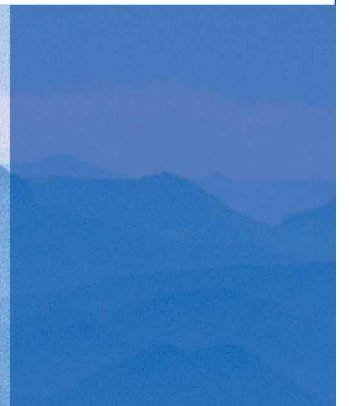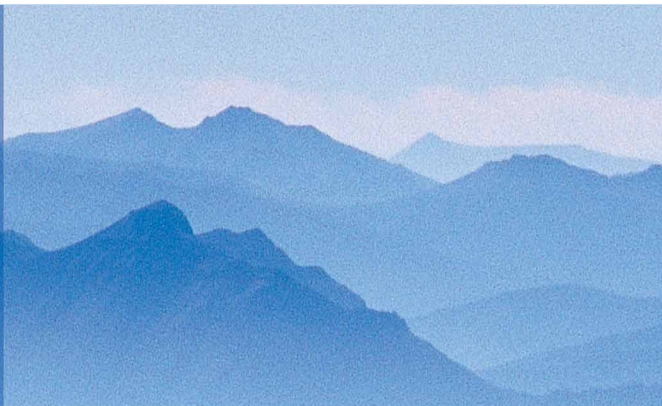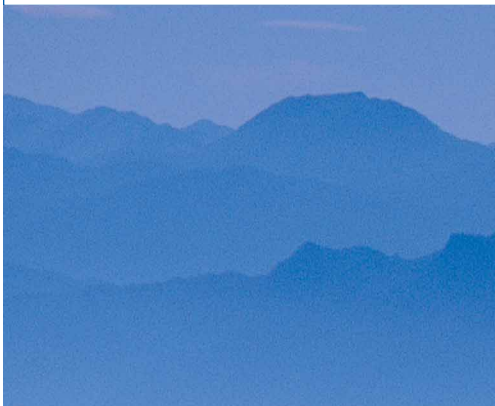# Aboriginal Mental Health: 'What Works Best'

A Discussion Paper

JULY 2001

PREPARED BY: VICKI SMYE AND BILL MUSSELL

Aboriginal Mental Health: 'What Works Best'

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EXECUTIVE SUMMARY

CONCERNS

ABORIGINAL MENTAL HEALTH: 'WHAT WORKS BEST'

In July 1999, the first meeting of the Aboriginal Mental Health Committee was held at the Longhouse, The University of British Columbia(UBC). The meeting was sponsored and initiated by Mheccu, UBC in response to concerns that mental health service delivery, including the field of community psychiatry, did not adequately – or appropriately – deal with the needs of Aboriginal people. At the initial meeting, the membership appointed an Aboriginal person to facilitate the meetings and ongoing funding support for the initiative was provided by the Mental Health Evaluation and Community Consultation Unit (Mheccu). Adult Mental Health Division, Ministry of Health Services (MHS), formally agreed to continue support for the initiative in the spring of 2000 until the end of the fiscal year (2001). It was at this time that the Aboriginal Mental Health Committee began its focus on and this draft discussion paper as the Aboriginal Mental Health 'Best Practices' Working Group.

The committee membership has changed and expanded over the past 18 months, however, the recommendations described below are not necessarily considered a representative view of Aboriginal perspectives. This discussion paper represents the discussions of the working group based on their viewpoints and the current literature available in the area of Aboriginal Mental Heath, including information from the Assembly of First Nations (AFN) and Inuit Tapirisat of Canada (ITC) Environmental Scan (Federal) and the Royal Commission Reports on Aboriginal Peoples. It is intended for distribution across the province for input in focus group format. As well input will be sought via email, fax etc.

CONCERNS *continued*

AREAS OF PARTICULAR CONCERN WHICH GENERATED THE RECOMMENDATIONS OF THE COMMITTEE ARE AS FOLLOWS:

■ There are many agencies/organizations offering components of mental services with minimal coordination between them.

■ There is no core Aboriginal Mental Health program federally or provincially.

■ There are few formalized systems of case coordination, including a lack of protocols re: information sharing across agencies. Client/patient confidentiality is highly valued by providers as well as the provision of seamless, coordinated care. As a consequence, this is considered an important matter.

■ Federal/ Provincial/ Regional jurisdictional debates continue to be a major barrier to service provision to First Nations and other Aboriginal people. Also, in relation to regional boundaries, little acknowledgement is given to the barrier those boundaries impose to those individuals moving between reserve and urban life.

■ Interministerial jurisdictional debates also continue to be a serious barrier to the provision of service.

■ There is a lack of coordinated services related to the well-being of children.

■ Distinctions between the urban and rural experience remain poorly understood.

■ There is a lack of education, training and support for mental health care providers on the front-line.

■ The partial positions available through transfer are inadequate.

■ There is not enough resource to meet the mental health concerns, in particular, the needs of those people affected by the residential schooling system.

■ Overall, there is a lack of coherent mental health programs.

■ The traditions, values and health belief systems of First Nations and other Aboriginal people are poorly understood by many providers and often are not respected or considered. Aboriginal knowledge tends to be devalued and marginalized.

CONCERNS *continued*

AREAS OF PARTICULAR CONCERN WHICH GENERATED THE RECOMMENDATIONS OF THE COMMITTEE ARE AS FOLLOWS, *continued*:

- Data management is not done consistently across agencies. Information systems regarding available resources are missing.

- There is a lack of timely, coordinated treatment and support for individuals with alcohol and substance use issues (in particular, across agencies and communities) as well as for those people with serious mental illness who require immediate intensive care. A lack of funding for travel to external treatment facilities also has been a barrier to care.

- Although there is some follow-up provided for individuals returning from treatment centres outside of the community, there are few rehabilitation programs. Individuals often find themselves returning to the same set of circumstances that precipitated and/or perpetuated the problem.

- Housing is considered to be one of the most pressing social issues affecting mental health. Youth without safe homes and elders requiring varying levels of supervised living and care have been identified as priority concerns. Safe housing for women also has been identified as an important issue in several communities. Although the hospital sometimes serves the latter function, many women continue to express the need for refuge for themselves and their children to prevent further abuse/assault.

RECOMMENDATIONS

Mental health services and programs must be supported by a reform process which recognizes the unique needs of First Nations and other Aboriginal people.

The following are priority needs:

1/ Mental Health Services which are:

■ Culturally relevant/ safe, i.e., respectful of the diverse 'cultures' of individuals, families and communities

■ Strength-based

■ Integrated, that is complete 'the Circle of Care'

2/ Support for Mental Health Community-Based Initiatives (including Suicide Prevention Programs)

3/ Accredited Education and Training

4/ Research

■ Evidence-based practices i.e., what is working?

■ Data collection regarding suicide

■ Linkages with the Health Information System to ensure baseline data in keeping with standards across the country.

■ Consultation with National and Provincial mental health bodies and First Nations and other Aboriginal people to develop program standards, outcome measures and evaluation criteria and methods

PREAMBLE

In July 1999, the first meeting of the Aboriginal Mental Health Committee was held at the Longhouse, UBC. The meeting was sponsored and initiated by the Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC, in response to concerns that mental health service delivery, including the field of community psychiatry, did not adequately – or appropriately – deal with the needs of Aboriginal people. At the initial meeting, the membership appointed an Aboriginal person to facilitate the meetings and ongoing funding support for the initiative was provided by Mheccu. Adult Mental Health Division, Ministry of Health, formally agreed to continue support for the initiative in the spring of 2000 until the end of the fiscal year (2001). It was at this time that the Aboriginal Mental Health Committee began its focus on Aboriginal Mental Health 'Best Practices' and this draft discussion paper.

The committee membership has changed and expanded over the past 18 months, however, the recommendations described below are not necessarily considered a representative view of Aboriginal perspectives. This discussion paper represents the discussions of the working group based on their viewpoints and the current literature available in the area of Aboriginal Mental Heath, including information from the Assembly of First Nations (AFN) and Inuit Tapirisat of Canada (ITC) Environmental Scan and the Royal Commission Reports on Aboriginal Peoples. It is intended for distribution across the province for input in focus group format. As well input will be sought via email, fax etc.

It is expected that the information collected across the province will inform the development and implementation of an Aboriginal Mental Health Plan in B.C. consistent with the plan being developed by the AFN and ITC Mental Health Working Group (Federal). This plan also is intended to intersect with the current B.C.'s Mental Health Reform Best Practices documents re: Housing, Assertive Community Treatment, Crisis Response/ Emergency Services, Inpatient/ Outpatient Services, Consumer Involvement and Initiatives, Family Support and Involvement, Psychosocial Rehabilitation and Recovery and Rural and Remote as well as the Suicide Prevention document. The Aboriginal Mental Health Plan will be made available to all of the health authorities across B.C.

ABORIGINAL MENTAL HEALTH

Regardless of the variations in the acculturation histories and health beliefs of First Nations and other Aboriginal people across Canada, many hold to the view that health refers to a person's whole being. The notion of health captures aspects of physical, mental, emotional and especially spiritual being. Equally important, it captures the context in which the individual and community lives, that is, both the physical and social environment. In illness terms, the First Nations people believe that illness is the outcome of a lack of balance or harmony in one or more of the physical, mental, emotional or spiritual aspects of life.

CONTEXTUAL FACTORS

European-introduced disease; evolutionary shifts in diet; the Indian Act with its attendant assimilationist policies including reserves and residential schools; and, integration and current devolution policies all have contributed to the disruption to First Nations cultures and as a consequence, their [mental] health.

There is no lack of data describing the disproportionate burden of [mental] health problems suffered by First Nations people[2]. Brant (1994) identifies the following mental health issues in Native community across Canada: widespread substance abuse, including alcohol, solvent inhalation, street drugs and prescription medications; family violence, including spousal assault and the sexual and physical abuse of children; and depression and hopelessness, often culminating in suicide. These issues are identified consistently across many of the Aboriginal communities in Canada (CUPPL, 1995; Elias & Greyeyes, 1999; Jodoin, 1997).

Mental health problems are also clearly connected to the law – " the vast majority of Aboriginal crimes, for example, are petty offences associated with alcohol abuse, or involve forms of minor assault that are connected to interpersonal problems" (Warry, 1998, p. 130).

1 Unless otherwise stated, this section sited directly from Smye, 2000.

2 It must be remembered, however, that most of the epidemiological literature is based on data collected from status populations (Inuit and First Nations people living on reserve). According to O'Neil's report on the Round Table proceedings, many participants of the Round Table argued that the health of approximately two-thirds of Aboriginal people is not reflected in this data....
.....some Aboriginal regions and communities suffer from health and social problems at far higher rates than others; indeed many Aboriginal communities should be characterized as healthy (O'Neil, 1993a, p. 16). If health service planning is to be grounded in the real needs of Aboriginal communities, an accurate picture of health conditions off reserve and outside the Territories is required.

THE CENTRAL PROBLEM: WHAT WE KNOW

The 1998 Mental Health Plan, 'Revitalizing and Rebalancing British Columbia's Mental Health System', sets out the objectives and strategies for mental health reform designed to promote the optimal mental health and participation of people with mental illness in British Columbia's communities (R.R.B.C., 1998, p.5). This plan is the product of a review of mental health care systems over the past decade as well as an extensive consultative process across the province of British Columbia in an attempt to address the current challenges that compromise quality care for people with mental illness (R.R.B.C., 1998, p. I), that is, those who experience long-term mental illness and disability, and those who experience acute, episodic serious and persistent mental disorder[3].

The overall tenor of the plan is reflective of 'Western' understandings of health and illness and continues to be strongly influenced by psychiatry with its attachment to biomedical traditions, individualistic approaches to treatment and its long-standing history of cultural blindness (Fernando, 1991; Good, 1996) and racism[4] (Fernando, 1991). Although most recently there has been gradual shift to family-focused and community-based care, the mental health system remains aligned with an illness service model. Even where illness service models used across Canada reflect a more holistic, multidisciplinary, and multi-sectoral approach to health, generally this development within western society, does not fully reflect the holistic approaches of Aboriginal traditions (O'Neil & Postl, 1994, p. 81) nor does it recognize or acknowledge the sociopolitical and historical context of Aboriginal health.

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3 'Severe and persistent mental illness' refers to following categories of illness as found in DSM IV (A.P.A., 1994): schizophrenia; affective disorders, including bipolar disorder; anxiety disorder; and, substance use disorder.

4 [We] use racism in the same sense that Fernando (1991) does as essentially about "'institutionally generated inequality' based on concepts of racial difference; although it affects the behaviour of individuals, 'prejudiced people are not the only racists'" (p. 24). As Fernando notes, acknowledgment of difference based on notions of race tends to inscribe patterns of inclusion and exclusion based on colour and/or phenotypic characteristics.

THE CENTRAL PROBLEM: WHAT WE KNOW,
continued

Although many Aboriginal people have constructed a coherent and complex medical system out of disparate biomedical and Aboriginal medical systems, generally speaking, program delivery models which reflect predominately western European concepts of [mental] health and illness have been identified as largely ineffective in responding to the needs of First Nations people (McCormick, 1996; 1998; O'Neil, 1993; Warry, 1998). There is a tendency by First Nations people not to use the mental health services provided by the dominant culture (McCormick, 1996; Trimble and Fleming, 1990). If services are accessed approximately one-half drop out (Sue, 1981) and for many, treatments are not effectual (McCormick, 1996; Trimble & Fleming, 1990). Mental health programs and services designed in keeping with dominant cultural (biomedical) views of mental health and illness, ignore the unique cultural identities, histories and sociopolitical contexts of the everyday lives of Aboriginal peoples, putting them at risk of not having their health care needs recognized and met.

PART 2 WHAT WORKS[5]
COMMUNITY APPROACHES TO [MENTAL] HEALTH PROMOTION

The strength of the social bonds in many Native communities and the willingness to act for the benefit of the group has provided a supportive network where programs flourish[6]. First Nations-chosen partnerships with outside institutions also has provided access to outside expertise and high caliber information drawn from a variety of sources for the enhancement of programs/projects. Community-based initiatives which provide a broad range of treatment, prevention and health promotion strategies appear to 'Work Best'.

5 Unless otherwise stated, this section comes directly from Smye, 2000.

6 Especially in the rural and urban reserves where kinship ties remain strong.

SUICIDE PREVENTION

In the *Choosing Life* document (RCAP, 1993), there are several examples of community responses to the crisis of adolescent suicide, child neglect and abuse. Although somewhat different in their origins, all of the projects/programs had in common the mobilization of whole-community efforts. For example, in response to the high suicide rates on reserve and consequent community distress, the Meadow Lake Tribal Council (MLTC) in northwestern Saskatchewan decided to make child care (a day care centre and home day care) a reality in their community despite numerous obstacles. The organizing committee was instructed by the MLTC executive director to "dream the best child care program" imaginable, and they did. The daycare would be guided by First Nations culture, traditions and values, and would be operated according to the highest standards of education and care in the country. It also would have a training program to certify Aboriginal people in the daycare field. This latter component prompted the MLTC to propose a partnership relationship with the School of Child and Youth Care at the University of Victoria, B.C. to assist in the training of potential staff within the community. Elders also became partners in this project by participating in the process of curriculum development and committing time to teaching in each week of the course.

As a spin-off of this program, child welfare, with its logo *'Children Are Our Future'* became a whole-community issue with numerous positive consequences for the community: As such, the Meadow Lake Tribal Council's child care program only marked the beginning of an expanding vision of health and wellness for its people (RCAP, 1995, pp. 60-64)[7]. Unfortunately, at the time of the RCAP report this program was in jeopardy due to the financial arrangement with the federal government and currently the program looks quite different than at its inception, at least in part, related to this issue[8].

In response to another community crisis (a cluster of seven suicides within the space of less than a year) and the conviction that *'Children are our Future'*, members of the Wikwemikong community on Manitoulin Island mobilized to initiate the development

SUICIDE PREVENTION, *continued*

of a non-medical, alcohol and drug treatment program as well as an independent mental health support service. Five years after these programs began, a study was conducted in which the success of the program was attributed to the multidimensional nature of the program consisting of residential alcoholism treatment, family counseling, community feasts, job creation for youths, and self-esteem enhancement programs in the schools (Fox, Manitowabi, & Ward, 1984; Waldram, et al., 1995). Aboriginal mental health workers were employed to provide crisis intervention as well as liaison with the non-Aboriginal professional health and the social service sector (Waldram et al., 1995, p. 92).

Through its evolution, this program has brought together several aspects of both the biomedical and traditional systems: Notions of 'mental health' promotion and community development were gradually accepted and the emphasis of the clinic has moved from the more biomedical approach of individual treatment (to deal with the crisis of the 70s) to a family treatment and support model aimed at prevention. Today, public education to build awareness of and collective responsibility for mental health and wellness in the form of early detection and intervention as well as community development more generally, are identified by the manager of the program as the key to having a healthier community [and a lower suicide rate]. A strong component of this program is the way in which a formalized volunteer program enlists the support of the many people in the community (RCAP, 1995).

7 One of the spin-offs of the program was that many individuals developed excellent parenting skills and have served as role models in their community even though many of them would not go on to become child care workers in their community. Also, it was found that home day care worked best on reserve because few people had the financial resource to spend on the larger day care service (Telephone contact with the MLTC Health Clinic nurse coordinator, August, 1999).

8 Telephone contact with the MLTC Health Clinic nurse coordinator, August, 1999.

ALCOHOL AND DRUG PROGRAMS

NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM

The National Native Alcohol and Drug Abuse Program NNADAP was one of the first federal health programs to be devolved to Aboriginal administrative authority (O'Neil et. al., 1999). Since its inception, hundreds of community-based alcohol prevention and community treatment projects have been set up across the country. According to O'Neil et al. "it has contributed to the emergence of some of the most significant Aboriginal health initiatives in the country including: the Four Worlds Development Project, the Nechi Insitute and the Alkali Lake prohibition strategy" (p. 11). Although there have been mixed reviews in relation to the extent to which the program truly has been responsive to community needs, the most recent review suggests that " the majority of people feel that NNADAP does serve community need". However, it also concludes that to remain effective, the NNADAP workers need "infrastructural support, such as training, better recognition by management and external agencies, and increased resources" (p. 11).

ALKALI LAKE

The Alkali Lake program in B.C. is an example of a social/health initiative which has used a model of community mobilization to prompt improved health status[9]. In response to the devastating effects of alcohol and its impact in their community, Andy and Phyllis Chelsea mobilized their community towards a goal of sobriety (Johnson & Johnson, 1993; Waldram et al.,) Based on an historical study of the interventions used in this program between 1972 and 1993 as well as the data gathered in the research study, " A Study of Sobriety and After-Care at Alkali Lake Reserve-1993", it has been concluded that there were a couple of essential components to the success of its success: community-level interventions through the authority of the band chief and band social worker and the after-care component to assist people at a personal level to maintain sobriety. Interestingly, although not present at the initiation of the program in the early 1970s, over the past 20 years, this program has increasingly incorporated aspects of traditional healing such as the sweat

9 A film entitled *The Honour of All – The Alkali Lake Story* was produced in 1985. This film offers a message of hope for communities "who are still caught in a trap of poverty, hopelessness and alcohol". (Johnson & Johnson, 1993, p. 228).

ALCOHOL AND DRUG PROGRAMS, *continued*

ALKALI LAKE, continued

lodge and pipe ceremony as part of a purposeful movement to revive and relearn Aboriginal spiritual ceremonies (Johnson & Johnson, 1993, p. 229). The incorporation of these traditional practices has been thought to have had an influence on the overall improved sense of solidarity in this community.

Although this program has been considered quite effective, [we] think it is important to note that both this program and the Nechi Institute programs argue for a disease model which incorporates a culturally adapted version of AA. Obviously the devastation that has accompanied alcohol and drug use across Aboriginal communities (and in particular this community) has prompted this approach (abstinence), however, this model is not useful for everyone. Many programs across Canada are incorporating 'harm reduction' strategies to address this issue.

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE

Common to the RCAP (1996) discussions regarding health and healing was the expressed view that holistic approaches need to be incorporated into community healing centres. "For example, if the health problem presented is an infant's diaper rash, the need could be for an adequate water supply to do laundry; a holistic service would respond accordingly" (p. 238). Clear distinctions were made between centres which would offer services (treatment centres) and those dedicated to holistic approaches, that is, healing centres. Although these community-based centres might look somewhat different across locations based on their various needs, it was generally felt that they would include a broad spectrum of services and approaches including both medical and traditional healing and other culture-based programs. The following is an example of a community-based centre offering holistic approaches with some reported success (Postl et al., 1990 [as cited in RCAP, 1996, p. 341]).

WILLIAMS CHARLES BAND, COMMUNITY HEALTH CENTRE (MONTREAL LAKE)

As a reponse to poor living conditions, over crowded households and health problems including skin conditions, respiratory disease and addictions, the Montreal Lake reserve opened a healing centre in 1987. Central to this initiative was the use of families to act as health promoters and providers in the support of family relations. The centre offered school-based immunization, alcohol education and prenatal care and education. Pivotal to the delivery of those services was the bolstering of families as participants in community healing. This "resulted in an increased sense of security about health, public participation, preventive health care and family management of minor illnesses. People who used to live in fear, isolation and despair had a greater sense of belonging" (National Forum on Health, 1997)[10].

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10 In their study in Montreal Lake, Moore, Forbes and Henderson (1990) found that people reported thirteen direct or indirect healthy outcomes: "People feel the reserve is safer; People feel better cared for; Confidentiality and trust of health care staff has been enhanced; Elders feel better cared for; Healthy changes in lifestyle were reported; Children were hospitalized less often; Less violence was reported in the community; There was less alcohol and more "dry" activities; Coordination with hospitals was better; More comprehensive services were provided; There were better emergency and acute care services; Earlier intervention in the disease cycle was reported, with projected lower hospitalization rates; and, Health center staff were perceived as role models for community health development" [also cited in O'Neil & Postl, 1994, p. 78].

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE, *continued*

FISHING LAKE METIS SETTLEMENT

Although not operating a healing centre per se, this settlement also used a community-based family centered approach with success. The use of the healing circle was believed to be crucial in the improvements experienced as a consequence of this initiative.

This three year community development initiative focused on reducing high levels of violence. During the three years of the project, 100 of 460 members of the settlement participated in self-esteem enhancement and personal empowerment training. Weekly healing circles were run by trained volunteers. These efforts were funded by the settlement council and government. The healing circles resulted in the resurgence of spirituality, the closure of local bars, a renewal of community ties and economic development. Many residents are now pursuing education, small business endeavours and addiction-free lifestyles. Role modeling by a core group of residents influenced the health of this community (National Forum on Health, 1997). The Fishing Lake Metis Settlement council also imposed a no smoking bylaw in 1993.

As mentioned previously kinship/family is considered to be a core institution of Aboriginal society. "It is central to all social needs, including governance, economy, education and healing" (RCAP, 1996, p. 244). Although family often plays an important role in non-Aboriginal community, individual rights and autonomy often take precedence over family ties and obligations. Many RCAP participants (1996) felt that family-oriented healing centres and residential programs (healing lodges) are important for the recovery of Aboriginal people who have become overwhelmed by social, emotional and spiritual problems.

Although there are several healing lodges across the country, many of these lodges do not incorporate a family treatment component, are not easily accessible to urban Aboriginal populations and/or due to funding constraints, "offer only individual therapies which exclude

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE, *continued*

FISHING LAKE METIS SETTLEMENT, *continued*

attention to the broader social, emotional and spiritual approaches to healing" (RCAP, 1996, p. 243). At the time of the RCAP discussions several communities were planning residential programs to meet the expressed need for culturally-appropriate residential facilities which would incorporate family treatment and support and address a variety of issues[11] and several existing services were considering how they might include family care into their programs.

NECHI INSTITUTE AND POUNDMAKER'S LODGE

The *Nechi* Institute and *Poundmaker's* Lodge in Alberta which have an excellent reputation for training counselors and treating addictions (using an AA model with the goal of abstinence), offer a wide range of services which include incorporation of traditional healing practices and other culture-based approaches. However, many Aboriginal people continue to access the medical services in urban centres for addictions treatment.

11 Including residential facilities for women who require a safe place away from their partners/husbands (RCAP, 1996).

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE, *continued*

THE CASE OF THE ANISHNAWBE HEALTH CENTRE

In terms of urban health centres, Anishnawbe Health in Toronto is a culture-based multi-service health centre in downtown Toronto which has been operating with since 1989 with the support of the Ontario Ministry of Health and the City of Toronto. *"No funding is provided by the Federal government"* (George & Nahwegahbow, 1995, p. 242) [italics mine].

Many different Aboriginal communities (status and non-status) with varying socioeconomic backgrounds are represented in the population who access the services and programs and as such, care delivery is offered in Cree, Ojibway and English. The common theme amongst the people served by Anishnawbe Health is that they are searching for "a sense of Aboriginal identity" and healing – mentally, emotionally, spiritually and physically. In this setting, Aboriginal people are exposed to an understanding of their political, social and economic situation from an historical perspective and are assisted in learning about "the traditional ways through exposure to ceremonies, elders, traditional healers and teachings etc." (George & Nahwegahbow, 1995, p. 242). Dedicated to full recovery, health and well-being of the community, the centre provides timely education and health promotion. The centre's focus is to help prevent STDs, HIV/AIDS and to promote proper nutrition and a healthy lifestyle.

The notion of being 'culturally-based' in this setting translates into a service which places traditional healing approaches and healers at the centre of the organization as the primary healing methods with western practitioners as secondary helpers to the traditional healers[12],[13].

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12 The centre is grounded in the medicine wheel (O'Neil & Postl, 1994, p. 77).

13 However, funding arrangements do not reflect this commitment to traditional healing systems. The annual budget for physicians (1995) is almost $300,000 and for the traditional healing program is $45,000[13]. As well, the Medical Services Branch continues to reject applications for funding to bring healers into the centre. Federal responsibility for status First Nations people living off reserve remains an issue. Also problematic in relation to the issue of healers is the scarcity of traditional healers, teachers and elders who are credible and willing to travel to the urban setting.

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE, *continued*

VANCOUVER NATIVE HEALTH SOCIETY

The Vancouver Native Health Society has developed clinic and outreach services to a diverse group of First Nations and other Aboriginal people in the Downtown Eastside, Vancouver, similar to the Anishnawbe Health Centre in Toronto. In addition, over the past year, the Residential School Survivor Healing Centre has been opened, offering a broad range of services including counseling, acupuncture, traditional healing, support groups, recreational activities and healing circles.

[14]SAL'I'SHAN INSTITUTE: EDUCATION AND CARE FOR THE CAREGIVERS

In the late 1980s, the Sal'i shan Institute designed, developed and began to deliver residential education/training opportunities for workers doing community health education, counseling, and associated work, including treatment and prevention of addictions.

Their programming begins with learning about one's personal inner world, getting in touch with unresolved issues, learning how to learn and finding a personal path towards increased wellness and effectiveness. To complement and supplement this process, learns learn more about their family and community history, and the balance of forces in their lives, generation to generation, that have contributed to their colonization.

As learners learn more about personal growth processes and theories of human and social behaviour, they apply what they are learning to their own growth and development. Such a strategy contributes to understanding ways and means to promote decolonization.

14 Bill Mussell, July, 2001, 'Examples of 'Best Practices'.

HEALING CENTRES AND LODGES: COMMUNITY-BASED HOLISTIC CARE, *continued*

SAL'I'SHAN INSTITUTE: EDUCATION AND CARE
FOR THE CAREGIVERS, *continued*

After they increase their awareness, understanding of knowledge of communication, and their oral and writing skills, they move into studies of "violence, abuse and addictive behaviours" within families and communities, wholistic health and major illnesses, counseling skills, planning and community development.

Critical to the success of the learners who have completed this Institute's program is the residential nature of the education and training. Learners share accommodation, share meals together, work together on assignments, play together and learn together in the classroom. The manager of the teaching/learning becomes a member of the group who shares his/her personal resources, while mediating the learning in ways that increase learning skills, and support capacity building.

Early in their studies, the learners discover that they share a similar personal, family and community history, and that they are able to actively support one another in the 'self-discovery' process. Their interaction becomes increasingly reciprocol as they begin to gain feelings of satisfaction from taking risks. Feeling more and more safe in the group, each member begins to function more and more like healthy family members.

For most learners in this residential teaching/learning environment for 3 consecutive weeks each time, their first experience exposes them to a new kind of support. This support is anchored in life experiences with other adults, their fellow learners, who enjoy relative wellness, and therefore possess the ability to 'give of self' in ways that are new for many others in the group. Development of mutually supportive relationships informally and non-formally, contributes immeasurably to the quality of learning that takes place in the more formal teaching/learning environment of the classroom. The Sal'i'shan Institute practices 'transformative education'.

ABUSE RESPONSES

[15]HOLLOW WATER COMMUNITY HOLISTIC CIRCLE HEALING

In the mid-1980s, workers in health , education and welfare came together as a resource group concerned about addictions, sexual abuse, and other kinds of violence in their community. "As we progressed in our own healing we began to prepare ourselves to assist in the healing of others. We made a real effort to learn more about sexuality, the nature of sexual abuse, and the healing process." Then in 1986, there was a disclosure in the community. Action taken resulted in the creation of a strategy to address violence and abuse (Community Holistic Circle Healing [CHCH]: An Approach, Summary May 12,1997).

"The Community Holistic Circle Healing is our attempt to take responsibility for what is happening to us, to use the power of the circle to bring ourselves back into balance, to make our community a safe place for future generations. Community Holistic Circle Healing stems from our beliefs that victimizers are created, not born. That we have to break the cycle of abuse now, and that given a safe place, healing is possible and will happen" (Community Holistic Circle Healing: An Approach, p.2).

The traditional way to break this cycle was for the community to:

1/ Bring the problem out into the community;

2/ Protect the victim in such a way as to minimally disrupt functioning of the family and community;

3/ Hold the person accountable for his/her behaviour; and,

4/ Provide the opportunity for balance to be restored to all parties.

15 Bill Mussell, July, 2001, 'Examples of 'Best Practices'.

ABUSE RESPONSES, *continued*

[15]HOLLOW WATER COMMUNITY HOLISTIC CIRCLE HEALING, *continued*

This community has operationalized a 13 step process to address the uniqueness of the needs of the victim, victimizer, families involved, and the workers associated with incident. The process contributes to the education of all people present about the seriousness and the dynamics of the offence. It sets the emotional stage necessary for change in attitudes to take place. It is, in effect, a mini-workshop, and can include lectures, videos and handouts.

The Hollow Water process addresses prevention, intervention, and healing. The process is owned and supported by the community members themselves. Offenders who choose the Hollow Water process become an integral part of the community, with desired supports. The whole process identified with the 13 steps may take more than a few years. Movement from denial to accountability is demonstrated by candidates who chose the Hollow Water CHCH process which enjoys significant success. Many candidates who have completed the program, have become desirable community citizens, and a resource for the process.

15 Bill Mussell, July, 2001, 'Examples of 'Best Practices'.

PART 3 COMMUNITY
COMMUNITY-BASED FINDINGS

ABORIGINAL MENTAL HEALTH/ WELLNESS: THE FOCUS

'Healthy Children' is the central focus for many Aboriginal people in B.C., alongside healthy families and adults and elders. For many First Nations and other Aboriginal people, healing means dealing with approaches to wellness which draw on the culture for inspiration and means of expression (Gladstone, 1994 re: Heiltsuk healing, p.8).

PRINCIPLES

In keeping with the **relational** perspectives of many Aboriginal people, the committee would advise that the following four principles be adhered to in all discussions related to Aboriginal [mental] health/ wellness programming (Royal Commission Report on Aboriginal People, 1996):

1/ Mutual respect
2/ Mutual recognition
3/ Mutual sharing
4/ Mutual responsibility

In addition to the four principles, the following principles and values are viewed as key to the achievement of 'Best Practices':

HOLISM/ BALANCE

According to most First Nations traditions, mental health problems are a reflection of imbalance or disharmony in the circle of physical, emotional, intellectual and spiritual dimensions of the self. These aspects of the self are closely tied to both the physical and social environments (RCAP, 1995, p. 21). The medicine wheel, which is used widely across Native communities, symbolizes wholeness and the importance of balance (Mussell, 1994). Common to the RCAP (1996) discussions regarding health and healing was the expressed view that holistic approaches need to be incorporated into community healing centers. Therefore, the root causes of mental health problems such as intergenerational trauma, poverty, unemployment and lack of housing need to be addressed alongside the consequent mental health issues, that is, depression, substance use, abuse, PTSD, and anxiety disorders.

Therefore, instead of defining "serious" mental health problems as only comprising the medically defined disorders (DSM IV), many Aboriginal caregivers and policy analysts feel it is more appropriate to focus on mental health issues which are posing the most serious threat

PRINCIPLES, *continued*

HOLISM/ BALANCE, *continued*

to the survival and health of Aboriginal communities. This does not mean that Aboriginal people do not live with schizophrenia, bipolar disorder and other affective disorders and that these are not of concern to Aboriginal communities but rather that these are not a threat to the survival of Aboriginal people (Smye, 2000). Holistic healing services are being sought by many Aboriginal people and often include: psychological/ counseling services, individual and/or group healing re: alcohol and/or drug, traditional/ spiritual healing, acupuncture/ massage and herbal remedies.

[16]CLIENT-FOCUS

– clients/patients will be invited to participate in the design of mental health services as they develop, i.e. their knowledge and input is valued;

COMMUNITY/ FAMILY-CENTERED

– the relational aspect of people is considered to be of primary importance and often extends beyond the family and friends to the larger community;

SELF-DETERMINATION

– a collective of people constituting a community is viewed to be self-governing when its members are responsible and accountable to each other for the lifestyle they share. Being self-determining and self-sufficient are key to the well-being of Aboriginal individuals and communities, therefore, empowerment models are valued. Building personal, family and community capacity is an essential aspect of working towards self-governance and wellness;

16 The following principles and values are also drawn from the document by Jorgenson, L. & Smye, V. (2000), *'Working Towards an Integrated Central Coast Mental Wellness Plan'*.

PRINCIPLES, *continued*

CO-RELIANCE

– members of a soccer team who rely upon each other's skills without expecting more of one player because of his/her exceptional abilities are co-reliant. They share responsibilities to win the game much in the same way that whole families, in more traditional times survived 'on the trapline' for weeks at a time. Each member believed in his /her ability to do his/her job, believed that other members would do their job, and believed that the whole family would succeed in its undertaking;

COMPREHENSIVENESS

– provision of a range of assessment, triage, treatment and consultation programs;

INTEGRATED AND COORDINATE

– services and programs are integrated at all levels, micro, meso and macro;

ACCESSIBLE

– services are available to all individuals and their families, delivered in a timely fashion in locations and at times designed to meet individual and family needs with clear points of entry into the system and formalized referral arrangements;

ACCOUNTABLE

– services undergo ongoing monitoring and evaluation activities designed to ensure the provision of quality service;

ETHICAL

– services are respectful of the rights of persons, e.g. the right to confidential accessible and safe services;

SUSTAINABLE

– services are designed in keeping with the idea that the communities will be able to sustain them, e.g. a change in personnel will not mean that the service will cease to exist;

PRINCIPLES, *continued*

HUMANENESS

– services are designed so that all persons will be treated with respect and dignity, regardless
of the presenting features;

FUNCTIONAL/PRACTICAL

– the services are a good fit with individual and community need; and

CULTURALLY SAFE/RELEVANT

– services are reflective of respect for the traditions and values, i.e., the cultures of
First Nations and other Aboriginal people, including their notions of spirituality. Cultural
congruence ensures that the client's value system, life experiences, and expectations about
the therapeutic process will be integrated into the therapeutic process even when the client is
not fully conscious of these factors. Because of the varied acculturation histories and practices
of First Nations and other Aboriginal people, 'cultural relevance' needs to be articulated by
each community and/or individual. It is by developing meaningful relationships with one
another that we come to understand the particular 'culture' of individuals, families
and communities.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES'

It is a generally accepted view that although B.C.'s Mental Health Reform 'Best Practices' documents (2000) will be helpful in providing guidelines for mental health planning across the province, the rather crucial lens of culture is missing. As a consequence, in critiquing these documents, we make the following general comments.

Consistent with efforts in other areas in Canada, B.C. has committed to targeting mental health resources and services to the approximately 3% of adults with the most disabling forms of mental illness usually associated with the DSM IV diagnostic categories of schizophrenia, bipolar disorder and other affective disorders. Because of the usual association of "serious mental illness" with diagnostic categories (DSM IV), the mental health needs of Aboriginal people have been largely glossed over or ignored. Also, the dominance of ideas in the current health system which separate mental health issues from other aspects of the self as well as into categorizations which delineate 'adult mental health' from 'child health' and 'alcohol and drug' has precluded examining the realities of Aboriginal mental health concerns in a culturally relevant/ safe fashion – concerns which actually are threatening the survival of some Aboriginal communities.

"In the summer of 1999, the Ministry of Health released *Criteria for identifying persons with the highest priority for service.* These criteria conveyed a definition of "serious mental illness" that was based, not on psychiatric diagnosis but, on the degree of disability or functional impairment associated with a mental disorder" (Mheccu, 2001). Although, it is our hope that this kind of shift will assist in the struggle to gain support for Aboriginal Mental Health/ Wellness in B.C. by focusing on function rather than diagnosis (e.g., B.C.'s Mental Health Reform Best Practices 'Psychosocial Rehabilitation and Recovery'), it still fails to adequately address the divide across health which marginalizes Aboriginal health needs, e.g., the exclusion of alcohol and drug from mental health and tends to be 'illness' focused.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES', *continued*

The second ideological underpinning of the Best Practices documents which runs counter to Aboriginal perspectives is the emphasis on the individual. As mentioned previously, family and community are an essential aspect of the self for most Aboriginal people. While recognizing that the 'Family Support and Involvement' document is an attempt to point to the importance of that aspect of a person's life, for Aboriginal people integration of family and community into all aspects of mental health planning is essential. The relational language of an Aboriginal worldview generally is missing from the 'Best Practices' documents.

Aboriginal Mental Health 'Best Practices' needs to reflect a worldview consistent with Aboriginal understandings of and response to mental health and illness.

Best Practices Documents:

Housing

■ It is agreed that housing is one of the most important considerations in mental health planning. Homelessness is one of the root causes of mental health problems for Aboriginal people. Those persons with serious mental health concerns who are unable to access appropriate, safe, affordable and secure housing will have a significantly reduced quality of life and an increased need for and reliance on emergency, support and treatment services. Some Aboriginal people live in abject poverty. These issues can no longer be ignored.

■ Many Aboriginal reserve communities lack adequate housing and as a consequence, special housing initiatives such as supported housing for those with mental health concerns and safe housing for women and children, elders and youth are largely unavailable. Addressing the housing issue demands integrated approaches which cross jurisdictional divides and address the politics of life on reserve. For example, strong linkages need to be made with Band Councils. Also, models of housing for supported/ assisted living need to fit with the family and community orientation of Aboriginal people.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES', *continued*

Best Practices Documents, continued:

Assertive Community Treatment

■ This is a service delivery model that provides flexible, comprehensive services to individuals with multiple and complex needs. ACT is distinct from other models of case management in its key components, which include a low staff-to-consumer ratio, a *team approach*, consumer directed delivery of care, assertive outreach and continuous services. Participants suggested that this model of service delivery would fit for persons with complex mental health issues who require follow-up for an extended period of time. The model described in small communities would fit for many of the Aboriginal reserve communities because of the small number of people who would require this kind of care. Again, ACT needs to fit with the family and community orientation of Aboriginal people.

Crisis Response/Emergency Services

■ Definition of mental health crisis/ emergency needs to include child abuse, family violence, sexual assault, suicidal ideation/ attempt and alcohol and/or drug use which has resulted in self-harm behaviour as these are the most frequently cited mental health emergency situations in Aboriginal community.

■ As outlined in this Best Practices document (pp. 40-41), the most challenging aspect of this service for Aboriginal people relates to how it can be realized in rural and remote communities. As suggested these services need to be integrated into a comprehensive framework of community development and specific capacity building initiatives within community to ensure their success.

■ In some communities, crisis intervention staff will be lay community members trained through outside programs (preferably, they come into the community to do the training) and supported by mental health provider staff. 'Care for the Caregivers' is an essential element of these programs.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES', *continued*

Best Practices Documents, continued:

Crisis Response/Emergency Services, *continued*

■ Services need to be culturally relevant/ safe (for example, they need to include access to translators – some elders do not speak English). Many Aboriginal people complain of feeling unsafe when accessing emergency services.

Inpatient/Outpatient Services

■ One of the most consistently voiced barriers related to accessing inpatient/ outpatient services is admission and discharge criteria. For example, often alcohol and/or drug use will mean denial of service, including a complete assessment. Numerous examples have been given in which Aboriginal people have been turned away from receiving assessment and appropriate interventions because of this issue. Although the dually diagnosed are acknowledged as being appropriate for the mental health system within this document, those with a primary mental health issue related to alcohol and drugs without an apparent mental health diagnosis would not.

■ Many Aboriginal people have felt that inpatient and outpatient services do not reflect the value of Aboriginal knowledge. Services offered do not incorporate the broad range of approaches to [mental] health and some health providers are not open to explore the options important to Aboriginal people. Also, assessments are not always sensitive to the unique realities of Aboriginal practices (e.g. spiritual practices). Secondary services in general hospitals as well as tertiary psychiatric services need to be culturally relevant/ safe. Racism needs to be addressed in these centers.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES', *continued*

Best Practices Documents, continued:

Inpatient/Outpatient Services, *continued*

■ Acute care services need to be provided in a way that is respectful of privacy and confidentiality. Effort needs to be made to provide consistent care across providers with minimal disruption. It must be remembered that Aboriginal people often are traveling great distances at great inconvenience.

■ Inpatient services need to include residential programs which focus on the most pressing mental health concerns for Aboriginal people – including alcohol and/or drug use.

■ Outpatient services need to include long-term ongoing counseling support for persons traumatized by residential and/or boarding school experiences.

■ It is agreed that integration is an essential element in the provision of 'Best Practices' in Mental Health.

Family Support and Involvement

■ As mentioned, this is an integral aspect of care for most First Nations and other Aboriginal people and would be integrated into all aspects of programming and service delivery. "The family is the heart of our lives and our communities" (Ktunaxa Kinbasket Tribal Council & East Kootenay Health Authorities, Memorandum of Understanding, 'Healthy People in Healthy Families in Healthy Communities', March/April 2001).

Consumer Involvement and Initiatives

■ Client-focused care is strongly supported. Self-determination and reliance on working from one's inner capacities is encouraged.

INTERSECTION WITH B.C.'S MENTAL HEALTH REFORM 'BEST PRACTICES', *continued*

Best Practices Documents, continued:

Psychosocial Rehabilitation and Recovery

■ Community treatment programs are a preferred mode of treatment for many Aboriginal people. This component of mental health care has been established to provide treatment/intervention for short-term and longer-term care, sometimes in a residential setting. Such programs usually use an interdisciplinary team approach to psychosocial rehabilitation and recovery and to provide support and individualized treatment plans. It is important to consider assessment tools carefully to ensure they are culturally relevant/ safe.

■ The care provided in the treatment program is different from the psychiatric care focus of a hospital inpatient psychiatric unit in that this program provides treatment and interventions that enable a person to gradually attain the vocational, intellectual and communicative skills necessary for successful re-integration into the community. Employment opportunities are limited on reserve and in other rural and remote areas, therefore, persons living in these areas present special challenges. Capacity building in community needs to go hand in hand with efforts to provide psychosocial rehabilitation.

■ The community treatment model has several advantages. Firstly, the persons requiring this type of treatment can remain closer to their communities and receive treatment in a less clinical environment. This is especially important for [First Nations[17]] people whose families and community are important partners in treatment and rehabilitation. Secondly, this kind of treatment program is able to integrate the whole family in the treatment processes, and finally, community treatment programs can integrate holistic and traditional approaches to mental health in their treatment plans . Interestingly, the Royal Commission on Aboriginal People strongly recommends the development of a network of family-oriented "healing lodges" for residential treatment oriented to family and community healing.

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17 We bracket First Nations to indicate that we know that many non-Aboriginal people also place value on family and community, however, living on reserve makes this a qualitatively different experience for the First Nations people.

PART 4 MEETING
MEETING THE CHALLENGES

CHALLENGES

- There are many agencies/organizations offering components of mental services with minimal coordination between them.

- There is no core Aboriginal Mental Health program federally or provincially.

- There are few formalized systems of case coordination, including a lack of protocols re: information sharing across agencies. Client/patient confidentiality is highly valued by providers as well as the provision of seamless, coordinated care. As a consequence, this is considered an important matter.

- Federal/ Provincial/ Regional jurisdictional debates continue to be a major barrier to service provision to First Nations and other Aboriginal people. Also, in relation to regional boundaries, little acknowledgement is given to the barrier those boundaries impose to those individuals moving between reserve and urban life.

- Interministerial jurisdictional debates also continue to be a serious barrier to the provision of service.

- There is a lack of coordinated services related to the well-being of children.

- Distinctions between the urban and rural experience remain poorly understood.

- There is a lack of education, training and support for mental health care providers on the front-line.

- The partial positions available through transfer are inadequate.

- There is not enough resource to meet the mental health concerns, in particular, the needs of those people affected by the residential schooling system.

- Overall, there is a lack of coherent mental health programs.

- The traditions, values and health belief systems of First Nations and other Aboriginal people are poorly understood by many providers and often are not respected or considered. Aboriginal knowledge tends to be devalued and marginalized.

- Data management is not done consistently across agencies. Information systems regarding available resources are missing.

CHALLENGES, *continued*

- There is a lack of timely, coordinated treatment and support for individuals with alcohol and substance use issues (in particular, across agencies and communities) as well as for those people with serious mental illness who require immediate intensive care. A lack of funding for travel to external treatment facilities also has been a barrier to care.

- Although there is some follow-up provided for individuals returning from treatment centres outside of the community, there are few rehabilitation programs. Individuals often find themselves returning to the same set of circumstances that precipitated and/or perpetuated the problem.

- Housing is considered to be one of the most pressing social issues affecting mental health. Youth without safe homes and elders requiring varying levels of supervised living and care have been identified as priority concerns. Safe housing for women also has been identified as an important issue in several communities. Although the hospital sometimes serves the latter function, many women continue to express the need for refuge for themselves and their children to prevent further abuse/assault.

RECOMMENDED PRACTICES

Strength-Based

Beginning from the position of the strengths of individuals, families and communities is strongly supported in Aboriginal traditions (Van Uchelen et al., 1997; Waterfall et al., 1994).

Integration: 'Completing the Circle of Care'

As a concept, integration is usually perceived as the bringing of people of different racial or ethnic groups into unrestricted and equal association, as in society or an organization. In contrast with assimilation, integration supports the retention of cultural distinctiveness/ uniqueness.

This concept is also applied to the delivery of programs and services, especially in communities that value the family and community. In the case of First Nations, three different levels of programs and services are identifiable: the macro, meso and micro, when considering the importance of integrated delivery.

At the macro level, decisions are made by the federal and provincial governments, as part of respecting responsibility for the well-being of First Nations and other Aboriginal peoples. Jurisdictional debates between these levels of government related to mental health services and programs impacts the ability to offer integrated services and programs and ultimately the well-being of Aboriginal people. We recommend that this issue be addressed by the new Provincial Government's Mental Health Minister of State. In addition, interministerial approaches need to be supported to address issues of poverty, unemployment and poor housing which plague many Aboriginal communities. Also, decisions and actions taken by regional levels of government and non-government organizations deserve scrutiny by leaders who value maximization of outcomes.

At the meso level, integration needs to occur between hospital and community mental health programs and services. "*Best Practices in Mental Health Reform* promotes

RECOMMENDED PRACTICES, *continued*

Integration: 'Completing the Circle of Care', *continued*

the integration of mental health services across the hospital and community, from both administrative and clinical perspectives. It recognizes breaking down silos in the funding and management of mental health care, allowing for a broader review of systems issues and consumer needs" (Inpatient/ Outpatient Services, p. 12). The ability to offer integrated services hinges on the ability to establish structures which support integration in Aboriginal communities.

At the micro level, mental health services and programs need to reflect an acknowledgement of and respect for the importance of family and community for personal healing and well-being. Therefore, family and community-centered care is strongly supported.

Community-Based Initiatives

It is recommended that community-based initiatives be strongly supported. Community development is a process whereby individuals and groups voluntarily come together to collaborate for the achievement of shared interests. It is a democratic experience concerned with responding to unmet needs and interests that involves those most directly affected as full participants and is concerned with social change that improves the social and economic well-being of individuals, families and communities (Mussell, 1994). Community development models are sensitive to community level needs, wants and best thinking. The strength of social bonds in many Native communities and the willingness to act for the benefit of the group has provided a supportive network where programs flourish, especially evident in the rural and urban reserves where kinship ties remain strong (Smye, 2000).

RECOMMENDED PRACTICES, *continued*

Cultural Relevance/Safety

It is considered essential that all providers, including administrators, will possess a knowledge of the history, traditions, values and forces that have contributed to the lifestyle of families and community. It is expected that providers possess an awareness of their own social location and the impact that may have on service and program development and delivery. Mental health services and programs that reflect a respect for the knowledge, traditions and practices connected with the 'good ways' of Aboriginal peoples and/or communities are necessary to bring change and move toward a brighter future. Indigenous healing practices need to be accessible.

Because of the heterogeneity of First Nations health and illness beliefs, prevention and health promotion strategies need to be tailored to reflect the cultural uniqueness of the individuals and community in which a health program is being established. Many Aboriginal communities across Canada have taken the lead in constructing health programs from aspects of both biomedical and traditional medical services dependent on the particular issue being addressed and the beliefs of the population accessing health care (Waldram et al.,1995; Warry, 1995). For example, *healing lodges* of whatever type have been the most effective in incorporating cultural content into their programs. Local nations should have their own healing lodges since, the cultural elements consumers are exposed to will be at least somewhat familiar in a real way and will be reinforced in their community. This makes the chances of follow-up better, addressing issues such as continuity of care and cultural safety etc.

In urban settings, health centers need to attend to the issue of 'cultural diversity' across Aboriginal community, i.e., offering programs with the understanding that seventeen percent of Canada's Aboriginal people live in B.C. This represents a large and culturally diverse community consisting of over 94,000 status Indians as well as 70,000 non-status Indians and Metis. There are almost 200 bands (the bureaucratic organizational structure) with membership ranging from less than 100 to over 2000.

RECOMMENDED PRACTICES, *continued*

Education/Training

High priority needs to be given to prepare and equip practitioners of First Nation and Aboriginal backgrounds (as well as non-Aboriginal people) with the knowledge, values and skills required to promote holistic wellness with their families and communities. It is important to provide these practitioners with the foundation necessary to undertake advanced accredited courses of study and to develop and demonstrate capacities for ongoing self-care, commitment to lifelong learning and the capacity to provide leadership in the field of mental health.

'Care for the Caregivers' needs to be built into all mental health programs including strategies such as: crisis debriefing sessions, ongoing case reviews, regularly scheduled leaves, supported educational opportunities, meaningful recognition and supportive backup.

Research

■ Evidence-based practices i.e., what is working?

■ Data collection regarding suicide

■ Linkages with the Health Information System to ensure baseline data in keeping with standards across the country.

■ Consultation with National and Provincial mental health bodies and First Nations and other Aboriginal people to develop program standards, outcome measures and evaluation criteria and methods

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