The Red Road Meets the

Information Superhighway:

Using Telehealth Technology

for Psychological Services

in a Northern

Aboriginal Community

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By

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Abstract

From September 2000 through May 2001, a team of two psychologists and two psychology graduate students (myself included) from the University of Saskatchewan delivered a variety of psychological services to a remote reserve community in northern Saskatchewan via telehealth from the Royal University Hospital in Saskatoon. Using telehealth, we provided psychoeducational information, therapy, assessments, case consultations and support services to Aboriginal health workers in this community. The present study is an evaluation of the use of telehealth in the delivery of psychological services to remote reserve communities. A semi-structured interview was employed to gain knowledge about the experiences of people involved in this telehealth project as well as the insights, thoughts and beliefs of Aboriginal and non-Aboriginal mental health workers regarding the use of telehealth with remote communities. In total, eight interviews were conducted for this study. Results indicate that although telehealth technology was seen as positive, psychology is often perceived in a negative manner by Aboriginal people. Due to this disconnection between Aboriginal people and Western psychology, psychological service provision with telehealth needs to be considered in conjunction with building relationships and trust in the community. Despite the difficulties, the results indicate that there is much that can be gained by providing psychological services to remote Aboriginal communities via telehealth.

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Thanks as well to the community members with whom we worked on the telehealth project. Your dedication to your community provides inspiration to myself and to others working to improve mental health services for Aboriginal people.

To the other participants of this research, I thank you for your time and your insights. Your voices are what make up this research project. To the Elder who

participated, thank you for trusting me with your words and wisdom to be included in these pages.

I am grateful for the help and support of my partner, my family and my friends during this research. Your encouragement, acceptance, guidance and understanding helped immeasurably throughout the process of completing this project. Each of you contributed a great deal to my ability to complete this process. Thank you is not enough.

Dedication

This thesis is dedicated to Aboriginal people and to the mental health service providers working in collaboration with them and their communities. In the words of the Elder who participated in this study:

> Just keep up the good work, work with First Nations people, give them the best because they deserve the best. They have the right to get well, they have the right to stay well, but also for them to be encouraged to get an education—not at the expense of their culture, not on the expense of their way. [Be]cause our way is so beautiful.

All my Relations

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CHAPTER 1

University of Saskatchewan Telehealth Project: An Introduction

From September of 2000 until May of 2001, a team from the University of

Saskatchewan, two psychologist faculty members and two psychology graduate students

(myself included), delivered a variety of psychological services over telehealth from the

Royal University Hospital (RUH) to a remote Aboriginal community. In this project,

telehealth consisted of a real time audio and video link between RUH and the remote

community. Using telehealth, the team provided psychoeducational information,

therapy, assessments, case consultations and support services to workers in this remote

northern reserve community. As a part of the telehealth project, the telehealth team also

traveled to the community in November 2000 for a two-day visit.

The telehealth project we were involved in was part of the National First Nation

Telehealth Project, which began in 1998 and ran through 2001 in five Aboriginal

communities in Canada. The equipment and funding for this telehealth project was

provided to the reserve community through this national project (Dal Grande, 2001).

Members of the University of Saskatchewan were initially contacted in the fall of 1999

to solicit involvement in this project. Initial consultations with members of the

community and preliminary plans were made in the first year, with the service provision

over telehealth beginning in September of 2000.

The community we worked with is a small (less than 1500 people) remote

community that can be accessed by a gravel road year round. Although it has year round

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access by gravel road, it is a long drive on gravel. It is likely that there are certain times of the year when the gravel road is less serviceable than others, limiting travel to some extent.

Like many other Aboriginal communities, the population is quite young, with approximately 60% being under the age of 25. The Cree language is the main language spoken in this community, with English representing mainly a second language. Although Native languages are in danger of being lost to many communities, it did not seem to be in great danger of extinction in this community. Part of the reason for that may be its remoteness, but also members of the community were aware of the importance of maintaining their language, and how languages are being lost in other places.

We did not spend enough time in the community to make informed statements about the mix of spiritual practices in the community. However, there appears to be a strong Western religious influence, represented in the community by Catholic and Pentecostal churches. According to one community member, all children from the area were sent to residential school in Manitoba until 1960. Traditional Aboriginal spiritual practices appeared to have less influence than Western religion. For example, at a meeting at the band office with foster parents in the community, the prayer that began and closed the meeting was "Our Father." However, traditional Aboriginal spirituality symbolism was present in the main buildings we visited, such as the health centre, band office, and group home.

The community shares many of the difficulties encountered in other remote and isolated Aboriginal communities such as lack of housing and high unemployment. Housing was an issue that was easy enough to see, with homes around the community

boarded up. A community member told us that unemployment is high, with summer guiding as the main form of employment. There was some trapping around the community, but this was done mainly as a way of providing meat for the family rather than for income. Some of the further areas in which the community is struggling include problems with Fetal Alcohol Syndrome (FAS), substance abuse, spousal abuse, sexual abuse, bullying and lack of access to training for service providers.

To its advantage, the community has a number of facilities and services, including a group home for adolescents, a medical centre, a school with Kindergarten to Grade 12 that includes a daycare for young parents and school staff, and a Head Start program for pre-kindergarten children. A nurse we spoke with told us that the community was better supplied with resources than many other northern reserve communities she has worked in. There are also two stores for groceries and supplies, a band office and a small RCMP detachment.

The community does have a number of significant strengths besides the facilities and programs already in place. One of these strengths is the presence of individuals who are invested in community development. As well, it is the community members themselves who provide the majority of services. During our time there we met a number of these services providers, including the mental health coordinator, the prenatal worker, an employee of the Head Start program, a guidance counsellor from the school, one of the youth workers, a number of group home employees as well as the manager of the group home, foster parents, and other community health workers who provide psychoeducational and support groups such as Alcoholics Anonymous, parenting skills groups and a spousal abuse support group.

Our interactions via telehealth began in October 2000 when we presented psychoeducational information via telehealth on sexual abuse including some guidelines for interviewing clients who are suspected of having been sexually abused. There were six paraprofessionals from the community in attendance at the presentation, mainly consisting of employees from the group home. We were able to interact with the workers there and ask as well as answer questions.

Weekly sessions were undertaken with one client, an adolescent girl who was living at the group home. The telehealth format seems to have worked quite well with this client who quickly warmed up to the idea of talking to us over the television. This was evidenced by her preference to meet alone with us without the support of a worker from the group home, after a few meetings with an adult present. Using telehealth for therapy did have some drawbacks at times, such as occasional difficulty ascertaining non-verbal behaviour. As well, the audio tended to become interrupted if two people were trying to speak at the same time and the sound quality made it sometimes difficult to hear this soft-spoken client.

Four intellectual assessments were undertaken with adolescents from the group home in the community for the purpose of helping with their school programming. With a few alterations of the testing procedure, we were able to administer the Wechsler Intelligence Scale for Children – Third Edition (WISC-III) via telehealth. With the help of workers in the community to present the necessary materials, we were able to administer the necessary subtests. Although there needs to be more research into providing assessments over telehealth to ensure the validity of the results, our initial attempts suggest that telehealth should provide the opportunity to offer assessments to the community without the need for clients to travel to a larger centre.

In November we travelled to the community and spent two days meeting with paraprofessionals and clients and learning about the community. During our stay there we presented psychoeducational material, consulted with paraprofessionals, met with clients, and toured the group home as well as the Head Start program. The trip was invaluable in gaining an understanding of the community, their needs and their strengths. It also gave us the chance to connect with some of the people we were working with over telehealth to continue to build professional and personal relationships.

A large part of the services we provided over telehealth were case consultations and support for mental health workers. We met via telehealth on various occasions with the main mental health worker, the group home manager and group home workers. This afforded us the chance to gain an understanding of the services they provide as well as some of the difficulties they encounter in their work in the community. The workers in the community were able to access our services and ask questions about problems they were encountering with their clients or programs. We also used telehealth to gather information about the clients we would be seeing and specific concerns that the workers had regarding these clients. Throughout the fall, winter, and spring, we met with community workers on a weekly basis.

The Present Study

In the spring of 2001, I began working on completing my masters thesis on the topic of telehealth and on the project we had undertaken in this northern community. After preparation and some initial discussions with people in the community involved in the project, a proposal was submitted to the health board that oversees health issues in the community we were working with. Although initial reaction was positive from the

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community and the acting director of the health board, the idea of doing research in this community encountered some resistance from other members of the health board. A process of negotiation was initiated and a revised proposal was submitted. In the end, the proposal to involve the community in this project was rejected by the health board. The reason given was that there were a number of research projects already in progress in the community and that it was thought that there should not be any more undertaken at the time.

The decision by the health board to not allow involvement of the community caused the process of my thesis to come to a halt while I worked out whether continuing with a thesis on telehealth would be feasible. As well, I was considering whether continuing without the community's involvement would produce a research study that would be beneficial to others who may be thinking of using telehealth in Aboriginal communities. In the end, the inability to talk with the community members about their experiences was seen as a loss, but that this thesis could still provide knowledge and understanding of the issues surrounding the use of telehealth with Aboriginal communities.

Fortunately I had access to the psychologists involved in the telehealth project. However, to partially compensate for not being able to interview the members of the Aboriginal community who took part in the telehealth project, I met with and interviewed people outside of the community we worked in who had knowledge and experience working with Aboriginal people and Aboriginal communities. Their knowledge about and experiences regarding mental health issues and Aboriginal people enriched this project.

There are many reasons I was interested in pursuing a research project dealing with telehealth for Aboriginal communities. As a Metis person, I feel a strong sense of commitment to using my training in clinical psychology to improve mental health services for Aboriginal people. With this in mind, I believe that telehealth can provide a unique opportunity to work collaboratively with Aboriginal health workers in their communities to provide education, support and consultation and to help increase their ability to manage their own mental health services even with the geographic isolation.

Despite the promise of this mode of service delivery, there is very little research that has evaluated the use of telehealth as a way to overcome some of the barriers to mental health services and training in remote Aboriginal communities. Research is essential for exploring the possible effectiveness of telehealth as an alternative approach to providing these services to remote reserve communities.

This present project evaluated the use of telehealth to circumvent some of the problems encountered when delivering psychological services to remote reserve communities. To attain this goal, the psychologists involved in the telehealth project undertaken in northern Saskatchewan were interviewed to gain an understanding of their experiences and thoughts about the use of this medium for providing mental health services at a distance to Aboriginal people. As well, Aboriginal and non-Aboriginal mental health workers were interviewed for their insights into the use of telehealth with remote communities as well as their views on mental health service provision more generally. A semi-structured interview was employed with eight participants. Qualitative methodology was used to uncover the main themes present in the interview data.

CHAPTER 2

Telehealth: Literature Review

Defining Telehealth

The most widely used definition of telehealth in the literature is the one

delineated by Nickelson. He defines telehealth as "the use of telecommunications and

information technology to provide access to health assessment, diagnosis, intervention,

consultation, supervision, education, and information across distance" (Nickelson, 1998,

p. 527). Telehealth can refer to a wide variety of information technology including the

telephone or the internet. However, most of the recent focus has been on the use of

technologies that allow real time audio and video to link geographically separate sites.

The most common type of telehealth network consists of a hub and spoke model; where

the hub is generally a hospital or university in a large urban centre and the spokes are

small clinics spread over a wide geographic area (Nickelson, 1998). The present study

made use of the hub and spoke model, by providing services originating from the Royal

University Hospital (the hub) to a remote northern reserve community (the spoke).

The term telehealth has been used to connote many different types of services

delivered via telecommunication and other information technologies. Some disciplines

have developed more specific terminology to suit their particular services, such as

telemedicine, telepsychiatry, behavioural telehealth and telepsychology. The term

telemental health has also been used to describe all mental health services that are

mediated by telecommunications technologies (LaMendola, n.d.). However, the

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terminology has not been used consistently in the literature. At times, the term telehealth is used to describe all types of services provided and other times the more specific terminology is used. As there does not appear to be agreed upon terminology at the present time, the term telehealth will be used to describe the services we provided.

Although telehealth is being seen as a new advancement, it has been in use since the late 1950's (Nickelson, 1998). A number of telehealth systems were developed throughout the 1970's, but most of these systems fell into disuse due to the cost of the technology as well as a lack of acceptance by providers (Bashshur, 1997). Since the 1990's, the development of more cost effective equipment has meant a return to the use of telehealth systems (Nickelson, 1998). Technological advances continue to create cost effective means of telecommunications such as videophones and PC teleconferencing (Jerome & Zalor, 2000). Such innovations will likely ensure the continued use of telehealth as a means of service provision.

Benefits of Telehealth

With the desire to keep health care costs at a minimum, cost of service provision is one of the major forces pushing for the use of telehealth for service provision. Schopp, Johnstone and Merrell (2000) included cost of service as a variable in their study of neuropsychological service provision via telehealth. The authors point out that telehealth can provide cost saving for clients, providers and referral agencies. For the client who has to travel to obtain treatment, they may lose wages of their own and/or the wages of the family member or other support person travelling with them. As well, clients simply may not have the financial resources to travel to a larger community. Psychologists will lose potential revenue from their clinical work while they are

unavailable due to travel. Referral agencies, which subsidize travel for their clients, also stand to gain financially from the use of telehealth due to reduced travel costs.

Cost reduction is only one component of telehealth, and cost should not be the main determinant for the use of telehealth. However, telehealth systems do have further advantages, such as providing the opportunity to improve access to care for clients, consultation between providers, as well as education and support to mental health professionals working in isolated areas (Conrad, 1998; Nickelson, 1996). Telehealth has emerged as a potentially effective way to provide psychological and other specialty services to communities and populations that would not normally have regular access to these services. Certain populations, including Aboriginal people living on isolated reserves, military personnel stationed in distant locations, people who are restricted to their homes, and incarcerated individuals stand to gain a great deal through the use of telehealth (Reed, McLaughlin, & Milholland, 2000). With these types of populations there is often little opportunity to access psychological services, or the services that are provided may be insufficient or extremely expensive due to the need to travel to another geographical area. The availability of telehealth may represent a significant improvement in service delivery in these cases (Reed et al., 2000).

Telehealth applications also include assessment, diagnosis, interventions, supervision and group therapy (Nickelson, 1996; Conrad, 1998; Stamm, 1998). At the present time, mental health services are by far the most commonly used services over telehealth (American Medical News, 2000). Yet in a survey sent to 1000 members of the American Psychological Association (APA), it was found that only 2% of practicing psychologists that responded to their survey had used the internet, satellite technology or closed circuit television in the delivery of their services (VandenBos & Williams, 2000).

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As the use of telehealth continues to expand and the technology becomes more accessible, more clinicians will be likely to use telehealth as part of their practice.

Issues in Telehealth

Although telehealth increases the possibilities of service provision to underserved populations, there are important considerations that must be explored. Issues such as licensure, liability, competence and efficacy are frequently debated in the literature on telehealth (Nickelson, 1998; Conrad, 1998; Koocher & Morray, 2000; Reed et al., 2000). Standards are needed to ensure good practice, privacy, confidentiality and competence while using telehealth and to ensure a minimum quality of technology (Nickelson, 1998).

In 1997, members of the Joint Working Group on Telemedicine (JWGT) formed an Interdisciplinary Telehealth Standards Working Group to identify principles and standards for telehealth services that would be applicable for telehealth providers from different professions, including psychologists (Reed et al., 2000). The Interdisciplinary Telehealth Standards Working Group created ten core principles for telehealth practice to address the concerns raised by professional groups working with telehealth and to act as the basis for further development of standards that would be specific to particular health care professions (Reed et al., 2000, p.172):

Principle 1: The basic standards of professional conduct governing each health care profession are not altered by the use of telehealth technologies to deliver health care, conduct research, or provide education. Developed by each profession, these standards focus in part on the practitioner's responsibility to provide ethical and high-quality care.

Principle 2: Confidentiality of client visits, client health records, and the

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integrity of information in the health care system is essential.

Principle 3: All clients directly involved in a telehealth encounter must be informed about the process, its attendant risks and benefits, and their own rights and responsibilities, and must provide adequate informed consent.

Principle 4: Services provided via telehealth must adhere to the basic assurance of quality and professional health care in accordance with each health care discipline's clinical standards.

Principle 5: Each health care discipline must examine how its patterns of care delivery are affected by telehealth and is responsible for developing its own processes for assuring competence in the delivery of health care via telehealth technologies.

Principle 6: Documentation requirements for telehealth services must be developed that assure documentation of each client encounter with recommendations and treatment, communication with other health care providers as appropriate, and adequate protections for client confidentiality.

Principle 7: Clinical guidelines in the area of telehealth should be based on empirical evidence, when available, and professional consensus among involved health care disciplines.

Principle 8: The integrity and therapeutic value of the relationship between client and health care practitioner should be maintained and not diminished by the use of telehealth technology.

Principle 9: Health care professionals do not need additional licensing to provide services via telehealth technologies. At the same time, telehealth

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technologies cannot be used as a vehicle for providing services that

otherwise are not legally or professionally authorised.

Principle 10:   The safety of clients and practitioners must be ensured. Safe hardware

and software, combined with demonstrated user competence, are

essential components of safe telehealth practice.

In Canada, initiatives are beginning to take place to develop standards of practice

for telehealth. A research project named the National Initiatives for Telehealth

Guidelines: Environmental Scan - Stakeholder Survey is being undertaken by

investigators from within the Faculty of Medicine at the University of Calgary. This

survey is aimed at people and programs that are involved in the use of telehealth. The

goal is to develop comprehensive national guidelines to provide the groundwork for the

further development of telehealth standards by various health care organizations in a

way that best suits the needs of the providers and the receivers of these services.

Telehealth for Psychological Services

Although research is lacking in the area of providing psychological services with

telehealth, some recent studies are emerging which seem to provide support for its use in

this area. A study by Ruskin et al. (1998) examined the reliability of psychiatric

diagnosis and of patient satisfaction when using telehealth technology. Two

interviewers trained in the use of the Structured Clinical Interview for DSM-III-R

(Diagnostic and Statistical Manual of Mental Disorders – Third Edition – Revised)

interviewed thirty psychiatric inpatients. To assess patient satisfaction, participants

filled out a patient satisfaction scale after each interview. Half of the participants were

interviewed in person two times, while the other half had one in person interview and

one via telehealth. The 15 patients that had both an in person interview and a telehealth interview were asked three additional questions: "Overall, which did you prefer?," "Would you rather have a video examination with a psychiatrist or an in person interview by a general practitioner who might know a little less about psychiatry?" and "If you lived two hours away from the hospital, would you rather travel to the hospital to see the psychiatrist in person or go to a place close to your home and see the psychiatrist by video?" All participants met one-to-one with the two interviewers. The interviewers alternated between administering the first interviews as well as with performing the telehealth interview.

The results suggest that the diagnoses made via telehealth were as reliable as those that were made with in person interviews for the four most common diagnoses (i.e., major depression, alcohol dependence, bipolar disorder, panic disorder). As well, there were no significant differences in participant satisfaction for in person interviews or telehealth interviews on the patient satisfaction scale. Ten of the fifteen participants that were interviewed over telehealth stated they would prefer an in person interview to telehealth, five said they had no preference, and none chose the telehealth option. However, 12 participants said they would prefer the telehealth method over seeing a less knowledgeable interviewer in person and would choose telehealth over travelling two hours to have an in person interview. These results indicate that although most people tended to choose in person interviews in favour of telehealth, no significant differences were found in patient satisfaction between the in person interviews and the telehealth interviews, and most would prefer the option of telehealth if it means seeing a clinician with more expertise and if telehealth is more convenient.

Schopp et al. (2000) conducted a study on the satisfaction of clients and providers of telehealth as well as the cost effectiveness of the use of this technology. The authors matched, by age and diagnosis, 49 adult outpatients with cognitive deficits who were interviewed by telehealth with 49 outpatients who were interviewed in person. The client participants had been referred from the same agency for neuropsychological assessment to assist with vocational planning. Each psychologist completed both in person and telehealth interviews. All participants, psychologists and clients, filled out questionnaires including general information and to assess their experience in the interview. The participating psychologists were interviewed to further assess their experience of using telehealth. Clients were asked additional open-ended questions about their experience and the referral sources were asked to provide feedback regarding the assessments completed by telehealth. Neither the clients nor the psychologists had any prior experience with telehealth.

Schopp et al. indicated that none of the clients interviewed by telehealth would have preferred in person interviews. The telehealth clients asserted that they found no difficulties with communication and felt as relaxed in the telehealth setting as they did with the in person setting. As well, the clients who were interviewed by telehealth were more likely to want to repeat the experience than clients who were interviewed in person. By way of possible explanation for this finding, the authors report that several clients indicated that they found it interesting to take part in videoconferencing and enjoyed having the opportunity to be involved in the use of such technology. Clients also stated that they believed telehealth would allow them to access high quality care while allowing them to remain closer to their communities. The only concern expressed by some of the clients was that of confidentiality of signal transmission.

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However, psychologists reported less satisfaction with the telehealth setting than with the in person interviews. As well, they reported more frustration than the clients with delays in hook up times or other technological problems. Schopp et al. report that significant delays created strong negative reactions in the participating psychologists. They suggest that this difference in reactions between psychologist and client to delays relates to clients being accustomed to long waiting times for appointments and other inconveniences associated with receiving medical care, whereas the psychologists are less familiar with these types of delays in their own clinics. The authors state that the biggest barrier to the success of telehealth for mental health may be in the "culture of practitioners," as they appear more resistant to the technology than their clients (p. 182). They suggest that education of psychologists to the potential benefits of telehealth for their clients may offset their reluctance to use this technology.

The referral sources used for the participants in this study noted that they did not find that there was any difference in the quality of the reports and other information they received for the clients who were seen over telehealth than for the clients who were seen in person.

Cost of the service is another factor that was investigated in this study. Schopp et al. indicate that costs for the telehealth service were found to be slightly lower than having the client travel to a larger centre for care ($67.70 versus $83.60) and were substantially lower for the telehealth provision than for outreach service provision ($238.77). Clients indicated a lack of financial resources as a reason for supporting telehealth as they reported that financial limitations probably would have prohibited them from getting to a large medical centre. This suggests that although the range of costs for telehealth versus having the client travel to a medical centre is not substantial,

it makes a significant difference for clients with limited financial resources. For these clients, having access to telehealth may be the only way they would be able to get needed care.

Chapter 3

Aboriginal Mental Health

Aboriginal Perspective on Mental Health

It is difficult to delineate an Aboriginal perspective on mental health due to the diverse nature of Aboriginal groups and the dynamic nature of Aboriginal culture. Aboriginal peoples beliefs about mental health range from a 'traditional' Aboriginal perspective to a perspectives similar to those held by non-Aboriginal people, and includes all shades in between. Aboriginal people come from different traditions, differing levels of acculturation and experiences and may have distinct as well as shared views on what constitutes well being (Uchelen, Davidson, Quressette, Brasfeild, & Demerais, 1997).

Traditionally, the value placed on the balance of mental, emotional, physical and spiritual health is integral to Aboriginal culture. The ability to keep this balance or return to it when it is lost is taught and supported from birth to death (Mussell, Nicholls, & Adler, 1991). Aboriginal culture has continued to contain within it an understanding of mental health, one that often differs from the understanding shared by Western psychology. The differences in viewpoints on mental health are illustrated in part by Connors (1990), who believes that psychology tends to have too narrow a focus when looking at healing. Focussing only on the mind and the emotions may seem short-sighted to some Aboriginal people as their perception of mental health is more holistic, involving balance and harmony between the physical, mental, emotional and spiritual

aspects of human nature (Mussell et al., 1991; Connors, 1990). This emphasis on balance between the four aspects of human nature is often maintained in present Aboriginal contexts as Aboriginal people in Canada work to overcome the consequences of colonialism and attempts at assimilation (McCormick, Vedan, McNicoll, & Lynman, 1997).

Epidemiology

Epidemiological studies suggest that there are high levels of mental health problems in Canada's Aboriginal population (Kirmayer, Brass, & Tait, 2000). Schwean, Mykota, Robert and Saklofske (1999) state that indicators of mental health problems among Aboriginal people include mortality, suicide, substance abuse and violence. Statistics indicate that Aboriginal people have lower life expectancies and higher mortality rates than the Canadian average (Norris, 1990). The difference in life expectancy between Aboriginal people and non-Aboriginal Canadians is seven years (Kirmayer et al, 2000). For Aboriginal people, causes of death often involve violence, accidents and poisoning, with many of these causes relating to alcohol (Norris, 1990). Suicide rates are much higher among Aboriginal people, up to five or six times the Canadian average (Kirmayer, 1994). Markedly high rates of mental health problems have been reported with the most common being anxiety, family emotional problems, sleep disturbance, depression, physical abuse and drug and alcohol abuse (Kirmayer et al, 1994).

Mental health problems seen in Aboriginal communities today are generally thought to be as a result of poverty, unemployment, powerlessness, discrimination, cultural loss and anomie (Brant, 1996; McCormick et al., 1997; Kirmayer et al., 2000; Schwean et al., 1999; Waldram, 1997). Schwean et al. indicate that institutional

discrimination, including our school system, prevents Aboriginal people from becoming fully participating members of Canadian society. Historical and present day mistreatment of Aboriginal people has an impact on the prevalence of mental health problems in their communities.

Aboriginal Health Workers

Despite high levels of mental health problems, Aboriginal people underutilize mental health services (Sue, 1981). The geographic isolation of some reserves can make it very difficult for the people living on the reserve to access mental health services outside the community without great cost and inconvenience. People who are seeking mental health services often need to travel long distances to other communities or wait until a mental health professional travels to their community. Neither of these options may be feasible. In particular, frequency of visits for ongoing psychological services makes travel prohibitive. In addition, there are few mental health professionals who are willing to work in small isolated communities.

Having Aboriginal health workers with training in mental health services within isolated communities can allow far greater access to care than would normally be afforded. Continuity of care is more likely with Aboriginal mental health workers as clients would likely be able to access the same care provider over a long period of time as they live in the same community. Kirmayer et al. (2000) suggest that a shared sense of history, ethnic identity and social values contributes directly to the mental health of Aboriginal people. Aboriginal health workers are more likely to understand the history, identity and social values of their community than non-Aboriginal mental health providers and therefore have an advantage towards creating positive mental health within the communities they serve. The knowledge of the community that is held by

Aboriginal community workers also better prepares them to deal with kinship ties and family conflicts (Timson, 1984).

Despite the advantages, there are some difficulties that Aboriginal health workers may encounter and some potential shortfalls of relying heavily on these individuals. The small size of remote Aboriginal communities means that there are fewer resources available and that a few key people in the community may be required to take on many roles (Kirmayer et al., 2000). Aboriginal mental health workers that live in small isolated communities have to deal with confidential information about their neighbours, be on call 24 hours a day and are subject to constant observation by community members (Timson, 1984; Kirmayer et al., 2000). For these reasons, Aboriginal health workers face a high risk of experiencing burnout (Timson, 1984; Kirmayer et al., 2000). Aboriginal health workers and their potential clients occupy certain social positions in their community and these positions may hinder the ability or acceptability of certain clients seeking care (Miller & Pylypa, 1995). Alternative avenues for seeking care must be in place in order to allow access to mental health services for all the members in a community. Providing alternatives may entail having more than one health provider from different social positions or families or allocating funds for outside services. As well, the workers themselves may need to be able to access mental health services in order to increase their awareness of personal needs, which in turn would allow them to better assist other community members.

Non-Aboriginal Service Providers

Due to the lack of Aboriginal professionals and paraprofessionals, there are many instances when non-Aboriginal people provide mental health services to Aboriginal people and communities. Until more Aboriginal people are able to attain the

training needed to serve as mental health professionals, non-Aboriginal people are likely to be involved in direct care, consultation and training in Aboriginal communities (Timson, 1984). The use of non-Aboriginal service providers can be positive as they may have more training in the areas of need and be able to work in a culturally sensitive manner (Kirmayer et al., 2000).

However, even if non-Aboriginal professionals are sensitive to the culture within which they work, as well as highly skilled, a major barrier to helping can be one of language. People may be most able to express their thoughts and emotions in their Aboriginal language (Kirmayer et al., 2000). The saying "the culture is in the language" captures this most profoundly. Although interpreters can be used, Timson (1984) points out that translation from one language to another may have results that are less than exact. For instance, meaningful changes in tone of voice cannot easily be conveyed and concepts not recognized by both cultures may prohibit appropriate translation.

Other considerations can also make it difficult for a non-Aboriginal provider to work effectively with Aboriginal clients and communities. The non-Aboriginal professional is unlikely to have the same sense of shared history and social values as their Aboriginal clients. Although there are positives to not having close kinship ties in the community, it may also hinder the ability of the mental health provider to connect with important members of the community. Community connections may also be more difficult if the non-Aboriginal provider does not live within the community. There may often be a differing socio-economic status, which may act as a barrier to the therapeutic alliance. The history of colonization and relations between Aboriginal and non-Aboriginal people may heighten perceptions of the power differential between the non-Aboriginal professional and the Aboriginal client.

Barriers to Collaboration

Boone, Minore, Katt and Kinch (1997) state that people's beliefs about the superior nature of their professions is one of the most frequent obstacles to collaborating with an Aboriginal community. Non-Aboriginal service providers and Aboriginal community workers must be able to understand and respect each other's strengths in order to work well together. Boone et al. suggest that in order for professionals and paraprofessionals to be effective, each person must: understand the roles of each member of the team; respect the knowledge and capabilities of each member, seeing each as equal but different; become part of the community; involve the community, especially the leaders; discuss client confidentiality; keep communication open between human service sectors; understand the human service sector within which you are working, including any constraints or overlapping areas.

Breaking Collaboration Barriers

Janzen, Skakum and Lightning (1994) assert that professionals working in Aboriginal communities should approach the community with an attitude of acceptance of the uniqueness of Aboriginal and non-Aboriginal cultures and with the aspiration to work with the community in an egalitarian way. Janzen et al. suggest that the provision of services by a non-Aboriginal professional must start with the building of relationships with the Aboriginal community and with the recognition that trust can only be established over time. The authors state that it is important for professionals to listen more than they talk, and to allow the community to gain a sense of them as a person, their personality, their likes and dislikes, in order to be known and accepted. They acknowledge that this approach is foreign to Western professionals, who tend to put

more stock in credentials, but they maintain that the Western approach has never worked well in Aboriginal communities.

The importance placed on personal relationships with clients may run contrary to the way non-Aboriginal mental health providers are used to interacting in their practice. The role of the non-Aboriginal mental health provider is generally less interactive with their clients on a personal level and the necessity of personal privacy is often the norm. This may vary depending upon the size of the community within which the non-Aboriginal person practices, but even if a non-Aboriginal professional is used to working in a small rural community where there are many community ties, working in an isolated Aboriginal community would still likely be qualitatively different. Interactions in an isolated community are often more frequent and necessary and the roles filled by the non-Aboriginal service provider and the community members may be more interconnected. There is even less chance to be autonomous in an isolated community than would be afforded in a small rural community. An understanding of these issues and a willingness to become an active community member could enhance the ability of the non-Aboriginal service provider to collaborate with an isolated Aboriginal community.

Although mainstream and Aboriginal approaches are often seen as polarized, it is conceivable that a combination of mainstream and culturally specific approaches to mental health services is likely the best way to address the needs of Aboriginal populations (Peters & Demerais, 1997). Peters and Demerais suggest that conceptualizing mainstream and culturally specific mental health services along a continuum reflects the heterogeneity of Aboriginal communities and that the heterogeneity of these communities is best served by a variety of service types. For

example, services could range from psychological assessments completed by a non-Aboriginal psychologist to traditional healing ceremonies provided by an Aboriginal Elder.

Uchelen et al. (1997) stress the importance of recognizing strengths in the Aboriginal community. They suggest that the nurturance and encouragement of these strengths represent a potential pathway to wellness. Aboriginal people have their own healing programs that continue to evolve. Aboriginal people continue to incorporate what is useful for them from the mainstream and adapt it for their own use, and yet retain a strong sense of what mental health means to them. Aboriginal people are working towards finding a balance that will heal their communities. Mainstream psychology does have applicable knowledge to offer Aboriginal people in the area of mental health. As well, Aboriginal people have much to contribute to psychology, including a different way of looking at mental health and healing (Chaimowitz, 2000).

Towards a Better Future

Community development and local control of services, including mental health services, is necessary to create services that are responsive to Aboriginal people and to add to the sense of efficacy that will promote mental health (Kirmayer et al., 2000). Research is beginning to be done that corroborates the view that Aboriginal control of community resources has beneficial results for mental health. For example, Chandler and Lalonde (1998) found that there was a significant relationship between the level of community control over services and the rate of suicide in 196 Aboriginal communities in British Columbia. Communities that had more control over services had lower rates of suicide. They distinguished six variables that were strongly related to reduced rates of suicide: community control of police and fire service, education, health, local

facilities for cultural activities, self-government and involvement in land claims. Increased self-efficacy, a sense of empowerment, encouragement of cultural value, a sense of community and social support are likely all involved in the reduction of suicide.

Aboriginal People and Telehealth

There is a dearth of published research on the use of telehealth to address the health needs of Aboriginal people. More specifically to this project, there is scant information available on the use of telehealth for mental health services. This is in spite of the fact that many Aboriginal communities in Canada are geographically distant from urban centres. Dal Grande (2001) reports that approximately one-third of Aboriginal and Inuit communities are classified as remote, isolated or semi-isolated. The ability that telehealth holds to provide specialized services at a distance speaks to the importance of evaluating this method of service provision for these types of communities.

There is interest in using telehealth as a means to address the health problems seen in Aboriginal communities, as evidenced by the National First Nation Telehealth Project. This project was funded through the Health Services Branch and run by Health Canada's Medical Services Branch, and included five First Nation communities in Canada. The project did not include mental health as a main focus, in fact, mental health services were part of only one of the five projects. Despite this, many of the suggestions and findings of the National First Nation Telehealth Project are applicable to mental health services.

The impetus for the National First Nation Telehealth Project springs from many of the issues that have already been mentioned, including the remote geographical location of many Aboriginal and Inuit communities, the restricted access to services that

follow from being remote, the hardship and financial costs related to travel, the isolation of care providers and the difficulties this creates in recruiting and retaining health workers (Dal Grande, 2001).

An initial evaluation of the financial implications of this telehealth project indicated that the use of telehealth may increase costs in some areas and decrease it in others (Dal Grande, 2001). Increased costs were expected due to access to new services that could not be previously provided, increased access to professionals with specific expertise, increased training needs and increased appointments and management of people who are in need of chronic care. Decreased costs were indicated as telehealth can reduce travel related health risks, increase the level of knowledge of primary care givers in the community, increase client knowledge about healthy lifestyle choices, greater access to specialists helps with correct diagnosis and treatment and ultimately, morbidity and disability may be reduced.

Other positive results of the use of telehealth included a decrease in the waiting time of clients for appointments, which in turn can reduce client anxiety when they are dealing with a serious health problem (Dal Grande, 2001). Dal Grande suggests that telehealth can also result in an increased rapport between primary health care providers working in remote areas and specialists in the larger centres. As well, having telehealth as part of the health system allows remote communities to develop health initiatives that may not have been previously feasible (Dal Grande, 2001).

A few other Aboriginal communities are recognizing the potential of using telehealth to provide mental health services. Aboriginal communities in Alberta and Ontario are beginning to develop mental health services as a part of their telehealth plan (Dal Grande, personal communication, February 5, 2002). Although the idea of using

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telehealth for psychological services has been slow to develop, if it proves useful for the communities who are trying it, it is likely to expand to other communities who are using telehealth for other applications. Dal Grande suggests that telehealth is receiving considerable financial support from the federal government and that the view from Ottawa suggests that telehealth may become the preferred method for providing many services to remote communities (personal communication, Febuary 5, 2002). It appears that now is the time to provide research into the use of telehealth for mental health in order to ensure its place in the future.

CHAPTER 4

Method

Participants

    Three of the participants in this study are from the University of Saskatchewan and were involved in the provision of psychological services via telehealth to a remote community in northern Saskatchewan that was the impetus for this study. Two members of this telehealth team are clinical psychology faculty members at the University of Saskatchewan. Neither psychologist had experience using telehealth prior to the present project. A clinical psychology graduate student from the University of Saskatchewan was the third participant in this group. This student had used telehealth on a limited basis at another setting. These participants were chosen due to their experience using telehealth for this project to provide psychological services to an Aboriginal community and for their ability to speak to the experience of the process of this project. They are identified in the analysis section as psychologists.

    The remaining five participants were selected due to their expertise in working with Aboriginal people as well as their knowledge of mental health issues. This set of participants were chosen to gain the additional perspective of Aboriginal and non-Aboriginal people who are involved in the field of mental health and the provision of these services to Aboriginal communities. Participants were chosen from among local (Saskatoon and area) Aboriginal and non-Aboriginal people. None of the participants had experience using telehealth with a video and audio link. Two of the participants had

experience with either providing or receiving therapy over the telephone. The participants include: a practicing PhD clinical psychologist of Aboriginal ancestry, a non-Aboriginal social worker, an Aboriginal Elder, a non-Aboriginal PhD clinical psychologist from an academic setting, and an Aboriginal man who works within a large Aboriginal organization in Saskatchewan. All participants have many years of experience working with Aboriginal communities. These participants are identified as Aboriginal advisors in the analysis section, other than the Elder, who is identified as such.

Procedure

The participants that were part of the telehealth project in northern Saskatchewan were approached in person and asked if they would be interested in sharing their thoughts and experiences of the project. The participants who were not part of the telehealth project were recruited by querying local (Saskatoon) professionals for referrals to people who had experience in working with Aboriginal people. An introductory letter outlining the study was provided to these participants (See Appendix A). Participants were contacted by phone or in person to seek their involvement with this study. In keeping with Aboriginal tradition, the Elder was approached with an offering of tobacco when requesting her participation.

Participants were asked about their thoughts regarding the use of telehealth for providing psychological services to Aboriginal communities. Participants who were involved in the telehealth project were asked to describe their experiences with the project. Guiding questions were used when needed to facilitate the interviews and to ensure that all relevant topic areas were covered (See Appendix B). All interviews were audio taped and transcribed.

This research project was reviewed and approved by the University Advisory Committee on Ethics in Behavioural Science Research at the University of Saskatchewan in October 2001.

Analysis

Interview transcripts were analysed with an idiographic approach, which begins with particulars and works towards generalizations, in order to understand the important themes present (Smith, 1995). More specifically, I was guided by Smith's Interpretive Phenomenological Analysis (IPA) approach. This method involves exploring the participant's personal perceptions. The method of IPA also recognizes that while trying to understand the participant's personal world, access to this personal world is dependent on the researcher's interpretation through the transcripts.

Smith's procedure involved looking at one transcript in detail before moving on to the other transcripts. The initial transcript was read a number of times, noting important thoughts or comments in one margin, and then recording emerging theme titles in the other margin. Next, a separate page was used to list emerging themes and to look for connections between the themes. Attention was paid to evidence of master themes that connect prior themes. The transcripts were often re-examined to ensure the actual data remained the basis of the themes. Through this process, a master list of themes was produced. For each master theme, key words and page numbers were used to indicate where in the transcript evidence for each master theme was found. This master theme list from the first interview was used to begin the analysis of the rest of the interviews. The analysis of the remaining interviews was guided by the list of master themes, giving consideration to new themes that emerged.

Chapter 5

Analysis and Discussion

A number of master themes have emerged from the analysis of the transcripts of the interviews, each with sub-themes. The three master themes are: telehealth technology, working in isolated Aboriginal communities, and psychological services and Aboriginal people. Cultural factors were found throughout, imbedded in the master themes. As culture seemed to be a central point in all areas, I did not attempt to have a separate category for culture as it became apparent that culture was a central thread running throughout all the themes.

Telehealth Technology

Participants spoke to their concerns, optimism and the potential uses of telehealth within this master theme. There were six sub-themes within the master theme of telehealth technology with a number of components in each sub-theme (See Table 1). The sub-themes and components address particular issues regarding the use of telehealth for Aboriginal communities.

Table 1

Telehealth Technology: Sub-themes and their Components

Sub-themes	Components
Optimism Regarding Telehealth	Participant Optimism
	Possibilities
Concerns Regarding Telehealth	Cautions
	Language Barriers
	Cultural Barriers
Therapeutic Alliance and Technology	Connection and Nearness
	Time Factors
	Cultural Communication Style
	Positives
	Technology / Personal Investment
Potential Benefits of Telehealth	Travel Reduction
	Local Service Provision
	Client Transportation
	Overcoming Geographic Barriers
	Anonymity
Suggested Applications of Telehealth	Supervision / Co-Therapy
	Education
	Consultation
	Assessment
	Child / Adult Therapy
	Continuity of Care

	Court Ordered Treatment
	Language Service Provision
Potential Limitations of Telehealth	Play Therapy for Young Children
	Adult Therapy
	Crisis Work
	Home Visits
	Listening / Traditional Counselling

Optimism Regarding Telehealth

The idea of using telehealth to provide psychological services to remote Aboriginal communities was seen in a positive manner by participants. One psychologist stated that she was optimistic at the outset of the project, "I was... intrigued, excited." Another psychologist stated that "I enjoyed the technology and I think it is really useful, I think it can be really helpful.... I enjoyed it. It was a really good learning experience for me."

The Elder interviewed for this study was also optimistic about the use of technology, adding that she sees that it needs to be used to connect with the entire community. She stated:

See today now we have this technology with satellites and computers and those could be used to make life better. That's what I would think, but at the same time too, it has to be the whole community to get involved.... I would think that it is great and that's one way that they can get instant help. It's good, but at the same time too, it should be reaching more people, like even a class and everybody again, from the chief and council, because the chief and council have

to be also very knowledgeable. If they don't look after the welfare and the mental state of their people, they won't have a healthy community.

One Aboriginal advisor was also quite optimistic in her views of the use of telehealth. She reported her feelings towards telehealth to be:

Very positive. In terms of I mean when we talk about telehealth in general I mean I think if some of these remote areas aren't going to be serviced and somebody is willing to do something like telecommunication or teletherapy or whatever they want to call it I think that's tremendous because then a person who is motivated to do counselling can actually get some of the services that they need and yes I think it is a great thing.... If somebody is motivated to be in treatment it is a shame anyway you look at it, Aboriginal or not, that they not be able to have the services, so any such way that you can get them I think would be great, and I mean even if it is telephone it is phenomenal but if it is teleconferencing... a link where you can actually see the person, that is even better, where psychologists can pick up on the body language and the facial expression etc, etc. Yes I think that it would work.

The above participant had experience in receiving some telephone counselling and spoke of her experiences with that type of therapy and how she sees that it relates to telehealth as it was used for this project. She relates:

I can't speak for everybody, I can't speak for them but as someone who has used the service myself, I think that it has done me a tremendous service and I think that had I not had that then I wouldn't have had the service. So this is kind of the reason I have this opinion based on my own experience.

Overall, the response from these participants to the idea and/or experience of using telehealth to provide services to remote northern Aboriginal communities was seen as an interesting possibility. The participants that were involved in the telehealth project expressed their positive view of the project and the potential of this method of service. The Elder saw it as a way to connect with the entire community in order to improve the quality of life of Aboriginal communities by increasing the level of knowledge available to community members. One Aboriginal advisor related that telehealth affords a way of increasing services to under serviced areas, and that the use of the video link would allow mental health service providers an advantage over using the telephone as it includes the visual component. She also spoke of her experience with receiving counselling services over the telephone and how that was a positive experience for her.

Concerns Regarding Telehealth

Telehealth was approached quite cautiously by one psychologist, as he explains his initial expectations:

> Minimal expectations, I had a fair bit of scepticism about the use of telehealth, especially with clients, how it would be received. I thought it would present quite a great distance, some White professional in Saskatoon talking to a First Nations youth or adult.

An Aboriginal advisor also had some concerns about how telehealth would be accepted:

> I don't know what it would feel like for a First Nations woman who has never really left the community to sit in front of a TV screen and talk with a non-Native person about their issues. I mean if they were issues that weren't quite serious then maybe that wouldn't be so bad but to talk about family violence or

sexual abuse or the trauma that she's been through I don't know how that would fit.

Another Aboriginal advisor was open to the idea of using telehealth but had a number of concerns, stating:

I think it's worth a pilot project and seeing how well it works, for some situations it would work I think. I think for instance some situations it seems to be kind of impersonal. When you open up people how can you close them up? When you open up people they tell you a bunch of stuff, and I think the challenge would be that people would not open up because you are not there. I mean part of helping someone is creating a relationship. People do not spill their guts easily. You have to spend time getting to the root of the problem and you need to be there. I'd check it out but I'm dubious as to whether it would work.

The above participant was also concerned about issues relating to language:

We're going to run into a language barrier say in places like Fond du Lac, most of those kids there are going to speak Dene, you'd have to have translators in the community. How well would that work compared to going up there? .... Is that going to impact the outcome? I can see maybe for a screening process that might save a flight in there. For screening it might be fine but for anything other than that it would certainly be challenging. You are going to run into the language barrier anyway and that would be further challenged when you are talking to someone over the TV....

Psychologists and Aboriginal advisors alike spoke of their concerns about working with Aboriginal clients over telehealth and whether the technology would be a further barrier to existing cultural differences. One Aboriginal advisor suggested that

the difficulty of non-Aboriginal service providers working with Aboriginal people may be increased if dealing with issues of abuse. These concerns speak to the need of exploring the use of telehealth for all psychological services to understand the most important variables in provision of these services in a way that would be acceptable to Aboriginal people. It may be that the relationship between the service provider and the client can overcome the potential barrier of technology, that people seeking service would be willing to use telehealth, especially in the face of no service at all, or that a person would prefer to speak with a long distance provider for reasons of anonymity and security. It may also be that telehealth would not be successful when working with Aboriginal people who bring with them cultural differences as well as abuse histories.

There were also concerns regarding language barriers that will often exist between professionals in the south and their clients in the north. Telehealth may actually improve the situation of language barriers due to the access to the number of people able to speak different languages in the larger centres. It would be possible to have translators in the larger centre to allow the client to express themselves in the language they are most comfortable with. This may be particularly beneficial in situations where travelling to the community proves unrealistic.

Therapeutic Alliance and Technology

Despite initial uncertainty about the ability to build therapeutic alliance through videoconferencing, upon completion of the telehealth project the psychologists involved in the project were struck with the sense of nearness and connection afforded by the technology. As described by one psychologist:

>...I was impressed by the immediacy of it, really.... There were times when I felt like I was right there in the room. I kept thinking that this... is a powerful

medium, and it's not as bad as I expected actually, I thought... people would be very distant and reserved, and uncomfortable being on TV... sort of being in a show, so that there would be this level of alliance building that you would never get to because there would be this machine between you. And I was powerfully affected that I didn't think that if you did it right that it would be a problem.

One psychologist described the process of building therapeutic alliance over telehealth:

I think it took a long time to get any kind of rapport built, whereas you might have a couple of sessions [to build rapport], it took maybe like six sessions over telehealth to get some rapport built, but by the end I thought things were actually getting pretty good.

Recalling an interview over telehealth with a woman in the community, she reported how the process changed over time: "It was a little weird to begin with but by the end it was almost as if we were together in the same room."

One psychologist expressed concern that working with an Aboriginal population would be an additional barrier to the use of technology when building rapport: "It is bad enough that they come in from the north to see a White psychologist in Saskatoon and now they're not even coming to Saskatoon, they're seeing some White psychologist over a television screen." Her concern included the differences in communication style and the importance of adopting yourself to the style of the community in order to be able to build a therapeutic alliance:

Try to get a feel for the norm of communication and try to fit yourself into that rather than trying to just impose your manner of speaking.... I noticed that when we went up there, people spoke less, they talked slower, and they did not

interrupt each other very much. It is just a different style of communicating....

So it takes a long time, even face to face, to build rapport when you're working

across a cultural barrier. When you throw on the television you're going to be

even longer.

One Aboriginal advisor was less concerned than some other participants

regarding the issue of building a therapeutic alliance:

I think that the person who is wanting to receive the services will know that this

is the way that you are going to get the service at this time or you might have to

wait longer for services in some other manner or you might have to go off the

reservation or I think that it is a good service to provide to them because it is

right on their own home turf.

Telehealth does seem to have an attention getting aspect that may help with

therapeutic alliance:

And I think it worked both ways in that part of the draw was the sense of our

total undivided attention to them.... We were right there focussed on them as

individuals which strikes me as one of the things about therapy is that you get to

have somebody who is interested in you and the TV allowed this even more so to

be a two way kind of fun technology but also that sense of this person is listening

to me [psychologist].

Telehealth also allows more than one person to be on screen at one time, which could be

seen as a draw, "Here are four people and they are all focussed on me! That would grab

my attention [psychologist]."

Therapeutic alliance was also addressed in the context of other technologies and

the personal investment people make in them:

If you listen to people who use modern communication methods like chat rooms, people get very, very invested in those. They establish very intense relationships to the people over a written medium. So I don't see why the same thing couldn't occur [over telehealth] but it takes longer to build [psychologist].

One Aboriginal advisor also addressed the connection developed with modern technologies:

I don't think we should discount the idea that there are more and more young people whose world is quite… sometimes even dominated by, but certainly influenced by, a whole series of technological and computer generated images. And who would probably, and in some cases, really feel more comfortable and more in touch and would even say I had a really good talk--referring to a computer based talk as opposed to a talk with someone face-to-face.

Another Aboriginal advisor echoed this point, "It sounds a little weird but I know people who have met on the Internet and people find it easy to start a relationship. So if people are going to do that why not get counselling over telehealth."

Therapeutic alliance remained a concern even after exposure to telehealth for one of the psychologists:

The first set of concerns is the distance that I still see as inevitably there, difficult to cross when you are on a TV screen delayed by a second. Just the physical presence of being in a room with someone has an important impact to establish a connection, a trusting, working relationship. I'm sure it's possible on TV but I think it's rather unreal. So the impact that you can have is reduced and the connection is reduced. I don't know if people would keep coming back, maybe they would, week after week to the TV screen…. It would be too easy to skip

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out, too easy to fall by the wayside, there wouldn't be as much accountability to a person in terminating and walking away.

The ability to create a therapeutic alliance is an important aspect of any psychological service provision. The issue of creating a therapeutic alliance is likely to remain difficult to assess until more work is done with Aboriginal communities over telehealth. Two of the psychologists that were involved in the telehealth project expressed their sense of connectedness in spite of the addition of technology. They both stated that once the connection was established, they felt as though they were in the same room as the client. However, one psychologist felt even after the experience with telehealth that a level of connection would not be able to be created that would equal the connection when people met in the same physical space, and that this lack of connection would result in less accountability on the part of the client in maintaining the sessions. That two of the psychologists involved in telehealth felt that therapeutic alliance was achieved suggests that it is possible to attain, at least in some situations, with some clients.

A number of variables likely influence whether therapeutic alliance is established, including the comfort level of the service provider and the client with the use of technology. A potentially important variable was addressed by participants who spoke of the increasing use of technology to build long distance relationships such as the Internet. The increasing access to technology may well impact on people's ability and interest in the use of technological mediums to access services tied to technology. Remote communities may lag behind in the use of the Internet due to less access to technology services; however the proliferation of technology suggests that many people,

even those in remote communities will have at least some level of familiarity with the idea of corresponding with people in far-flung places via technology.

Potential Benefits of Telehealth

Telehealth was seen as having a number of potential benefits for service provision to remote Aboriginal communities, including reduced cost of services, reduced need for travel, increasing connection, access to a variety of services in one's own community, and anonymity.

When asked what she found effective about the use of telehealth, one psychologist said, "We don't have to travel up there so that's extremely effective." Another psychologist explained some of her past experiences and how they relate to what she would like to see telehealth be able to do:

> I have had families and referrals by telephone from other northern communities and had the sense that there was incredible need or certainly demand for psychological services that wasn't being met and I thought that maybe this would be a way without travelling to the north and living there that at least could begin to meet some of those needs.

One Aboriginal advisor spoke to the need for having psychological services on the reserves as opposed to having them available only in larger centres, and she explains her reasoning as to why:

> I think if you take any person who walks into a mental health centre for their first appointment sitting there in the waiting room is a very scary place to be... you are going to note in this field is about 50 percent of people don't come back and if you are sitting in this waiting room and you are a visible minority... I think that their feeling of being out of place or being different is even more magnified.

So we might get people coming to a first session off the reserve but then again we might not get them back for second time. So I think that is important as a reason why it is good to be able to have that [telehealth] on the reservation.

She also spoke to difficulties people living on reserves might face as far as being able to have reliable transportation to travel off reserve and that there is a possibility for a more flexible structure to provide therapy in:

> Also, not everybody has the transportation to get to these sessions either or the counsellor who is doing these session could opt to do these sessions at a time that are not your nine to five Western psychology kind of thing... I am just thinking that their schedules can be more, considered more in the process.

Another Aboriginal advisor spoke about the reasons behind pursuing telehealth:

> What I understand that you guys are trying to do is an effort to overcome the barrier. As I understand you didn't choose the technology because it's better to counsel by telephone than in person; you chose it because you had to overcome a geographical distance barrier and in that sense I've always felt that a phone call is better than nothing and I'll do counselling on the phone if I'm 300 miles away.... So I don't think that it's a disadvantage except if it's used when other things are possible as a way of increasing efficiency or something; that I don't really believe in.... The technology wouldn't intrinsically be valuable...but it has great value in overcoming some of these geographic obstacles.

Telehealth could also provide an anonymous outlet for community members to have access to psychological services without having to leave their communities. The potential use of telehealth as an anonymous outlet was addressed by the psychologists:

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...Like the chat room there is a distance, there is a barrier, so you can talk to someone and they don't have to worry that they are going to meet you at the corner store... so in some ways you are a safe person to talk to, especially in communities that are very small and where everybody knows everybody.... I think that is important, we should explore that more because the anonymity in a small community that is available through telehealth is probably quite important for a number or people, maybe a majority, maybe a large majority. 'Here I can go and talk to this person, there is some distance that provides some safety for me, they're not in the community and no one even needs to know.'

The reduction in the need for travel decreases the expense associated with providing services as well as hardship on the client and the service provider. Some clients may not be able to access a reliable source of transportation to and from a larger centre, or may not have the time to take a day or more away from other responsibilities such as employment or childcare. Having time to go to a local centre with a telehealth system may be far more feasible. Service providers as well may not be able to leave their practice or their families for extended periods of time to travel to a remote community.

Providing psychological services in remote communities rather than sending clients out to a larger centre may increase the profile of mental health in these communities. If these services are being provided in their community people may be more willing to access mental health services. One of the Aboriginal advisors spoke about the high drop out rate of visible minority clients from mental health services in general and the feeling of "being out of place" for visible minority clients when accessing services off their reserve.

The anonymity of telehealth is a further advantage. Telehealth can provide an anonymous outlet for both clients and mental health workers in the community. In a remote community, family ties and the small population are more likely to create situations where it would be more appropriate for outside professionals to provide psychological services.

Suggested Applications of Telehealth

The results of the interviews suggest that telehealth can have many applications for psychological service provision. Improving consultation and educational opportunities for community members, assistance in the creation and evaluation of programs, assessment, screening, keeping connections with families that move around, therapy, and service provision in a variety of languages were suggested applications of telehealth.

Providing more training for health workers by way of supervision and co-therapy was suggested as a way to increase the community's ability to manage their mental health services:

> I think, though, that it would have been more helpful, and a better use of the medium if there was a therapist there that was interacting with the client and we were more supervisors or so we could set up an event, for instance, or an opportunity for observation or support somebody to ask certain kinds of questions, that kind of thing, sort of do co-therapy sort of at the closest...[psychologist].

When asked about the possibility of using telehealth to provide supervision to community mental health workers, an Aboriginal advisor replied:

I think that that might be effective. When I was first there [in the community he works in] of course I was under supervision and we used video and I sent the videotape away and it was reviewed and sent back and that worked really well. There was no hesitation to do that...

Educational opportunities are also addressed by the medium of telehealth. "They offer university classes over television, why can't we have educational talks... and because it is telehealth, it can be interactive, they can ask questions, they can share their experiences [psychologist]." The visual component of telehealth was seen as having potential for developing educational projects:

...Developing a whole new lecture style, having demonstrations or something that takes more advantage of the actual fact that you have the voice and visuals so you are not just a group of people sitting around talking at each other, it could be more powerful [psychologist].

Consultation and education were both seen as useful applications to one of the Aboriginal advisors, "I think that component makes a lot of sense. It would fit and probably be quite helpful. The people I work with just eat up the training and the consultation is always just very much appreciated." Another Aboriginal advisor echoed the sentiment that education should be a mainstay of any telehealth program:

I think they are going to start using some of their own community people doing mental health services or social work services. I think that probably doing workshops, etc. working with these people themselves, giving them some training.... I think educating the people within these communities is the way to go and so maybe part of our role as myself, yourself other Aboriginal people might be in the role of consulting psychologists in these early years.

Participant's responses indicate that providing training and support to workers in remote communities is clearly a beneficial use of telehealth technology. Consultation, education and supervision are all areas that would increase the ability of mental health workers in remote communities to provide the services that are needed. This process would likely improve the level of services available in the community as the workers gain the skills needed to deal with issues that were previously outside of their capabilities. Supervision via telehealth could be the way to assess and support community workers in the application of these skills.

Mental health workers in remote communities are often isolated from other professionals in their area. Telehealth offers a way to reduce the amount of isolation experienced by these people and create connection with colleagues in different centres that have more access to information, training and have particular areas of expertise that may not be available otherwise to these remote communities. The increased connection allows for learning to happen on both ends, the larger centre and the smaller centre and should lead to better understanding between the two sets of providers, which would also be a significant benefit.

Psychological assessments were seen to be valuable:

I thought our assessments were fairly effective, the kids seemed to go with them pretty easily. Overall I thought administration was pretty... we were getting pretty good with it by the end. That would save time and money for everybody... when you have a waiting list of eighteen months, that's insane [psychologist].

There were concerns regarding the validity of using tests that are not normed with Aboriginal populations, but they were also seen as providing some useful information despite their shortcomings:

I think they are helpful because they do give some information, where is this kid having problems, there may be language barriers but you can tell if a child is having difficulty even understanding complex language. So you may not be able to get a really refined number but you can get a good sense of where they're at and what their problems are and what they might be having difficulty with [psychologist].

Testing was addressed by another psychologist:

I was impressed at how connected those kids seemed to be, they were there, they were paying attention, and that was impressive. I don't have serious doubts about the quality of a cognitive assessment given what I had observed.... I can imagine that it could be more difficult with some of those kids if you were an assessor doing a two-hour cognitive assessment just in a room with those kids. They might get up and move around, attention might lapse more.

Despite concerns regarding the cultural sensitivity of testing, using telehealth for assessment purposes was seen in a positive light. In the community we worked in, waiting lists for assessments are long, and assessments are required in order to access resources for children having difficulty. Without telehealth, getting assessments completed involves either sending the child to a larger centre or waiting until the child can be assessed by a professional that travels to their community. Sending a child out to a larger centre is costly in terms of time, the need to send an adult to escort the child, and costs associated with meals and shelter. Telehealth can remove the costs associated with

travel, and having a telehealth connection with a professional working with the community would allow for the child to be assessed in a place where he or she may feel more comfortable. As well, if the telehealth team has a working knowledge of the community, they may be better equipped to interpret the tests, in the context of the community, including language and culture. Professionals travelling in once a year would be less likely to have the same community understanding as people who are consulting on a regular basis. Using telehealth for assessment would be an avenue for working with community members to plan treatment programs for the children that are assessed, even including guidance in writing proposals for funding if they are encountering a need for program development in certain areas.

Play therapy for older children was seen as a possibility by one psychologist:

Older kids I think you probably could because you could make it more like TV or a computer game where you are interacting and you make that part of the therapy, part of the whole set-up and attraction. I think it is possible that you could make it into something really acceptable for kids.

A program for play therapy for older children would need to be developed. At the present time, I am not aware of any programs that have been attempted over telehealth of this nature. However, technology may provide a novel way to connect with children from a different culture in an isolated community, children that may otherwise be difficult to engage. In the telehealth project from the University of Saskatchewan, the use of the computer screen and cameras did seem like quite a draw when working with children and young adolescents.

Regarding adult therapy, one psychologist stated:

I would see it probably more effective than a lot of things you could do for providing sort of impactful assessments to an adult, 'this is your life situation, this is what I see as the problems in you life.' I think the impact of having that delivered by a professional far away could be enhanced. If you had done an assessment or some consultation about a case, shorter term, more problem focussed work could be accomplished over a handful of sessions, for sure, could reasonably be done over telehealth with adult clients.

The ease of the provision of therapy over telehealth has not been well established, even without considering cultural variables. A lack of evidence does not indicate that therapy provision via telehealth will not prove to be effective, it simply means it is relatively untried. It has been suggested that telehealth provides anonymity that would be an essential ingredient for some people living in isolated communities, and that therapy provision by professionals outside the community is sometimes preferable due to the nature of small communities. Further experience of therapy provision over telehealth will need to be undertaken before anything definitive could be said about the possibilities.

There were also other suggestions offered that could widen the potential scope of telehealth:

...I think you could, if you were a professional in the community here and were established, and were going to be around, and were doing telehealth services with a northern community or anywhere at some distance, you could be a regular person, professional therapist, in a client's life and you could establish a connection so that the person would come back over the years at certain difficult times, working on the same problem, raising kids, abusive past, substance abuse.

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You could be like a family physician, family psychologist type who would be there and with whom the client would consult for briefer periods of time but over a period of time. And I think that could be effective, a long distance expert [psychologist].

Another psychologist saw that telehealth could perhaps begin to address a particular problem she has experienced while working with young families:

So there could be that possibility exists with telehealth to maintain contact, instead of having people be lost. Which is one of the reasons that I think telehealth could be useful, is to keep track of people.... The sort of general picture of health services in the north seems to me, at least amongst the young child bearing population that I work with, that people don't necessarily stay in that community all the time. The health services have to be able to be fluid like that and telehealth would allow that kind of face to face, and keep track of people, whereas now people just disappear and so they have health workers, support workers in multiple communities....

The ideas of the family psychologist and the ability to track families that move around both support an increase in the continuity of care. Being able to remain in contact with people as they move through life, encounter different difficulties, and move to different communities would be beneficial. A potential benefit besides the continuity of care includes increasing the likelihood of a person or family accessing mental health services if they were able to meet with a familiar professional with whom they felt comfortable.

One of the Aboriginal advisors provided a document that outlines the policy that medical transportation will not be provided for people who have been required by the

Court to attend counselling, indicating that telehealth could be used in these instances to provide service to people who are required to undergo treatment but are unable to afford travel. Provision of court ordered treatment via telehealth would allow people in remote communities to stay in their community to receive treatment. Travelling to treatment may not be feasible, and having to spend extended periods of time in a larger centre may cause financial hardship and separate people from their family supports. Since treatment is court ordered, not completing treatment may result in incarceration.

The above Aboriginal advisor saw that telehealth may also be able to be used to provide services in different Aboriginal languages to different regions of the north:

> The other thing is that maybe there are people that speak the language but they don't want to move to the north. For instance here we have a call centre where you can call in and speak to someone in any language you want Saulteaux or whatever you want…. In Saskatoon and Regina we have a large concentration of professional Aboriginal people and are more likely to find people who speak the language.

The call centre in Saskatoon underlines the importance of ensuring that Aboriginal people can speak in the language in which they are fluent. Telehealth could be an extension of this program, allowing a visual component. As telehealth allows for any number of people to be involved, interpreters could be used to translate to people who do not speak the language, but still allow all people to be included in the group.

It seems clear from the participants that telehealth has a number of significant applications for increasing mental health services in remote communities. The use of telehealth to provide consultation, support and training was seen as a valuable and obvious option for the use of telehealth. Due to the diverse nature of the clientele and

program needs, community mental health providers who are working in geographically remote regions are in need of connections with service providers in larger centres with different areas of specialization in order to increase their knowledge and ability to address different situations.

Potential Limitations for Telehealth

There were also a number of psychological services that were seen as less well suited to telehealth technology. One psychologist explained the shortfalls of using telehealth for play therapy with younger children:

Play therapy was not as effective as I would have hoped, simply because you cannot get down there and play with them, and I think testing with some younger kids would be difficult too because I have followed kids around on the ground, chasing them with test material and you cannot do that over telehealth.

Therapy with adults was also seen as potentially limited, at least without some modifications to the existing structure. One psychologist explained her reservations regarding using telehealth for therapy:

One of the things that happens with clients, especially someone in crisis, is that you need to have someone available and we are not available, we are only there for that one hour, so what do you do between then and the next week? You need to have a contact there if you are actually going to do something effective I think…In terms of actual therapy anyway…. You have to expect that periodically there will be a crisis that will emerge in the course of therapy and if you can't be available…. I don't deal with all crises, but at least I know this community well enough to support people who get into some sort of problems whereas I don't know that community… and there isn't enough that I am aware

of in terms of crisis intervention that would be helpful. So it could be quite dangerous....

Another psychologist had similar concerns:

Any kind of crisis work, in my view, you could not do over just telehealth, so any sort of suicide work, any sort of long-term work like alcohol, substance abuse I just wouldn't see it as a venue.... I think it would be possible but difficult to deal with people in an intensely emotional, critical time or somebody who is in their life working through a terrible problem, or abuse issues is very emotional.... I'm not saying it's not possible, it probably is possible but I have reservations.

An Aboriginal advisor also outlined the need for making contingency plans for clients when you are dealing with them from a distance:

I think if you are talking about someone who is clearly in distress, for example, someone who is suicidal or homicidal and you're 300 miles away it is kind of hard to maintain, it makes it kind of scary for a clinician to monitor somebody from 300 miles away... I think as clinicians we are obligated to have thought of and figured those out and put those things into place before we really get into some deep issues anyway, these types of issues are to be discussed in the first couple of sessions.

Another Aboriginal advisor had concerns in terms of his particular practice and the community in which he works:

The other piece is that I do most of my work in their homes mainly because in most communities the level of poverty is so high that people can't necessarily afford to drive to the health clinic all the time or their car only lasts so long, child

care isn't available, they can't necessarily afford a baby sitter etc, etc. It has come to a point where either I go and pick them up in the home or I pick them up and bring them to the office and we do the work in the office and then I give them a ride home. So I don't know how technology would fit into that.

One Aboriginal advisor was concerned with the idea of conveying the concept of listening over telehealth, a concept that is important in traditional counselling:

The thing about what might be called traditional counselling is that a lot of it is based on the idea of this person (this Elder) actually being there, listening, listening, listening, and then maybe telling a story, but a lot of listening. I guess the question then would become how effective is the notion of listening conveyed through a technological medium? So that notion of traditional counselling where listening is such a critical notion, and it's not a listening that is using words of great length but real listening.... That would be a hard one to understand how that would be conveyed by telehealth....

Important concerns were raised regarding individual therapy and crisis situations that could occur when the service provider is far away from the client. However, building strong ties with community health workers and involving them wherever possible in therapeutic endeavours may be a way to address the concerns regarding physical distance from clients. Certainly clients in these remote communities are going to encounter times of crisis regardless of whether they are working via telehealth, so providing the supervision and training for community workers may improve their ability to cope with these clients when they are experiencing crises. The urban-based service provider would need to know what crisis services were available in the community and

have confidence in the skills of the community health workers to deal with crisis as they arise outside of telehealth meeting times.

The limitations of telehealth will be more completely understood after time and experience with this technology. It is clear that some psychological services are not amenable to telehealth, such as certain forms of play therapy. Whether the concept of listening can be conveyed over telehealth remains to be seen, but preliminary findings, even within this study indicate that it certainly is possible, at least from the service providers point of view.

Working with Isolated Aboriginal Communities

The Elder spoke to her concerns about the differences between city and reserve life:

> I am talking about First Nation people, how we are in our communities and also on the reserves, cause it's different, we're different when we live in a city. We have access to a lot of things the reserves don't and sometimes mental health is more jeopardized on the reserve than us here. We can just up and leave and take off to the doctors, walk in clinics, to the hospitals, we have access. On the reserve some of them have to fly in, or a storm can keep them back, and sometimes the communities are not equipped...

Access is a key issue for telehealth and mental health services, as it the ability of the communities to provide adequate service. If people in the community are not able to access the services they need in the communities where they live, we need to find a way to provide them.

There were two sub-themes under the master theme of working with isolated Aboriginal communities (See Table 2). The components within the sub-themes address some of the particular issues that arise when working in such communities.

Table 2.

Working with Isolated Aboriginal Communities: Sub-themes and their Components

Sub-themes	Components
Community Problems and Needs	Family Violence / Addiction
	Poverty / Housing
	Violence
Dual Roles in Isolated Communities	Advantages / Disadvantages
	Connections within Communities
	Supervision / Support
	Lack of Choice

Community Problems and Needs

One Aboriginal advisor spoke about the needs that he sees in reserve communities:

Family violence and addiction. It's a very serious issue. To be sitting with a committee that is working on family violence and to know that each man in that committee has at some point has committed an offence of some fashion gives you a pretty good sense of the level of abuse that went on or that continues to go on. The level of spousal abuse is very high, neglect very high, addiction issues very high, poverty extremely high, at [the community he works in] I think the unemployment rate is 80%.

He continues:

Poor housing, I can remember when I was in [a reserve community] and we were
visiting in one of the homes there had been a suicide and we were going in to
assist the family after the suicide and we were visiting one of the aunts in her
home and we were having some tea and I didn't finish my tea and I poured it
down the sink and there was no plumbing. I went 'wow this is interesting, I
came out of a beautiful health centre that had every bell and whistle that you can
imagine and visit a home one block down that they don't even have basic
plumbing.' Housing is poor, some of the homes that I work with the moms have
thirteen or fourteen kids in a two or three bedroom bungalow. That leads to
social problems.

Another Aboriginal advisor spoke of the violence he sees on reserves:
There's a lot of violence, the violence rate is about five times as much on the
reserves as it is in the urban area.... If you're living on a reserve and if you're a
woman or a child, you will experience some kind of violence in your life. The
victimization, there is a lot of victimization going on up there. We're trying to
raise a traumatized society that has not only been traumatized individually, but
been traumatized historically, and that has to affect people in how they think.
And you live this way and that becomes normal life. There is a big time need to
have mental health services for every segment of society whether man, woman,
or child, family, spouses.

When one considers the degree of needs in reserve communities, it may be
tempting to dismiss telehealth as having any significant impact on the well being of
communities. The immense need in the community we visited and serviced via

telehealth gave some pause for thought as to how helpful telehealth could be. One psychologist addressed this in his interview:

> One of my reactions after leaving there was that there are so many central community challenges here that, my tendency then was to dismiss telehealth as not really useful in addressing the community development work...but then we would just take a long time with those beginning services, those traditional services.

Telehealth does allow for connections to be built between these isolated places and urban environments, creating understanding and relationships to develop. As well, the process of training Aboriginal health workers allows these communities to eventually have more control of their mental health services. Research has indicated that community control of services results in a lowered rate of suicide in Aboriginal communities (Chandler & Lalonde 1998). Telehealth will have only a small part to play in some of the large problems facing remote reserve communities, but its part could have some impact on larger issues, at least for some community members.

Dual Roles in Isolated Communities

Other types of concerns related to isolated communities were also raised. One psychologist addressed the issue of dual roles faced by mental health workers who are a part of the community:

> Which then raises the issue of the worker in the community who is a member of the community. So it raises those kinds of concerns, how does that worker, and it happens obviously in every small community, all the professionals know that they too are members of the community and have issues of anonymity and confidentiality are problems and ... there are advantages and disadvantages, it's

a two edged sword…. But my sense is that some mental health workers or professionals pull it off better than others. I don't know how much discussion there is in those communities about the kinds of boundaries and how fluid they need to be and how to be a member of a community, fully accepted and participating, and where that grey area is of 'everybody's going to know' and how much you should know, how much you should share in order to maintain the status within the community.

An Aboriginal advisor spoke of dual relationships and the nature of being in an isolated community:

If you're up there on any kind of long term basis, you are also often related to those people so when you're seeing them, the passing of information, you can't really separate the relationship so that you're seeing them in a much broader context than as a client with a particular diagnosis. So they may be your uncle or cousin, you are aware of their family issues and any problems that come out in the soup.

He continued to speak to the stresses providers in remote communities can be under and the support that they need to continue to do their jobs:

There was a woman that was working in a village up there [north] who had responsibility for about 4 or 5 villages, each of which might have had maybe 200 to 300 people and maybe about 1000 people…. A good part of the supervision was in just supporting her personally. What she found was as the only Western trained service provider much of her work was community development, community maintenance, and crisis management. In that regard there were a lot of stresses put on her personally, her family life, personal life, there was very

little boundary between her professional and personal life and a number of our conversations were on how to take care of herself, and then I would say less than 50% about people that she was seeing for professional counselling.

When questioned about how the problem of dual roles is considered, one Aboriginal advisor explained:

> In one sense the first thing I would say is that there is no choice. There is a choice if you are coming in as a consultant, because you are often not there, but if you are working in the community on a long term basis and in particular if you are from that community, there is no choice, you can't say 'is it appropriate to have'…. There may be 4 or 5 main families, and if you're from that community, you are likely to be from one of those families and so you are related very directly to at least one or two and then you have maybe some long standing enmities against the other two families so you're enmeshed you can't even say 'is it appropriate?' If you are a consultant, you can say 'is it appropriate?' So the notion of… what a mental health worker is, is very different.

It seems that psychology's notion of dual roles is conceptualized quite differently in Aboriginal communities. Whether that different conceptualization results entirely from lack of choice or from a different understanding of dual roles is unclear. Regardless, belonging to a small, isolated community will result in an increased likelihood of developing dual roles. This may be one area that community health workers could use consultation and support of outside mental health providers as they navigate through the many dual roles they face.

Psychological Services and Aboriginal People

       Under the master theme of psychological services and Aboriginal people,

participants addressed a number of issues. There were five sub-themes with a number of

components in each (See Table 3).

Table 3

Psychological Services and Aboriginal People: Sub-themes and their Components:

Sub-themes	Components
Worldview Differences	Conceptualization of Mental Health
	Specialization of Services
	Spirituality and Ceremony
Psychology and Aboriginal People	History / Problems
	Lack of Cultural Understanding
	Assessment
Non-Aboriginal Service Providers	Does it Matter?
	Concerns
	Positives
	Language
	Need to Connect with Communities
	Misunderstandings
	Previous Community Experiences
	Need for Time / Commitment
	Aspects of the Individual Provider
	Current need for Outside Services
Assessment	Limitations of Tests

	Norms
	Lack of Cultural Understanding
	Collaboration / Test Construction
	Wariness Regarding Testing
Western Meets Traditional	Combinations for Treatment
	Problems with Integration
	Lack of Training
	Cultural Complications

Worldview Differences

One Aboriginal advisor talked about the different conceptualization of psychological services within Aboriginal communities:

I think one of the things about mental health work that I would see is that it's like in a community that is not into the terminology or the concepts or even the process of mental health. Therapy for mental health, the mental health issues, become much broader and more generic life issues, community issues, family issues, friendship issues, and many of them elude definitions as mental health problems and certainly elude diagnosis and that's the work you do, and that has been my experience.

The Elder echoed this sentiment of defining mental health issues very broadly:

Life, the way we live, the way we eat, our communities, housing, because you have to have a good home to be able to have good things happen. If you don't have a very healthy home, four walls holding up a roof and a flooring, it is really, really hard to have a good life…. People will be getting sick, people don't get along, family breakdowns because when you live in poverty, already most of the

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time we live in poverty.... Even that alone it's emotional illness, they get

emotionally sick, physically, mentally, and emotionally they get bankrupt. It is a

miracle that they are still living. Unless a person has a good job and can really

help themselves and help their families, but jobs are scarce.... When we look at

mental health, we have to look at everything, even spirituality—that's the

foundation of our life.

Another Aboriginal advisor also defined mental health broadly:

Good mental health... a lot has to do with your family. Having a healthy

family, having healthy relationship, having the skills to cope with everyday life.

I think it's easy when you're working and have access to resources, it's much

easier and healthier if you're working. If you're impoverished and don't have

employment, I think it's a pretty big challenge to your mental health....

One Aboriginal advisor spoke of the concept of balance:

Good mental health I would say, balance. I mean from an Aboriginal point of

view I think balance of body, mind, spirit, emotion would give somebody good

mental health.... So balance, and I think understanding also who you are also

contributes to having good mental health. Understanding who you are, what

your limitations are, what your gifts are, those kinds of things, and being able to

deal with those constitutes good mental health.

The Elder highlighted the importance of seeing mental health as a broad concept,

and suggests that part of the problem of the loss of seeing mental health in the broadest

sense lies in the area of specialization of services:

See when we become, when we join a society, everything is categorized,

everything. You just work with drugs and alcohol, you just work with mental

health, you just work with family and I think it shouldn't be like that, everybody should come together in a circle and help out. That is what I do in this community and again I deal with all kinds of things, not just a few things but lots of things here, but I know where the resources are, I'm very knowledgeable about them.

This broad based approach to mental health can be seen as a contrast to how mental health is often conceptualized in Western psychology. A committee formed to examine mental health issues in northern Saskatchewan included Aboriginal people's ideas about mental health (Feather, 1991). Their understanding of mental health was much the same as presented by the Aboriginal advisor participants in the present study. They included in their definition of mental health things like relationships, family and community. Results of Feather's study indicated that even the term 'mental health' was seen as problematic as people perceive it as something mysterious. Further, they felt that being seen as someone with mental health problems could impede healing. This group went as far as to propose the use of social health to replace mental health, as it is more inclusive of the person's environment.

The Elder also spoke to the importance of spirituality and ceremony:

...Spirituality to me means living a good simple life. A very, very simple, simple life and also spirituality has nothing to do with going to church or receiving communion or going to confession. It has to do with that good life, caring for yourself, being balanced physically, mentally, spiritually and emotionally, and also attention to your family, attention to your life, taking charge of your life, making life better for your surroundings.... Ceremonies, those people that know about their culture, their ways, there is ceremony there,

but also if they're living to their culture.... When people get to know their

culture it brings a good sense of feeling, a good calmness that it's not good

enough to be thankful, we have to show gratitude. And showing gratitude is

being knowledgeable and looking at other sources of life, like even what the tree

brings, you know, shade when it's hot—it purifies the air that we breathe.

Another Aboriginal advisor also addressed the importance of ceremony:

And the thing about ceremonies, including prayer and smudging, that I think

really needs to be stressed is, as I understand it, they are very critical in the area

of health and mental health from a traditional point of view. As is counselling,

but the ceremonies are very important, they always talk about the ceremonies as

being the foundation.

Although the use of ceremony and their importance to individuals has a great

deal of variation, spirituality is a central component of a general view of mental health

as seen in an Aboriginal cultural context. Telehealth would not be able to address

ceremony as a part of mental health, but an awareness of the importance of ceremony for

Aboriginal people is key to a successful project when dealing with communities or

individuals for whom traditional spirituality is a significant factor.

Psychology and Aboriginal People

One Aboriginal advisor spoke to the problematic relationship between

Aboriginal people and psychology:

My understanding is that the history of the relationship between psychology and

Aboriginal people is like the history of almost any colonizing oppressive

influence. I don't think that psychology is exempt from that. I think that

psychologists, including yourself, when you accept the mantle of psychology you

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take on some of the history. So it's hard to accept that, as a psychologist, because part of the training is that we are trained to help people and we are trained to think we know what to do to help people. So, if you then say that you have to own the fact that as a person called a psychologist you will initially be very much held in distrust and not listened to and so forth for the people to hear that, but I think that's the case. I don't think I have spoken to any Aboriginal people that I can think of, that would say that psychology is a good thing or has good experiences, I can't think of one. I am sure that's an exaggeration because I am sure, not in my own experience, but I am sure that there are people who have had good experiences and where psychology has helped. But I think by in large the history is just the opposite, so that prevails. I don't think anything has happened in the last five to ten years to change that.

He further addresses some of the reasons he believes reinforce this relationship between psychology and Aboriginal people:

Psychology as I see it, clinical psychology, is an office centred practice, and it's your office, not theirs. So you set up an office and people come to you. That's been the predominate model of therapy.... So the idea of spending time and working in the community and living in the community and doing the kind of, what I call really important counselling such as having tea and visiting in Aboriginal communities, is not seen as part of psychology.... I remember hearing an interview, and this was about someone who was over in Southeast Asia, and they were actually in the business world but the example still holds. He was asked how his work went and he said, 'well, it was very inefficient, I spent 80% of my time having tea and visiting and talking about relatives and

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then only 20% doing business.' You know, missing entirely the whole point. The 80% was real community work, the necessary foundation to the 20% 'business'—in a sense the 80% was the real business [participant's emphasis]. And I think psychology would say the same thing, you know if you said to… a conventionally trained psychologist, 'how was your day?' They would say the same thing, 'it took me a long time to finally get to my testing because I had to meet this grandma, then that grandmother had to… you know I had to have bannock there'… and they would see that as a waste.

The Elder, when asked about her views on psychology, stated:

I would say in some areas it affects negative, because people don't understand our way. They don't understand our culture, they just don't understand. So, and also, especially if a person's never ever had any dealings with First Nations people, the impact would be negative. I remember one time I was keeping this little girl, a violent little girl… she had been in a foster home for many years…. So, one day I was at home and I didn't know that the worker was coming… we were just relaxing. All of a sudden the worker comes there and she became very aggressive. So, I stood up to her and I spoke to her in a very firm voice and I told her that she could leave and when we want to see her, we will come and see her, but, she is not to barge in like this on me, on my space like this again. I told her to leave now…. She wrote in her report about me--a very aggressive, large, woman she put…. I couldn't believe it…. Then it went on that she didn't think that this child was put in a proper home, because I just stood up to her. I got up after when we went to court, so I told the judge that I would like to keep the little girl because she is First Nations, and I know how to work with children…. I

took the little girl home and she stayed with us for a long, long time. But, she again, she made me look bad... where was that coming from?.... She was a psychologist, a child psychologist, for the courts. All kinds of things happen in there, the child has to get assessed and I understand that, but sometimes they don't understand our way.

The Elder continued:

But Westernized psychology... and the way we do things too is we study the children our way. I don't know nothing about psychology, I never went to school, but I know lots just by dealing with children, how they think.... Even the Elders, they have Indian psychology and they are like psychologists, and also they know about science, in their way.

It may be difficult for psychologists to hear these words spoken about their profession. It was a struggle for myself as an Aboriginal person to understand that these words also apply to me as a psychologist in training. However, I think there is hope for a better relationship between psychology and Aboriginal people, given a great deal of work on the part of psychology and psychologists, and a great deal of patience on the part of Aboriginal people. Large institutions such as universities and disciplines within them can be difficult to change.

Non-Aboriginal Service Providers

Psychological service provision by non-Aboriginal services providers was addressed by a number of participants. There was a fair degree of variation in the views of participants on this topic.

One of the psychologists from the telehealth project stated:

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If you were honestly there to help and you're sensitive to the needs of the person who was with you, why does it matter if you are from their culture? If you spend time with them letting them tell you their world view, because even within the same culture you're going to have differences.

Another psychologist held similar beliefs:

I don't know, I don't think it's the Aboriginal or not, but the sensitivity issue that's more important and a willingness to learn about how other people learn, which hopefully psychologists should have as part of who they are. The only advantage it seems to me is more, getting your foot in the door. Maybe because it is one thing to sort of live that way, and if you are only on the end of a screen and you haven't met people and been able to establish a relationship of trust, maybe the fact that you have blue eyes and white skin is a barrier initially.... There are as big divisions within communities, whether you are Aboriginal or not.... To say therefore you have to have an Aboriginal psychologist, whose culture could be completely different than the one they are serving in whatever community. That it is just a question of appearances as far as I am concerned.

However, it is also acknowledged that the history of Aboriginal people in Canada plays a role in the provision of psychological services by non-Aboriginal people. "Although, this is all overlaid by the whole Canadian climate, issues that we are facing. I would like to say we can just go up there and just pretend that I'm not White and you're not an Aboriginal, and we're just two people. But... you have to remember that you are working in a context [psychologist]."

Another psychologist from the group saw things somewhat differently:

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I don't have a good sense of the community and their separateness or distance

from White communities... some of the Aboriginal educated health people are

looking to White knowledge for kids, they see the programs that are available as

good, beneficial. Too much so, I think, I have cautions about that... but it

differs.... I am a little more pessimistic about an adult client who has had a

rough life, being able to accept a White culturally sensitive professional as easily

as being able to relate or accept a dark skinned person. I think the concrete

differences because of the history and personal conditions, huge horrors that

have gone on, some stereotypes are pretty strong and not so easy to bridge,

especially at [hundreds of] kilometres south speaking to you through the marvels

of modern technology.

One psychologist explained her views in relation to the potential benefits of

having service provision by someone separate from the client's culture and community:

Although I know it works the other way just like the anonymity issue, if you

speak to someone outside the community then it is easier sometimes. Also the

set of assumptions that the therapist has about their experiences and judgmental,

to be able to monitor your own biases if you lived in that community, or even if

you haven't lived in that community, if you too have had similar experiences it is

harder to separate your own experience from what they are telling you about

theirs, so that the biases work, that sense of assimilation, accommodation of

experience has challenges whether you are an Aboriginal person or a White

person, they are just the flip side of each other.

One Aboriginal advisor stated that she felt that the lack of Aboriginal psychological

service providers added to the stigma of receiving these services:

...When you talk about mental health, it is usually I guess maybe when it comes

to mind are like psychologists, psychiatrists and there don't tend to be a lot of

them who are Aboriginal so I think that it has a very negative stigma. Anyway

what I think is even further negative on a reservation because usually it is

conducted by people who are not Aboriginal....

However, when talking about the use of non-Aboriginal people to provide psychological

services, she stated:

...I think in order for anybody to be a good counsellor they have to gain the trust

of the people they are working with.... I don't think one necessarily needs to be

Aboriginal to work clinically with Aboriginal people but I think they need to

understand and to respect the culture of the people.... They are not really going

to get a lot of services so they are either going to be given by non-Aboriginal

people or they might not have it at all. So whether or not these people choose to

see non-Aboriginal people is not a question.... I think that if somebody is non-

Aboriginal and wants to work in a remote area then that sounds like a person

who wants to help and wants to be there, so why not?

Another Aboriginal advisor went further than simply preferring service provision

by any Aboriginal person:

The preferred way is if someone's going to provide service to someone's who is

a Cree person that person should not only be Aboriginal but should also be a

Cree offering services who understands the language. In the north there are a lot

of Dene people, certainly Aboriginal person is more attractive but preferred is to

get Dene people, they are the most northern group linguistically, to have Dene

therapists. I'm not aware of anybody who does that, could be, but I'm not aware

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of it. Actually there's a list of 26 or 27 Aboriginal psychologists that are PhD but it's not enough.

The reality at the present time is that there are not enough Aboriginal psychologists to provide services to Aboriginal people. Non-Aboriginal service providers are therefore necessary. With this knowledge, what becomes important is to learn how to work with Aboriginal communities in a way that works for them.

The Elder expressed her thoughts about what she would see as a good way for mental health professionals to understand how to work with Aboriginal people:

I would say, an example of someone who wants to work with us, the way we work, we'd invite them to come to sweats, we'd invite them to come to the round-dances, to the powwows, to our feasts, so they would get to know us more, and also they can learn. The more you learn about First Nations people the better the job is going to be and the jobs will be more effective--to help people stay well.

An Aboriginal advisor also expressed her belief in the importance of connecting with the community:

I think making a trip out there to wherever they are going, to meet the community and the people with whom they are going to work is part of the thing I was talking about earlier about establishing trust and you know cause I don't think that somebody is going to just get on the monitor or whatever and start doing therapy with somebody. I think they have to have been involved in the community whether they have come out and looked around, had a community feast with them, or whatever, I think that would be very important.

Another Aboriginal advisor had similar thoughts on the subject, and was

sceptical of Western trained psychologists ability to understand Aboriginal people:

> I think the challenge for psychologists who are trained from a predominately
> Western point of view... they need to be taking into consideration the Aboriginal
> client group who see things differently. For instance, Correctional Services
> Canada is a very large organization and has the types of resources to do mental
> health for the inmates. There's a guy who is hearing voices in the sweat lodge
> and the psychologist, I heard, thought that was a sign of instability. I go to
> ceremonies myself, that I hear voices in there, that is part of the experience.... I
> think that a non-Aboriginal person can do that [work with Aboriginal people] but
> I think that it's not just something that you learn in university. You'd better be
> prepared to make a commitment if you're going to work with Aboriginal people,
> to be a part of their culture and immerse yourself in it. Not just think you know
> it from a book.... It requires time too, right. I mean there are some people that
> are, it sounds like they're doing those kinds of things. I have some friends that
> are therapists on the reserves in the Saskatoon area and they have been there for
> years and they have made that transition. And they have made that commitment
> and they respect the world-view and they're not condescending.

Immersion in cultural activities, commitment, and openness to learning are

explained as important components of working with Aboriginal people. Spending the

time with people in the community allows for a deeper understanding of their issues,

how they understand them, and how they want to approach them. It is likely to reduce

misunderstandings like the example given about the man who heard voices in the sweat

lodge and was thought to be unstable. Being willing to learn also shows respect and an ability to be open to different world-views.

One Aboriginal advisor provided an example of one experience that an Aboriginal community had with mental health service providers:

> What had happened prior to my arrival is they'd had some professional people come prior to us that had billed them a huge amount of dollars and opened up many wounds and then left. And that seemed to be a not unusual experience. So what that had left that community with is that they were very cautious of a non-Native person and I can remember when we went in there we were interviewed by the health board to see if I would be a reasonable candidate to do what it was that they wanted to do, they were just really nervous about asking me questions and etc. So I think that what that led me to believe is that there has probably been many First Nations that feel as though they have been burned by non-Native professionals.

The same Aboriginal advisor addressed this difficulty in gaining the trust of a reserve community by relating his own experience working as a non-Aboriginal professional in an Aboriginal community:

> It's been slow.... As we moved along and continued to do the work that I was doing there was a strong resistance for me not to be there.... I think there will always be a level of mistrust but each time I work with someone and there is a successful outcome they take that back to their family so a sense of trust and faith have developed over the years.

There are reasons why Aboriginal people often have a less than positive view of psychology. Keeping this in mind when working with an Aboriginal community should

help the service providers to remain understanding if it seems that they are not being well accepted or trusted, even when they are there to help.

An Aboriginal advisor spoke to the need of considering not only whether or not a person is Aboriginal but who they are as in individual:

...I think that you have to look at the health of the individual who is doing the counselling, for example if you have Elders, an Elder will take one person who is doing some counselling or whom people are seeing, yet this person is not a mentally healthy or is not as mentally healthy as they could be, like whether they are involved with any violence, whether they have a substance abuse problem. These may not be the kinds of people that would be the healthiest role models to be working with some of these people and they might do more harm than good actually so I am not all for people in the community working with others in the community, I mean just because they are Aboriginal.... I think that is what I would prefer... if I were an Aboriginal person on a reservation I would prefer to see... a non-Aboriginal person who has training in the area than perhaps an Aboriginal person who needs to do a lot of personal work him or herself and doesn't really have a grasp of basic psychological factors or necessities that we need for successful counselling, successful therapy....

Another Aboriginal advisor also addresses the notion that who the individual is that is providing treatment may be a more important variable than whether one of Aboriginal or non-Aboriginal:

But again, the ceremonies are not automatic, I think that is a misconception that some people have, including Aboriginal people. Another misconception is that I can just hire that Aboriginal psychologist over there and she will know how to do

it, because she will know the ceremonies… As if that is going to solve the problem. The notion of sending a client to a sweat as if that's the entire answer is kind of a romantic notion of what sweats are about.

He further outlines a few disadvantages that can occur from relying on the Aboriginal ancestry of a mental health provider as the most important part of their abilities:

A lot of times people say well I only want a mental health worker that is from the area whom maybe speaks the language or who is Aboriginal. I think what I have seen happen it really depends very much on who the person is, cause it also can be a very big disadvantage, in particular if you are from the wrong family or if the people look upon that person as becoming too good for the community, if they have gone out and now they have come back. I think in a way the whole notion of what it means to be a mental health worker is different as is the experiences of mental health and mental illness.

Another Aboriginal advisor spoke to the necessity of mental health providers from outside the community:

That community [that he worked in] is very close to a residential school… and that residential school had been in that community since the late 1800's and early 1900's and the impact of the residential school is significant in that it took away language, took away culture, took away family structure, in replacement to that provided a Catholic belief system which for some has been okay for others it has been devastating. Many of the people that attended had been sexually abused by priests as well as nuns and corporal punishment was huge. So what all of it kind of boils down to is a culture that has really been damaged extensively and I think

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it is probably easier for somebody outside of the community to work with those

issues than for somebody within the community. And I think that is beginning to

bear itself out also with their Indian Child and Family Services [ICFS]. I have

had some involvement with the ICFS agency and I see some of the workers in

counselling. To try to do a child abuse investigation within your own

community is very difficult, especially if your life hasn't necessarily been all that

clean and people can easily have things on you. So I think the one thing...

outside services of some fashion are necessary....

The above participant provided an illustrative example of some of the further

problems mental health workers in the community encounter, and how it limits the work

they may be able to do:

The other thing is we've tried running groups in the community and we've had

mixed success and what has happened more than once is that the first women's

group I ran there for battered women was just not moving and people were not

talking and I finally sat down with two women from the group on the side said

'What's going on?' and they said that 'We're not about to disclose anything in

this group because she's still drinking and we know that if we tell our story that

the next time she drinks it's going to be out and about.' So the whole issue of

confidentiality is really significant in the fact that confidentiality hasn't been

respected and that has had a significant impact in terms of the type of work they

have been able to do within their own community.

These participants outline that Aboriginal ancestry is not the most important

factor in choosing a mental health practitioner. A number of personal variables and

community variables must be considered when ascertaining a good fit between a

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provider and a community. Issues of training, mental health, and the ability to navigate community ties are areas that should be considered.

Assessment

Psychological testing was another issue that was clearly felt to be complicated when working with an Aboriginal population. One psychologist spoke about her thoughts on testing the children in the community we provided telehealth to:

All that those tests will tell us is how those kids compare to Western Canadian kids. We have no idea what is typical in that community and it is very difficult to use our test to measure kids from another culture, and they clearly are from another culture. For most of them their primary language is Cree, not English, a good example is the kids that I saw I did a little mini assessment with them and some play therapy and there was nothing wrong with those kids, they were bright, creative, problem solving. They were not learning disabled or intellectually challenged, they were bright young kids. The test that I gave them showed them to be below average.... A lot of it was language and... tweezers, there is no Cree word for tweezers. What we would really need to do is go up there and do a mass test and get some norms but even after we had the norms we would know how each child is doing against the norm but we still don't know how to compare that norm to other norms.

Another psychologist stated:

Testing... I would have real reservations about using the WISC [Wechsler Intelligence Scale for Children] for making meaningful practical predictions about behaviour about kids who are in that reserve community as standards are different. WISC is good for estimating and predicting achievement in our

culture. If that is where a kid is headed then it has more value. The tests are useful where Aboriginals are in an urban setting, wanting to pursue schooling, they have to compete with the standard in the world in which they will be acting. The tests we have are poorly adapted in rural settings.

The third psychologist expanded on the above point:

I don't think there is a problem using the test, it's the misuse of them, and the fact that there are not tests available for some of the things that the people who live in a northern community need to be able to do. We don't have tests for that, it's a lack of tests in some senses, or the potential that people would use them to predict social functioning in the community which is obviously inappropriate.

One Aboriginal advisor spoke about the use and interpretation of psychological tests:

...I think more norms for Aboriginal people have to be established. You cannot use a MMPI [Minnesota Multiphasic Personality Inventory] for example or a MMPI-A [adolescent version] that was normed on kids from Minnesota, middle class, and then try to compare them as they are just not the same. But I think what's happening now with some of these new tests coming out is that they are becoming more and more sensitive to not just Aboriginal norms but other norms whether they be African American, whether they be Hispanic etc, etc. I believe that clinicians should be ethically bound to use instruments that are going to represent their clientele in accurate ways, and if they are using a test that clearly is not suitable, then you might just as well not be doing an assessment because your results aren't really going to be valid. But some people might see them as

valid and not have been sensitive to the cultural thing and then it is just not a pretty sight.

The Elder expressed her views of psychological assessments and their use with Aboriginal people:

Yeah, assessments are not very accurate. Even the Fetal Alcohol Syndrome assessments, they're not accurate.... But, yet they're assessed and then that child has to live that for the rest of their lives, that label. I find sometimes assessments creates people to be labelled, that one I don't like. I don't like that cause people change with time and where their circles are, if it's a well circle, people get well, and then they'd be different, if an assessment was done then they would be different. It would probably be a positive assessment. And also the assessments aren't culturally appropriate. Even me one time, I was classified borderline mentally retarded because I bombed out on an IQ test. For one thing, I didn't understand the language, I didn't know what they were talking about.... Because I couldn't read and write, I couldn't understand, so I had to be borderline mentally retarded.... I just laugh at that today, but if they were asking me about culturally appropriate questions like an eagle, when they mate, they have life-long partners, they can only have one or two little eagles at a time, and the pair mates for life. If they would make that assessment in that area, I would score high.... If they asked me something about the directions, the four seasons, I would score high, if they were culturally appropriate questions.

The Elder also addressed test development:

Also, if there's ever anything that needs to be developed it should be down to earth people, along with people that are educated, together to do it, but it's got to

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be right from the foundation. Cause some of them have been done too already, but the educated people have the last say, but you can still tell that they're not right for us. They're too—they don't understand and I don't think they'll ever understand, that's the right thing I know. Because they base too much on knowledge and not wisdom. They fail to recognize common sense—it's always the academic of something.

An Aboriginal advisor spoke of his experience with assessments in the community he works with:

Well, you know when I think of about when I first went there we tried to use assessments, psychological assessments not that the same as a psychologist would use but the consultant had training in that particular area so we attempted to utilize him. It didn't work, the minute I made an assessment the door was closed so we took a much softer approach and used a more what we would call a social assessment in a sense of how and what the issues are and now we've incorporated an addictions assessment and there's been no resistance to that but we're now into this for ten years and so I think there's much more of a openness to the whole process.

Using psychological tests that were not developed with Aboriginal people in mind does make it more complicated for interpretation. When English is a second language, there is a significant risk of test results being inaccurate. It is in situations such as these that psychologists need to have knowledge regarding test bias and have good clinical skills in order to provide a more accurate assessment despite the limitations of the test. As one psychologist noted, there is a lack of tests, tests that are appropriate for Aboriginal people. And even if these tests were to be developed, as the Elder

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emphasised, Aboriginal people need to be included in the process in a meaningful way. Considering the assessments that are available and the relationship between Aboriginal people and psychology in general, it is not surprising that the Aboriginal advisors provide examples of Aboriginal people as being concerned about testing.

Western meets Traditional

Some mental health service providers are experiencing success in using both Western and traditional methods of healing as a way to meet community needs. An example provided by one Aboriginal advisor illustrates this:

The other thing that has been very interesting has been the traditional healing that has started to evolve over the last decade or so. We work hand in hand with the traditional healers but only with certain ones, ones that we know are quite healthy. So in a sense what we have done, we have combined what you'd call Western ways, being what I bring, with traditional ways that exist within the sweat lodge and with the pipe carriers and we've tried to sort of work with that together where that has been the most successful I think is with the youth. We've run a number of youth groups within the community. Myself and an Elder, a pipe carrying elder, to utilize... sort of what I present and then what the Elder brings into that in terms of culture and language has I think really been a nice mix.

He continues to explain the mixture of Western and traditional:

So what we've attempted to do is provide the Western psychoeducational sort of component but to encourage people who want to find or rediscover their culture or who are already sort of following a more traditional way to maintain that

contact but not just to do that, to expose themselves to other things in life and I think that has worked well.

Another Aboriginal advisor talks about his conceptualization of Western and traditional healing and the difficulties with seeing them as integrated:

I don't believe in integration because my experience with integration, I mean making them one team, is that almost inevitably there is a hierarchy created and almost inevitably the traditional healer is not at the top but more at the bottom.... So I'm in favour of collaboration where the two paths work from their strengths and collaborate in different ways. For example, for me, I have been given a sweat but I never do a sweat with my patients or my clients or the people I counsel. I will always take them to an Elder because that's the way it should be done. The sweat I do is for my family and friends. Likewise, I would not expect an Elder I work with to become conversant with DSM-IV [Diagnostic and Statistical Manual of Mental Disorders] and anything like that. That's not his job or her job. So I like this idea of parallel but intersecting or parallel but interacting paths.... So I really think that's the best way to do it because otherwise what you do is you take away from the strengths of both. Now the thing about that is that the psychologist then has to feel really quite comfortable giving up authority because I think a lot of times the professional really loves these multi-team relationships if they are in charge [participant's emphasis].

Seeing the strengths in both Western and traditional methods allows clients to have access to a combination of healing paths that is best suited to their personal beliefs and situation. When there is respect between the Western and traditional ways, both systems can provide support and healing. This inclusion of both systems allows for

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people to find their own way and allows people who have been away from the spiritual side of their culture a chance to reconnect. Often traditional healers have not been well respected, and have ended up not having their knowledge respected when working with Western professionals. Without due respect and proper treatment, we stand to lose the voices of the people who may know the client and their community the best.

One Aboriginal advisor speaks to the problems with Western training and the results they can have:

The point of fact is that it's a tremendously complicated mixture and I think in terms of mental health workers in the mental health profession are not trained to see things as a mixture of... it's like you're trained to look for the signs of a particular diagnosis and anything else that doesn't fit in, you just put aside. I think in many Aboriginal communities you don't do that. I remember I was working up in Alaska and again I was working in one of the urban centres and one of the young men that I saw was from one of the bush communities. All the young men that I was seeing, I was seeing six of them, and all of them were labelled... chronic men that were ill with Schizophrenia. They said, to the last person, that if these people had been seen earlier by an Elder then the voices they were hearing and the visions they were seeing might have been interpreted in such a way that it wouldn't have led to what was happening to all those young men.... So they made the point that those young men wouldn't have necessarily come to the mental hospital, if there had been healers or spiritual work. The voices and things they were seeing could have been interpreted differently by an Elder, in such a way that they wouldn't have turned into psychological problems,

but could have been 'we sometimes hear voices from the outside, the spirits do talk to us' [participant's emphasis].

This expert continued to speak to the complicated nature of using two different systems for mental health:

The dilemma is that suppose you see a person that comes to you for help and their complaint is that they're hearing voices and they can't sleep and these voices are telling them that they must go on a quest, a vision quest, they must go to the four directions and they must offer their offerings but they can't get this out of their mind and they're unable to really function properly... I guess what I'm saying is that you can look at that presenting picture from a conventional psychological standpoint and really work with that as a set of symptoms and help to bring some degree of balance or calm, and you can do that and in that sense what could be seen as a very conventional approach can be helpful. The question I would raise is does it take away more that it gives? Does it lose the chance to talk to that whole other area of concern? ....And so on the other hand, I try to be very careful because if I go the other direction again with this hypothetical person, we must take them to a sweat and take them to some of the Elders, and again ignore some of the things I can do with a fairly conventional psychological approach. Then I think I am not doing what could be done as well, and there are some psychologists who would say that there is nothing I can do, just let the Elders work, the sweats work. Well, in my experience the sweats don't work automatically you know, it's not like we send them to five sweats and that will be the cure. I don't think so, I think the Elders that I talk to, talk about the sweats being areas where the people can receive the healing power, but they have

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to continue to work on their issues after the sweat, and the Elders I work with do

a lot of psychological counselling as well. So I think either extreme of just a

narrow conventional psychological approach or a total reliance on ceremonies

and traditions, I think leaves something out. Right now, whenever I counsel an

Aboriginal client, I always work closely with an Elder. Of course, the first thing

is to find out where they are at because some Aboriginal clients don't care at all

about Elders. So, it's not an automatic precondition, it depends on who the

person is.

University education in psychology generally does not provide training in sorting

through complicated cultural mixes of symptoms. Without spending the time to learn

about other systems of psychology such as that used by Aboriginal people, it is the

Western training that comes to the fore. We are doing a disservice to people if we are

not able to offer treatment within their context, with sensitivity to their cultural

interpretations. Another area that mental health providers need to reflect on is the issue

of whether Western treatment takes away more than it gives sometimes, as suggested by

the participant above. For example, even if Western methods reduce symptoms, without

considering cultural explanations of distress, Western methods may reduce people's

connection with their cultural ways of healing or change the ways in which they

conceptualize themselves in their culture. There should be room for Western and

traditional ways if that is what is most suited treatment for the client. Assessing what is

desirable for a particular client becomes an important starting point.

There are examples of where psychology and traditional Aboriginal methods are

working together, and where psychology is not defined as focussing on the individual

without considering culture, family and community. Within the responses of the

participants there are indications of service providers working successfully in collaboration with Elders to provide services to Aboriginal communities, incorporating traditional knowledge and ceremonies for healing. Undoubtedly many other mental health providers are working within Aboriginal communities providing services that are valued and respectful.

Within psychology, the field of community psychology in particular addresses the issues of working within the context of communities. Community psychology is one area within psychology where the interaction between the individual and the society is the focus (Dalton, Elias & Wandersman, 2001). Dalton et al (2001) outline the trends in community psychology as prevention and the promotion of competence, building community, the importance of citizen participation and the empowerment of the citizens, gaining understanding in the areas human and cultural diversity, and the development of alternative research methods to address the complex nature of community research. These trends speak well to some of the concerns of Aboriginal communities.

Other researchers have published studies that speak to the importance of respecting the role of traditional healing. Napoli (2002) wrote of the importance of coordination between health care providers, mental health care providers and traditional healing to increase physical and spiritual health. The importance of "taking the journey with the client," the building of personal relationships and the integration of Aboriginal traditions are highlighted in the author's examination of providing health care services (Napoli, 2002, p.1575).

Santiago-Rivera, Morse, Hunt and Lickers (1998) provide an example of a community based project with an Aboriginal community in a collaborative research project. These researchers worked in partnership with the Mohawk Nation of

Akwesasne with the guiding principles of respect, equity and empowerment in their study of the effect of toxic chemicals and their effect on human health. Under the principle of respect, the researchers listened to the concerns of the residents and respected their knowledge regarding the issue under study. Equity entailed community involvement and power in the process of decision making as to what would be studied and how it would be studied. Empowerment involved training local people to conduct psychological research and gain education credits for their involvement. These researchers comment that although it was sometimes difficult to negotiate a project in collaboration with the community, what they learned from the community was well worth the effort.

The changes within the discipline of psychology that are focussed on providing services that address the concerns of Aboriginal people continue to strengthen as researchers and clinicians stress the importance of culture and community for mental health. Although there are many examples of mental health providers and researchers who are working within a holistic frame, it appears that there is a lack of transmission of changes in psychology to the community level. Further work in presenting the changes within the discipline of psychology to the general public and to Aboriginal communities should be pursued in order to improve the perceptions of psychology.

CHAPTER 6

Conclusion

Dal Grande (2001) reports that approximately one-third of Aboriginal and Inuit communities in Canada are classified as remote, isolated or semi-isolated. These communities often do not have access to needed psychological services, and health workers in the community in charge of mental health lack support and training. The ability that telehealth holds to provide specialized services at a distance speaks to the importance of evaluating this method of service provision for these communities.

The potential of telehealth needs to be communicated to Aboriginal communities in order for them to evaluate it as an option for psychological service provision. The optimism expressed by participants in this study suggests that there is a place for telehealth as an addition to existing services. Potential uses and limitations of telehealth should be discussed with communities so they fully understand the types of services that would be able to be provided. Telehealth does not contain all the answers for solving the problem of lack of service provision in the northern Aboriginal communities. Nor will it play a large part in addressing the serious needs for community development that are necessary to create lasting and impactful changes in the lives of people from reserve communities. However, it does do a few things well.

Benefits

Telehealth can reduce the cost of providing psychological services for clients and service providers by reducing the need for travel. Accessing services in ones own community also reduces hardships that may be experienced due to travel. Telehealth creates a way for psychologists to provide services to areas in need without the prohibitive time commitment that extensive travel entails, as well as opening avenues for professionals with different competency areas to provide access to their particular specialty. The difficulties encountered in recruiting and retaining qualified psychologists in remote areas is addressed as the service provider can remain in a larger centre. Continuity of care can be better served with telehealth as the same professional can provide services regardless of where they live.

Telehealth can also increase the ability of workers in the remote communities to provide services to their clients by having access to supervision and education from urban professional people. Training, support and consultation of community mental health workers was seen as an obvious and important use by all participants. These community workers can also access mental health services and support for guidance and for their own good mental health as they navigate dual roles and other community ties. This support from outside mental health providers reduces the isolation these community workers generally deal with. Further, the telehealth connection allows for stronger relationships and understanding between rural and urban providers to develop.

The use of telehealth to provide services such as assessment and therapy is also possible. Assessments would be more accessible to community members if done via telehealth, without the extensive waiting lists. Despite difficulties with test interpretation over cultural barriers, assessment information is often important for

gaining the needed resources to provide services. Therapy via telehealth needs to be further explored. Some of the concerns expressed regarding therapy at times of crisis could likely be worked out with the help of community providers. It seems at this time that therapy provision over telehealth will be something that people, both providers and clients, will need to experience before a comfort level is reached. Given the limitations of the options, I believe that telehealth has the potential to provide a good therapeutic environment for one on one counselling. The anonymity afforded by telehealth may provide the impetus to utilize it for therapy provision. Further evaluation of telehealth as a therapy tool should be completed in the future.

The use of telehealth to provide mental health services may have the important benefit of raising awareness of mental health in communities. Having more services available, increasing the knowledge and skills of community mental health workers, and providing services within the community creates a higher awareness of mental health services and issues within the community. As suggested by one participant, Aboriginal people may also feel more comfortable accessing services on their own reserves, rather than travelling to an urban centre, where they are less represented among other people accessing mental health services and where they may feel even more set apart as a result.

Limitations

The limitations of telehealth at the present time for Aboriginal communities includes the cost of equipment, the need for telehealth to be evaluated on an ongoing basis as a long term project, and the limitations of its uses. It is clear that telehealth cannot address issues of community development nor the provision of ceremonies. The applications of telehealth are quite specific as opposed to general, although it may have

some broader impacts, but only in the area of enhancing the mental health for individual clients.

Recommendations

The results of this study suggest that telehealth holds a great deal of potential for the provision of a broad range of psychological services to remote Aboriginal communities. Lessons learned from this project can inform future telehealth endeavours.

In the process of the University of Saskatchewan telehealth project, we learned that we required connections with all levels of community. It was realized through our project that our lack of connection to others in the community limited our capabilities. Without being connected to the community in a more complete way, we were unable to expand the types of services we were trying to provide, and we were limited in our understanding of the community. Although we were welcomed and well received when we visited the community, as outsiders who did not know the community, we experienced a fairly high level of guardedness by some community members. This guardedness or cautiousness was manifested in the mixed messages we received about what problems the community was facing.

This level of mistrust speaks, at least in part, to mistakes we made in approaching the project. Going up to the community in the beginning, before a project is entirely underway, spending at least a week there, and returning on a regular basis would provide a better base for community support and understanding. Our two-day trip to the community we worked with was valuable, but it clearly left us with more questions than answers. Having more time in the community would allow for more time to talk with a larger variety of community members, to have more casual interactions for

relationship building, and to participate in community functions. Spending more time in the community with the community members would show commitment to the community as well as to telehealth.

Building relationships with community Elders would help guide telehealth service providers in an understanding of how the community conceptualizes mental health and how they would prefer to approach projects. There will undoubtedly be individual and group differences within a community, but having a sense of the general view allows mental health services to be tailored to fit the community rather than the other way around. As expressed by one Aboriginal advisor, for some communities and some individuals a strictly Western psychological approach will be what is wanted, others may require more traditional methods, or perhaps a mix of both.

Working with traditional healers guards against displacing the traditional psychology of the community and shows respect for Aboriginal knowledge. The negative views expressed by the Aboriginal advisor participants in this study regarding psychology should cause mental health providers to reflect on their beliefs and allow themselves time to begin to see what the community's Aboriginal psychology has to offer. Seeing the value in both systems builds on the strengths of both and creates a more solid relationship for psychology and Aboriginal people.

The experiences of the present telehealth project outlined that establishing a path for service provision was problematic. Understanding how mental health is viewed and administered in the community before a telehealth project is developed would help avoid some of the difficulties we experienced that seemed to be related to a lack of understanding between the model we brought and the one they may have expected. Some of the difficulty in establishing goals and an acceptable model for the service

providers and the community likely came from the newness of the use of telehealth. Neither party had experience with this style of service provision. The community did not have a solid base of outside psychological service provision in general, leaving both parties needing to work out all options for psychological service provision with the addition of telehealth. To help facilitate a path for service provision, it would be beneficial to have discussions regarding the community's past interactions with outside mental health service providers, what they found useful, and what they would like to see handled differently. From there, the community members and the service providers from outside the community could negotiate a project that improves on past services.

Providing telehealth in a context of a great deal of need is also difficult. The community in which we worked has problems with violence, including bullying, substance abuse, high unemployment, lack of adequate housing, sexual abuse, Fetal Alcohol Syndrome, and a very young population to name a few. The community mental health workers are at the very front of the line in trying to provide services for all of these community issues. Supporting these workers in facing these community challenges is necessary. Psychologists or other mental health service providers need to be aware of the context and the scope of the mental health needs in these communities in order to plan for appropriate services. The addition of telehealth provides an opportunity to maintain regular contact with remote Aboriginal communities and the people working within them who are providing the day to day services. Commitment to building these relationships is one way in which we can begin to build the trust needed to mend relationships between Aboriginal people and psychology.

Showing commitment should include having community members involved directly in the service provision and in the research process and research results should

be shared with the community. Involving community members in all aspects of the project and sharing research results increases their capacity to manage their own mental health services. Focussing on these issues early in the project would reduce the likelihood of situations such as I encountered in this research project, where the community ended up being excluded from the research process.

The short-term nature of the project was also problematic. The difficulty of the time limited nature of the project and the lack of future directions was addressed by one of the participants involved in the telehealth project, who stated: "I don't see why we'd be asking them to invest themselves when clearly we are not ready to invest." Engaging in short term projects when long term solutions are needed run the risk of being just one more example of a lack of commitment from outside providers. The project in northern Saskatchewan was time limited as it was a pilot project, but even with time limited projects, re-evaluating the project at the end to provide direction for the future would be useful for all involved.

Funding opportunities exist at present to create telehealth linkups to remote communities. What is needed is the commitment of mental health providers to advocate for these services and help communities develop proposals for funding and then stay to help provide the services. At the end of this project, it is clear that there is much to be gained by the use of telehealth for providing mental health services to under serviced remote Aboriginal communities. However, unless programs are created and fostered, telehealth may return to disfavour as a method of service provision and the potential strengths that it offers to remote Aboriginal communities may be lost.

CHAPTER 7

From the Other Side: My Reflections on this Project

I have learned a great deal in the process of completing this project. Certainly I learned a lot about telehealth and about using it to provide psychological services. But I learned a great deal more. I have begun to learn and understand more fully the many issues that influence research and clinical work in Aboriginal contexts.

I did not begin with a total lack of awareness of the process and results of colonization in Canada, or with a lack of awareness of some of the problems of psychology as a discipline in its work with Aboriginal people. In my undergraduate training I focussed my courses in Native American studies almost as much as I did in psychology. My reading interests have always included texts written by Aboriginal authors. In short, Aboriginal culture has always been a part of my life. However, it became apparent to me during the process of this thesis that I have a lot more reading, listening, and thinking to do.

Part of the force behind the need for greater personal reflection was that one of the main issues that became a focus of this thesis was that of Aboriginal people's perception of their treatment from psychology as a discipline. As well, the statement from one of my participants who said to me that his understanding of the history of psychology and Aboriginal people is one in which Aboriginal people have, once more, experienced colonizing oppressive influences. He told me that psychologists, including

myself, take on part of that history when we choose our discipline. His words impacted me and made me realize that I need to integrate these thoughts into my practice.

Addressing the depth of the history of the reasons for this perception of Aboriginal people towards psychology was not central to this thesis, and has been addressed well by others. In this closing chapter, I wish to reflect on the challenges facing psychology as it struggles to find a new relationship with Aboriginal people.

A significant contribution to this area is a book by Duran and Duran (1995), *Native American Postcolonial Psychology*. Eduardo Duran is a Pueblo/Apache psychologist, and along with his partner Bonnie Duran, they have given considerable thought to the issues in clinical practice, training and research in the area of psychology and Aboriginal people. In their book, Duran and Duran speak to the problems they see in psychology today, and how they conceptualize the mental health issues they see in Aboriginal communities today. Duran and Duran (1995) state:

> The past five hundred years have been devastating to our communities; the
>
> effects of this systematic genocide are currently being felt by our people. The
>
> effects of the genocide are quickly personalized and pathologized by our
>
> profession via the diagnosing and labelling tools designed for this purpose. If the
>
> labelling and diagnosing process is to have any historical truth, it should
>
> incorporate a diagnostic category that reflects the effects of genocide. Such a
>
> diagnosis would be "acute and/or chronic reaction to colonialism." In this sense,
>
> diagnostic policy imposes a structure of normality based in part on the belief in
>
> the moral legitimacy and universality of state institutions (p. 6).

It is difficult to make the point any more clearly that Duran and Duran have. The suggested diagnosis of an acute and/or chronic reaction to colonialism indicates the need

to have a context in which one works with Aboriginal people. Considering the effects of colonialism when working with Aboriginal people reminds us of the impact of this history that continues to be felt by many Aboriginal people today, and that we should not move quickly to personalize and pathologize, as suggested by Duran and Duran.

The process of completing research in an Aboriginal community also brings with it a host of considerations. Tuhiwai Smith (1999) opens her book *Decolonizing Methodologies: Research and Indigenous Peoples* by writing:

> From the vantage point of the colonized...the term 'research' is inextricably
>
> linked to European imperialism and colonialism. The word itself, 'research' is
>
> probably one of the dirtiest words in the indigenous world's vocabulary. When
>
> mentioned in many indigenous contexts, it stirs up silence, it conjures up bad
>
> memories, it raises a smile that is knowing and distrustful (p. 1).

If we take these words as a starting point when embarking on research projects in Aboriginal contexts, hopefully we will take more care than the researchers who have created this perception.

A report from a series of Northern Town Hall meetings in September 2001 by the Canadian Institutes of Health Research (CIHR), the Institute of Aboriginal People's Health (IAPH) and the Institute of Nutrition, Metabolism and Diabetes (INMD) outlines a number of research needs that were expressed by northern Aboriginal communities, northern researchers and health care providers. This report indicates that the principle concerns were Aboriginal ownership, control, access and possession (OCAP) of research. The participants in these meetings emphasized that Aboriginal people should have ownership of the research being done in their communities, to provide assurances that their knowledge is not appropriated. Aboriginal people want to be active

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participants in the research process as well, including the design, implementation and interpretation of research in their communities. Having access to the results allows Aboriginal people to use the research in their communities. Ownership of the data of results allows Aboriginal communities to have some power over the way in which research unfolds in their community.

There are other issues important to research in Aboriginal contexts. Aboriginal people understand the need to build capacity within their own communities, and within their own people, to complete their own research projects. The inclusion of Aboriginal knowledge is also being raised as an important issue to examine. At a recent conference, one graduate student spoke of the importance of quoting her Elders as we generally quote experts in the literature. Although it is a struggle to gain understanding in academic environments for the validity and importance of quoting Elders, as more researchers argue for the importance of changes, changes will come.

There is a continuing need for inclusion of Aboriginal knowledge in psychology as it is practiced and researched. Although gains have been made in many areas of education for Aboriginal people, education of Aboriginal people in different disciplines continues to be difficult. Hampton (1995) states this sentiment strongly in his book chapter, *Towards a Redefinition of Indian Education* by writing:

> For the vast majority of Indian students, far from being an opportunity, education is a critical filter indeed, filtering out hope and self-esteem....For whatever reason, whoever is to blame, Indian education defined as non-Indian education of Indians has a long and conclusive history of failure (p. 7).

Despite this, non-Aboriginal institutions continue to be the places one needs to work in to attain the necessary credentials for a number of disciplines. It is possible for

Aboriginal people to succeed in non-Aboriginal institutions. It would be made a great deal easier with appropriate cultural support and teachings and with true acceptance of Aboriginal knowledge.

Learning to do research in Aboriginal communities highlights the problem of one area that is not generally taught in graduate schools of psychology. Tuhiwai Smith (1999) speaks to the expectation that indigenous researchers come to their research with an already developed understanding of research in indigenous communities. She states that although there is this expectation that indigenous researchers bring this knowledge with them, the knowledge of the history and a critical analysis of research in indigenous communities has not been learned by the researchers by their training in universities, rather it has "been acquired organically and outside of the academy" (p. 5). I have done much of my learning about being an 'indigenous researcher' outside of the academy. In doing so, I have made many mistakes and made many oversights. I fell short of many of the important principles of completing research in an Aboriginal community.

Through the process of completing this thesis, I learned that I have a lot more to learn. Perhaps more importantly, I learned that I do not need to forget who I am as a Metis woman to complete the research and clinical work required to become a psychologist. In fact, it is essential that I remember it.

As I continue down the path to my goal of becoming a clinical psychologist, I will remember the lessons I have learned throughout this project. I hope that others, Aboriginal and non-Aboriginal will read about the concerns and voices of Aboriginal people as they embark on their educational, research, and clinical journeys as well. As my friend Taka said to me, we should gather data the way we gather our plants. This is

a great responsibility and of vital importance to learn to do things mindful of the respect

and understanding needed for the task of research and for clinical practice.

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APPENDIX A

My name is Tara Turner, and I am a MA student in clinical psychology at the University of Saskatchewan. I am completing a qualitative study on the use of telehealth (real time videoconferencing) to provide mental health services to geographically remote Aboriginal communities from a larger centre such as Saskatoon.

I am writing to ask you to consider having an interview with me for my study. I have a personal interest in this research as I am a Metis person as well as a psychologist in training. I have also had experience in providing psychological services with telehealth to a remote Aboriginal community in this province. It is for these reasons that I would like to explore new possibilities for providing mental health services to Aboriginal communities in need of these services via the use of telehealth.

The study involves one-on-one interviews with Aboriginal people who are knowledgeable about the mental health issues faced by remote Aboriginal communities and who have some experience in or knowledge about mental health service provision to Aboriginal people. As well, I will conduct interviews with psychologists who have had experience in service delivery via telehealth. Because the use of telehealth to provide mental health services to geographically isolated Aboriginal communities is a fairly recent initiative, I am especially interested in hearing what Aboriginal people with involvement in the mental health field have to say about this.

If you are interested in participating in this study, we would meet for an approximately one hour long audio-taped interview at a location of your choice. Some time after the interview, I will give you a copy of the transcript of our interview and allow you the opportunity to comment on the transcripts and add any other thoughts you may have. If you decide to participate, I will be sure to keep your identity confidential by not using your name or identifying information. As well, if you have any suggestions regarding any other people who you think would be interested in discussing this topic with me, please let me know.

I will contact you by phone within a week to see if you are interested. You may also reach me at 492-2384, or email me at turner.barry@sk.sympatico.ca.

Sincerely,

Tara Turner
John Conway, Research Supervisor
Professor of Psychology Emeritus

APPENDIX B: INTERVIEW GUIDELINES

Psychological Services:
- What has been your experience with, or knowledge about, psychological services in remote reserve communities?
- What types of psychological services are generally provided?
- Is there a need for ongoing psychological services?
- What services do you feel should be provided? (e.g., short or long term therapy, testing, psychoeducational programs, consultation, support)
- What are the most important mental health issues that should be addressed?
- Is there anything you would like to add with regards to psychological services in remote reserve communities (past, present or future)?

Telehealth:
- What are/were your expectations of telehealth?
- What goals do/did you have for the use of telehealth?
- Have you had previous experience with telehealth? If so, what was your experience like? If not, what do think of the idea of using telehealth?
- Do you think telehealth is an effective way to provide psychological services to a community?
- What services do you feel are most suitable for delivery over telehealth? (e.g., short or long term therapy, testing, psychoeducational programs, consultation, support).
- Are there psychological services that you feel are ill suited to the use of telehealth?
- Do you think that people in a community would use this service?
- Would you recommend the use of telehealth to isolated reserve communities? Why or why not?
- Is there anything you would like to add about telehealth and the use of telehealth in a remote reserve community?

University of Saskatchewan Telehealth Project Questions:
- What were your expectations of what we would provide in the way of psychological services to the community?
- What do you think about the services we provided?
- Was our visit to the community beneficial? Why or why not?
- What could we have done differently to make this project better?
- What would you tell a colleague about working via telehealth with a northern reserve community that would help her/him prepare for the experience?
- Other comments regarding working with this community?

Aboriginal Communities and Psychology:
- What are your personal perceptions of psychology in general?
- What do you believe constitutes being in good mental health?
-
- What is your opinion on what the general feeling in a remote reserve community might be regarding mental health and psychology?
- In your opinion, is there a stigma attached to seeking mental health services among Aboriginal people?
- What do you think about using non-Aboriginal psychologists to meet the communities mental health needs?
- Do you think that technology needed for telehealth would present another barrier to Aboriginal people's willingness to see a non-Aboriginal psychologist?
- Do you think psychological testing is appropriate for Aboriginal people?
- What do you think about working towards community control of mental health services (e.g., Aboriginal psychologists and workers, traditional healing methods)?
- Is there anything else you would like to add to help me understand community perceptions, or your own perceptions, of mental health and psychology?

Conclusion:
- Please feel free to add anything you wish...