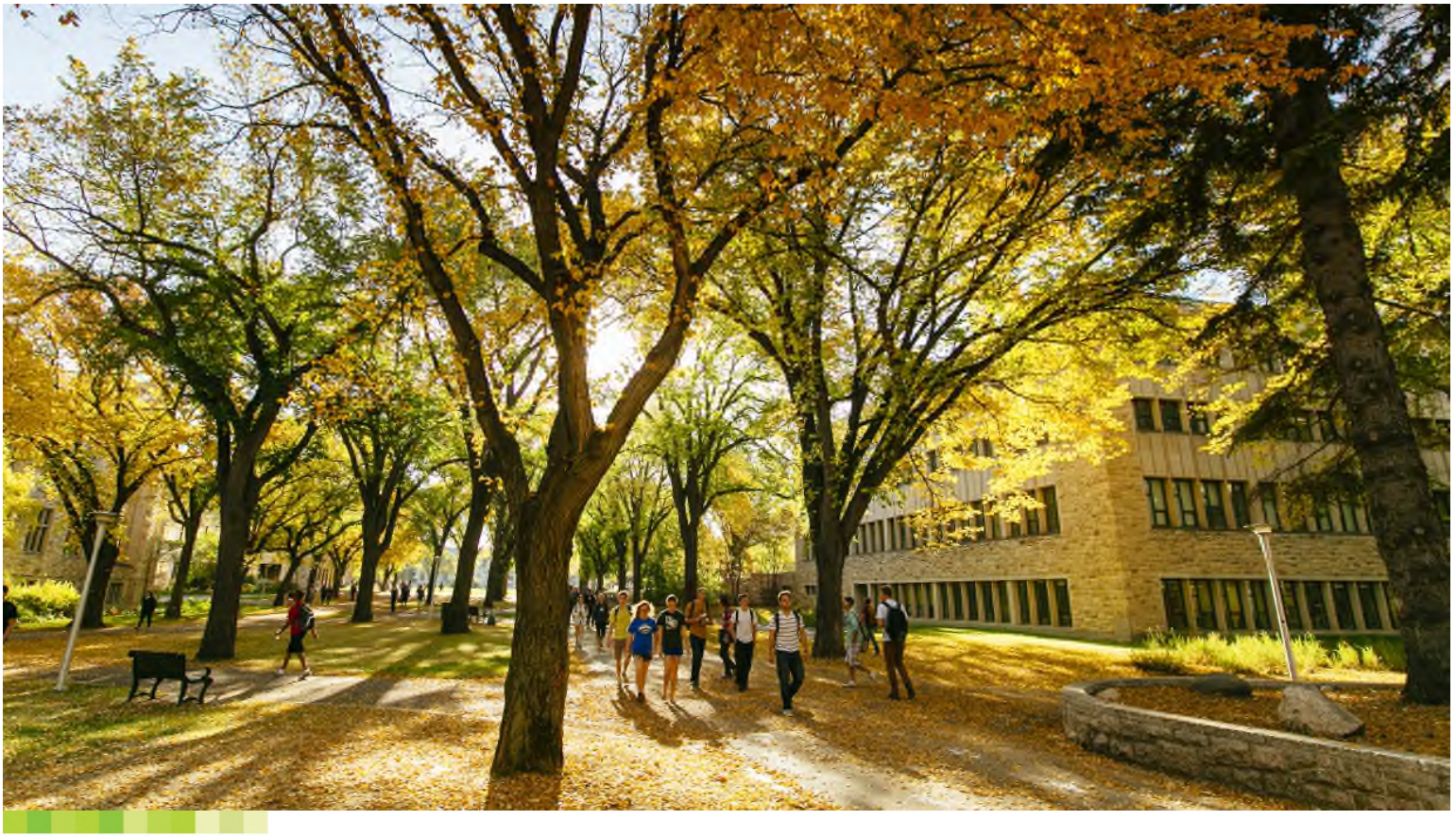

UNIVERSITY OF SASKATCHEWAN
College of Medicine
DIVISION OF SOCIAL ACCOUNTABILITY
MEDICINE.USASK.CA/SOCIAL-ACCOUNTABILITY

Social Inequity and Pressing Health Needs:
Thoughts for Health Educators
2020

Drafted by the Division of Social Accountability
January 2020 release

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Executive Summary

CACMS Accreditation Standard 7.5 "*Societal Problems"* specifies the need for medical education to include instruction on the health consequences of common social issues. Centering medical school programming and curriculum on pressing social equity issues enables medical graduates to respond appropriately and directly to related health needs. The CoM Division of Social Accountability supports UGME curriculum in fulfilling this standard by producing this report on a regular basis. The report summarizes current areas of concern for Saskatchewan; the social systems of oppression at the root of these issues; the health conditions they manifest as; and recommendations for training for health care providers along with additional curricular* resources. CanMEDS competencies that align with these issues are also presented in the Appendix A.

In our Canadian context, there are a number of social inequalities that lie at the root of disproportionately poorer health outcomes for various communities. There is demonstrated commitment to addressing a number of these inequities from our local and national governments and various health governing bodies, including CFPC, RCPSC, CIHR, CIHI, CPHA, etc. (Appendix B). Aligned with these commitments, this 2020 report highlights five social inequity issues of particular concern for Saskatchewan:

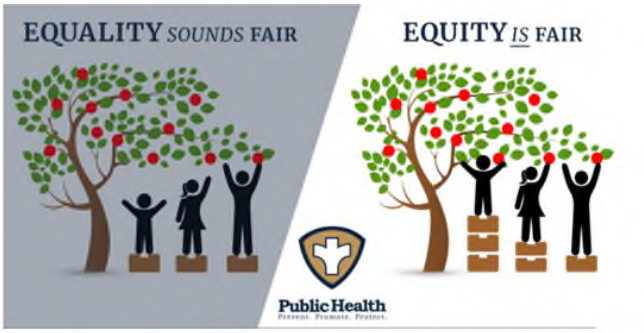
1) **Indigenous health inequities**
2) **Poverty**
3) **Mental health, suicide risk and substance use**
4) **Early childhood development**
5) **Climate change**

Curricular considerations related to these issues are outlined in the table below and discussed in greater detail in the report.

Social Issue	***Curriculum Considerations***
Indigenous health inequities	→ Curriculum that is responsive to the TRC Calls to Action (calls # 18, 22, 23, and 24) → Curriculum content that covers these issues and is strengths-based, grounded in Indigenous worldviews and challenges implicit biases → Provide cultural competency and anti-racist training → Implement experiential learning modules and robust clinical elective experiences → Directly involve Indigenous educators in design, review and teaching
Poverty	→ Emphasize SES as an important determinant of health → Improve students' understanding of the systemic causes of poverty → Training on strengths-based communication, relational skills and community-level interventions → Provide opportunities for community-engaged, experiential, interprofessional learning
Mental health, suicide risk, substance use	→ Training on mental health services and resources, appropriate screening tools, brief interventions and clear clinical pathways → Training in interdisciplinary team-based care → Anti-stigma education → Suicide prevention and intervention training → Identify opportunities for advocacy
Early childhood development	→ Provide training on early brain, biological development, early learning and literacy → Course content on the lifelong impact of poverty and trauma on development
Climate change	→ Training on the ecological determinants of health, changing environments, displacement, climate refugees and vulnerable populations → Training on integrating health professionals into Emergency Preparedness Plans → Develop role of medical students as advocates for climate and environmental policy

Background

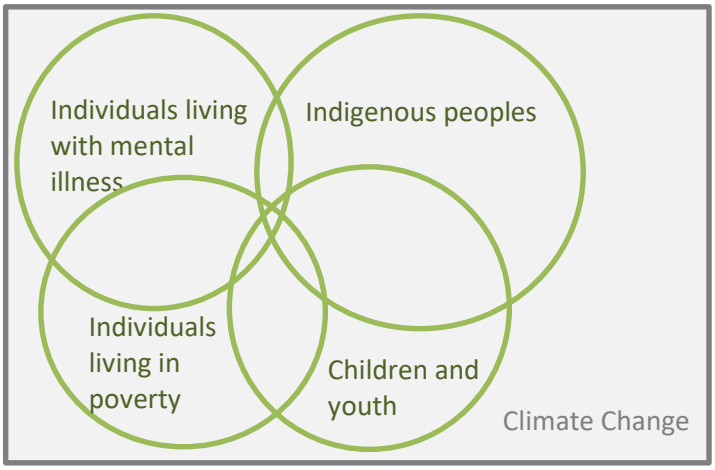
At the request of the College of Medicine (CoM) Curriculum Committee, the Division of Social Accountability regularly produces reports to help ensure medical curriculum includes instruction on the health consequences of common social equity issues (CACMS element # 7.5 *Societal Problems*). More commonly known as the *social determinants of health* (SDoH) – these issues are the interrelated social, political and economic factors that create the conditions in which people live, work and play and drive inequities in health outcomes[1]. Social determinants play a pivotal role in persistent, and in some cases growing, health inequities. Under the CanMEDS framework, physicians act as *health advocates* by promoting health equity and contributing their knowledge of the determinants of health to positively influence the health of the patients, communities and populations they serve[3]. Centering medical school programming and curriculum content on pressing social determinant issues enables CoM graduates to respond appropriately and directly to health needs.



https://www.mmshealthycommunities.org/collective-action/health-equity/

The inaugural *Pressing Health Needs* report was produced in October 2016 and highlighted three issues of particular concern for Saskatchewan: 1) **Indigenous health inequities among First Nations and Métis peoples**, 2) **poverty,** and 3) **mental health, suicide risk and substance use**. A document review to identify local, regional and national priorities corroborated the focus on these three issues. The 2017 report added two other areas requiring attention: 4) **early childhood development** and 5) **climate change**. A small group of key stakeholders were consulted by the division to validate the information in the 2017 report and identify additional background sources of data and curriculum planning tools. The Social Accountability Committee and the Indigenous Health Committee was engaged to provide feedback on the 2018 report, which was updated with the current status of inequity in the areas, recommendations for training for health care providers and additional resources. After gathering feedback from UGME course chairs, we added an *Executive Summary* to the 2020 report. Further, the overlapping nature of these issues and the impact of the intersectionality of factors on health is outlined.

Figure 1: Intersectionality of Pressing Health Needs in SK



Intersectionality is an approach that recognizes that health is shaped by overlapping factors that intersect at the individual level to reflect multiple interlocking systems of privilege and oppression at the social-structural level. It goes beyond single factor explanations which sometimes assume that groups are homogenous in their composition and pays attention to the relationships between determinants[4]. Intersectionality considers how different systems of oppression overlap and are compounded. A focus on intersectionality allows us to solve the systemic problems, instead of just replacing one system of oppression with another.

Indigenous Health - The Historical Root of Current Day Inequities among First Nations and Métis in Saskatchewan

The reality remains that Indigenous peoples in Canada continue to live with unacceptably disproportionate burdens of ill health. SDoH approaches remind us that First Nations, Inuit and Métis peoples' health status reflects the socioeconomic, environmental and political contexts of their lives - a context inextricably linked to past and contemporary colonialism[5]. Different health outcomes for different Indigenous communities across the country reflect, in large part, differences in the social determinants of health.

Historically, Saskatchewan has shown some of the most extreme inequities when comparing Indigenous and non-Indigenous populations[7]. As the First Nations and Métis population continues to grow at a faster rate than the general population (expected to increase to 32.4% in SK by 2045[6]), the health status of these groups continues to be an important focus for researchers, health care professionals and policy makers.

First Nations, Métis and Inuit communities in Canada experience higher rates of [5,6]:

- Infant mortality
- Maternal morbidity and mortality
- Obesity and diabetes
- Infectious diseases (e.g., tuberculosis, HIV/AIDS)
- Suicide and mental illness
- Malnutrition and stunted growth
- Exposure to environmental contaminants
- Heart disease
- Disability
- Accidents and interpersonal violence
- Shortened life expectancy

COLONIAL STRUCTURE

- Indian Act
- Residential schools and Sixties Scoop
- Forced displacement and loss of traditional lands
- Cultural assimilation
- Loss of langauge
- Lack of public or private economic development investments
- Systemic discrimination across social, criminal justice, health care and employmet environments

*"Ultimately, for health planning and action to be effective, indicators must be **Indigenous-specific and community-driven**, taking into consideration Indigenous peoples' holistic worldviews, histories and resources. A balanced approach that identifies **protective factors** such as resilience, self-determination and identity provides a more complete understanding of the issue[8]."*

Indigenous Health Inequities - Curriculum Considerations

Curriculum programming related to Indigenous health inequities should:

→ Include a required course dealing with Indigenous health issues, including the history and legacy of residential schools, the Riel Resistance, the Scrip process for Métis, the UN Declaration of the Rights of Indigenous Peoples, the Truth and Reconciliation Calls to Action, the Missing and Murdered Indigenous Women and Girls National Inquiry, Treaties and Indigenous rights,

Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights and anti-racism[6] (TRC #23 & 24)

→ Highlight the interconnectedness between health inequities and their rooting in historical and ongoing settler colonial policies[9] (TRC #18)

→ Outline the concept of inequity of access to health care/health information for First Nations and Métis people and the factors that contribute to it; identify ways of addressing inequity of access (see Appendix A, Table 1, *Health Advocate*)

→ Separately address issues specific to First Nations and Métis, given that their jurisdictional, funding and capacity issues are unique

→ Include content on the experiences of Indigenous communities resulting from colonialism in Canada including (TRC #18):

- How Canadian health care providers' own experiences of privilege and oppression affect their practice
- The lived experience of Indigenous peoples (e.g., invite guest speakers, conduct sharing circles with Elders, etc.)[12]

→ Directly involve Indigenous educators in design, review and teaching[12]

→ Embrace an Indigenous worldview and a wholistic definition of health and wellness[9] (TRC #22)

→ Discuss how racism affects health and access to the health care system

→ Shift the paradigm towards a strengths-based approach[9]

→ Implement experiential learning modules into pre-clerkship curricula in order to promote understanding, validation and respect of Indigenous knowledge and cultural practices[11]

→ Implement robust clinical elective experiences during clerkship in Indigenous health and evaluate the outcomes for learners, as well as patients, communities and health care providers[11]

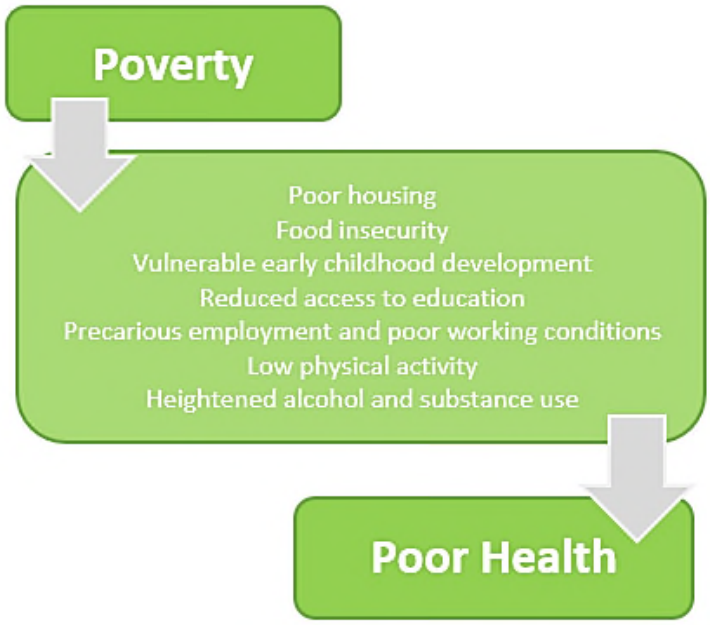
Poverty-Related Health Inequities - The Widening Gap and the Cost to Healthcare

The *World Health Organization* has declared poverty the single most influential determinant of health[13]. Hundreds of research papers have confirmed that people in the lowest socioeconomic groups carry the greatest burden of illness[13]. What's worse is that since the early 2000s, these economic inequalities have persisted and widened. In 2012 the top 10% of Canadians owned almost half of all wealth, while the bottom 50% owned less than 6%[14]. In Saskatchewan 14.8% of the population in 2014 lacked the income needed to afford basic necessities[15]. Further, the cost of poverty in Saskatchewan is unfathomable – $3.8 billion lost in heightened service use (health care, etc.) and missed economic opportunities annually[16].

"Mortality rates in Canada's poorest neighbourhoods are 28% higher than in more affluent neighbourhoods. Suicide rates are double[13]."

Poverty and Health - Curriculum Considerations

Curriculum programming around poverty-related health inequities should:

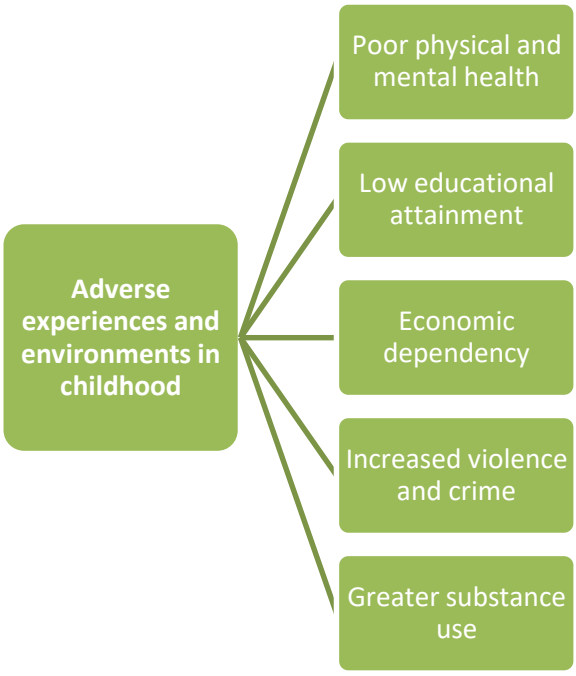


- → Emphasize socioeconomic status (SES) as an important determinant of health and outline the extent – and growing level – of inequity across social groups
- → Improve students' understanding of the systemic causes of poverty; examine the political and economic systems, government policies and positions that either exacerbate or alleviate poverty
- → Improve students' knowledge on the living conditions of persons living in poverty
- → Improve relational skills pertaining to communication and interaction with persons living in poverty
- → Improve student's strengths-based communication rather than focusing on deficit-based communication
- → Include education about community-level interventions (e.g., housing, social assistance, government benefits programs, etc.) and the role of other professionals (e.g., social workers)[17]
- → Provide opportunities for experiential, community-engaged and interprofessional learning to supply real-time education on how social, political and economic conditions impact health[18]
- → Improve students' capacity for self-reflection by helping them identify and recognize their biases and limitations[19]

"In 2012, the top 10% wealthiest Canadians owned HALF of all wealth, while the bottom 50% of the population collectively owned less than 6%[14]."

Early Childhood Development - Impact on Health

Early childhood (ages 0-6 years) is the most important developmental phase of life where crucial advancements in physical, cognitive, emotional, social and language areas take place[20]. Numerous students have shown that the physical and social environments in which children live profoundly affect their health[21]. Experiences during this time – and even before birth – influence health, education and economic prospects throughout life and can become biologically embedded[20]. Adverse childhood experiences (ACEs) can lead to trauma and toxic stress, and impact children's brain development and physical, social, mental, emotional, and behavioral health and well-being[22]. The affects of ACEs are lifelong; ACEs have a clear, dose-response relationship to an individual's likelihood of developing physical, behavioural, and social problems in adulthood[23]. Evidence suggests that adult diseases should be viewed as developmental disorders that begin early in life[20].



In terms of early childhood education and care, Canada is lagging behind – **tied for last place** among 25 countries[20].

*"Ensuring healthy child development is one of the most cost-effective investments in human capital that a country can make (**a 7:1 return on investment for young children** compared to 1:1 for adults[24])."*

"On a global level, those societies – rich or poor – that invest in the early years have the most literate populations, the best health status and the lowest levels of health inequality in the world[24]."

Canada, compared with other OCED countries, has a high overall rate of child poverty (15% compared to 13.4% on average)[25]. The strong intersection between early childhood development and poverty makes this group particularly vulnerable. Low-income families experience several disadvantages that can impact the home environment and quality of childrearing[24]. Addressing poverty could significantly minimize problem areas in child development. According to a 2009 report by the Chief Public Health Officer of Canada, of 27 factors that have an impact on child development, 80% showed improvement as family income increased[20].

Early Childhood Development - Curriculum Considerations

All physicians interacting with families with children have a role to play in supporting parents to improve their children's health. There is a need to ensure that future and current physicians are knowledgeable on:

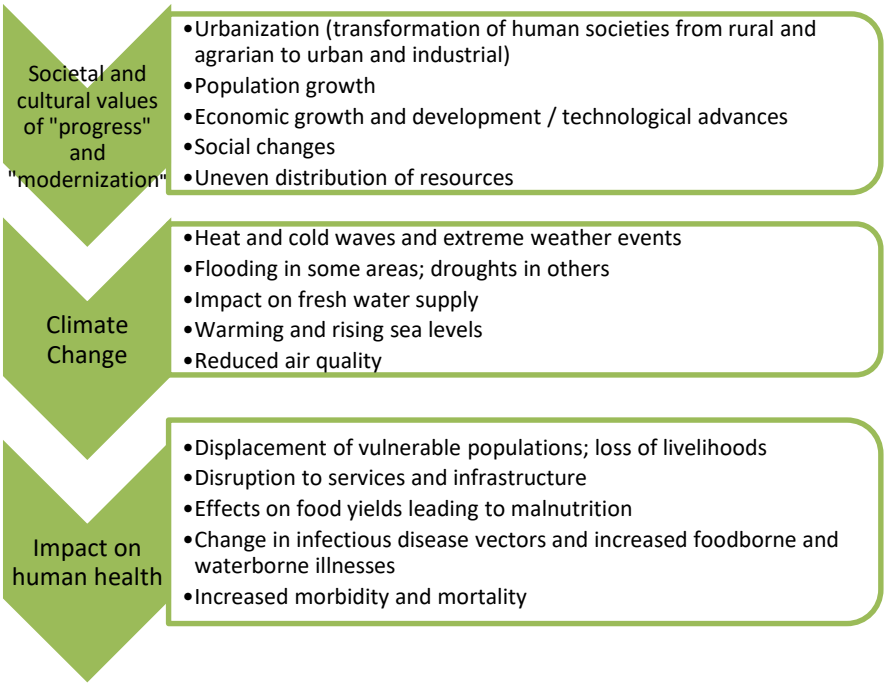
- → Early brain, biological development and early learning including early literacy[20]
- → Poverty-related health inequities, given the lifelong impact of childhood poverty on development
- → The impact of determinants of health specific to Indigenous children, such as colonialism and racism[20]
- → The connection between adult mental health issues and early childhood traumas and events (see Mental Health section below).

(see Appendix Appendix C, Table 5 for resources related to early childhood development)

Climate Change and Human Health

Climate change is increasingly recognized as one of the greatest threats to human health in the 21st century. Global ecological change is a normal process in the evolution of the Earth; what makes it a

concern today is the unprecedented speed and scale of decline in ecological functioning over the last 50 years especially[26]. The rapid loss of species we are experiencing today is 1,000 – 10,000 times higher than the natural extinction rate[26]. The health effects of climate change are happening now – morbidity and mortality from forest fires in Western and Central Canada, heat waves in Ontario and Québec, and floods and storms across the country. Canada is slowly taking measures to mitigate these impacts.



"The Earth itself is a living system and the ultimate determinant of health[26]."

"We are creating the 6th mass extinction of species – the first ever to be induced by humans[26]."

Health Impacts of Climate Change - Curriculum Considerations

Health professionals have a critical role to play in advancing public understanding of the impact of climate change on health and promoting health protective responses (e.g., advocacy). Medical students are asking for enhanced education around climate change. The *Canadian Federation of Medical Students* recommends, "Canadian medical schools need to comprehensively address the topic of climate change as it pertains to human health in the curriculum[27]". Medical education curriculum should:

- → Include education on the ecological determinants of health (e.g. pollution, access to clean water and food, infectious diseases, etc.)
- → Consider changing environments and impacts of infectious disease; understand who is vulnerable and why
- → Revise core competencies to foster interdisciplinary and multi-sectoral approaches to environmental change[26]
- → Cover the integration of health professionals into Emergency Preparedness Plans so that physicians are adequately prepared to manage climate change-related emergencies[28]
- → Recognize the implications of environmental hazards at multiple levels (e.g., impact on practice, impact on the health system, impact on populations)[29]
- → Recognize the health and economic challenges involved in displacement of climate refugees[30]

→ Develop the role of medical students as advocates for climate and environmental policy as it pertains to health (see Appendix A, Table 1, *Health Advocate*)

"Chronic exposure to air pollution from greenhouse-gas-emitting activities is contributing to the deaths of an estimated 7,142 Canadians a year, and 2.1 million people worldwide[31]."

Mental Health, Suicide Risk and Substance Use

Every single Canadian is affected by mental health issues, either directly with firsthand experience or indirectly through someone they know[32]. In any given year, 1 in 5 Canadians experience a mental health problem or illness[33]. Further, mental illness costs the Canadian economy up to $50 billion annually in lost productivity[34].

"The WHO predicts that by 2030, the economic burden of depression alone will exceed the costs of all other physical diseases[35]."

Seventy percent of mental health problems in Canadian adults have their onset in childhood and adolescence[36]. While many believe that young children will outgrow early mental health problems, longitudinal studies show this is not the case[36]. There is an urgent need to improve mental health outcomes/wellness for children and youth in Canada. It is estimated that nearly 75% of children and youth with mental health disorders do not receive specialized treatment – a stark service shortfall compared with physical health services. The recent 2016 Saskatchewan Youth Health Survey of students grades 7-12 revealed that nearly 20% had considered suicide in the past year, and half of those who had considered it had also attempted suicide during that time[37]. Mental illness is experienced disproportionately across various social groups, including Indigenous peoples, those of low socioeconomic status, children and youth. Indigenous youth die by suicide 5-6 times more often than non-Indigenous youth[33].

Substance use often has rooting in mental health challenges. Most recently in Canada, opioid use has become the largest public health emergency to date and is strongly rooted in social inequality. Between January 2016 and March 2018 there were more than 8000 apparent opioid-related deaths in Canada[38]. Saskatchewan has some of the highest rates of significant opioid poisoning hospitalizations in the country[39].

Mental Health - Curriculum Considerations

As it pertains to mental health, medical education programming should:

- → Include training on mental health services and resources, appropriate screening tools, brief interventions and clear clinical pathways[35]
- → Include training in team-based care that includes mental health and addictions counsellors, psychiatry and psychology, and those with lived experience[35]
- → Incorporate effective anti-stigma education at the UGME, PGME and CME level[40]
- → Include suicide prevention and intervention training such as ASIST[41]
- → Identify opportunities for advocacy, health promotion and disease prevention to optimize the care of patients with mental health conditions (see Appendix A, Table 1 – *Health Advocate*)

APPENDIX A - Related Medical Education Competencies

Table 1 : CanMEDS Roles and Related Competencies

CanMEDS Role	Related Competencies
Communicator	**MCC**[42] 4.1 Facilitates discussions with patients and their families in a way that is respectful, non-judgmental, and culturally safe. **CFPC**[43] 1.6 Adapts communication to the unique needs and preferences of each patient and to their clinical condition and circumstances ensuring that care is inclusive and culturally safe. 2.3 Explores the patient's personal life context, including cultural influences. 4.1 Facilitates discussions with patients and their families about the plan of care in a way that is respectful, inclusive, non-judgmental, and culturally safe, including using an interpreter or cultural intermediary when needed. 4.3 Recognizes and respects diversity, including but not limited to the impact of gender, race, religion, and cultural beliefs, on joint decision making and other interactions. **IPAC-AFMC**[44] *Students are able to…* 2.1 Describe cultural safety as it pertains to First Nations, Inuit and Métis patients. 2.2 Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis patients, families and communities. 2.3 Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit, Métis patients and their families, characterized by understanding, trust, respect, honesty and empathy. **Mental Health Core Competencies Steering Committee**[45] Physicians communicate with their patients with respect and without stigma irrespective of their mental health condition.

Health Advocate	**MCC**[42] 1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources. 2.0 Respond to the needs of communities or populations by advocating for them for system-level change in a socially accountable manner. 2.1 Work with a community or population to identify determinants of health that affect them. **CFPC**[43] 1.0 Responds to an individual patient's health needs by advocating with the patient within and beyond the clinical environment. 1.1 Works with patients to address determinants of health that affect them and their access to needed health services or resources. 1.2 Works with patients and their families and social or cultural support networks to increase opportunities to adopt healthy behaviours. 2.0 As a resource to their community, assesses and responds to the needs of the communities or populations served by advocating with them as active partners for system-level change in a socially accountable manner. 2.1 Works with a community or population to identify the determinants of health that affect them. 2.4 Identifies specific needs of underserved patients and populations, including reducing barriers and improving access to culturally appropriate care. **IPAC-AFMC**[44] *Students are able to*… 5.1 Outline the concept of inequity of access to health care/health information for First Nations, Inuit, Métis peoples and the factors that contribute to it. 5.2 Identify ways of redressing inequity of access to health care/health information with First Nations, Inuit, and Métis patients/populations. **Mental Health Core Competencies Steering Committee**[45] Identifies opportunities for advocacy, health promotion and disease prevention to optimize the care of their patients with mental health conditions. **CFMS – HEART Competencies**[30] -The recognition of health and economic challenges involved in the possible displacement of vulnerable individuals including climate refugees, the elderly and children. -Understand that the role of doctors and medical students as advocates for patients' health extends to climate and environmental policy collaboration.

Professionalism	**MCC**[42] 2.1 Demonstrate accountability to patients, society and the profession by responding to societal expectations of physicians. **CFPC**[43] 1.1 Exhibits appropriate professional behaviours and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality. 2.0 Demonstrates a commitment to society by recognizing and responding to societal needs in health care. 2.1 Demonstrates accountability to patients and society. 5.2 Demonstrates awareness of self and an understanding of how one's attitudes, beliefs, assumptions, values, preferences, feelings, privilege, and perspective impact their practice. **IPAC-AFMC**[44] *Students are able to…* 7.1 Identify, acknowledge and analyze one's own emotional response to the many histories and contemporary environment of First Nations, Inuit, and Métis peoples and offer opinions respectfully. 7.2 Acknowledge and analyze the limitations of one's own knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding with regard to First Nations, Inuit, Métis health practice. 7.3 Describe examples of ways to respectfully engage with and give back to First Nations, Inuit and Métis communities as a medical learner. 7.4 Demonstrate authentic, supportive and inclusive behaviour in all exchanges with First Nations, Inuit and Métis individuals, health care workers and communities. **Mental Health Core Competencies Steering Committee**[45] Recognizes through self-reflection the impact or their behaviours, attitudes and knowledge gaps that may negatively impact the quality of care and health outcomes of their patients with mental health conditions.
Leader	**IPAC-AFMC**[44] *Students are able to…* 4.1 Discern the concepts of community development, ownership, consultation, empowerment, capacity-building, reciprocity and respect in relation to health care delivery in and by First Nations, Inuit and Métis communities. 4.2 Identify key First Nations, Inuit, Métis community contacts and support structures in the provision of effective health care. 4.3 Describe successful approaches that have been implemented to improve the health of First Nations, Inuit, Métis peoples, either locally, regionally or nationally. **Mental Health Core Competencies Steering Committee**[45] Actively engages in the coordination with other health professionals for the care of their patients with mental health conditions, including the appropriate utilization of local community mental health resources. **CFMS – HEART Competencies**[30] -Recognize upstream policies that promote both health and environmental wellbeing, with the further understanding of benefits of climate change adaptation in various fields. -Understand the equitable family planning and reproductive rights have co-benefits for climate change mitigation and resource use. -Recognize the social responsibility within health care to incorporate green practices from hospital/clinic infrastructure design and process.

Medical Expert	**MCC**[42] • Understand how variation in the determinants of health in different populations promotes or harms health status. • Discuss how populations may have challenges with respect to access to health services, and how members of the population may rely on traditional or alternative sources of health services that are not commonly used by society. • Discuss the unique roles provided by government, social agencies or special groups (e.g., Indigenous health centres, Traditional healers) in providing services to the population. **CFPC**[43] 6.0 Establishes an inclusive and culturally-safe practice environment. 6.1 Demonstrates humility and openness to patients' ideas and knowledge. 6.2 Seeks to understand and respects culturally-based health beliefs. 6.3 Explores how the patient's previous experiences, including adverse life events, impact individual clinical encounters and interactions with the health system and incorporates this understanding in their provision of care. **IPAC-AFMC**[44] *Students are able to…* 1.1 Describe the connection between historical and current government practices towards First Nations, Inuit, Métis peoples (including, but not limited to colonization, residential schools, treaties and land claims), and the resultant intergenerational health outcomes. 1.2 Describe the various health care services that are delivered to First Nations, Inuit, Métis peoples, and the historical basis for the systems as they pertain to these communities. 1.3 Identify the diversity amongst First Nations, Inuit, and/or Métis communities in your local area in terms of their various perspectives, attitudes, beliefs and behaviours. Describe at least three examples of this cultural diversity. 1.4 Articulate how the medical, social and spiritual determinants of health and well being for First Nations, Inuit, Métis peoples impact their health. 1.5 Identify and describe the range of healing and wellness practices (traditional and nontraditional) present in local First Nations, Inuit and Métis communities. **Mental Health Core Competencies Steering Committee**[45] • Physicians will have working knowledge of the symptoms, etiology, and basic treatment of mental health and addiction conditions that may influence a physical condition that they are treating. • Physicians will detect/recognize physical health conditions in patients who present with what appear to be mental health conditions. • Physicians will recognize the signs and symptoms of basic mental health conditions most common to their specialty practice, (i.e., anxiety disorders, mood disorders, Psychosis, addictions, grief, situational stress, cognitive impairment, sleep disorders). • Physicians will undertake mental health screening where applicable. Recognizing the limits of their expertise, physicians will seek appropriate consultation from other health professionals. **CFMS – HEART Competencies**[30] -Understand the role and impact climate change has on food security, nutrition, health and the stress on global water supply (e.g., drought). -Recognize the contributions that climate change plays in the emergence of infectious disease threats to new regions. -Understand that air pollution causes more deaths than any other environmental pollutant, and that it is most strongly linked to cardiorespiratory diseases.

Collaborator	**IPAC-AFMC**[44] *Students are able to…* 3.1 Identify key principles in developing collaborative and ethical relationships. 3.2 Describe types of Aboriginal healers/traditional medicine people and health care professionals working in local First Nations, Inuit and/or Métis communities, and how they are viewed in the community. 3.3 Demonstrate how to appropriately enquire whether a First Nations, Inuit, Métis patient is taking traditional herbs or medicines to treat their ailment and how to integrate that knowledge into their care. **Mental Health Core Competencies Steering Committee**[45] o Recognizes and respects the diversity of roles, responsibilities and competencies of other professionals in relation to their own as it relates to mental health and addictions. o Works with and learns from others to assess, plan, provide and integrate mental health and addiction care for individual patients or groups of patients (shared, integrated care). **CFMS – HEART Competencies**[30] **-**Recognize the role health care professionals play in disaster response, including both early-disaster warning systems and response to climate related disasters. -Understand the importance of integrating multidisciplinary information to manage complex climate-related conditions in a variety of contexts. -Recognize that there are specific climate- and environmental-related health risks for Indigenous populations, as well as specific challenges for coping with them within existing health and social systems. -Honour Indigenous cultural practices and ways of being; acknowledge the role of Indigenous connection to land, and related expertise, that has an important role in protecting the health of humans and our natural surroundings.
Scholar	**IPAC-AFMC**[44] *Students are able to…* 6.1 Describe appropriate strategies to work with First Nations, Inuit, and Métis populations to identify health issues and needs. 6.2 Engage in effective strategies to share and promote health information with First Nations, Inuit, and Métis patients/populations. 6.3 Describe various ways of respectfully acquiring information (in a transparent manner) about First Nations, Inuit, and Métis populations which involves communities as partners. 6.4 Critically appraise the strengths and limitations of available data used as key indicators of Canadian Aboriginal health. 6.5 Demonstrate ways to acknowledge and value Indigenous knowledge. **Mental Health Core Competencies Steering Committee**[45] Identifies and integrates information and evidence related to the care of patients with mental health conditions in their specialty.

APPENDIX B - Demonstrated Commitment from National and Provincial Organizations

Table 2: Demonstrated Commitment from National and Provincial Organizations

Organization	Climate Change	Early Childhood Development	Indigenous Health	Mental Health	Poverty
CCSDH		x	x		
CPHA	x	x	x		x
CFMS	x		x	x	x
CIHI		x	x	x	x
CIHR	x	x	x	x	
Gov of Can	x	x	x	x	x
Gov of SK	x	x	x	x	x
RCPSC	x	x	x	x	x
CFPC	x	x	x	x	x
CMA	x	x	x	x	x
SPHERU		x	x	x	
SHRF			x	x	x

APPENDIX C - Resources for Medical Curriculum Planning and Delivery

Table 3: Indigenous Health Inequities – Resources

Reports and Guidelines	• National Inquiry into Missing and Murdered Indigenous Women and Girls (2019). • Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada (2016, CFPC) – brief guide for physicians to help understand the role that systemic racism can play in shaping an Indigenous patient's clinical experience and what they can do about it in their clinical practice, in their community, in advocacy efforts. etc. The document was developed in an effort to address the recommendations made in the TRC. • Truth and Reconciliation Commission of Canada: Calls to Action (2015, NCTR) • Addressing the Healing of Aboriginal Adults and Families within a Community-owned College Model (April 2015, NCCAH) - explores the potential for healing strategies within the education domain; examines how programs and curriculum have the potential to disrupt the intergenerational transmission of trauma • Policies, Programs and Strategies to Address Aboriginal Racism: A Canadian Perspective (July 2014, NCCAH) – examines anti-oppressive education, cultural safety within health care, and systemic policies. • Advancing Health Equity in Health Care – Cultural Considerations: Aboriginal Peoples in Canada (2014, Public Health Observatory) – a brief history of colonization and its sustained impact on health. • Towards Cultural Safety for Métis: An introduction for health care providers (2013, NCCAH) – fact sheet demonstrates how health care providers can create a culturally safe environment when caring for Métis patients. • Indigenous health fact sheet (2013, Royal College of Physicians and Surgeons of Canada) – a quick resource containing facts about health inequities and disparities in health outcomes of Indigenous communities.

	• Health Professionals Working with First Nations, Inuit and Métis Consensus Guidelines (2013, Journal of Obstetrics and Gynecology Canada) – aims to provide health care professionals in Canada with the knowledge and tools to provide culturally safe care. • Cultural Competence Education for Students in Medicine and Public Health: Report of an Expert Panel (2012, ASPH & AAMC) - provides recommendations to faculty and administrators developing and administering curricula in schools of medicine and the health sciences. • Access to primary health care in rural and remote Aboriginal communities: Progress, challenges and policy directions (2011, NCCAH) – offers students and practitioners a valuable resource for understanding the special, ever-changing needs of rural communities. • Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators (2008, NAHO) – looks at culturally safe environments in education and how culturally safe environments in health care and education are applied to Indigenous peoples. Also see PowerPoint presentation below.
Toolkits	• Cultural Competency & Cultural Safety Toolkit (2016, Saskatoon Health Region Public Health Observatory) – provides various learning resources for engaging in reflection, relationship building and reconciliation
In Practice Tools	• A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency (2009) – adopted by Saskatoon Health Region, outlines practices in the clinical encounter that physicians may adopt (pg. 20, 22) as well as strategies around communication, health literacy, etc.
Webinars	• What's new is really old: Trauma informed health practices through an understanding of historic trauma (2017, NCCAH) – provides an overview of pre-contact values and laws; explores the complexities of historic trauma and lateral violence within communities; reviews current trauma-informed health practices. • Cultural safety for Indigenous peoples: A determinant of health (2016, NCCAH) – explores how racism has manifested in the way health care services are provided to Indigenous peoples and is thus a barrier to optimal health. • Anti-Aboriginal Racism in Canada: A Social Determinant of Health (2015, NCCAH) – overviews race as a form of social hierarchy, expressions of racism and the impact of lived and structural racism on Indigenous peoples; examples of efforts to address racism including anti-oppressive education and cultural competency.
Case Studies	• The 2009 HINI influenza pandemic among First Nations, Inuit and Métis peoples in Canada: Epidemiology and gaps in knowledge (2016, NCCAH) • Pandemic planning in Indigenous Communities: Lessons learned from the 2009 HINI influenza pandemic in Canada (2016, NCCAH) • Treatment and Respect for Difference: Aboriginal Health (2013, Royal College of Physicians and Surgeons of Canada)

Table 4: Poverty-Related Health Inequities – Resources

Reports and Guidelines	• 12 Bold Ideas to Eliminate Poverty in Saskatoon (2019, SPRP) • Creating a Culture of Inclusion – "Nothing About Us, Without Us" (2017, SPRP) – a practical guide for community groups & employers to include people with the lived experience of poverty in their work. Guide is recognized as best practice across Canada and won an award in spring 2017 by Vibrant Communities' Canada.

	• Our People & Poverty – The Costs of Living for Families in Saskatoon (2017, SPRP) – local statistics on poverty. • Saskatoon Health Region – Social Determinants of Health (2017) – high level overview of the current status of income inequality, unemployment, housing costs, educational attainment, etc. in Saskatoon. • Office Interventions for Poverty (2013, Ontario Medical Review Series on Poverty and Health) – article suggests actions that physicians can take to mitigate the effects of income inequality on their patients. • Office Interventions for Poverty: Child Health (2013, Ontario Medical Review Series on Poverty and Health) – article focused on the role of physicians on the importance of interventions into poverty and heath when it comes to children. • Office Interventions for Poverty: Racialized Groups (2013, Ontario Medical Review Series on Poverty and Health) – fourth article in 5-part series on medical interventions into poverty focused on two specific groups: Indigenous peoples and new immigrants and refugees. • Identifying Poverty in Your Practice and Community (2008, The Ontario Physicians Poverty Work Group) – how poverty is measured and how this information can be used for clinical practice and public policy.
Clinical Toolkits	• Poverty: A Clinical Tool for Primary Care Providers – Saskatchewan (2016) - This clinical tool offers specific resources to help health care providers screen for and respond to poverty concerns in patient encounters. The tool is individualized for each participating province (including Saskatchewan) and territory, designed for quick and intuitive use in day-to-day practice and endorsed by the College of Family Physicians of Canada (CFPC) and its provincial chapters. • Poverty: A Clinical Tool for Primary Care in Manitoba (2015, The Manitoba College of Family Physicians) – three ways to address poverty in primary care, including screening, adjusting risk and intervention. • Poverty Intervention Tool (2014, Division of Family Practice GPSC). – steps to address poverty in a clinical encounter.
Learning Modules and Case Studies	• Make the Month Online Poverty Simulation (2017, United Way) – digital poverty simulation that aims to help Canadians understand and experience what its like to have to make your paycheck last the month. • Poverty and Health: Key Issues in Patient Care (2014, Family and Community Medicine University of Toronto) – modules and case studies that provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. • If You Want to Help Me, Prescribe Me Money (2013, TEDxStouffville) – video with *Health Providers Against Poverty* founder, Gary Bloch, that connects the evidence to action and proposes radical rethinking of the role of doctors in addressing income and other social issues that affect their patient's health.

Table 5: Early Childhood Development – Resources

Reports and Guidelines	• Patient First Review Update: The Journey so far and the Path Forward (2015, Government of Saskatchewan) – outlines Saskatchewan's commitment to improving health services, including services for children, Indigenous peoples and rural and remote communities. • Early Childhood Development: Royal College Position Statement (2014, RCPSC) – includes areas for action, including in medical education

	• Children Vulnerable in Areas of Early Development: A Determinant of Child Health (2014, CIHI)
Educational Resources	• Early Brain and Biological Development and Early Learning (EBBDEL) – Educational and Practice Resources including videos, podcasts and interactive tools in six major categories (concepts and language, adverse childhood experiences, resilience, epigenetics, literacy, tools for practice) • PREP in the Curriculum (CPS, 2018) – Pediatrics Review and Education Program (PREP) is a family of self-directed continuing medical education review products for health professionals. • ACE Response Online Course (University of Albany)- free online course • What You Should Know about ACEs (Adverse Childhood Experiences) (2018, Collaborative Toolbox) – best practices, presentations, journal articles • Adverse Childhood Experiences Resources (CDC, 2016) – case studies, infographics, etc. • Early Childhood Development (Canadian Paediatric Society) - online course
In Practice Tools	• Promoting Literacy: A Guide for Physicians (2019, Canadian Paediatric Society) • Rourke Baby Record (2017, Canadian Paediatric Society) – an evidence-based health supervision guide for physicians and health care providers caring for children in the first 5 years of life • Greig Health Record (2016, CPS) – promotion guide for physicians and clinicians caring for children and adolescents aged 6 to 17 years • Using the ACE Questionnaire in Practice (2014, Alberta Family Wellness Initiative) – the questionnaire is an intervention tool designed for clinicians to complete with patients • Promoting optimal monitoring of child growth in Canada: Using the new WHO growth charts (2010) – a practice guideline for health professionals in the promotion of consistent practices in monitoring growth and assessing patterns of linear growth and weight in infants, children and adolescents to support healthy child growth and development.

Table 6: Climate Change and Health– Resources

Reports and Guidelines	• Climate Change and Children's Health (2019, American Academy of Pediatrics) – various resources • Climate Change and Health: Key Facts (2018, WHO) • Lancet Countdown 2018 Report: Briefing for Canadian Policy Makers (2018, CMA, CPHA) – focuses on the links between climate change and health • The 2018 Report of the Lancet Countdown (2018, The Lancet) – provides independent, global monitoring system dedicated to tracking the health dimensions of the impacts, and the response to, climate change Video resource available here : https://youtu.be/moYzcYNX1iM • DivestInvest for Health: A Guide for Health Advocates (2018, DivestInvest Network with CAPE) – answers to common questions about divesting from fossil fuels, resources and sample resolutions your organization can adopt. • Health and Climate Resource Guide: Step Up for Health at the Global Climate Action Summit (CAPE, 2018) – highlights the important work performed to date, an abundance of resources, including health professional specific resources. • A Physicians Guide to Climate Change, Health and Equity (2018, Center for Climate Change and Health) • Unless We Act Now: The Impact of Climate Change on Children (2015, UNICEF) - • Climate Change: Should Family Physicians and Family Medicine Organizations Pay Attention? (2013, Canadian Family Physician Journal) – describes the health effects of climate change and the various roles of physicians • Climate Change and Human Health (2010, CMA Policy)

Educational Powerpoints and Student Manuals	• Climate Change 101 for Family Physicians: World Café of Practical Implications for Practice (2018, Family Medicine Forum) – response to climate change in day to day practice powerpoint slides • Climate Change and Health: A Global Call to Action (2018, American College of Physicians) – powerpoint presentation that can be used for grand rounds • Climate and Health Training Manual (2016, International Federation of Medical Students)
In Practice Tools	• Climate Change Toolkit (2018, ACP) – resources to help physicians reduce energy use and greenhouse gas emissions in their practice • Green Office Solutions for Physicians (2018, Ontario College of Family Physicians Environmental Committee)
Advocacy Tools	• Advocacy Tools (2019, US Climate and Health Alliance) – resources supporting health professionals to take action on climate change

Table 7: Mental Illness, Suicide Risk and Substance Use - Resources

Reports and Guidelines	• Infant Mental Health Promotion (IMHP) provides a number of best practice and policy guidelines on the promotion of optimal development and well-being in infants (prenatal to age 3) and their families. • CRISM National Guidelines for the Clinical Management of Opioid Use Disorder (2018, CIHR and CRISM). • Saskatchewan First Nations Suicide Prevention Strategy (2018, FSIN) • Opioid Wisely (2018, CFPC) – a campaign of Choosing Wisely Canada that outlines a set of 14 specialty-specific recommendations for when it is unsafe to prescribe opioids. • The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain (2017, CMAJ) – guidelines for clinical practice developed by an international team of clinicians, researchers and patients • Joint Statement of Action to Address the Opioid Crisis: A Collective Response (2017, CCSA) – highlights progress of non-governmental partners in their commitments in the 2016 report • Opioids: We Can do Better (2016, CMPA) – summary of the issues with increasing opioid use and recommendations for physicians. • Competencies for Practice in the Field of Infant Mental Health (2011, IMPH and Hospital for Sick Children) – includes competencies guide and interactive learning module • Core Prevention and Intervention for the Early Years (2011, IMPH and Hospital for Sick Children) – intervention framework, interactive learning module and supporting references • IMHP also offers webcasts and videoconferencing distance learning opportunities, as well as Hand in Hand: Nurturing the Seed, a resource that can help practitioners use Indigenous ways of knowing to respectfully engage with and support Indigenous families. • The 2014 Best Practice Guidelines for Mental Health Promotion Programs: Children and Youth provides support and best practice advice for health and social services professionals who work with at-risk youth, families and whole communities to promote mental health (developed by the Centre for Addiction and Mental Health, the Dalla Lana School of Public Health at the University of Toronto and Toronto Public Health). The collaboration also provides Best Practice Guidelines for Mental Health Promotion Programs: Older Adults 55+. • Recommendations on Screening for Depression in Adults (2013, Canadian Task Force on Preventive Health Care) – for adults 18 years of age or older who present at a primary care setting with no apparent symptoms of depression, known depression or history of depression. • Alzheimer Education Materials (2012, Alzheimer Society of Canada, CFPC endorsed) – information and questionnaires to be used by patients, their family members and family doctors to be aware of early signs of Alzheimer's or other dementia.

	• Ending Stigma and Achieving Parity in Mental Health: A Physician Perspective (2010, CMA CPA, CPS, CFPC) – summary of workshop presentations
Resource Centres	• Addressing Stigma (CAMH, 2019) - seven things you can do to reduce stigma • The Hospital for Sick Children (SickKids) have developed a mental health resource that provides credible, plain language content on children's mental health for caregivers. • The CAMH has an extensive resource list of accessible, reliable, professionally produced publications on an array of addiction and mental health topics for professionals and the public. http://www.camh.ca/en/education/about/camh_publications/Pages/default.aspx
In Practice Tools	• Mental Health: Screening Tools and Rating Scales (2018, Canadian Paediatric Society) – tools to help health care providers recognize and diagnose mental health problems • Collaborative Mental Health Care Child & Youth Mental Health Toolkits- practical, user-friendly resource for screening, assessment and treatment of child and youth mental health problems commonly presenting in primary care. • Opioid Manager (CEP, 2017) – a clinical tool designed to support primary care providers manage opioid prescriptions for patients across Canada who experience chronic non-cancer pain. • The General Practices Services Committee of British Columbia provides a plethora of online clinical tools and physician resources for both adult mental health and child and youth mental health.
Videos and Webinars	• Various webinars available (2017, Mental Health Commission of Canada) – regular webinars in many different areas of mental health • Stigma and Mental Illness (2012, MK Health Center and MHCC) – innovative video designed to help combat stigma attached to mental illness used to educate health care providers who work with children and youth
Elective Training	• The Centre for Addiction and Mental Health (CAMH) provides training opportunities for students in their respective disciplines at the University of Toronto CAMH teaching hospital. • The CAMH provides an extensive list of online courses, certificate programs and training in for clinicians.

APPENDIX D - References

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