (researcher), with assistance from a community research liaison. The goal of the research is to document a portrait of the situation for English-speaking First Nations when accessing health and social services in English in the province of Québec.

For the research:

- I agree to participate in a focus group and/or interview.
- I agree that the focus group and/or interview may be recorded.
- I agree that pictures / video may be taken, which may be used for the report.
- I understand that my participation is voluntary, and I only need to answer those questions that I am comfortable answering. If at any point during the process I wish to withdraw for any reason, I may do so without explanation.

The results of the research will be shared at a forum with the First Nation communities, and their federal and provincial partners. Thank you for taking the time to participate in this research project. Your assistance is appreciated.

Please indicate

Community name: _____

Organization: _____

Signatures:

_____

Participant (focus group or interviewee)

_____

Facilitator

_____

Date

The following questions will be used to guide the focus group:

IDENTIFYING CHALLENGES & BARRIERS, AND WHAT IS WORKING

1. What were some of the general obstacles that you faced when accessing health and social services?
2. Did you experience any challenges because of language and culture? (Who, what, where?).
3. Tell us about your positive experiences when accessing services from the province (highlight what is working).

PRIORITY AREAS

4. (Group Exercise – Optional): List out in point form the challenges, issues and obstacles when accessing services (general access issues, related to language and culture).
5. As a group, what are the five most pressing challenges, issues or concerns that need to be addressed with respect to accessing health and social services from the province?

SOLUTIONS

6. Describe ways that you (or your organization) have overcome the barriers that you face when accessing health and social services in English from the province?
7. In your view, what is needed to make sure that you and your clientele can access health and social services in English from the province? i.e., What are the best ways to share information? Can culture play a role? Describe ways to overcome barriers.

Health Services Integration Fund (HSIF)

Access Issues and Challenges: Transportation / Lodging

The following questionnaire was developed to gain insight into any challenges or issues that your organization (or clientele) may have encountered when travelling to larger urban centres for medical reasons. As well, the purpose of the questionnaire is to identify solutions (either in place or recommended) to overcome those challenges.

If you wish to participate in this HSIF follow-up research, you may respond to the questions in writing; or, if you prefer, you may arrange for a short telephone interview (15-30 minutes).

The interviews will be held October 8-11, 2013. ***All questionnaires must be returned no later than October 11, 2013.***

CLOSING COMENTS

Any other comments or questions?

Appendix F: Questionnaire – Transportation and Lodging

1. Your name and position within organization: _____

   _____

2. Organization's name:

   _____

3. Contact information (email or telephone number):

   _____

4. Are you satisfied with the transportation/lodging services that your organization (or clientele) accesses when travelling, for medical reasons, to larger urban centres? (check one)

   Yes (satisfied) _____ No (not at all satisfied)

   _____ Somewhat satisfied _____

5. Explain the reasons (why or why not) that you are satisfied with the transportation / lodging Services:

   a) Transportation (comments):

   b.) Lodging (comments):

6. Describe strategies that your organization has used to address any challenges or issues with either transportation or lodging services.

7. Do you have any recommendations to improve transportation or lodging services?

8. Any additional comments?

Appendix G: Key Access Issues and Challenge for English Speaking First Nations

Kawawachikamach

Community Resources & Community Members

- **Respect:** for culture and among people.
- **Language barriers (communicating)**: between First Nation and provincial institutions and lack of information about where and how to access services are available in English from the province.
- **Accessing English language services:** in the community and from the province is challenging in the North.
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French.
- **Training**: limited training available in English in Québec.
- **Emergency (ambulance) services are inadequate.**

Gesgapegiag

Community Resources

- **Lack access to health and social services both general and specialized** (English or French).
- **Language barriers (communicating)**: between First Nation and provincial institutions and lack of information about where and how to access services in English from the province.
- **Training**: limited training available in English in Québec.
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French.
- **Double discrimination**: English speaking persons and as First Nations.

Community Members

- **Emergency services** at provincial hospitals are not always available in English.
- **Quality of services in English**: Communication issues when seeking services, lack of documentation in English, privacy issues when translation is needed.
- **Cultural discrimination.**
- **Long wait times** (at emergency hospital and for specialized services).
- **Lack information** about what where and how to access services from the province.

Listuguj

Community Resources

- **Rights and responsibilities:** Information lacking about services available to First Nations from either federal or provincial systems.
- **Access to specialized health and social services in English** (specifically for mental health services and addictions).
- **Language barriers (communicating)**: between First Nation and provincial institutions and lack of information about where and how to access services in English from the province.
- **Cultural discrimination / lack of cultural sensitivity.**
- **Jurisdictional issues** (local, regional, provincial and federal). Difficult to access services in English from out of province.
- **Lack of funding**: First Nations services expected to provide more services with same level of funding.
- **Lack access to judicial services in English** for clients under Youth Protection.

Community Members

- **Attitudes and perceptions**: Fear, anxiety, frustration, being alone, not being understood because of language and culture.
- **Long wait lists for services**: longer wait for services in English.
- **Lack of funding** (provincial and federal governments) for health and social services.
- **Need liaison and escort services** (translation and support for Native people).

Kanesatake

Community Resources

- **Attitudes and perceptions**: province's general unwillingness to provide services in English.
- **Legislation**: Québec's language laws creating when seeking services in English.
- **Long wait times for services in English.**
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French.
- **Jurisdictional – corridors of service** — difficult to access services in English.
- **Cultural discrimination**: Lack of cultural knowledge outside of the community.
- **Lack of access to provincial services** (specialized) (despite previous AHTF work).

Community Members

- **Access to local general and specialized services in English** (psychologists, family doctors).
- **Emergency phone services (dispatch**) – French only.
- **Cultural discrimination**: ignorance (cultural insensitivity).

- **Attitudes and perceptions**: Staff at provincial institutions not willing to speak in English.

Kahnawake

Community Resources

- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French.
- **Jurisdictional issues / accessibility of services** for clients closer to home in English—corridors of service is a challenge to obtain services in English in the Montérégie.
- **Communication**: Need a basic understanding of information from doctor/nurse, or institution.
- **Time-frames** for accessing services (long wait) due to language barriers and at same time dealing with day to day life. Impact for individual gets compounded.
- **Training**: limited training available in English in Québec. If legislature is from the province and they expect us to do things in a certain manner, they should be providing us the ability to take the training. "They obligate" us but "do not accommodate."

Eagle Village – Kipawa

Community Resources

- **Accessing specialized services in English** from the province (extra distance to access those services, added cost and stress to individual and family members).
- **Training** (limited training available in English in Québec.)
- **Documentation** – follow up reports, feedback, and treatment plan.
- **Funding** (Funding for English language services at private clinics, when unable to access services from provincial institutions in Québec; Translation services; point of service charges for 'out of province' medically required care.)
- **Quality of services in English** – evaluations and assessments.

Community Members

- **Communication** – Verbal communication with staff at provincial institutions (reception, doctors, nurses) (lack of translators).
- **Documentation** – Forms, letters, information.
- **Jurisdiction –provincial boundaries / travel**: Being "forced" to stay in Québec, rather than being able to access closer services in English outside of the province. "*It's difficult to deal with the long travels… my father has to travel two days to travel to Montréal for a one-hour appointment, whereas Sudbury is only two hours away.*"
- **Funding** – NIHB and difference in pay rates between provinces.
- **Long wait times** for specialized services, and longer wait times for services in English-language.

Kitigan Zibi

Community Resources

- **Accessing specialized and general services in English from the province.**
- **Language barriers (communications)** with provincial institutions.
- **Documentation**: Forms, documentation, resources, and correspondence from the province are primarily in French.
- **Cultural discrimination**: Racism, need to be more culturally sensitive.
- **Training**: limited training available in English in Québec.
- **Jurisdictional issues** (provincial boundaries, and with different levels of government, both federal and provincial)—difficult to access services in English out of province.

Community Members

- **Emergency service**s – Need to address the 'Emergency response time' (ambulance services).
- **Care for Elders** – Linguistic and culturally appropriate care for ageing population (long term residential care) is needed.
- **Attitudes and perceptions**: Respect for basic human rights. Community members have a right to receive health and social services in the language they can understand.
- **Documentation** –Receive documentation in English (forms and information).
- **Communication** – with specialists is difficult because of language.

Timiskaming

Community Resources

- **Accessing specialized services in the language of your choice** (i.e., speech and language pathologist, audiologist, treatment centres).
- **Training**: limited training available in English in Québec.
- **Documentation**: Forms, documentation, resources and correspondence from the province are primarily in French.
- **Quality of services – gaps in discharge**: Lack communication between institutions when clients are discharged; discharge summaries are all in French.
- **Jurisdictional issues**: Lack of freedom of choice to access services because of corridors of service, provincial jurisdictions, and transportation.

Appendix H: Community Findings

English-speaking First Nations Communities – Community Findings

The Community Findings section is a compilation of the findings from all 14 of the focus groups, as well as the interviews held with each of the eight participating First Nations' communities; namely:

i.) Kawawachikamach

ii.) Gesgapegiag

iii.) Listuguj

iv.) Kanesatake

v.) Kahnawake

vi.) Kitigan Zibi

vii.) Eagle Village | Kipawa

viii.) Timiskaming First Nation

Specifically, data was collected from two groups—First Nations community resources and community members. For the majority of the communities (five of eight), focus groups or interviews were held separately with the two groups; two communities held focus groups or interviews with community resources only (note that most of the participants are community members); and one community held its focus group with representation from both groups (community members and community resources).

Thus, the data is presented to reflect the manner in which it was collected, and the composition of the groups; as such: **a.)** Community Resources; and **b.)** Community Members. (Note: For the community of Kawawachikamach, the findings are presented together, Community Resources and Community Members, because one focus group was conducted with deliberate representation from both groups.)

The findings were grouped into four broad areas:

i.) General access issues and challenges;

ii.) English language access issues;

iii.) Access issues related to culture (Aboriginal); and

iv.) Positive experiences.

These finding are included in the report to enable each First Nation community to develop action plans for their respective communities based on their individual needs and priorities.

NASKAPI

1. Kawachakimachach

a.) Community Resources (Health Services and Social Services) and Community Members:

i. General Access Issues and Challenges

Lack of general and specialized health and social services in the region (in either English or French).

- We don't have any specialists. For all kinds of specialists we have to go down south. To get a scan or all kinds of tests.

Distance to access services (travel).

- Distance to access specialized services: We don't have any roads here. We only travel by plane or by train.
- Costly to travel (lack funding).

Quality of care – 'errors are being made', mixing up clients' names due to communication issues.

- My sister was sent to Montréal for something, and the doctor told her there's nothing wrong with you. It was another person who was supposed to go.
- They sent the wrong patient to Sept-Îles.
- There was a case where there was an error in medication. The names [of clients] were the same, but the medication was sent to the wrong house.
- *Elder's experience (translated from Naskapi into English)*: Our Elder was explaining to us, his daughter has a medical problem, epilepsy. She received medication and the medication that she received was expired.

ii. English Language Access Issues

Language barriers (communicating) – Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses and reception (front line workers). Participants spoke about being unable to fully participate in meetings with provincial workers because of language barriers.

- The first language [at the CLSC] is all in French, it's very hard for a community where that is their second language, to go and see the professionals where they can't speak English.
- It's very dangerous [if professionals and clients are having difficulty communicating].
- Just because it's a CLSC run by the provincial government, that doesn't mean that every one of us speaks French.
- Community workers are not attending meetings with the province because of language barriers.

Calling provincial institutions is difficult because of language barriers. Participants described the long delays waiting for an English speaking professional when calling provincial institutions (hospitals, CLSCs). Some stated that they were being hung up, while waiting for an English-speaking worker. Community resource workers may persist and call back; however, concern that, 'some people will not phone back.'

- I phoned the [hospital] to ask for information and they asked me to speak in French, and I said I don't know how to speak in French. They said they would send me to someone else, but they hung up. So, I phoned right back, and found someone who can speak in English.

Medication/prescriptions: Information (in writing) about medication and prescriptions is not readily available in English.

- All the instructions are in French, and they won't give you them in English [in writing].
- Doctor prescribes medication and writes prescription in French. And they will translate and tell the patient how to take them. If they give them three or four different medications, how do you know how to take them? Easily mix up the medication.
- Sometimes the doctors don't talk about what are the side effects with these medications (relaxation, depression pills, sleeping pills), when they are prescribed.
- When they order medications to come in, all their instructions for use are in French. The nurses will rephrase in English. Then, they give you instructions [in writing], but they are all in French. I am tired of fighting, but I keep doing it.

Lack of mental health services in English – Participants spoke about the lack of English-speaking mental health professionals. A psychologist visits the community on a monthly basis, and frequently only speaks French.

- We also need an English psychologist. Frequently the psychologist we have here comes once a month. We have huge problems regarding mental health and it's only once a month he comes here and he frequently speaks French.

- All the instructions for the medications are in French. Our community's second language is English [third language is French].

Translation services are insufficient – There is a translator at the provincial hospital; however, participants noted that the translator is unable to keep up with the demand for English language services.

- Regarding health issues, when I went to see the Elder this morning, when he went down south for a medical examination they sent him a written letter, and it was written in French and he had to run around and look for a translator regarding that letter. He found one outside of the community.

- In Sept-Îles we have a translator, but we only have one translator in a big hospital like Sept-Îles. Sometimes there are two or three clients there at the same time. That translator isn't going to go from room to room to translate for the Elders. The hospital in Sept-Îles is French. Why can't they send them to an English hospital with a translator? With an escort?

Documentation from the province is primarily in French (forms, posters, clients' records). Community resources spoke about being impeded in their work because of the lack of availability of English-language documentation.

- All the information, all the posters everything is all sent in French. I threw it all in the garbage and phoned them back and said 'Please send it in English, this an English-speaking community.'

- Just because we work for the provincial government doesn't mean we have to speak French. Kawawachikamach, their second language is English.

- I'm a social worker and I have access to peoples' files, records. I can't read them because they are only in French. I can't help the clients because I don't know their backgrounds. It impedes me.

Ageing population – Community resources reported that Elders are not seeking services from provincial institutions. 'Elders don't go to the doctors if they have pain.' Participants stated that the elderly are not comfortable going to the CLSCs because of language and there is a 'lack of trust in the system'.

- A lot of Elders don't go to the doctors if they have pain. In the end they may have something very serious. They are not comfortable going to CLSC because of the language.

- Elders won't tell. They won't say anything. I just know that with cancer, they are dead within a few months. A lot of people outside of the community down south, who have access to all the services if something is wrong they go to see a doctor their cancer is caught in time. If you trust where you are going you will go and get help, but if you don't trust where you are going you won't go to get help.

Judicial: Social Services interfaces with the Department of Youth Protection and the Provincial Court System—limited services are available in English. Language presents an obstacle when accessing a client's reports/assessments. Confidentiality must be maintained, which makes translation of the documents more difficult.

- Youth Protection – access issues resulting from language.
    - The Justice Department sends everything in French to parents—they [parents] don't understand anything.
    - Every document that is processed through the Department of Youth Protection is written in French.
    - Requests for translation of Youth Protection documents (assessments) are rejected by the province.
    - The challenges that people here in Kawawachikamach face regarding Youth Protection is translation. They need to have someone translating the interviews to English.
    - They say that the Youth Protection here is like the residential school system.
- Court system (divorce, custody, child protection.)
    - When the papers arrive here in Kawawachikamach they are in French. I can't translate, I can't take these documents and give to anyone to translate because they are confidential.
    - Even in the court, we had to complain a lot of times in order to go to court and have proceedings done in English. They were given

in French and you have to complain and write letters before individual cases are heard in English.

- Your lawyer won't translate everything said by the prosecution.

Emergency services: There are challenges accessing ambulance services because of language—there is a lack of bilingual emergency workers. Participants described their frustration with the system, for example it was stated that an ambulance will only go to individuals' homes if a nurse or provincial health care professional places the call. There is a lack of information about funding (who is responsible to pay for the ambulance). The response time is very slow, generally speaking, which is only exacerbated by poor roads. [general access issue and obstacles because of language].

- We also have bad experience with ambulance services. They are all in French. Ambulance services, they speak only in French, they're not too good when they speak in English.

- They are not equipped, they don't have the certificate equipment that Québec City, Montréal, or Sept-Îles have in the ambulance. I don't know if they are trained. It takes a long time to get ambulance from town to here, from Schefferville to here. Sometimes the cases here are severe. We had one that took over one hour and half, for the ambulance to come in. And the Elder died at the CLSC.

- [Elder's experience, translated from Naskapi into English]: Even when the ambulance arrives and it goes back to Schefferville with a patient in there, our road is really bad. It's not paved, if a person is having a minor heart attack in the ambulance it's bumping around all over the place.

- I had to take an Elder to the CLSC that night and to me, she died in my truck. She was already fading away. We kept talking to the nurse, he was speaking in French. He refused to get that ambulance in…I think that the services here in our community are not too stable. We know we live in an isolated area, but more and more services have to improve. We have to get more improved services for our people here in our community. It's not there right now.

- At the CLSC when there is an emergency, and when you call the CLSC the first thing you get is a recording. The nurse will accept your call and they have to go out and evaluate the problem, assess the problem and they are the people who will decide if the ambulance will come into our land. They will decide that…If you live in the city and you dial 911, that ambulance will be there at your doorstep. Why isn't it the same here in the northern region?

Limited access to training in English in Québec.

- [Social workers/nurses]: All the education that I am supposed to be getting every year, all the workshops, are all in French. I can't go because I don't speak French.

- Language legislation causing barriers for clients seeking services in English: Participants spoke about the difficulty of striking a balance between the workers' rights to speak French in workplace and clients' rights to receive services in English.

- Elder's experience, translated from Naskapi into English]: Our Elder went down south for a medical check up, when he got to the hospital he had a face-to-face confrontation, but when he was speaking English he was told 'You have to speak French you are in Québec.'

- At the CLSC, the nurses talk to each other in French, and you don't understand anything. That happened to me a couple of times at the CLSC I experienced that with my mother died. I didn't get much information about what was happening with my mother. They were talking in French.

- Nurse will talk to the doctor, explain the case right in front of them to explain the case in French. Patient is sitting there listening to this conversation and doesn't know what is happening. Getting more stressed. Happening everywhere in Québec, and here at the CLSC.

iii. Access Issues related to Culture (Aboriginal)

Recruiting and retaining English-speaking professionals in the First Nations community is a challenge. English-speaking professionals may be limited to working only in the First Nations' community because of language barriers. Further, nurses, social workers and other professionals in health and social services are required to be part of the Professional Order; however, the documents and correspondence are all in French.

- Native nurses [English-speaking] aren't coming back because of the language problem.

- The Professional Order of Social Workers—everything is sent to me in French. Because I don't speak French, I am a reserve only social worker, but I pay

the same dues as everyone else, $600. Yet, no access to documents, I can't even ask questions.

First Nations' rights are not being respected. Participants stated that community members are "being taken advantage of" if they don't speak French. Client's rights are being violated because "workers [at provincial institutions] talk about you, but you don't know what they are saying." Elders, in particular, are vulnerable: many elderly only speak Naskapi, and they may not be aware of what is happening with their health.

- [As a nurse], I feel that they are taking advantage of people who don't speak French in this community. They are really taking advantage of you. They talk about you, but you don't know what they are saying about you. They know you don't understand.

- [Community members] can't talk back. You can't tell anyone what they said because you don't know what they said. You can't complain.

- Talking about you, but you don't know what they are saying, your rights are violated.

- Elders over here only speak Naskapi. Their escorts may talk French, but the Elders themselves don't know what is going on. And that is part of the patients' rights! You need to get all the information in English.

- If they don't want to see a certain nurse, they are told they have to. People need to be informed about what are their rights. Here they think it's a privilege, not a right, to have health care. To be more informed. It's also a communication thing they don't have enough information forwarded to them.

- Not only the Naskapi, but all Native people are facing racism. There is an attitude of colonization. The White values, the French values are more important than the Naskapi values. That all of us are just children, we all drink too much. We are not very smart. Our work is not good enough…we have to be fighting all the time for rights that are already given to everyone else. But we have to fight for them every day. We don't have the right to be informed. We don't get any respect given to us for who we are and what we are.

Discrimination and lack of cultural sensitivity – Participants stated that First Nations are facing discrimination at provincial institutions. Community resource workers spoke about their frustration with the lack of cultural understanding and awareness about Aboriginal history, culture and social context. Many spoke about the lack of respect and 'feeling judged' by provincial workers.

- One time, there was a conversation that was in French. [The provincial worker said], 'this money comes from our pockets. It's my money, I pay taxes.' … Someone like that should not be working in the Health Centre or in the Native community. It's very discriminatory.

- At the CLSC, they sometimes are judging—they think everyone drinks in the community. That mentality.

- It's a constant battle—one youth protection worker told me, 'Naskapi people are not fit to be foster parents.' This is the attitude, there is a complete lack of respect to say something like that.

Provincial training provided to health professionals in the community: Obstacles because of language and a lack of respect for cultural protocols.

- Education institutions that send students to the North for training need to respect community protocols, culture, and language.

- The doctors they come in here to practice, but they can't practice alone. They treat us like guinea pigs. Imagine how high risk we are!

Funding issues – in particular for travel and escort services.

- Travel is according to how much money we get every year. We have to stay within that budget, or we won't get another CLSC. In the meantime, we don't always get the money for travel. In order to save money we can't send Elders on the train. Still it's very hard on people when they don't have what they need.

- [Elder's experience, translated from Naskapi into English]: Our Elder spoke about the escort that was needed. His son had a small surgery, a small bypass. He was going to have an escort, but at that time he was not provided with one because there were no funds for an escort.

MI'GMAQ

2. Gesgapegiag

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Lack of general and specialized health and social services in the region (in either English or French).

- It is a challenge to access services in either English or French in this region.

Long wait time for services (specialized).

Distance to access services (travel).

- Challenges accessing specialized services because of distance and the travel involved.

Perceptions and beliefs about the quality of services at provincial institutions.

- Clients sometimes don't go to get services they really need because they believe it's going to be frustrating.

Gaps in discharge from provincial hospitals.

- A client suffering from PTSD who went to the hospital for help. He didn't want the medication they offered, and became frustrated. Security threw him out at 3 A.M. and he had to walk home.

Quality of care.

- When you call you get bounced around and end up in a department you don't even want. One member tried to get his address corrected and couldn't manage to do it. He also had a problem in that his file was confused with his son's, which could have resulted in a significant accident. "I don't trust those guys, I have to be pretty damn sick to go there."

ii. English language access issues

Lack of access to specialized services in English – Participants spoke about the lack of services for detoxification and treatment services, special needs, speech language therapy, and mental health. Clients need to go out of province to receive services in English. Further, the funding for services is inadequate, in particular for mental health services.

- Lack services in English for detoxification and treatment services.

- Access to services for families with special needs is very difficult. First Nation health centre brought in services from New Brunswick for autistic child because none in the area. Services in English for Downs syndrome children are very limited, even off reserve.

- Lack services for English language speech therapy.

- Mental health services are very limited in English.

- Clients are being referred to institutions out of province for individual counselling, etc.

- Funding issues—Under RAMQ, 10 hours of counseling is covered, and then Gesgapegiag Health and Community Services must pay.

Lack of access to services in English at local hospital: maternity services hospitals and emergency room services.

- Labour and birth are not ensured in English, even though the Gesgapegiag birthrate is so high.

- At [local hospital], the emergency room nurses are not bilingual, except at triage.

Judicial: Social services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. Participants commented that 'Facts get lost in the translation; confidentiality is difficult to maintain if interpreters are used; issues with fairness when going through the court system; lack of local services in English for young offenders.

- Young offenders—First Nations' social workers seek assistance with translation from co-workers to deal with the Justice Department about young offenders, "that's confusing as there is so much back and forth, the facts get lost in translation." Using an interpreter also raises the problem of confidentiality and privacy for the client.

- Clients have a right to legal proceedings in English but it is the client who has to ask. Often the judge and lawyers are trying to speed things up by proceeding in French. Workers reported that 'sometimes clients are pleading guilty when they should not, just to speed things up.'

- Long-term young offenders must serve their time in Montréal, as there are no English services locally.

Language barriers (communicating) – Nurses and reception are less likely to speak English.

- Sometimes nurses yell if people can't understand French, as if speaking louder would help!

Calling provincial institutions is difficult because of language barriers – clients and workers face obstacles when attempting to speak with someone in English by phone.

- Even bilingual service providers leave French-only telephone messages so [community workers] cannot understand what they are saying and don't leave a message for them. Once someone at the hospital actually hung up on a worker [community resource] when she was dealing with an emergency situation.

Issues accessing services from provincial help line numbers because of language. Community workers rely on out of province lines or U.S. lines.

- Service providers need to check telephone help lines before giving them out to clients, and many are not capable of serving people in English (rely on out of province lines or U.S. lines).

Documentation from the province is primarily in French. Participants described the difficulty in their work because documentation from the province is mainly available in French. Examples provided include: information provided to patients about their respective conditions; client assessments/records; documentation from the province about English Access Plan; forms from the province; directives from Centre de jeunesse.

- For follow-up care, for example, documentation in English is inadequate—people need reassurance when hearing diagnosis, etc., they come back from the hospital not sure of the information and so it's scary. They come back from Rimouski (for specialized services) with nothing but French documentation.

- Social Services: All documentation on young offenders is received in French only and often the court proceedings are in French only: "If I am struggling I can only imagine what our clients are going through."

- Documentation is in French only about English Access Plan.

- Invitation to meeting about access to services in English came only in French.

- Forms are in French only.

- Centre de jeunesse directives come only in French.

Tracking information – Participants described obstacles because clients' information may be charted in French, which then requires translation for English-speaking home care nurses and clients themselves.

- Nurses have the option to chart in French or English. If nurses are French speaking, they may choose to chart in French even if they work in a First Nation English speaking community. These summaries (in French) then go to a home care nurse who only speaks English, they have to have them translated.

Provincial boundaries – Obstacles for clients seeking English services for detoxification 'out of province.' Participants stated that clients are seeking services out of province, primarily from New Brunswick and Nova Scotia. Although there are service agreements in place between provinces, nevertheless some clients are being turned away from centres because they are 'from out-of-province.' Participants stated that the distance to obtain detoxification services is 'somewhat of problem', however it also ensures that people may complete treatment because 'return transport' is only provided to those who complete their treatment.

- First Nations organizations are sending clients to New Brunswick and Nova Scotia for detoxification services.

- Campbellton [detoxification centre] will not accept referrals, except after all New Brunswick patients first. Miramichi does not follow that same rule.

- Québec and New Brunswick have a service agreement, so there should be no difference in access to services for clients.

- While the distance is somewhat of a problem, it also ensures that more people stay to the end of their treatment cycle because return transport is only provided for people who complete their treatment.

- Being forced into corridors of services rather than where we feel comfortable (out of province).

Limited access to training in English in Québec – Health workers are required by law to have training, yet there is limited opportunity to access training in English in Québec. Funding for training can also be an issue.

- Training opportunities in English are limited in Québec.

    - We are taking the mental health training in New Brunswick instead of here because it was not available in Québec.

- Workers seek training in the Maritimes.

- Issues with the quality of training, when translated.
  - I don't get the full impact if it's translated.
  - The Commission should arrange for some of its training in English with French translation because sometimes the translation is not a great quality and it's tiring having the headphones on all day.

- Under Law 21, health services needs to keep up regular training, but access in English is often a problem.

- Funding for training can be an issue.

iii. Access Issues related to Culture (Aboriginal)

Jurisdictional issues between federal and provincial governments: in the community, there is a lack of services for physically handicapped persons (disputes over fiduciary responsibilities).

- Health services is having a hard time with a physically handicapped person who is living on the reserve: the federal government does not provide services and the province argues they should not have to provide services either.

Difficult for First Nations to access to services despite being included in the population count for the region

- Why are Natives not given equal access to services when we know they are counted in the population figures for Québec health care?

Discrimination and lack of cultural sensitivity. First Nations community resources need to 'go beyond their mandates' to make up for the gaps in services resulting from language obstacles and discrimination.

- [Hospital] nurses have told First Nation' workers that First Nation clients should get health care in their own community: imagine what they say to the clients.

- Lack of services in English and discrimination against First Nation members means First Nations' resources often go beyond their own mandates to make up for gaps.

- Feeling of being doubly-discriminated—(English-speaking and First Nations).

- If I learn anything I will learn Mi'gmaq, not French.

iv. Positive Experiences

- **Joint projects between the province and First Nations** (i.e., through Aboriginal Health Transition Fund (AHTF)) – Projects have helped to foster relationships at the management level between First Nations community organizations and provincial institutions. Participants commented that, "as a result we have some protocols in place and some things have improved. At the managerial level, there is a good rapport with the CSSS managers; however, it does not necessarily trickle down to the front-line workers."

- **Agreements with the province** – Health services has an agreement with the CSSS to hire our nurses to give home care services (soutien à domicile) in the community.

b.) Gesgapegiag Community Members:

i. General Access Issues and Challenges

Quality of care – Participants described their general lack of trust in the provincial institutions responsible for providing health and social services.

- Too many residents practicing at the hospital, impacts the quality of the services.

- Those who go often [to the hospital emergency walk-in] see consistently poor services.

- Another time, a participant had gone in for mental health services, but all they wanted to do was put her on medication. "I felt they were trying to kill me. My body is not used to that."

- The yelling by the hospital staff makes people feel afraid and defensive. "And they never say they are sorry."

- An Elder who would like to be at home is being kept in the hospital because he might fall—but he has fallen in the hospital and also in a rehab centre, so he might as well be at home where he is more comfortable. "He is being held against his will."

- The emergency ward is the worse department, and generally it's always the same staff members there.

- Those who go often at the emergency in the hospital see consistently poor services.

Perceptions and beliefs when seeking services from provincial institutions – Participants described their fear and anxiety.

- Elders are afraid to go to the hospital by themselves. They do not want to ask questions and so do not usually understand what is going on.

- Clients sometimes don't go to get services they really need because they believe it's going to be frustrating.

- There was general agreement that many community members avoid going to the hospital out of fear, and therefore they are deprived of prevention medical treatment.

Long wait times, in particular to access specialized services and at emergency rooms in hospitals.

- At least one participant waited three years to see a specialist.

- One participant took a child with a fever to the waiting room and had to wait for hours, but nobody every came to check on the child.

Distance to access services (travel) is an issue.

ii. English language access issues

Language legislation causing barriers for clients seeking services in English.

- Many community members believe that nurses can speak English but many simply do not want to, "they want you to speak French." Québec's new language policy [Bill 14] is creating even more problems, according to one community member. He said he has picked up most of his French from extensive time spent at the hospital.

Language barriers (communicating): Doctors may be bilingual, however less so for nurses or front line workers (reception).

- Participants often have to call the hospital for family members whose English or French is not as good. One community member lost 40 pounds as she did not understand fully the impact of the cancer treatment she was receiving.

Perceptions and beliefs – Community members stated that language is interfering with quality of care when seeking services from provincial institutions.

- They are rude if you can't explain in French and don't take the time to get to know you.

iii. Access Issues related to Culture (Aboriginal)

Discrimination and lack of cultural sensitivity.

- There was a general feeling that local hospital is not a very good place for Native people.

- There was general agreement that First Nations are twice discriminated against: first as Natives, and then as English-speaking clients. "The first thing they ask you as a Native person is if you drink or smoke." One participant, who was 17 at the time, was not believed when she said she was not pregnant. They dismissed her pain and sent her home. In about one month it was discovered she had ovarian cancer. She also believes they did not give her strong enough painkillers after her surgery because she was native.

- "Pain is pain; First Nations people should be treated like French or English patients and not denied painkillers when they are needed."

- [Staff at provincial institutions] look down at you for being native. There seem to be stereotypical attitudes towards natives. One person was told during the recent road blockade, 'You should let the doctors and nurses through,' although they had nothing to do with the blockade.

- One participant had to go for a surgery at a hospital [further away] and says she was treated much better there. When she had to use [local provincial] services due to an infection and other complications, she was told "Why aren't you getting services at your own [First Nations'] clinic?" She was made to feel very bad about going to the local provincial institution.

Jurisdictional issues – Lack of clarity about who is responsible to fund services for First Nations (federal and provincial governments).

- They start passing you around, who is going to pay; the province or the federal government? You just about need a psychiatrist by the time you come out.

- They don't care about you, they only care about the money they are getting.

Some First Nations are not aware that they have a right to access services from provincial institutions (such as CLSCs) – lack information about where and how to access services.

- During the meeting, a number of First Nations' community members realized for the first time that they have a right to go to the CLSC for services. They suggested we make sure people know their health care rights.

Quality of services – Community members felt that patient's confidentiality was not being maintained in the communications between the hospital and the community health services.

- It would appear hospital personnel are dealing with Gesgapegiag Health Center Services about personal medical situations, rather than calling community members directly to set up appointments, etc.

3. Listuguj

a) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Lack of general and specialized health and social services in the region (in either English or French).

- Difficult to access specialized services from the province (in either French or English).

- Difficult to find family doctor—long waiting lists in the region.

Lack information and knowledge about where and how to access services from the province.

- Do not have enough information about where and how to find services or specialists in the province.

- It is difficult to understand the medical terminology for health conditions, even if the explanation is in English.

Distance to access services (travel).

- Distance to access specialized services is an issue.

- Costly to travel (lack funding).

- Difficult for caregivers to accompany clients/family members to urban areas for medical reasons (costly).

ii. English Language Access Issues

Language barriers (communicating): Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses, reception (front line workers), and support staff. Participants described the need to have English services for mental health. Participants described the difficulty of participating fully at meeting with provincial workers because of language obstacles. There is a general feeling of frustration because of language barriers when communicating.

- The doctors all speak English, but it's the support staff who can't, or don't want to, speak English. That's the difficulty.

- Mental health services: If the person walks into a place and they're getting the impression that this person doesn't really understand them, they'll ask 'why am I going there?'; It's hard enough to get them to go to counseling. They won't go back; They won't open up, they won't talk; You have to have someone who is fluent…you want to be comfortable that what you are saying is being interpreted in the way and meaning of what you are saying.

- Long term care at hospitals: "If you send them to the hospital in Québec, they're grumpy about it because most of the patients are French-speaking so they can't communicate with other people, or even their roommate."

- Obstacles because of language at meetings: When at meetings, and because we're English, it's like we're punished. We're the one's having to wear translative devices all through meetings for days on end, we're listening and we're watching lips, we're trying to take notes, and you're exhausted by the end of the day.

- People are frustrated so they don't want to go [seek services].

Calling provincial institutions is difficult because of language barriers – Participants described their frustration

when trying to call institutions and the lack of English services at reception.

- When you call an institution, the person answering will say 'Can you hold on a moment, we're going to find someone who speaks English! Ten minutes later, they might come back.

Participants described the difficulty of accessing English language services from provincial help line numbers.

- Elders abuse hotline, sexual assault hotline: no options or limited options for English services.

- The Elder abuse, the hotline number is very difficult to access for a lot of community members. We've always come back to that same question 'When an Elder is being abused, who do they call?' Where do they go? Because when they try to access that 1-800 number, it's all French, all French.

Documentation from the province is primarily in French. Examples include: forms, information, and materials. Lack funding to translate documents, and waiting for translation means delays in services.

- A lot of information that we get is in French, even from organizations that deems themselves bilingual.

- Lack funding to translate documents, materials or forms: If you want to translate it yourself you can, but do you realize how expensive that is?!

- Long wait period when requesting province to translate documents.

- Reports [for Youth Protection] come back [from the province] in French, need to ask for reports in English or our liaison will translate for us. That causes delays.

- [Social services]: Especially with Centre Jeunesse, all of their forms, and all of their information is in French and we have wait a year if not longer to get it in English. Sometimes we don't even get them, they just say 'Oh, we never got that translated yet!'

Provincial databases are mainly available in French.

- Social services: We're still waiting for the Information Management System from the province for the foster care to be translated—it's been over one year.

- Health services: Database system for vaccine immunization and updates are available in French only.

Provincial boundaries – Participants described a range of barriers when seeking services in English from 'out of province': jurisdictional issues, being 'bounced back and forth', being denied services, in particular for detoxification, because clients are from 'out of province'; issues with funding and clients need to pay out of pocket for services, and full reimbursement from the province is not guaranteed. Participants are being encouraged to stay in the province of Québec rather than go out-of-province to obtain services in English (even if the service is closer in another province).

- People are bounced back and forth between the hospitals in New Brunswick and Québec depending on the issues.

- [The boundary] divides the population and influences when they are willing to go to the hospital.

- Psycho-social care is not accessible in New Brunswick for Québec residents (at the NB regional hospital): If you are struggling with mental health issues, end up in an ambulance all the way to Maria [rather than nearby bilingual hospital in New Brunswick], then I will have a French speaking person, and not deal with what I am really struggling with, language barrier and of course the cultural components.

- Funding: For some services, you have pay up front, and then get reimbursed [from the province]; Patient isn't reimbursed for the full amount (i.e., methadone clinics).

- There's not that many border towns in Québec, I can't see why an agreement can't be made between the provinces!

- Detoxification services and treatment services: Patients seeking services from some institutions in New Brunswick are put on waiting lists because they are from Québec (New Brunswick clients first)—"a pregnant lady inquired about detox services in New Brunswick. Because she is from Québec it was indicated that she was put on a waiting list, despite the urgency of this request."

Lack of access to specialized services in English – Participants noted that there is a need for English speaking specialists in areas such as mental health services, speech and language specialists, and physiotherapists; there is a lack of support group services in English for special needs and chronic conditions; and patients are 'left on their own' to find English speaking specialists.

- We don't have many English speaking specialists (for instance, for mental health services, speech and language specialists, physiotherapists).
- People have problems accessing services for addictions in English in Québec.
- You can always find a psychologist or psychiatrist to do an assessment, but you can't find someone to do the therapy in English.
- Lack support group services in English for families (mental illnesses, physical disabilities, or different disorders, such as autism).

Long wait times for services in English

- The waiting list is long if we need a psychological assessment done because we are limited to the number of psychologists or psychiatrists who actually speak English. It tends to delay services, it's a longer waiting list, sometimes up to a year.

Judicial: Social services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English (legal and follow up care.)

- [In our region] there are no English-speaking lawyers accepting legal aid for Youth Protection files. Going to court and a lot of our clients don't have representation. Difficult for family, difficult for us as workers. Difficult process for everyone involved, tends to be lengthy.
- Under Youth Protection and adult care—many barriers that we see for services in the province of Québec, almost 90% of services are from the province of New Brunswick. Montréal is where we would access English speaking services [follow up care.]

Rehabilitation centres (addictions, Elders, youth) – Limited services in English in Québec (distance, long waiting lists, jurisdictional issues.)

- In my area [social services], we are seeing higher numbers of mental illness coming forth, we're doing more placements for young adults who suffer from mental illnesses and cannot live independently on their own, we don't have any services in Québec that we can have access to.
- Another barrier with clientele is rehabilitation centres for addictions—centres are far away, and we can't always access services in New Brunswick.

Crisis situations (trauma, crisis, and emergency) – Difficult to access services from the province because of language barriers [general access and obstacles because of language.]

- There are people that are in trauma or crisis, they will not access the services in the area because of the language. If they want to go to the [nearby English speaking hospital, out of province], they are interrogated, assessed, then sent to [hospital on the Québec side] so you have to go through the process twice. And if you are kept there, they only have French speaking staff—you could be waiting a long time before you see anyone who speaks English.
- Recently, while I was on call [social services] I received a call from [Québec hospital in the area] at 4 A.M. for a sexual assault victim. They were looking for someone at 4 A.M., and there was no one who spoke English.

Limited access to training in English in Québec.

- Social services—We haven't had any training in English.
- Health services—Training is limited, we usually have to go out of province.

Lack of information and knowledge about which services clients may access in English from the province.

- What are the rights of clients to access services in English? We're lacking information.
- Trial by error, experience. [A person] may go to a few places before they arrive at where they need to start treatment, and then they're confronted with a language barrier.

iii. Access Issues Related to Culture (Aboriginal)

Lack of communication between First Nations' and provincial organizations

- The CLSC, CSSS, and Listuguj Health Centres all have decisional trees—but, do they look at it? Do the people who work there now, do they know about what services are being provided?

Funding issues: First Nations' organizations are expected to provide more services, with the same level of funding

- You are expected to do more reports, and provide services, but they are not providing you with additional funding, they want you to do x, y, and z with the same amount of funding and always with the threat that funding can be cut and it's the same with all sources of funding.

Jurisdictional issues: First Nations have access to health and social services from both federal and provincial governments, but there is a lack information and clarity about who is responsible for what services (delivery and funding).

- Non-Insured Health Benefits (NIHB) is a real issue for us.
- It's awareness—people don't understand what is the [Non-Insured Health Benefits] NIHB, what is provincial. It's all one to them.
- There's no collaboration between federal and provincial systems about the issues.
- Lack of clarity about which medications are covered by Federal government.
- Lack of services for people with disabilities.
- Difficult to access dental care (in particular for orthodontic services) from the federal government (paper work, delays in services while waiting for approval from Ottawa, lack of clarity about which services are covered).

Rights as First Nations are not being respected – lack of consultation and ability to participate fully in decisions that impact communities.

- We're the last to be consulted, there's no consultation about changes to legislation (i.e., Law 21, First Nation communities not consulted about impact on communities).
- Under Article 21, and having people who are registered with the province…we'll be scrambling around to find qualified social workers to replace our workers
- When it comes to laws and legislation, we don't have a voice and this impacts our communities
- As English speaking Mi'gmaq people, our language rights are not being met. People are asking for [services] in Mi'gmaq.

Discrimination and lack of cultural sensitivity. There is a lack of cultural understanding and awareness about First Nations history, culture and social context.

- Provincial institutions and specialists lack knowledge and awareness about First Nations culture and history. You feel as though you are hitting a brick wall because of language and cultural sensitivity. You hear that more and more. There is a lack of understanding…there is a lack of understanding about ceremony, it's all hocus pocus to them.
- Not being acknowledged as Aboriginal, our background, population's needs. [As First Nations] we're not a priority.
- There's a litany of issues—from a cultural context, most of the people [who need social services] are marginalized already. There's intergenerational issues, historical loses regarding residential school and so on and so forth. Most of the referrals that are done outside of the community are done so with people who have no interest or knowledge of our history and that speaks volumes. This is all relevant, but there is a definite lack of understanding and I don't think it's a priority.
- The view from outside resources is that Aboriginal resources are fragmented, lack faith in community work. Institutions don't trust each other.

Services from the province are not meeting First Nations' health priorities and needs.

- The needs are always changing. We're not seeing the same issues that we saw five years ago.
- There are specialized needs for children with autism, or babies coming off methadone, or their mom's coming off methadone.
- That's the reality of our world today. We are seeing more children diagnosed with different disabilities, we're seeing more mental health issues with young adults, and we're seeing deep rooted issues.

- We need to address historical trauma. How do you deal with people from a human place? Deal with sexual abuse? Dealing with having had alcohol during pregnancy? All that stuff and how we [as First Nations] approach it is unique.

- It can start here, plant the seed but this not where it ends. It has to be taken to our leadership, that's where someone will be advocating on our behalf and someone at the top level, at those tables where they can make those changes happen to increase the funding, deal with the jurisdictional issues so that we don't have difficulty accessing professional services.

- Medical transportation services—If there are cuts to the funding for medical transportation, the patients who really need the service will suffer.

iv. Positive Experiences

- Today, there is increased awareness among community members that First Nations may access services from the provincial CLSCs. For a long time, when our office [social services] would call the CLSC they would say, 'You have your own people," that [attitude] has changed since then, but there are still limitations.

- Hospital is reaching out to First Nations community during crisis situations—victims of sexual assault are asking for community members to support them, and the hospital is calling us.

- Mental health services (suicide prevention): Hospitals are making efforts to accommodate English-speaking workers from community organizations. When I'm speaking with someone and we can't understand each other [because of language] the hospital has me fax over the information in English, then they will find someone to read my assessment of a client.

- First Nations are building connections and relationships with local provincial institutions through joint projects.

b.) Listuguj Community Members:

i. General Access Issues and Challenges

- It is difficult to get a family doctor.

- Long wait times to access services (specialists).

ii. English Language Access Issues

Language barriers (communicating): Communicating with specialists and support staff can be difficult across language barriers. Participants described their frustration and fear when requesting services in English.

- Even if [the specialist] speaks English we're not always able to communicate. I had a hard time with the translation. It's frustrating.

- Try to communicate in French, but you're brushed off.

- Some participants described "confrontations" between themselves and workers at hospitals over language.

- Other participants said they did not want to "rock the boat" or ask for services in English, for fear of repercussions to themselves or their loved one's: I always get scared that they're going to lose my paper work, and it will be put on the back burner, and I'll have to wait another month to see that specialist.

Calling provincial institutions is difficult because of language barriers – frustrating experience, long delays waiting for English services, and being 'hung up on' while waiting for an English-speaking person.

- Calling hospitals and waiting for a person who speaks English is frustrating for patients: "When I called the hospitals and they come on, and I ask them, 'Do you speak English? They say 'No', well then put someone on who does! They said well you have to wait. I said, No, I don't want to wait. Put someone on."

- Difficulty with automated telephone services: reception not always available in English, delays to speak with someone, resulting in increased frustration. *"You know the services that they have on the phone, that number for English, that number for French—dial 9, what comes on? French. They tell me, 'Someone will call you back who speaks English.' No! I tell them, I dialed 9. I'm not hanging up. I'm waiting. Sometimes, they hang up and then I have to call them back."*

Ageing population – Language barriers at long-term care facilities for the elderly; there is a lack support services in English for caregivers.

- I had a family member who had a problem at [long term care facility in the region]. They were speaking to him in French, so he doesn't understand and I don't understand. He couldn't say what was wrong with him.

- Participants described patients' difficulties at the long-term care facilities when unable to communicate with one another because of language barriers.

Language legislation causing barriers for clients seeking services in English: Striking a balance between workers' right to speak French in workplace balanced with clients' right to receive services in English; attitudes and perceptions about bilingualism.

- They [staff] understand [English] they just don't want to speak it.
- At first we had problems with the nurses, but after a little while we kept on pushing them to speak English. A lot of them do speak English, but they don't want to speak English. There was one nurse that came to us, and started talking in English and then she gasped. We're not supposed to speak English, that's what she said.
- The nurse talked to us in English, but she kept on looking around to see if there were any nurses around. They're not allowed. Language barrier there, it's not right.

Documentation from the province is primarily in French. Examples include: forms, reports from specialists, and communications/information from the province (notices).

- Forms, questionnaires and documents
    - The forms are all in French! They tell you to write it out, but I can't.
    - Filling out questionnaires is challenging: I had to have someone fill out the questionnaire for me, it was about five-pages long and all in French.
    - Why are they sending me a French form when they know I speak English? I bring my stuff [to the health centre].
    - I throw the information in French in the garbage, I don't care.
- Reports from specialists
    - My doctor in New Brunswick gets reports from [Québec hospitals], and he can't read in French, he doesn't understand…

Provincial boundaries – Barriers for clients who are seeking services in English.

- Need more information about how to access services from another province.
- Depends on the doctor, some don't want the paper work [for out of province clients].
- I had a choice for my daughters when they needed to see a heart specialist—either Montréal or Halifax, but that was twenty years ago! They won't let you choose now.

Lack of information and knowledge about which services clients may access in English from the province – participants stated that there is misinformation and communication breakdown. With respect to accessing medical services, participants asked, 'What are our rights? What are our responsibilities?' Some asked whether or not increased health services could be offered at a clinic in the First Nation community.

- As a client of the medical services what are our rights? What are our responsibilities?
- As a resident of the province of Québec, do I have the right to access, for instance a physiotherapist, on Québec's dime? I don't know. In the meantime, we're going out of province, seeking private care. Could we have our own clinic here?
- Lack information about what services are available at the local CLSCs: I only take my medical care card there, for renewal, that's it.

Emergency services: community members described their frustration when calling for an ambulance as well as the difficulty seeking emergency or walk-in services in English at provincial hospitals in Québec. [*General access and obstacles because of language.*]

- I tried calling the ambulance and they spoke French. I just threw the phone, I was so upset. And, I didn't get any English speaking person.
- I'll go the emergency [walk-in services] in [New Brunswick], rather than on the Québec side. I'll go there because I know that someone will speak to me in English.
- When my aunt was brought to the hospital, they told her 'We have to take you to Maria, My son

said, if you are going to take her there, get her off this stretcher this instant and I will take her to the hospital myself!

iii. Access Issues related to Culture (Aboriginal)

Medical transportation services are not always available in English for clients travelling to urban centres for medical reasons. Participant unable to communicate with drivers went to the wrong hospital and missed appointment.

Double discrimination—as English speaking persons, and as Native people. I've noticed something at the CLSCs, they get your file, they put it right there, then they get another file and [gestures, puts on top]. And, I've seen them do that. If the person's English or Native, they put them down, then two or three people, you're supposed to pass, but they go ahead of you.

Ageing population – For some Elders who are at long-term care facilities there are challenges because many Elders speak Mi'gmaq and they are not able to communicate with staff or with other patients.

- A lot of Elders are at these institutions [long term care] and they do speak Micmac and nobody understands what the devil they are talking about. [The staff doesn't know] if something is sore.

- They [elderly] forget English. They start speaking Micmac, and they'll talk to anyone in Micmac they don't understand that this person is not fluent. My aunt was always talking to them in Micmac. She used to tell them she felt pain here or there, but they didn't understand nothing…we would have to let the nurses know what is going on. The nurse said, 'We don't understand her.'

iv. Positive Experiences

- CLSC social worker assisted a client to access rehabilitation services from out of province for a youth who is severely autistic. The participants stated that she had been waiting for 10 years to access services, and although it took a crisis for the intervention to happen the mother describes her experience: "I was able to access services (rehabilitation) from the province of New Brunswick for my son who is autistic. It took a crisis to be able to access the services, but that's my happy story."

- Quality of care—Some participants described the compassionate nurses, willing to speak English with patients when undergoing surgery. "When my son went in for surgery on his lungs. Everybody spoke French, when he went for his operation no one came and talked to me in English. I was sitting there, getting angry and nervous. Finally, a nurse came over and explained everything to me in English. She stayed with me, and I said 'My God, I love you!"

- Services are available in English at some provincial institutions, including hospitals and CLSCs.

- Doctors and specialists are bilingual, "I see a lot of specialists, but I've never had any problems with the doctors they all speak English. French and English. I've spoken to nine different doctors all together, and they all spoke English."

- Some reported that support staff are bilingual and willing to speak in English, "If they know that you speak English, some of the support staff [at hospitals] will speak to you. Some of them do. And we speak to them in English, they understand." Another participant commented on the importance of cooperation and both parties being willing to communicate using each other's language. "You have to cooperate. If I have something that I don't understand, I'll ask. Some of them have broken English, but at least they're trying. And, we're trying to speak French, because I understand just a little bit."

MOHAWK | KANIEN'KEHÁ:KA

4. Kanesatake

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Ageing population – Participants described the difficulties that elderly people have communicating with specialists and asking questions about their health issues. Others described the difficulty that elderly clients have to navigate and find services at hospitals.

- You'll get that with a lot of Elders, not asking the proper questions that they need to ask…because a lot of times clients are too scared to even ask or know what the situation is when it comes to a health issue or problem. [Elderly taking an escort with them when going to appointments.]

- Some elderly patients, and their caregivers, have a difficult time navigating their way at hospitals: "they were French speaking and they still didn't understand, and [elderly man in his eighties] needed to get help from a stranger."

Lack information and knowledge about where and how to access services from the provincial network.

- This is part of the problem, because people don't understand…what hospital you need to go to. First of all, you'd need to go to the regular hospital, and then they would send you to the big hospitals, the teaching hospitals, the more complex, depending on your condition and what's wrong.

Long wait times (accessing appointments to see doctors and specialists)

ii. English Language Access Issues

Language barriers (communicating): Participants described the difficulty because of language barriers when communicating with specialists and support staff.

- When I escort patients, there's times when I'm trying to explain to them and it's like pulling teeth trying to have doctors speak English. Thank God I understand a little French.

- [Support staff unable or unwilling to speak English]: It took three people before they found somebody [who could speak English], just for [her to ask for] a glass of water with ice at the hospital.

Emergency services: Participants described the obstacles to obtain services in English. Clients require escorts during emergency situations to make certain that they can access the correct services (for example, drug rehabilitation services).

- I've gone on emergency calls in an ambulance, and the ambulance driver and the one working on the patient, they speak French…that's been a big barrier.

- I went to emergency about a month and a half ago, and even at the emergency desk they didn't understand English.

- I know from the rehab centre, in an emergency situation, should we have to send someone out, very often we will have to send someone French along with them in order to access the right services.

Calling provincial institutions is difficult because of language barriers – Elders are reporting difficulties when placing phone calls.

- Some Elders have a hard time calling the hospitals to ask questions or make changes to their accounts.

- Difficult to understand phone directions/instructions, which are in French.

Lack of access to specialized services in English – Participants reported difficulties accessing services in English for mental health. Confidentiality is an issue when clients need assistance with translation.

- The mental health issues are more impacted by the language barrier.

- Clients need assistance with translating personal information relevant for them to obtain services.

Long waiting times for services in English. Participants report having to wait longer to get services because of language barriers (speech language therapy, rehabilitation services, mental health services, for example).

Documentation from the province is primarily in French. Participants report that they are trying to translate information/documentation for clients. Lack of access to translated documents (legal aid).

Language legislation causing barriers for clients seeking services in English. Participants described the obstacles they face because of attitudes and perceptions around language. Participants reported feeling 'pushed aside' at provincial institutions because they are English-speaking.

- It's the attitude as well. I think that's the big thing—their attitude. It's frustrating.

- Now because of legislation it's harder to access English services.

- There's a privacy issue; it goes against Health and Social Services Act because you are entitled to receive services in your language preference.

- Double standards—If you go to a francophone speaking hospital and you know only English, there's a double standard because they know you don't understand. But I understand enough to know that we are being pushed aside, but not enough to converse with them to let them know exactly how I feel.

Corridors of service – Participants reported delays in assessments and treatment, for services such as speech language pathology because of the corridors to access services from the provincial network. Others reported challenges for any

type of mental health services in English if sent to closest hospital (by ambulance).

- Now they say that if you are not from that region you cannot access those services. I have had children caught waiting months to receive services at a hospital in a different region only to hear, 'No, we will not give you English services here. Having to go through a committee first. I have seen delays of a year-and-a-half to two-years trying to get speech language pathology assessments done.

- In our community, when it comes to people who have any type of mental health issues, or anxiety… if they are going by ambulance, then they have to go to the local hospital, which poses problems. The person must go through assessments again, when all they needed was a 72-hour watch or an adjustment to their medication, by the doctor who is following them.

- We can't get services in English if you follow the corridors of services.

Judicial: Social services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. Participants stated that clients accessing services, under Youth Protection, are experiencing delays because of language. There are challenges with translation when going through the legal system. However, clients can have their court proceedings in English, if requested.

- It may take a little bit longer, because the lawyers are searching a little bit more for their words. They will do it.

- Their language does not always match their translation, either.

- They'll ask you 'French or English?,' and if you say English, then they have to.

iii. Access Issues related to Culture (Aboriginal)

Submitting proposals for funding – perception that language is an issue when submitting proposals to government to access funding for projects.

- There are strong perceptions of language being an issue when submitting funding proposals. For example, a proposal submitted to Québec government for elderly services and three years in a row is not accepted. This past year proposal was submitted in French and it was accepted.

Jurisdictional issues – Lack of clarity about provincial and federal responsibilities for health services. Clients are 'caught paying bills' for health services. Reports about obstacles accessing services (medication) under the Non-Insured Health Benefits (NIHB) program. Participants reported inequities in what is covered under the NIHB in comparison to provincial programs geared for individuals who are receiving social assistance.

- There are a lot of different issues I'm faced with when trying to access the services that Health Canada has to offer.

- People need to find out ahead of time if the institution deals with Health Canada, if not they can be stuck paying for bills.

- Lack of knowledge about what services are covered by the province, and what services are not covered.

- For an Elder that goes in and wants to get their eyes done, there's a little bit of a barrier, wondering, 'Do they pay for the drops at the optometrist?' They go to pharmacies, and the pharmacists say, 'it's not covered.' If a person doesn't have money to pay, they may not receive their medication.

Discrimination and lack of cultural sensitivity.

- I often find that there's no knowledge that they have on how we are as a nation, versus our realities, how our version family, it is not exactly, 'your mother, your father, your aunts, your uncles,' it's the whole family.

- I find they don't know about how we are as a nation, as natives, our medicines.

- There's a second barrier, when they know you're native. There's another barrier there, so culture plays a role.

Ageing population – There are challenges for Elders because of linguistic issues and challenges related to health issues associated with ageing. Reported that many Elders are 'falling through the cracks'.

- They fall through the cracks a lot, because when you talk about Elders…first of all their first language is Mohawk. They always have someone with them to help.

- Elders face additional challenges because of language, and issues associated with ageing.

- It's happened to Elders who speak Mohawk first, where the staff [at the hospital] thought they were crazy because they've never heard that language before.

iv. Positive Experiences

- Agreements between First Nations organizations and provincial institutions have allowed for the inclusion of cultural practices. Policies in place for birth practices following Mohawk cultural practices (i.e., Aboriginal Health Transition Fund established a policy to allow parents to obtain placenta after birth, protecting rights to practice culture).

- Some participants reported that they are satisfied with the quality of care and services at provincial institutions: some hospitals described as "excellent" and "culturally sensitive". Some staff people try to speak English or provide English documents.

- Staff at CLSC are helpful—assisting individuals (knowing where, how, what is required).

- RAMQ services: Very helpful and efficient.

b.) Kanesatake Community Members:

i. English Language Access Issues

Emergency eervices: Participants reported difficulties because of language when calling for an ambulance: long wait time and needed to re-explain emergency to different dispatchers. There are delays in services when unable to communicate.

- When my 76-year-old father required an ambulance for medical emergency and needed to be hospitalized upon calling 911, I was transferred four times to different emergency responders and was told by one dispatcher, "I will forward you to the department that manages the reserve emergencies."

Lack of access to services in English; It's not right that we have to go to another province for health care in English.

Language barriers (communicating) – Communicating with specialists about health issues is difficult because of language. Participants reported that they felt that some specialists are unwilling to speak in English, despite being able to.

- For myself, I can get along fine in French, but when it comes to my own needs or my own services, I would much prefer it in English so that I can understand precisely what a doctor, a nurse, is actually saying.

- Specialist to whom I was referred for physiotherapy could not speak English.

Perceptions and beliefs when seeking services from provincial institutions – Participants reported that they felt they were being discriminated because they are English-speaking.

- I remember being laughed at because I didn't speak French very well.

- I had an appointment for physiotherapy and was getting laughed at because I was Anglophone. I was treated unfairly due to language barrier.

Corridors of service – presenting obstacles to obtain services in English.

- Ambulance is required to go to closest facility in your region. Issue for patients requiring services for mental health issues and they cannot go to hospitals where they are already receiving services.

- You may want to go somewhere else, to receive English services, but the ambulance has to go to institution in their corridor of service.

ii. Access Issues Related to Culture (Aboriginal)

Discrimination and lack of cultural sensitivity.

- The hospital nurses were unable to pronounce my name in Mohawk, so they started calling me moccasin.

iii. Positive Experiences

Quality of care – Staff at provincial institutions described as "understanding", and "willing" to provide services in English. Other participants reported that emergency service providers spoke English and were "attentive" and "caring".

- Some staff are very understanding and willing to try to communicate.

- The ambulance team that responded to my emergency was fantastic. The paramedic who immediately took charge was attentive, caring and he spoke English. He is from our community, so that helped with the transition.

5. Kahnawake

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Provincial rate of pay (fee schedule) varies among the provinces. Participants report that for some provincial services they are paying the difference out of pocket.

Lack of access to doctors and specialists.

- Health crisis due to fewer doctors and specialists (i.e., pediatrician).
- Huge issue is access to a general practitioner (GP) in the province of Québec and being able to remain in long term care with that GP.
- Quality of care—need a doctor who knows family histories.
- Lack of clarity about how Montréal's 'super-hospitals' will impact health care.

Long wait times for services.

- Length of time that patients wait for a referral to specialists is too long
- Long waiting lists to see doctors (specialists).
- Rescheduling of surgery is a problem.

Two-tiered health care: Participants reported that clients see there is an emerging two tiered health care system, and that "for a fee" individuals can buy their way to quicker services (public health vs. private care).

- For a fee, you could buy your way to quicker services (private).
- Doctors are being capped for hours (public).
- How many people get bumped by private paying patients when they are waiting for surgery or appointments? Doctors are getting capped on hours they can work, for fee you can move up the line.
- If you pay for private services you can get your results in English. We are told we don't have a two-tiered system, but we can get results if we are willing to pay.

Quality of care – Some participants spoke about their dissatisfaction (generally) with the quality of care at provincial hospitals: good service was a matter of 'luck of the draw', depending on individual staff and/or institution.

- Roulette: Shifts at hospitals determine caliber of service.
- Navigating the social and medical system isn't user friendly, it can be very complicated.
- 'Luck of the draw'—everyone has had different experiences depending on who is working and where in the hospital you are going.

Government cutbacks to health services – Participants reported that government cutbacks (provincial and federal) are impacting health and social services.

ii. English Language Access Issues

Participants reported difficulty accessing programming, support services and resources in English.

- Lot of programming out there for clients, but everything is in French.
- Finding resources in English is another story. There are not a lot of resources.

Language barriers (communicating): Participants stated that doctors are more likely to be bilingual (English and French), and less so for nurses, reception (front line workers), and support staff. Participants spoke about the difficulty of participating in meetings with the province and networking with provincial workers because of language barriers.

- The doctors are mostly bilingual, but the nurses are mostly French. The initial intake for clients is in French, which can be troublesome.
- Communicating with physicians and nurses—impacts quality of care.
    - Sometimes at triage, nurses aren't bilingual. Sometimes they will only speak French.
    - Sometimes, with nurses, you get the feeling that you are talking for nothing due to the language barrier.

- People who aren't bilingual have a hard time because most of the hospitals, clinics and doctors offices are French only.
- If I am sick, it is already scary enough and if I have a nurse/doctor telling me what is wrong and I don't understand what they are saying, it further affects me—I may not understand the diagnosis and service plan.
- Sickness is scary. Lack of understanding because of the language barrier makes it a more anxiety-ridden situation.
- Understanding is hard if you don't speak the language.
- Even hospitals themselves aren't user friendly. Everything is fast, vast and not personal and not always bilingual. It is very intimidating.

- Meetings.
  - During meetings it is hard sometimes because I can't keep up with the French.
  - Conversations get complicated because of language sometimes. I don't get everything they are saying.
  - Trend now is conference calling. Can be difficult because of language.

Lack of English-language services (general and specialized). Difficulties accessing diagnostic testing, respite, and general support services in English.

- General services: Difficult to access diagnostic testing, respite, and general support in English. If outside the Montréal area and you require health services you will experience difficulty accessing English services.
- Auditory services
  - Clients turned away from auditory testing services when seeking access to services from Montréal (different corridor of service).
  - Long wait times for English services (auditory testing) and the whole process is very confusing.
  - Lack of services for deaf clients, there are no translators (sign language) at the Kateri Memorial Hospital Centre (KMHC), it is harder to get services because there is no one to help. This is specific to our hospital, because other hospitals have these kinds of accommodations.
- Speech language therapy
  - Lack of English services for speech therapy within a good time frame.
  - We can't get English/Anglophone specialists and time is of the essence in many cases so parents/clients get very frustrated. The hospital in Montréal region only sees a child up until age of two.
  - A mother was turned away for her child's speech therapy [in Montréal region].
  - Clients went to the hospital [Montérégie region] to obtain speech therapy services for their pre-school child and were told that services were provided in French only.

Critical care – Participants reported issues with language at provincial hospitals for family members who are in 'critical care'.

- Once surgery and diagnosis is finished and the person is in critical care, then you need to be able to communicate with people who are assessing you to determine if you are passing benchmarks or deteriorating. It's that lack of confidence that community members feel that people will understand them and communicate their needs in very vulnerable situations. The hospital is not always able to ensure that bilingual people will be available.

Long wait time for services in English.

- The waiting lists for a client to be seen by English speaking doctors is long and specialists are mostly French.
- Hospital out-patient or other English programs—long waiting lists.
- Difficult to see a specialist—not enough health care providers and those that are available only speak French. When trying to get to another hospital the waiting list for a specialist was six months.

Detoxification services and treatment services – Participants spoke about the limited availability of services in English for detoxification and treatment. There are long waiting lists to access English services in other administrative regions in Québec. Clients are seeking services either out of province or in the U.S., which presents obstacles for funding (for the services and travel). There are very few treatment centres for families in Québec. Quality of English language services is problematic, participants stated some centres claim to offer bilingual services, but "in reality the services are predominately offered in French."

- Not many detox services/support for adults/youth/adolescent in Québec in English. We have experienced detox restrictions for a number of years now.
- Long waiting lists for detox services (i.e., in Montréal region).
- Not able to access beds in other administrative regions (i.e., in Montréal region).
- Psychological ward in the corridor is predominately French. They will do medical intakes for detox, but will turn away clients who are intoxicated.
- We are having difficulty finding places that will accommodate us and offer services in English. Most of the services [for detox] in our catchment area are predominately in French.
- There are also American facilities for detox, but those need to be paid for.
- Centres in the area (i.e., for long term chemical dependency) claim to offer English/bilingual services, but in reality services are mostly available in French.
- We have had some clients do their treatments in French, but it doesn't work for everyone (communication issues, coupled with the need for treatment).
- Continuity of care: If [clients] are sent to the hospital [in Québec], they will release them, and we don't have a facility that will accept them for 5–10 days. Some of them need the longer period of time for a medical detox (wash out). They need that before going into a treatment centre.
- One of the biggest client demographics is single homeless men, and the homes for them are limited. There is a recovery home in Ontario that offers a place to stay after detox; we might have them here [in Québec], but they are probably in French.
- For women using drugs with children there is no treatment program in the province in English that will work with the mother and children at same time. Have to send family to southwestern Ontario.

Provincial boundaries - barriers for clients who are seeking services in English.

- We had access to the Cornwall detox [in Ontario], however, they are changing to outpatient services, which is not accessible to us. This centre is one of the only English ones we have available.
- Funding issues (detoxification services).

Lack of mental health services in English

- It is hard to get a diagnosis in English for mental health clients, and this is needed in order to access services for the client.
- Waiting lists everywhere: patients are leaving hospitals, yet no psychiatrists available for these mental health patients. Discharge from hospitals is an issue (strain on family/community).
- We have limited options for psychologists in English.
- Assessments—limited pool for conducting assessments (non-insured, psychiatrist services). Report provided in French and organization needs to pay to have assessment translated, increases the cost of doing an assessment.

Medical vehicles (ambulances) – Participants reported obstacles because of language. English-speaking communities need to make certain that the writing inside of the ambulance is in English and not solely in French (because of Québec's language requirements).

- Issues ordering ambulances. We get them from Saskatoon and if we don't watch, the writing inside will be in French because they are meeting Québec requirements.

Translation services – Participants report that there is a lack of liaison (escort) and translation services, which are needed by English-speaking clients. Further, community organizations do not receive additional resources for translation services. Participants questioned the quality of translations, noting that there can be "serious delays" because of the "extra step" of translation (reports, assessments).

- Provincial services—There are no translation services within the Order of Nurses of Québec (re training/teaching/documents).

- Cost of translation—Lack of funding.

- Quality of translation—Attitude/beliefs, time consuming, meaning 'lost' in translation.

- [Home care nursing]: When doctors write in French, they use abbreviations that don't make any sense for translation. This is dangerous because we need to help the patients and our lack of understanding requires an extra step of trying to find someone to help.

- Waiting for translation creates delays because can't have a full understanding of documents. May miss a serious deadline. When we finally get documents in English, delay in waiting to get response to our English questions. This is all very time consuming getting response in French or poor English translation.

- When community workers asked for clarification about translated documents (reporting for data collection purposes), community workers were provided with "new" translations, along with a statement that the "translator may have been too literal with some of the wording." Concern that such translations may lead to misinterpretation, thus inaccurate data or statistics for certain programs.

- Dealing with the Montérégie (asking questions) sometimes can take up to two weeks because of the translation, or transferring of people. We have a liaison, but when she was on leave, it posed some problems.

- Delay [for translations]: impacts decision-making and deadlines.

- Verbally, orally have to find someone who is able to speak English when contacting someone at a provincial institution.

- [Paramedics]: We can't just send a document to just anyone for translation because of the medical terminology. Someone needs to have a medical background in order to translate.

Calling provincial institutions is difficult because of language barriers.

- Calling hospitals is a challenge because messages are recorded in French. If you don't wait through it, you miss the opportunity to access services.

- Problem calling hospitals for appointments, they are not mindful of Anglophones and the older population who need to speak to someone.

- Recorded messages are not always easy for the older population (50+), and if [the message] is in French, it becomes a two pronged challenge.

- French telephone-trees are a problem (at hospitals).

Provincial databases are mainly available in French – Participants commented that databases for prevention programs are not yet available in English. Working with French databases 'requires time' to get used to the French menus and titles. Some participants noted that if First Nations wanted to use data from CLSCs using the programs, the data would only be available in French.

- Enhanced Prevention Programs—access to I-CLSC program has yet to be translated completely from French to English.

- I-CLSC program (English version) is for use by First Nations communities, thus if First Nations wanted to access any data from the CLSCs using this program, the data would only be available in French.

- Centre Jeunesse of Québec—Programme Intégration Jeunesse (PIJ) program: 'We liked what the program can do, but it is only available in French.'

- For English-speaking users, it requires time to get used to French menus and titles when using a database that is in French only.

Judicial: Social services interfaces with the Department of Youth Protection and the Provincial Court System – limited services available in English. "There are problems with the translation of court orders—everything comes in French and then we have to have them translated."

Documentation from the province is primarily in French – For example, information from Professional Orders (which professionals such as nurses and social workers are required, by law, to be members); Clients' assessments; reports, invitation letters (for example, prevention programs such as 'breast cancer screening clinics'); signage at provincial

institutions; medical alerts and protocol procedures; and training information.

- Professional Orders
    - Information from Ordre des travailleurs sociaux et des therapeutes conjugaux et familiaux du Québec (OTSTCFQ): All of their information on their website and other sources of documentation (including any letters or information mailed) is provided only in the French language.
- Signage.
    - French signs make hospital navigation difficult.
- Information.
    - Provincially run institutions provide documents only in French.
    - Government literature is always in French except laws (in both).
    - Documentation given at hospital in French; nurse spoke in English but this did not help as she could not explain why client had to take medication.
    - Discharging patients only have medicine info documentation in French.
    - A lot of literature is sent to us is in French, this is a challenge for nurses.
    - Documents are only available in French on government sites. Should be an obligation to provide information in the two official languages. We need information, written documentation in English to be able to make informed decisions.
- Reports, assessments, forms, discharge papers.
    - Hospital reports are in French. Specific information/details can be lost in translation.
    - Difficult to obtain information from your own hospital file: documentation / charts are in French.
    - Requests for English reports have been denied.
    - Receiving client assessments and reports in French. When translated there are things lost in the translation. Even when requested in English, never receive it. Delays relay of information because things need to be translated first.
    - Information forms can be answered in English, but the questions are French. For medical/social, you need to be sure about the information.
    - Some templates (i.e., Home and Community Care) are sent to community organizations in English; however, the instructions may be 100% in French.
    - Ambulance forms—The forms are all in French, but all of the first responders have adapted and learned to use them. They might not specifically be able to translate what things mean, but they could tell you what box they need to tick of for something like respiratory problems. They get the sense of what it all means, and make do.
    - Discharge papers are usually in French. Montréal has more access to English documents, but other places in Québec, not so much.
    - The discharge papers are usually in French. I have some French, but it can be hard. [At hospitals that are supposed to be bilingual, participants reported difficulty obtaining discharge paper in English].
- Letters from province– French only.
    - Breast cancer screening invitation letter from provincial hospital is in French—it is not uncommon for clients to ask what it says. Contact can be challenging because it is all in French.
    - Québec health records: all the documentation came in French to everyone. If they don't understand they just toss it. There is a small box that tells you where to get it in English.

- Medical alerts, protocols and medical information.
    - Paramedics: We get special alerts and immediate protocol changes that are always sent to us in French, constantly trying to play catch up to everyone else, because we have an extra step of translation.
    - Nurses: Working documents (immunization policies and procedures)—French only.
    - Need important working documents in English i.e., Immunization Protocol.
- Training information – lack of access to English materials.
    - Networking/teaching/client information limited—all in French.
    - There is a process to translate training information. There is often a delay in getting translated English documents to use. Some don't know that they need to translate it or, they just don't want to do it in English.
    - For example, a manager spoke about attending a training session for Continuing Care Program where a document provided at the training was only made available in French.

Ageing population – obstacles for Elders to access services in English. There is a lack of English-speaking, long term care providers (and facilities) for Elders. Discharge from hospital is an issue (English reports), with additional strain falling on homecare nursing and family members. Participants noted that the elderly may miss appointments because they are too "shy and scared" to go provincial institutions.

- Lack of English-speaking, long-term care providers/ facilities for Elders.
- We have a lot of clients that are sent home from hospitals and their care falls to homecare nursing and family members. This is true in the area of special needs as well. There is no place for clients to go.
- Discharge from hospitals is an issue—places strain on homecare / family / community.
- For the Elders, the majority of the services come from Kahnawake, which is always in English.
- Elderly won't go to appointments because they are shy and scared to go there. This happens with others also, but mostly with the elderly.

Accessing English services and placements for adults and children with severe special needs is difficult. There are challenges because of limited services in the area, and transferring to a different region is difficult (corridors of service and issues with funding). Although there are organizations mandated to serve the Anglophone communities, participants stated that English-speaking First Nations are not the 'top priority'.

- Child/adult placements: Severe special needs—trying to negotiate English services is difficult
- Placements in our language of choice is difficult. Province has been very difficult in transferring the funding for placements to facilities on the island—there is a lack of English facilities in Montérégie area—we have to use [facility in Montréal], but there is a difficulty getting payments made.
- Group home and institutional care: problem to find ones that speak English. Partnership with [an agency that serves the Anglophone community]: assist in finding facility for placement, our organization is not on their priority list. Their clients come first, and we are under them. Can happen that a client is put in a French placement for one night till can find an English facility. Told by the agency that Kahnawake is not a top priority—issue for English speaking children from communities under the agency's mandate.
- Finding funding to send adults/children to English Montréal services: Province is responsible for it, but are not paying.

Access issues for youth seeking services in English. Transportation is an issue.

Corridors of service – The corridors of service have been changed in the province. For individuals on the South Shore, access to institutions and services in Montréal is restricted. The services available in the South Shore are almost all in French. Participants stated that travel is also an issue: clients must travel farther, and with less public transportation available to them, in order to access services in their own corridor.

- The corridors of service have been changed for people living on the South Shore. Access to hospitals in Montréal is restricted, clients being referred back to South Shore.

- More and more we are being delegated to the South Shore for services, which are almost all French. The "State of the art" medical services are on the island and we are being shut out because of our postal code address.

- It was stated that someone was turned away from [hospital in Montréal] and sent to hospitals on the South Shore.

- Lack information about where to obtain services, in particular if outside of the administrative region.

- When you try to call on the island they try to sector us off back to south shore.

- Mental health sector—confined to corridors if trying to get on Island.

- Hospitals in our corridors of service are far away (difficult to access services or to visit family).

- We ignore sectorization and take our patients where they should be going. Service providers are not in bureaucrat mind frame. We have built up a network with certain key people who are still willing to help our community.

- English services are available in the city. It does not make sense to be using south shore hospitals because hospitals in Montréal are only 10–15 minutes away.

Limited access to training in English in Québec.

- Nursing: Education sessions for nurses' order isn't always offered in English for those not comfortable wholly in French. Language, educational opportunities are offered only in French.

- Paramedics: We can't get paramedics trained unless they go through a program recognized by the Québec government. Not able to send anyone to New York anymore for training.

- Training offered by hospitals, but it is all in French.

- Social work order has English speaking training being offered, but it is in French so if you don't understand French you won't know there is training. Initial documents come in French. Websites or mail.

- Staff required to take training every two years, but the list of training is in French.

Liaising / networking with provincial institutions – Participants spoke about the difficulty liaising and networking because of language barriers.

- My experience liaising with hospitals is that there is a lot of bilingualism, but it is hit or miss sometimes. There isn't always someone who speaks English.

- I don't really network with services outside of the community.

- When trying to network—consistently asked if I speak French.

- Given the run around often because primary language in English. It's frustrating.

iii. Access Issues related to Culture (Aboriginal)

Jurisdictional issues – Lack of clarity about provincial and federal responsibilities towards First Nations health and social services. Participants stated that they are 'Caught in the vortex': 'We are federal responsibility and they pass us to the province.' There are gaps in terms of who is responsible to fund certain services and equipment for First Nations. For services that are covered by the federal government, there is additional waiting time while waiting for approval for funding.

- Caught in the vortex—we are federal responsibility and they pass us to the province.

- We fall under Medicare for certain things and federal government is supposed to cover other things, but there is a gap in what First Nations receive in care.

- The "Jordon Principle" has to be in place now because there is nothing being done. federal vs. provincial: who pays?

- No one catching discrepancies—no tracking what we had in the past or present.

- Funding for detox services from provincial and federal government is complex.

- Financial cut backs—impacting special needs and medical transportation

- There is inequity when it comes to health care and equipment. Simple devices that we should be getting, like the rest of Québec, are being denied to us because of funding sources.

Provincial legislation is impacting English-speaking First Nations access to health and social services.

- Bill 14: Participants expressed concerns about the impact of language legislation for individuals who want to receive health and social services in English. Bill 14 entitles workers to work in their language of choice, yet what will be the impact for those who want to receive health and social services in English?
- Bill 21: There were concerns about the Professional Order, which because of language requirements makes it difficult to recruit and retain professional workers (nurses and social workers) who are English-speaking.
- Bill 49: Impact of the Act for Family Resources, which would impact the foster care services. Information about the new criteria for accreditation is only available in French. Note: *The Health Commission is working on translating the form to English*. Database System (STRIF SYSTEM)—The data (from the 'accreditation' and 'Grid' (criteria)) will need to be inputted into a database called the 'STRIF system'; however, database is only available in French. In addition to language, there are also issues because First Nations were not consulted about the proposed changes. The new system for Foster Care placements "does not take into account First Nations culture, spirituality, sense of identity of the child and community."

Limited availability of culturally appropriate services from provincial institutions.

- We approach things differently on Reserve vs. the outside community. Family and homecare nursing mostly take care of their family members living on reserve.
- Urban First Nations call for culturally appropriate services but [Kahnawake] can't always accommodate them because we don't have the amount of staff.
- Detoxification services—We don't have any cultural/language service in English in our province for detoxification. There are cultural services in Ontario.

Medical transportation – Participants spoke about obstacles accessing funding to pay for travel in order to access services in English. Clients need to pay out of pocket for transportation to access detoxification services that are 'out of province.'

- Funding cutbacks are impacting access to medical transportation services (generally).
- Medical transport doesn't transport to some services that are past a certain distance, travel may be required in order to access services in English.
- We need to pay for our own transportation (i.e., train, bus) when accessing detoxification services out of province.

Discrimination and lack of cultural sensitivity.

- Services in Montréal are not always culturally appropriate.
- Some [clients] experience challenges because they're Native. They feel that maybe they don't get the whole service (or best) because they are Native or from Kahnawake.
- Elders have a hard time to understand papers or procedures; Pamphlets are usually in French. They express often that they are unable to understand what's going on with them and also what's going on in their environment.
- Sometimies, there is also a taboo in the way people feel about Native people. They think sometimes, maybe that there are special needs that they don't know about. I have to explain to them that they can help us.
- Culturally, we often have lots of people in the hospital. We don't fit into the mainstream way of things because we always go to the hospital for visiting in numbers. Culturally, accommodations should be made for severe illness and more traumatic instances when it comes to someone staying over night, or family visiting. One participant commented, "When my husband was at [hospital], we were having problems with them letting me stay the night because it was against their policy. They tried to take me out but I wouldn't leave, especially since he didn't speak French."

Respecting the rights of First Nations – Participants spoke about the loss of language that First Nations have already

experienced, which cannot be repeated. "There was a loss of language once, and [Aboriginal languages] were replaced with English, they cannot expect you to change your language again."

- There needs to be advocating for information for First Nations. People need to begin standing up for their rights…Making the need known is important. They cannot force you to know French. There was a loss of language once, and it was replaced with English, they cannot expect you to change your language again.

- We want the option to receive English services at provincial hospitals in our corridor, because it is our money going there, and we are entitled to it.

- Some people in Kahnawake have this mentality that they don't have to speak French, so there is negativity when going outside and everything is French.

- I believe French should be preserved because it has a similar title like all other languages and cultures. However, you cannot cram it down the throats of First Nations people. They should be offered services in their language of choice.

- It's not acceptable when people say Québec has to be French. They forget that we were here first, so we don't have to speak French.

Employment and hiring – There is a lack of opportunity for First Nations who cannot speak French, even within First Nations organizations of English-speaking communities.

- [Paramedics]: We need to bring in non-Natives to hire or to train. There are questions about why we always have non-Natives, but it's because we don't have French speakers.

- Bilingualism wasn't necessary for the position I work, but I think it helped…If someone else were in my position, they would have a really hard time. Everything that I get from hospitals is all in French. They don't have it in English unless you ask for it. I have to take the time the translate it and then relay the information.

<u>iv. Positive Experiences</u>

- Participants reported that the documentation and information available from pharmacists is in English. As well, some of the hospitals do provide information in English, however, clients' files are mainly available in French.

- When able to access services in English, participants spoke positively about the quality of services available to them. In the larger urban centres, there were usually no problems finding someone who speaks English.

    - Participants commented on the need for a positive attitude and a willingness to work together. "A lot depends on attitude."

    - There are people who do the best to help everyone and help understand.

    - Attitude of person seeking service also impacts experience. Expecting English in French environment can be difficult.

    - One–on–one calling has been positive experience.

    - There are people who are helpful and who give information you need.

    - Many of the psychologists and psychiatrists can be supportive and helpful, in particular for 'addictions and detoxification services'—however, the process can be difficult and the wait to see specialists can be long.

- Support services for certain chronic conditions are available in English from community organizations (for example, the Alzheimer's Society).

- Resources and networking—Participants reported that the Health Canada representative (regional office) is very helpful in giving direction for finding English regional services. As well, the Health Commission is also helpful getting information and direction.

- Info Santé—There were mixed responses about access to services in English from Info Santé. Some participants found the service helpful and able to provide services in English; others stated that there was a lack of English-language services available.

ALGONQUIN | ANISHNABEG

6. Kitigan Zibi

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Lack of general and specialized health and social services in the region (in either English or French). Because health and social services are limited in the area, clients need to travel to access most services.

ii. English Language Access Issues

Detoxification services and treatment aervices – Participants reported that there is a lack English treatment service centres (detoxification, specialized rehabilitation treatment for addictions, and a lack of 'after care' addictions treatment services in the area).

- There's hardly any English speaking treatment centres, and we have to choose from a list provided by Health Canada.
- A lot of the English speaking treatment centres are far away.
- If community members do access specialized treatment for their problems in Québec, in English, it's private treatment centres, which have an added cost, because Health Canada won't subsidize the cost, the additional cost, of those private treatment centres.
- Community has paid out considerably to send a few members to private clinics in Québec for English services (approximately $75,000 invested one year by the community to send three people from the community to long-term private clinics for English services in the province of Québec)
- There are issues with centres in Québec, which are supposed to offer English services: counsellors do not speak enough English to be able to deliver their programs to the English-speaking clientele.
- Our First Nations clients need to learn to speak French really quickly, or other clients at the treatment centre are translating for [the counsellors].
- For after care services (i.e., methadone maintenance plan) clients need to travel about one hour and a half to continue with their plan, distance is another challenge.
- Limited in our area, we need to go to Ontario to access services.
- We've been lucky, the detox services in Cornwall accepts our clients, although they don't usually accept anyone from Québec. If we tell them we are First Nations, they do accept our clientele.

Ageing population – Participants reported that elderly people face obstacles accessing long-term care facilities in English. There is a language barrier and are fears of 'being neglected'. In addition, some First Nations Elders face additional challenges when needing institutional care because of the traumatic history of residential schooling.

- The nursing homes in the province are all French. I'm not aware of any English-speaking nursing home.
- It's the language barrier. And the fear, for the Elders themselves, when they're getting transferred, they are scared they are not going to be understand once they get there. That they'll be neglected.

Lack of mental health services in English – Participants commented on the lack of English-services available for programming, communicating information to clients, and information from the province (reports/assessments).

- We have, as far as mental health services go, we have a real issue with [mental health hospital] because a lot of their programming is done for the French community, and it's going to be a very big barrier for our clients, especially the English speaking clients.
- Everything is in French. If we get reports, they're in French.
- Our clients will not understand what's being said about them, or why this stuff is being given to them.

Language barriers (communicating) – Participants reported difficulties because of language when communicating with doctors and nurses, in particular there are difficulties for mental health services and understanding diagnosis for chronic illnesses. Communication can be a challenge for the elderly at nursing homes. Participants noted that they find themselves acting as 'translators' between elderly clients and staff at provincial nursing homes.

- Being able to understand what the staff (doctors, nurses) are telling you, especially critical for mental health services and when receiving diagnosis for chronic illnesses.

- At the seniors' home, First Nations community workers often find themselves acting in the position as 'translator' (yet no funding provided for this service).

Calling provincial institutions is difficult because of language barriers – bilingual staff not always available to answer calls.

- If you have to call CLSCs after 4 p.m. or on weekends, it's French. They want to know why you are calling, and I myself am not totally bilingual, but I try to give them the information, it's hard because of the language.

Documentation from the province is primarily in French. Examples include: information from the province, correspondence, protocols (immunization). Participants reported that community organizations do not receive any funding from government for translation services.

- As a health care professional, it's hard because I only speak English, to access health care here, whether it's correspondence between me and a hospital, everything is done in French. Yes, we have to decipher this, but the patient has to understand the instructions given to them, and it's always in French, and since it's really hard for my clients to follow those orders, it puts their lives at risk.

- Discharge reports are all in French.

- Community health services translates documents obtained from the province, no funding provided for this.

- One of our nurses went to Santé Publique to get the new protocol for immunization, and [we were told] it's not going to be made available to us in English.

- Health Canada provided a translation [of the immunization protocol] years ago, but they do not do it annually. If there are any changes, there's an outdated English version. It's not regularly updated. We'll have to make a case to have Health Canada translate it into English. And that's just recent—the new protocol came out.

- We do have basic little hand-outs for [clients] that [the province] provides for us in English. But say a mother requires some information about the PIQ [Protocole d'immunisation du Québec] and the only information I can draw from is outdated from the older translation, I don't know how old the information is—maybe five years old. It's not right and downright dangerous.

- Community resource workers confirmed that they do not receive information from the province (for example, pamphlets) about services in English. Any information that they do receive in English is from Ontario.

Provincial databases and software programs are mainly available in French. Participants reported that it is difficult to enter and manage information in the French databases (both health and social services). The databases are not yet available in English.

- There's an immunization protocol program on our computers and it's only in French. It's a little bit hard to maneuver around that when you only speak English.

- It's hard to work with French databases, if you have it, it's really hard just to do something basic, figuring out how it works. We had to check the references all the time.

- They've tried to make [the database] available to First Nations communities in Québec, but it is still not available in English. So for us to keep up with the standard of delivery and tracking of data, in comparison with the rest of the province, we have to wait until that database is available to us.

- Panorama (database to track immunization across Canada): But as an English service health centre in a French region, are we going to be able to access the Panorama tool in English and will we be able to input our data in English, and will it be conducive to the French version?

Provincial boundaries causing barriers for clients who are seeking services in English – Clients are being denied access to some services (treatment centres and mental health services) that are out of province. (Additional paper work for First Nations, and reports that refusal from outside of the province are because of the length of time it took for the Province (Régie) to pay for services and because letters sent by the province are in French only.)

- Most English treatment centres are in Ontario, and they do not grant access without an Ontario health card (OHIP).

- We are required to fill in a lot more paperwork if we send clients to receive treatment services from Ontario's provincial institutions.

- When they ran into mental health problems, we tried to network with local mental health hospitals, but they did not have the English mental health services we needed, so we tried to move to Ottawa to access the [mental health hospital], but they were turned away. We were told, "You cannot access treatments here, you cannot access mental health treatments here. Go away. Go back to Québec." We were left with our clients who cannot speak French really well and needed communication with a mental health worker at a level they could not get. What can we do with them? We're pretty much it. [Community health services] is the extent of the mental health services that this community is going to get.

- I was doing a follow up on one of the programs at [hospital centre] in Gatineau to get an access form, a referral form, and the worker said, 'Oh, we'll put you in touch with the [mental health hospital],' in Ottawa! But, we're not even accepted at the [hospital] in Ottawa.

- There's a lot of concern about some community members. We don't know how long they're going to live in their [mental] state if we cannot access proper mental health services.

- There's a lot of refusals [from the hospitals in Ontario] because of the length of time it took for them to be paid by the Régie, and also the letters [in French] they got from the Régie.

Provincial legislation is impacting English-speaking First Nations access to health and social services. 'Bill 21' Professional Order will 'create barriers' for English-speaking professionals.

- If we do not belong to an order, there will be licensing issues because of the language.

- Barriers for us as English-speaking professionals in the community and performing assessments on our clients.

- That's a big issue for all First Nations in Québec, but more so for English ones who do not have the French training background that the other professionals have in Québec.

Lack of access to specialized services in English – in particular for speech language therapy and services for individuals with physical challenges (disabilities).

- Speech therapy for children is another place the language barrier creates obstacles.

- I think if you're accessing any provincial service, I don't know too many that are in English. For those who are disabled trying to access services, there's nobody in English.

Limited access to training in English in Québec – Cannot attain the same level of training as French-speaking counterparts (for example, for nurses and social workers). For nurses, although there is a requirement by law to receive yearly training to maintain their licenses in Québec, the training is not provided in English. Therefore, to gain clinical skills nurses are seeking training out of province.

- Kitigan Zibi English speaking nurses cannot get the same level of training that the French nurses of Québec are attaining. They are trying to gain clinical skills in Québec, but for now we send them to Ontario. However, the training needs to be compatible and comply with the laws in Québec: we need to know what the nurses are able to do and not able to do as far as delegation of responsibilities and what new skills are needed.

- There is a requirement—a 20 hour training requirement—that the nurses are supposed to obtain to maintain their licences in Québec, but if that training is not available in English how are they going to be able to do that? If they go to another province, is it going to be considered valid (by the Professional Order)?

- Social services: For training, I did try to call [someone from the province] to come down for training, but every time I made a request, it got lost somehow. I did try, and follow up, and then all of a sudden it stops. It's not that we don't try.

- Required to go out of province to Ontario in order to receive training in English "It's sad because we have to go about six hours away, when it's offered [in French] one hour away."

Participants reported that they lack information about where and how to access services in English from the province

- It's up to the [community health organization] to find services in English (for example, getting a speech therapist).

iii. Access Issues related to Culture (Aboriginal)

First Nations are included in the provincial per-capita funding, however services do not meet community's needs. "Even though the province receives per-capita funding, they are not able to offer the services up to the level that we require."

Discrimination and lack of cultural sensitivity.

- Professionals and other service providers interacting with our communities who do not understand and judge quickly.

Lack of communication from the province with First Nations because of language.

- There's a lack of communication between [First Nations health centre] and the provincial system. They don't have anybody in English to update us, and we don't find out about these changes until we go to access the services when in actuality we should have been updated with the rest of the province.

- They do publicize [information] in the paper, the local paper, but the paper is in French, so if you don't read French you will miss out on services.

Ageing population – Elders who need nursing home care face issues because of language, which may trigger 'reliving residential school experiences.'

- For some of [the Elders] who have lived in a residential school or a shared environment experience, for them it's like reliving that experience again being institutionalized. For those who cannot speak French, they feel they are reliving that situation where they are taken from a home environment and put somewhere they are not understood. For some of them it's trauma.

- Language is a big factor there. If you're an English speaker going into a primarily French environment, it's a basic communication challenge, and it triggers all other kinds of feelings.

Lacking of funding for escort/liaison services when clients need assistance because of language.

- An obstacle we face in accessing assistance, escort, or the translation services—Health Canada does not cover that cost. They took it out of our medical transportation program. At an administrative level, there's a problem from the beginning, so we need to find a way to bring these much needed services to a person who cannot speak French.

Jurisdictional issues – Lack of clarity about provincial and federal responsibilities.

- [The clients] are played like a yo-yo. If you live in Québec, [the federal government] thinks you should be the province's responsibility, but it's a challenge because we're on reserve. The province says, 'they are the responsibility of the federal.'

b.) Kitigan Zibi Community Members:

i. General Access Issues and Challenges

Lack of general and specialized health and social services in the region (in either English or French.)

- Lack of general and specialized services.

- We have to travel two hours to the city to get rehabilitation.

- Dentists. There's only one dentist and they're full all the time.

- There's no pediatrician or anything like that, and all the doctors are general practitioners. There are no specialists.

- Lack of obstetric care—you can't have a baby in the area. Any appointment you have when you're pregnant, you need to travel to the city.

- Distance to access services (travel).

- Travel – Distance to obtain specialized services. The "realities of living in a small rural town."

- We only have physicians who specialize in certain areas come in maybe once a month. That's the way it is. These are the realities of living in a small, rural town.

- Distance to obtain specialized services: we travel an hour and a half minimum; it's generally about two hours to access services in the city.

Lack of access to medical equipment in the area (i.e., dialysis equipment, wheelchair, walkers, etc.)

- Medical equipment not always available (i.e., dialysis).
- Another thing is equipment. We'll have to wait two or three weeks for certain pieces. And I guess that comes with living in a rural area, too.
- If you need a wheelchair, you need to go two hours.

Long wait times for testing.

- It took me a year to get my son tested for his allergies.
- I've waited, for certain tests, for six months or a year. I was on the waiting list here and they told me to keep waiting. It took a year.

Emergency services – emergency response time is slow generally speaking in the rural area. Participants reported additional delays because emergency workers are not familiar with the First Nations' community: they rely on GPS; however, the community 'has not yet been mapped.'

- For ambulance services, in most cases, it's a 30–40 minute wait. There are only two ambulances that cover the jurisdiction. For many of the emergency workers it's the first time they've stepped into the community of Kitigan Zibi, so they mostly rely on GPS, but a lot of our reserve hasn't been mapped yet. If they would hire somebody from the community it might make a difference. It might save lives.

ii. English Language Access Issues

Perceptions and beliefs about the services at provincial institutions: Participants reported that English-speakers avoid using hospital services because of language barriers.

- Even for community members staying at the hospital. I know there's a general feeling, 'Don't go to the hospital unless you absolutely have to.' because people don't want to deal with the language barrier.

Language barriers (communicating): Communicating with specialists and support staff can be difficult because of language. Participants reported that there is 'additional stress' on family members who are bilingual. Participants expressed the view that, 'It's a 'basic human right' to be able to receive information about your health in the language that you can understand.

- At the CLSCs not all the nurses speak English, some do—but most of them only speak French.
- I myself, I can speak French to get by, but once I happened to answer in French, they will speak really quickly. It's a big barrier.
- I had a family member in the hospital for a heart attack, and I'm the only one in the family who can speak French, so I was constantly asked to stay here and come wait to speak with the doctors. It's hard for family members.
- For older people, it's also hard understanding all these medical terms.
- No liaison services at the hospital to help clients
- It's very important to have service providers be able to speak in the language that their patients can understand because a lack of communication when you're dealing with your health could turn out to be something fatal.
- I think it's a basic right of an individual to receive that kind of information [about their health] in a language that they understand. It's a basic right, a human right.
- You need to know exactly what you're being diagnosed with. Like with my kid, my child—I'm not exactly sure what they're trying to say. So, I ask them to write it out so I can go home and Google it.

Lack of mental health services in English.

- It's difficult to obtain an English worker for mental health services. They already have limited facilities, but if you're trying to get services in English it's almost impossible.
- First Nation community workers asked to translate: "If the worker doesn't speak French, we have to be called in just to translate and make sure the information gets through."

- A child therapist and psychologist come to the community half-a-day a week, and their schedule is full all the time.

- We lack mental health services here. There are no services in Maniwaki.

- There's one psychologist here and they're always booked up.

- People are worried about seeing a therapist here in the community. They are embarrassed and don't want people to see them go into there. But if it's in the hospital, they will be less afraid. But, you need to prove you're really a threat to get a referral down to the city [to access English language services.]

Lack of access to specialized services (in either French or English) – for services such as physiotherapy, speech therapy, rehabilitation services.)

- I myself am doing physical therapy at the hospital here, and that's where I did run into problems. The first therapist assigned to me was French-speaking, and so they assigned me a bilingual one, and it seems like there's only one, because every member of the reserve is assigned this same physical therapist.

- If they need speech therapy, mental health issues, physical rehabilitation, they all have to go to the city for that.

Documentation from the province is primarily in French. For example: forms, information, signage. Reports that some staff unable to explain English (written) documentation to clients.

- At the hospitals, the emergency consent form is in French. And when you're admitted into the hospital, that's all in French.

- When my son was getting his allergy testing, they gave me a pamphlet in English, thankfully, because I'm not sure I really would have understood what he was allergic to.

- When I went for surgery, they will give you information on how to take that medication, and post-operation, how to take care of your bandages. But other than that, I can't recall ever bringing home any form of written explanation.

- Any poster or any little thing you see around the hospital, it's all in French and I don't know how they expect us to understand this. You never see anything written in English there.

Provincial boundaries – Barriers for clients who are seeking services in English

- We use a lot of services in Ontario, because of the English language. But now we're being told they aren't accepting the medical cards.

iii. Access Issues related to Culture (Aboriginal)

Discrimination and lack of cultural sensitivity.

- In our community, they will avoid the hospital at all costs. Number one, they don't understand when they do go in there. It's not only a language thing, it's prejudice—it's racist. They feel they don't get the quality of care that they should.

- I've heard talk of the racism…in the hospital. I've witnessed it myself.

- There was a nurse I knew who used to insist that you spoke French whenever you walked into the hospital, because you're in the province of Québec. She would insist, saying, 'You live in the province of Québec. You should speak French'. She would do that to most community members if she were on shift. You're not there for that. You're there for an illness, not a lesson. And it is racism.

- There needs to be understanding about our community. Why alcoholism and drug addiction is so prevalent in our community. There's a reason. We're not a whole bunch of drunks who live off welfare. Because that's what they think, I've heard it from my own ears. And that's something we could try, to provide cultural awareness to the health service providers.

Ageing population – Language and cultural barriers at long term care facilities for the elderly; lack of assisted living and long term care facilities for First Nations' community members; lack of support services for Elders who speak their Aboriginal language.

- When elderly community members require more care than what is currently offered in the First Nation community [those who require Level Three and Four, 'long term care'] they are transferred to provincial institutions. It's the language, the culture. It's all French in the province, and the neighboring town

everything is French. So that's a big issue for community members.

- When Elders have to be transferred to a provincial system, there's not an English one here whatsoever. And a lot of the seniors are residential school survivors, who were taken out of their community as children, and now we're doing the same when they're Elders, and we're placing them where they can't speak their language, where it's not culturally adaptable at all.

- There are only seven residential care facilities in First Nations' communities in the province (offering Level One and Two care, home care/ residential care).

- I was visiting a hospital and one of the doctors asked, 'Do you speak Algonquin?' I found someone to translate. The doctor said, 'We've been trying to communicate with this man for two weeks.' That's unacceptable.

Jurisdictional issues: Lack of clarity between federal and provincial authorities.

- Another issue is jurisdiction—who do we belong to? Say we try to get stuff from the province, we're told, 'No, you're under the federal.' And the federal will say, 'No, you're under the provincial, or you're a First Nations community.' You're running in a circle trying to get some assistance.

First Nations' health and social issues are well-known, yet there is a lack of funding to implement lasting solutions.

- That's another issue—Health Canada, Aboriginal affairs—there's always studies, studies, studies, but what's next? When are they going to implement this stuff? Big money's spent but we don't get results.

- It's frustrating because we all mention the same things—funding, jurisdiction, etc.—and I really hope that this time we will see some results.

Lack of clarity about Non-Insured Health Benefits (NIHB).

- Times I went to the drug store, the medication wasn't covered. I paid for it myself. 'Not all Medications are covered.'

iv. Positive Experiences

- Wait times for services have not been long.

- Bilingual staff at provincial institutions: A participant described her sister's experiences with provincial institutions. Her sister has been receiving kidney dialysis on a weekly basis—they have "lucked out" with respect to the services they have received in that ambulance attendants, nurses, doctors, physiotherapist, pharmacists have all been English speaking.

7.) Eagle Village | Kipawa

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

- Difficult to access to specialized services.

- Distance to access services (travel).

ii. English Language Access Issues

Lack of access to specialized services in English – Participants reported difficulties accessing English-language services for the following: nutritionist, speech language therapy, special needs, occupational therapy. In the school system, participants commented that support services in these areas for English-speaking students are lacking ("long delays and quality of services is not there.")

- When you got to see a primary physician, there are no issues as far as receiving services in English, it's just from then on. Once you get to the more specialized care, then language becomes an issue.

- Nutritionist.

    - For the diabetes program [at the health centre], we would often require the help of a nutritionist, we had problem accessing those services in English.

- Speech language therapy.

    - We do have speech pathologist with the school board, she travels twice a year to meet with the students and sets up programs for them, but we don't have someone to support that on a weekly basis.

- Support services for children with autism spectrum disorder.
    - There were two other students in our system, around the autism spectrum, they were supposed to be receiving support through the Centre Réadaption, but it hadn't been happening because they couldn't hire anyone. There is a huge lag in actually being able to provide services. [The worker] coming in now speaks very little English. I appreciate that she is putting a lot of effort to work with these kids, but it's certainly not the standard of care that a child would be getting in Ontario.
- Occupational therapy.
    - You know, I have an occupational therapist working with my students, but they can barely string two words in English together. They might be fabulous in French, but what good is that to my students?
- Support services in school (elementary).
    - The services provided by the CSSS to the students in the school is lacking. Because our students aren't capable of receiving services in French, then a lot of services are pulled back. They'll say, 'we can't offer it because we don't speak French.'
    - It's not uncommon for parents to just up and leave the province altogether because the services they get for their special needs child in English is not acceptable—long delays and quality of service is not there.

Detoxification services – Difficult to access local services for detoxification in English.

- Detoxification services, it's hard for clients. The treatment centres are in English, but for detox the closest one that we have is in North Bay, and that's in Ontario. I was speaking with a client about detox in Montréal; she said, 'I don't speak French.'
- If the person goes to Montréal, it's about 6 or 7 hours away, rather than being able to go 45 minutes away [out of province]. You need support from your family when you are going through something like that [detoxification], and to be far away, it's difficult.

Lack of services for primary eye care in English.

- Optometrists: Specialists don't speak English—just to get glasses, it's covered through Non-Insured Health Benefits (NIHB), but it's not available in English.
- I had to take my children outside of the province to see an optometrist.

Lack of mental health services in English.

- With regards to psychological assessments, the individual downtown [at a provincial institution] is French and so we have no access to that service.
- Mental health [in the school system]: Psychological counselling for our students is almost impossible.
- Psychological assessment for students [in the school system]—If a parent requests a psychological assessment to find out if their child has special needs, then it's up to them to seek out these services. They are being directed [out of province]. They are paying for it themselves.
- It's when we get to mental health that we run into some issues with language.

Shelters for women – lack of services in English.

- The shelters for women that are close by, don't have any services in English.

Language barriers (communicating): Participants reported that doctors are more likely to be bilingual, less so for support staff. Participants, however, reported difficulties communicating with specialists at meetings (i.e., for support services (developmental and occupational) required by English-speaking youth). Participants stated that 'more time was spent trying to address the language issue as opposed to dealing with the issue at hand.'

- Doctors are bilingual, less support staff:
    - We had a client hospitalized in Amos, Québec, for surgery, and he had a lot of trouble communicating to the nurses' aides. They'd come into a very, very difficult situation and it was frustrating on both sides, and they ran into some issues. It's not the physicians themselves—they were all A1, bilingual—it was the support staff coming into the rooms to help out with the client, the baths. Very, very limited in that area.

- Meetings.
    - Centre de Réadaption provides services for some students. Meetings [coordination and participation] with their team, when they speak almost zero English, is difficult. If there are any students who should be communicated in their language it's them: these kids can't handle someone trying to speak in French to them. It's a huge challenge.
    - I can get through a meeting, but it's difficult. Two hour meeting with specialists [Centre de Réadaption], we're sitting there trying to figure out the language issue, as opposed to how best to work with this child. It's very frustrating.
- Quality of services.
    - How can the specialist help when they can't even understand the child? How true can their assessment possibly be when they can't even communicate with the child?

Translation services – There is a lack of funding for translation services. Participants reported that First Nation community organizations are providing translation services for clients seeking services from provincial institutions. However, this service is provided 'on their own'—there is no funding and it is only because a particular worker may be able to speak French.

- Sometimes it's things they get in the mail [from the province], which clients need translated because it's all in French.
- The Agence de la santé has provided a translator on site at the hospital, and I believe it's four days a week within office hours. So, unless you time your sickness with those office hours, there's going to be some issues.

Calling provincial institutions is difficult because of language barriers.

- When it comes to booking appointments, often the secretaries in hospitals or doctor's offices are only French-speaking.

Documentation from the province is primarily in French – For example, information (public health), reports, assessments, correspondence, training information, and protocols (immunization). There is no funding for translation of written documents.

- Problems with forms and reports.
- All reports from the Centre Réadaption are coming in French—that's what's going to the parents and teachers who are English-speaking.
- With Agence de la santé, public health information, more often than not, it's only in French. However, since a few individuals understand that there are a lot of English workers in the area, they are making an effort. They put on workshops, got people from Montréal to do it in English.
- Information about training is sent to us in French. I get it all the time. The invitation letters, the invitations to the particular training sessions, all comes in French.
- *Protocole d'immunisation du Québec* (PIQ): Information for vaccines, even the notations and all of that is only available in French. You have to be able to read it and administer it, because they won't translate it. They are not required by law to translate it—that's what we've been told.
- For a while, we were having all our documents translated directly through Health Canada, which was a nice gift. We get the Québec manual [PIQ], because our communities are in Québec we worked underneath Québec protocols, the PIQ would be translated by Health Canada, and myself as a nurse, I would use that manual daily. But now they have stopped translating it.
- For health services, the forms are all in French. I believe there are a few translated forms we receive from time to time, but Health Canada took on the translation of those as well. It was not translated through the province.
- The news bulletins coming out of our provincial headquarters is all in French, the bulletin board is all in French. The news flash we get from the hospital (CSSS) is all in French. All the communication is in French.

Participants reported that there are difficulties for individuals from English-speaking agencies to fully participate in health planning and decision-making at meetings. Further, the participants felt that the province is not conducting meaningful consultation with English-speaking population about changes to health policies. (i.e., Québec's changes to computerized system for health records).

- Health planning and decision-making (meetings): The board of directors meeting for one of our hospitals is all in French. Basically it limits the amount of people who can participate, because it's all going to be done in French. And they'll view it as you being consulted, but we have a different definition of what consultation is.

- True, meaningful consultation is not happening. Decision-making and planning boards are predominately in French.

- If you are providing health care and best care practices and you have three large communities with a large portion of English-speaking people in your population, you think it would be important to reach them, too.

- 'Informed consent' is not being obtained from English-speaking population about changes to health policies (computerized health records).

Provincial boundaries – Barriers for clients who are seeking services in English Assessment reports from 'out of province' not always accepted in Québec (from both public and private clinics). Participants reported that clients who receive services in another province may need 'to pay up front' for insured services that are supposed to be covered by the province. 'Border communities' in Ontario offer bilingual services; however, it's not reciprocated: Québec institutions on the provincial border don't offer bilingual services. Participants reported that the 'link with hospital in Ontario is vital' – most specialized services (childbirth, testing, assessments) are obtained at the hospital in Ontario.

- Assessment reports from 'out of province' not always accepted in Québec. Québec has certain ways that they want things coded, for example for psychological reports for students.

- The Québec government is getting more and more picky about accepting reports. One student was turned down for a handicapped vehicle, they had to reapply, parents had to be involved in calling the government.

- Often there will be additional charges, depending on the specialist, if it's not in a hospital setting, and even sometimes in a hospital setting. And this is to have services in English. I remember going to a hospital where I had to give my credit card number for a patient to receive their surgery, because the anesthesiologist wanted the cash up front. And this is surgery—this is not a private clinic—this is insured services no matter where you are, but because of the price differences, it puts us in a predicament where we have to dish out dollars and wait for reimbursement.

- In a border community, you can access bilingual services from the other province [i.e., Ontario]. However, it's not reciprocated: Québec institutions that are on the provincial border don't offer bilingual services.

- The link with a hospital in Ontario is vital—it's where we go for most services other than what a general practitioner can give. We're having our babies in North Bay, the OBGYNs are there, and the more serious testing. There may be a time when North Bay hospital [in Ontario] says, 'We are full with Ontario folks now, and we are limiting the patients we take from Québec.'

- Family support available to a client traveling only 45 minutes away [to a hospital in Ontario] is huge. It's huge as far as all health services are concerned.

Corridors of service – 'greater pressure to stay within the region'. Participants reported that because they are required to stay in Québec they are required to travel further away in order to obtain services in English. The travel presents a challenge: sometimes clients will continue the service for a short while, and then just stop altogether because of the distance (i.e., parents who need to travel two hours for speech language pathology for their child on a regular basis.)

- There's a constant stress in that the provincial government wants to keep everything in the region.

- [Emergency services (ambulance)]: The ambulance has no choice but to go to the hospital in Québec. You used to have a choice. We're told, 'Stay in the system, we're not in the business of paying Ontario physicians when we should pay Québec physicians.'

- We wouldn't have any problem staying in Québec, if they could provide those services in English.

- Merger of institutions has lead to less emphasis on recruitment of bilingual workers at provincial institutions

- We have to fight to get a referral that's closer (in Ontario), rather than a referral several hours away (in Québec). Clients are being referred to whatever their corridor of service allows.

- Even if you stay in Québec, sometimes those services are far away.

- There's pressure on us to stay within Québec [rather than going out-of-province]. However, because of the language issue we end up further and further away from our communities. It's a big circle.

- Parents were driving them two hours to meet with a speech pathologist…it's a huge commitment from parents to be traveling every week with their child. Especially in the winter-time, these aren't good roads.

Limited access to training in English in Québec – Participants report that they need to go out of province in order to access required training in English. There are additional challenges to ensure that training taken out of province is accepted in Québec. Health Canada does provide limited training in English (for example, for diabetes).

- Often, all our professional staff need to be part of orders—psychologists orders, nursing orders, and that type of thing—and often the training for these orders is only in French.

- Anything for nursing training in Québec is only in French. I have been trying to get continuing education courses because you need them for your licence, and I need to go out of province for all that. It's not available in Québec.

- The challenge is that even if you find something in Ontario, a training course, it's not always accepted [in Québec].

- The training for diabetes is through Health Canada and it's in English, but you really need to work to get it.

iii. Access Issues Related to Culture (Aboriginal)

Limited coverage for Mental Health Services through Non-Insured Health Benefits (NIHB).

- There's still a corridor of service at the hospital that opens up for us—and there's an agreement with hospital [in Ontario] for psychological support. This service is not available from the province of Québec in English, and so we go to North Bay. They submit the treatment plan to Health Canada and it has to follow the ten sessions of therapy…it's like fast food therapy. Those are some of the challenges.

First Nations' clients are required to pay up front for some services and seek reimbursement from Health Canada, under NIHB. Participants reported that there is a lot of paper work involved for clients, and not all service providers will accept NIHB.

- Clients need to pay up front for services and then seek reimbursement from Health Canada. Providers are starting to say 'Why should I manage it, when I can get the client to pay up front and have Health Canada reimburse them later.'

- The clients are the ones who have to run around trying to get an appointment, just to get the paperwork for funding.

- I have called providers and I've been told, 'Yes, we deal with NIHB,' but when the client gets there, they make them pay up front, so that they will need to be the ones to deal with the process of reimbursement.

- Few and fewer specialists are accepting NIHB.

Detoxification services geared for First Nations (in the community, culturally appropriate care). Participants commented that there are gaps between the existing 'detoxification' services and treatment centres.

- It would be nice to have our own detox centre in a First Nations community. We have treatment centres, but it would be nice to have our own detox. That would make a difference, being with First Nations people, the culture.

- For detoxification services, we need to have a transition. There are gaps between detox and treatment centres. It's the continuity of care for First Nations.

Medical transportation – There are some issues accessing funding for travel when services are obtained from out of province, from a private clinic (required by clients to obtain services in English.)

- All the forms [for medical transportation] are Health Canada driven, so they are in English. It's not a problem.

- The issue with the travel funding is mostly that we'd need to go against the grain of the framework to do so. At times, the nearest 'point of service' is in another province—which leads to issues accessing funding for travel when we go out of province.

- The problem is that with Health Canada if you go to a private clinic [for English language services such as speech therapy] they won't cover medical transportation costs to those clinics.

Provincial legislation is impacting English-speaking First Nations access to health and social services. Legislation (Bill 21) is creating obstacles for English-speaking professionals. Participants reported that professionals (for example, nurses) are experiencing difficulties working in the communities and it has "nothing to do with competence", but rather "it has to do with language." Some professionals who do not speak French may work in Québec on a conditional basis only. Further, the province is not required by law to translate documents needed for prevention services (i.e., Protocole d'immunisation du Québec (PIQ) from French into English).

- Bill 21 (Professional Order):
  - Licensing issues because of language (Law 21)—required to belong to a professional order, yet training in English is limited in Québec.
  - From a management perspective, I look for [professional workers] best language to be English. But, when they get to Québec, they have to register to these [professional] orders, and there's some issues, and it has nothing to do with competence, it has to do with language.
- Translation of documents: Province is not required by law to translate documents from French into English. (For example, the Protocole d'immunisation du Québec (PIQ)—the vaccination protocols and guidelines is only available in French.)

iv. Positive Experiences

- There are hospitals in Québec (in larger urban areas) where the services in English are good. Sometimes, clients may be afraid about getting around, because it's all French, and when they come back, they always say, 'You know, it's not too bad. There was always someone around to help us out.'

b.) Eagle Village | Kipawa Community Members:

i. General Access Issues and Challenges

Distance to access services (travel), roads are not always good, especially in winter.

Long wait times for services.

- I think the long waits are right across Canada.
- My son was supposed to see a doctor within six months and it took a year. His doctor was really upset about that, and she made sure he would get to see her earlier, every six months.

ii. English Language Access Issues

Lack of access to general and specialized services in English. Participants reported that they need to go 'out of province' to access services in English. Others reported delays waiting for services in English.

- [Lack of support and services for children who have special needs]: If my mom didn't speak French, I would have moved to Ontario, because my child needs a lot of help and this is a permanent thing. It's not going away.
- We go to Ontario right now to get services in English, and they're closer—one hour away.
- All my appointments are in Ontario, so right now I have no problems, but I'm worried because I know eventually I will have to go through Québec.
- You need to get referred to see a specialist in Ontario, and if the doctors here don't want to refer you, then you're stuck.
- For general physicians and specialists, too, like dentists. We are referred to Ontario.
- I wouldn't know where to go in Québec for services in English.
- Some things you have no choice, but to go to Ontario, for example speech therapy. You're not going to find an English speech therapist around here.
- You know, if you go to a hospital, in Québec, and if you walk in there and there's nobody who speaks English, they should be able to bring someone in there right away, no matter what time of day it is or when it is. We're in Canada, not some other country! That's the way it should be. 'We have somebody,' not, 'We will get someone in five days or something.' And, 'If you need these documents in English, here they are. You don't need to wait three months.'

Language barriers (communicating) – Participants reported mixed experiences communicating in English with doctors,

nurses, and support staff. Overall, less likely that nurses or support staff are bilingual.

- We have a French-speaking doctor in our little community who doesn't speak English—she understands more than she speaks.
- The doctor in town doesn't speak English. Most of the time you can ask for a nurse who speaks English. The doctor knows she has this problem and she tries.
- Some of the doctors speak English, but it's the receptionists who are difficult. They only speak French. I get my mother to call because I cannot speak French, and when we go to the hospitals, my mother comes along for the same reasons.
- At the hospital, the nurses on the night shift were French speaking and I didn't understand anything they were saying, but if they needed to take blood at four o'clock in the morning, go for it. I told them I don't understand French, and they don't understand English, so that's the end of that.
- In our case, it's been the receptionists. You arrive to a hospital, you've got to try to go back to your French to get your information across because they don't understand English. Just your medicare number, little things, phoning for appointments. We have a little problem where we can't seem to get through to the doctor we need to speak to…and we'll call the receptionists and it's hard because it's all in French.
- For English language, there were problems with the nurses and the receptionists.

Perceptions and beliefs – Participants reported that they are 'worried' about going to provincial institutions because of language barriers.

- I haven't found these problems yet [with language], but I'm worried about it for later. Having to go to [the hospital] and not knowing what's going on, that would be pretty scary.

Calling provincial institutions is difficult because of language barriers. Participants reported that they miss appointments because voicemails are left in French only.

- They tell me, 'You missed an appointment,' but I get the phone calls in French and I don't understand it. This is for treatments, appointments, and it's all in French…I get by through sign language. Pretty much sign language, or find someone in another department to come talk to you, who knows both languages.

Translation services – Participants report that there is a lack of liaison at provincial institutions, which are needed by English-speaking clients.

- [The liaison worker] at the hospital is only available on work hours, and if she's not there, there's nobody there. There's no one there 24 hours.
- I called and they said [liaison person] was only available on Thursdays. So I guess I can only be sick on Thursday.

Documentation from the province is primarily in French. For example, assessments, forms, and letters received from provincial institutions.

- [Assessments and reports for children with special needs]: They gave me the doctor's assessment in French first, but they sent me an English translation later. They offered to give it to me, which is good, but it took three months or so.
- [Forms]: When I had my baby, all the forms to get their health cards and everything was all in French. I had to get my mom to translate; The forms were in French, but I wrote [my answers] in English
- [Letters]: We've had a few letters in French, too.

Provincial boundaries causing barriers for clients who are seeking services in English: 'It's important to keep the link [with Ontario] open'. Provincial 'rate of pay' (fee schedule) varies among the provinces. Participants report that for some provincial services they are paying the difference out of pocket.

- I had an issue going to Ontario. When I first got sick, she referred me to Montréal, and the reason was, she told me, because she couldn't send me back to Sudbury because Québec was slow paying their bills.
- There's an optometrist who makes you pay up front, and you bring the receipt to the health offices, because Québec was too late in paying their bills. Later you'll get your money in the mail.
- Lack of consistency between provinces for fees—I got pneumonia last year and I to pay for my own antibiotics, and I came home, sent the form to Québec, and they only gave me half the price. It's because the

government prices for the antibiotics between Québec and Ontario are different.

- I go to Ontario for all my medication and appointments with specialists, but I tell my doctor down here I won't go further into Québec than I am right now. But, I can see that coming to a stop because they want you to stay in Québec.

- If there's a link to Ontario, you want to keep it open. Even for x-rays and ultrasounds, if they can't do it here, they send you to [Ontario]. I don't want to be sent to [hospital in Québec]: the roads are terrible and there's no English up there.

iii. Access Issues related to Culture (Aboriginal)

Discrimination and lack of cultural sensitivity.

- There are still some people out there who look at you and treat you differently because the colour of your skin.

Jurisdictional issues: First Nations have access to health and social services from both federal and provincial governments, but there is a lack information and clarity about who is responsible for what services (delivery and funding). Issues with funding for services under NIHB.

- [Dental health]: My little girl needed her teeth fixed. They made me pay up front because they said that Indian Affairs takes too long to reimburse. I mean, not everybody has that kind of funds, and sometimes you can't wait for something.

- Clients need to pay for prescriptions up front and then wait for reimbursement from Health Canada—They say, 'Oh, you can pay for it now, and when it's authori.e. you can come back and we'll reimburse you.'

- Not always clear if the medication will be covered by NIHB.

- Staff at pharmacies are not always aware about the coverage through NIHB—quality of services an issue (long wait times).

- We are being made to pay out of pocket for NIHB, and there are different rates for services between provinces. We're not always reimbursed the full amount for services that are supposed to be provided by the province.

iv. Positive Experiences

In urban areas, doctors, nurses and specialists were bilingual. Participants reported that bilingual services were available, depending on where you were going.

- All my doctors spoke English at [urban hospitals].

- A lot of the nurses know English. They're mostly coming from Montréal.

- It depends where you're going. At some hospitals, I was surprised that the hospitals were mostly English. At some hospitals the nurses don't understand English but they'll muddle through and make you understand. Most of the doctors are English.

8. Timiskaming First Nation

a.) Community Resources (Health Services and Social Services):

i. General Access Issues and Challenges

Long wait times for services (specialized), longer if waiting for services in English

- Waiting lists in Québec are long, people wait and wait for their appointments. It can take 3 or 4 years on the waiting list (longer if waiting for services in English).

Distance to access services (travel).

- There is a big distance between our community and specialized assessments.

Quality of care can be a challenge.

- Clinics that have rotating doctors on staff can present challenges to clients in terms of continuity of care and understanding their health issues.

ii. English Language Access Issues

Lack of access to specialized services in English – Participants mentioned that they lack information about where and how to access services in English from the province (i.e., speech language pathologist, audiologist, treatment centres.) Some reported that they are experiencing obstacles accessing services 'out-of-province.'

- There's no English, there's hardly anything in English strictly, that I know of. Most of the caregivers, or doctors, are French speaking.

- Lack of time to search out specialists that may be available in Québec. The challenge now is to find specialists in Québec, when we've always been dealing with Ontario.

- Difficult to access speech and language therapy in English from Québec system. A community worker was told, 'You better send them to Ontario because I don't speak English.' I could not access the services there [institution in Québec]."

- With Ontario doctors refusing our patients, we need to find a place to send them, calling one hospital, another, a third hospital, a fourth, to get names of doctors, and because they are not locals and can only be here once a month, you send referrals and they get lost.

Language barriers (communicating) – Participants reported that there were issues with communication at hospitals depending on when you were accessing services: in the daytime you are more likely to access services in English.

- At hospitals, in the daytime, it's easier because there are more people, so we can always find someone English to translate, but at evening and at night the patients struggle, saying, 'I don't understand anything they told me.'

Calling provincial institutions is difficult because of language barriers – frustrating experience, delays waiting for services.

- Sometimes I had to call them at the hospital and they had to transfer me a few times to find someone who spoke English.

- When I call the pharmacist, the clerk may not speak English and won't answer my phone call. I have to call back, it's really frustrating.

- So when I call for an appointment, you can only call in the afternoon, and when I call back they say, 'Sorry, I do not speak very good English, could you please call back later and we'll make sure this lady's here, ask for her,' and I've already been waiting.

Crisis situations more challenging because of language barriers.

- In crisis situations, especially, if I had to access a shelter [for a client], I would need to see if there was an English speaking counsellor, which was hard to navigate in the heat of the moment, because the client wants to be safe now, not wait a half an hour for us to make phone calls.

Documentation from the province is primarily in French: letters, forms, information, and signage.

- The prevention work we do at the centre here, to get material in English here in Québec is very difficult.

- With the agency of social services, we get a lot of information…and a lot of our pamphlets and posters come in all French. Sometimes it's about suicide, but most of our material does not come in English, so normally we need to discard them and only keep a few because we cannot use them. The documentation we can have is very limited.

- [Personal experiences reported by community workers]: Even in the hospital, if I read the signs I can't make my way in the hospital, because I couldn't understand the signs. I was frustrated; It was never really clear where I had to be, I would miss my appointments because it was never clear where I had to go because the signs were all in French.

Provincial boundaries – Because of provincial boundaries, participants reported that they lack freedom of choice to obtain services, in English, from Ontario. Further, Québec residents are now being refused services. Reported that there are issues accessing services because of the provincial 'rate of pay' (fee schedule) varies among the provinces.

- Our village sits on the border of Ontario, but we're in Québec, and because our patients are mostly English speaking, they have always gone to the Ontario side, and if they needed a specialist they would be sent to an Ontario specialist. But now the problem is that more and more these specialists are refusing our patients.

- Québec patients being refused because of different rates between provinces, and the doctors have to wait a long time to be reimbursed.

Limited access to training in English in Québec – Training materials are not readily available in English. Participants reported that it is 'difficult to understand trainers who

are not fully bilingual.' Further, some workers whose first language is French stated that they would prefer to receive training in English to better meet the needs of their English-speaking clients.

- Difficult to obtain training resource material in English.
- [Front line workers]: It is difficult to bring people in to train our staff, or to provide workshops, in English.
- [Training for nurses]: When we have courses, often it is offered in French, and they say they will also offer it in English if enough people subscribe. Often they will say they are going to offer it in English but do not because they don't have the numbers to account. We do go to Ontario for training at the same time. There is some freedom in that training can be obtained from out-of-province and it is still recognized by the province. Others expressed concerns that training out-of-province doesn't provide you with the accurate information that you need (guidelines, recommendations) for the province of Québec.
- It can be difficult to receive training from a worker who is not fully bilingual.
- It's frustrating when you're trying to learn something while struggling to understand what the instructor is saying.
- When I go for training, I like to have the training in English, even though I am French. It is easier to learn the material in English, rather than have to translate from French into English for my clients.
- We used to have a lot of training with Health Canada but not so much anymore. We used to go once or twice a year for training, and offered the courses in both French and English through translators, and they don't offer it anymore. Now we're struggling to find stuff.

iii. Access Issues Related to Culture (Aboriginal)

Discrimination and lack of cultural sensitivity. Participants spoke about the lack of cultural empathy and respect. They stated that they, or their clients, have experienced discrimination and cultural stereotyping when obtaining services from provincial institutions.

- We are told because this person is coming in the hospital, is may be intoxicated, is Native, they will sit there for hours until they sober up and can be seen. We've been told that numerous times.
- Sometimes patients that have never touched alcohol before will be treated in the same way. Just because you're native, they expect you to be treated that way.
- [Personal experience reported by community worker]: Generally, any hospital near any reserve, I will be sitting there for hours and hours on end. It's frustrating and you almost don't want to go back, unless you're dying, because you don't want to be treated like that. It's very frustrating… sometimes I should go seek medical advice, but I don't because I wonder, 'What am I in for today?' I think, How am I going to be treated? Will I be sitting there for hours? Will I get the attitude? Or am I actually going to be treated with respect?

Gaps in discharge – Lack of communication between institutions (First Nations and provincial) when clients are discharged. Language is an obstacle because the discharge summaries are 'all in French.'

Case management – Participants (First Nations health care workers) reported that they are spending a lot of time and energy on case management, primarily because of language issues (referrals, booking appointments, and follow up).

- First Nations' health workers are spending a lot of time and energy on case management (referrals, booking appointments, following up with after care)—bilingual staff person is needed for this work: "It is surprising how many hours of case management we do. It is almost unreal the amount. Sometimes. you can be on the phone back and forth for hours, hours on end."

iv. Positive Experiences

- At the health centre, nurses track information in English (homecare stats, vaccines, reports) for the community.
- Provincial institutions sent invitation letters in English to community members about breast cancer screening: there was an increase in the number of community members who went for screening. [As reported by one participant]: The letters were all in French and most of the people from the community just chucked it aside because it was in French, and then a lot of people asked me why we were not participating in the screening—the next year—or maybe it took two years—their letters are in English, and now that their letters are in English, they get a lot more people to go to their mammograms. The technician explained the proce-

dure in English and documentation was provided to patients in English.

- English training available for provincial workers, reported that there have been 'big improvements' over the past few years. "Over the last couple years there's been a big improvement. There's still lots to do, in some departments, I guess. And they do give courses for people to learn English at the hospital, to encourage them."

- Efficient services from local CLSC: when making an appointment, the CLSC provided the client with a date and time when they would call, all communication was in English.

- [Personal experience reported by a community worker]: I had to call to make an appointment for children I look after, and the clinic said they would call me back on a specific date and time. They called me back and the person spoke perfect English, now all I have to do is sign an authorization form. It was pretty fast.

- Doctors at provincial hospitals are encouraging English-speaking clients to access services from the province.

- [Personal experience reported by a community worker]: When I had my baby at the hospital in Québec, they asked me 'How come you came to Québec? You don't see many English people from your community coming to Québec?' And I told her, 'My doctor's here now, we moved to Québec.' And she said, 'That's very good. I'm glad to see that. Tell your friends we speak English.'

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