Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *Aboriginal peoples*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

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A Toolkit

February 2006

OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Preface

Welcome to the CCMHI Toolkit Series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services*, are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Persistent socioeconomic inequities and continued marginalization have taken a toll on the mental health of many Aboriginal people. Although they suffer many of the same mental health problems as the general population, rates of mental health problems such as suicide, depression, substance abuse and domestic violence are significantly higher in many Aboriginal communities. The overall mental health status of Aboriginal Peoples is markedly worse than that of non-Aboriginal people by almost any measure. The rate of suicide among First Nations is 2.1 times the Canadian rate. Mental health problems need to be located within the context of intergenerational trauma and grief due to extensive losses of land, language and livelihood, and the legacy of residential schools.

The purpose of this toolkit is to assist health care providers and others to work collaboratively to best meet the mental health needs of Aboriginal Peoples. Highlights of this toolkit include: seven key issues for consideration when planning and implementing an initiative; six key recommendations; and brief descriptions of five positive practice initiatives.

Defining the population

According to Canada's Constitution Act, 1982, the Aboriginal Peoples of Canada include Indians, Métis and Inuit. The term 'First Nations' is now widely used instead of 'Indian'.

Consultation process

Consultation focused on members of the Expert Panel (composed of representatives from across the country) and their colleagues and networks.

Key messages

- **The traditional Aboriginal concept of 'health' is holistic**. Although access to high-quality medical services is important, Aboriginal health caregivers see 'health' as an outcome of many things besides services, including early childhood experiences, poverty, personal and political self-determination (Mussell & Stevenson, 1999).
- **Accessibility is a critical issue**. A systematic and organized national mental health program does not currently exist in Canada, and at the national and regional levels, existing mental health services (e.g., access to assessment, consultation and treatment) are inadequate and poorly integrated.
- **Resource distribution is not equitable or consistent**. Funding mandates do not respond to communities in crisis.
- **There is a lack of integrated health services that are holistic** (physical, emotional, mental, and spiritual) and they are not well linked to other services such as social

services, education, etc. Services provided through various federal and provincial departments are fragmented, and funding is allocated separately.

- **Training of service providers is inadequate**. There is a need for training for non-Aboriginal mental health care providers, e.g., family physicians, psychologists and psychiatrists, in Aboriginal realities and mental health issues that would support collaboration strategies. Training for traditional Aboriginal elders in mental health care has been carried out and is being suggested as a useful collaborative technique.
- **There are few models of shared/collaborative mental health care for Aboriginal Peoples** in which consumers, primary care providers, mental health care providers and allied health professionals work together in an integrated approach.
- The ongoing lack of clarity regarding responsibility of federal or provincial governments for provision of comprehensive mental health care highlights the need for the **development of a national mental health framework for Aboriginal Peoples in Canada**. Other countries, e.g., New Zealand, have developed such frameworks.
- **It is essential to include Aboriginal communities in the planning of mental health services** to ensure appropriateness and accessibility of such services. Active community participation in planning of mental health services with a focus on capacity-building is highly recommended.
- **Stable funding for mental health services** would significantly improve service delivery. Funding must be sought for new collaborative initiatives from a variety of sources, including federal and provincial/territorial governments, and Band Council/Tribal Council budgets.
- **Key principles** that are critical to collaborative mental health care initiatives for Aboriginal Peoples are: mutual recognition, mutual respect, sharing, and reciprocal relationships and responsibility.
- **Examples of collaboration** include:
  - Dilico Ojibway First Nations: Family physicians, nurse practitioners and mental health clinicians collaborating, psychologist and psychiatrists available on a consultation basis, and telepsychiatry with specialists available
  - Muskiki Mental Health Program: Counselling and other services that incorporate Medicine Wheel teachings; traditional medicine healer available
  - Waadiziwin Health Access Centre, Mental Health Program, Fort Frances, Ontario: Fly-in service, interdisciplinary team with family physicians, nurse practitioners, mental health workers, FAS (Fetal Alcohol Syndrome)/FAE (Fetal Alcohol Effect) co-ordinator, traditional healer.

- In the new paradigm collaboration model, traditional and biomedical practitioners would work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing (RCAP, 1996). This model calls for new and/or modified roles and responsibilities of community-based health personnel, family, peers and other social groups serving as therapeutic support for the consumer to gain the most from therapy. In many communities today, the paid workers are the major supports for the consumer. Under the new model, increased levels of involvement on the part of peers, family and other members of an individual's support network is desired for best outcomes. Indigenous spirituality and knowledge are important elements.

Copies of this CCMHI toolkit and companion documents are available at www.ccmhi.ca.

Introduction

The ongoing disparities between the health of Indigenous people and the non-Indigenous peoples of Australia, Canada, New Zealand and the United States of America are a matter of major concern. In each country, legacies of colonial dispossession; land alienation; forcible relocation; suppression of Indigenous cultural practices, values and beliefs; loss of language; disruption of families; and violations of Indigenous inherent sovereignty and right to self-determination have resulted in Indigenous people experiencing a deplorable health status compared to non-Indigenous peoples.

For First Nations people, dislocation of their communities; disruptions to their lifestyles; premature and tragic losses of family; self-medication and addictions; suicides and other mental health conditions are a direct result of the interference with transmission of culture, generation to generation, brought about by colonization. The absence of healing and mental health/wellness programs and services has added to the negative consequences of inadequate cultural continuity.

Defining the population

According to Section 35 of Canada's Constitution Act, 1982, Aboriginal Peoples are recognized as being of Indian, Inuit and Métis ancestry, with a diversity of indigenous languages, cultures and traditions (Canadian Institute for Health Information (CIHI), 2004; Health Canada, 2003b). In 2001, 3.3% of the total Canadian population was identified as Aboriginal (Statistics Canada, 2003).

Statistics Canada refers to First Nations (Status/Treaty and Non-Status Indians) as North American Indians.

First Nations

Although no legal definition of the term 'First Nations' exists, it is now widely used instead of the term 'Indian' to refer to both Status and Non-Status persons of First Nations ancestry. Registered or Status Indians are recorded as such in an Indian Register maintained by Indian and Northern Affairs Canada; status is determined according to rules set out in the Indian Act (CIHI, 2004).

- There are 596 Bands (First Nations) in Canada.
- There are 2284 (Indian) reserves in Canada; members of one Indian Band may live on three or four different reserves under the control of a Band.
- Just over 50% of the total status population live on reserve.
- Many reserves are rural and remote.
- Ten different languages and 58 dialects are spoken.
- The birth rate is about double that of the general population.

- The population is projected to be 939,666 by 2021 (Indian and Northern Affairs Canada, 2003).

Métis

The Métis are of mixed First Nations and European lineage. They total about 292,000 and live mostly in Western urban areas. They account for about 30% of the total Aboriginal population in Canada. The Métis have their own language and culture distinct from the Inuit and First Nations peoples. They are not under a federal statute like First Nations people, and live as citizens of a province.

Inuit

Inuit are the Aboriginal Peoples from Northern Canada. They total about 50,000 and share a common language. They generally live in 53 communities located in one of the following four (Inuit) regions: Nunavut, Inuvialuit (West Arctic), Nunavik (Northern Quebec) and Nunatsiavut (Northern Labrador). About half of the Inuit population lives in Nunavut (Statistics Canada, 2003), a Territory established in 1999. In 2005, the population of Nunavut was 29,000, 85% of whom are Inuit. Over 90% of Inuit communities are not accessible by road.

Aboriginal Peoples and health care

Health Canada has been responsible for providing health care services to First Nations and Inuit populations who live on reserves and/or in Inuit communities (Health Canada, 2003b). Since the establishment of Nunavut, the Government of Nunavut Department of Health and Social Services is responsible for the provision of health services for all residents of that territory. Public health services and health promotion and disease prevention activities are carried out by the First Nations and Inuit Health Branch (FNIHB) of Health Canada with the exception of those First Nations communities and Inuit communities outside of Nunavut that have opted for transfer of health services. By way of transfer, communities can assume control over community-based health programs that were formerly managed by FNIHB. Non-insured health benefits such as medications, dental and optical services are made available to the status Indian and eligible Inuit populations regardless of where they reside, on or off reserve (Health Canada, 2003b).

Little information about the Métis population has been either collected or made available. The Métis are not eligible for FNIHB health care programs and services. They must obtain health care services from provincial and territorial sources. Health Canada, however, through the Population and Public Health Branch (now the Public Health Agency of Canada), offers programs targeted specifically for the three Aboriginal groups, such as the Head Start Program, Community Action Program for Children and the Canada Prenatal Nutrition Program (Health Canada, 2003b).

Factors specific to Aboriginal Peoples

Culture is perceived as the complex of things that bind a community together, giving them, the group and its individual members, a sense of who they are and where they belong (Royal Commission on Aboriginal Peoples (RCAP), 1995). Cultural influences act as governors of the way all people think and how the mind responds to what is seen and heard (Battiste, 2000; Durie, 2003; Fixico, 2003). Just as human beings possess capacities to modify themselves and do this under favourable conditions, cultures also change. They are living, fundamental and functional whole systems complete with "do's and dont's"--rules, values, standards of behaviour, social systems, and culturally guided interaction patterns. Each culture has unique concepts of birth, death, health, illness, and healing (RCAP, 1996).

Aboriginal concepts of health and mental health

The traditional Aboriginal concept of 'health' is deeply and determinedly holistic. Most cultures use a definition that encompasses mind, body, emotions and spirit, and sees the health of the individual as dependent on the health of the family, community and the land (or natural environment) which surrounds him or her. Although access to high-quality medical services is important, Aboriginal health caregivers see 'health' as an outcome of many things besides services: early childhood experiences, poverty, personal and political self-determination, and more (Mussell & Stevenson, 1999).

Ill health has been viewed as the lack of balance between physical, emotional, intellectual and spiritual development in one's life. Inner peace reflects relative balance. Mental illness is the outcome of a lack of balance within a person, often due to overwhelming experiences and/or deprivation and the absence of external resources offering safety and opportunity for meeting needs and restoring functions.

Indigenous knowledge and spirituality

Ancestors of Canada's First Nations people valued wholeness symbolized by the circle, family, community, and other concepts such as the drum. They viewed spiritual life, family relations, emotions, thinking, physical health and the environment as interrelated parts of the whole, with mutual responsibility as a necessary aspect of this. There is a constant and necessary give-and-take between the physical, the mental, the emotional and the spiritual, and between the individual, the family and the culture (Swinomish Tribal Mental Health Project, 1991: p. 79).

According to Battiste & Henderson (2000), Indigenous knowledge is perceived as "a total way of life that comprises a system of respect, sharing and rules governing the use of

resources rooted in spiritual life, health, culture and language of the people." These Aboriginal authors stress that such knowledge embraces knowledge of how the world is--not how it looks or appears.

RCAP (1996) describes Indigenous knowledge as a cumulative body of knowledge and beliefs, handed down through generations…about the relationships of living beings, including humans, with one another and their environments.

Indigenous spirituality is underpinned by the belief that everything is alive and supports intimate communication, and is characterized by harmony, order to life, sacredness, inclusion, integrity and cultural renewal (Battiste & Henderson, 2000). The relationship between the people and the land, and the kinship of the people with other living creatures that share the land and with the spirit world, create the context for the sacred (RCAP, 1996).

Maintaining systems that support balance and harmony within human relationships and between human beings and the natural world are keys for survival and highlight the significance of kinship and community.

Evidence of "culturally good ways" that identify key aspects of Indigenous knowledge include the following:

- The support and nurture of the sort of community that links humankind to the Creator's life force. Interaction of people with each other and their environment creates communities, each with its own inherent qualities.
- Valuing family as a key institution for producing and preparing the next generation of culturally healthy, strong, balanced and confident human beings.
- Strong connection to the home territory, and knowledge of its resources, sacred places and history.
- Need for and significance of order to life, not confusion and chaos.
- Priority of language, literacy, and story-telling--and all that these generate for holistic development.
- Affirming the life-sustaining power of spirituality by promoting rituals, ceremonies and celebrations as vehicles for strengthening personal and cultural identity, as well as intra- and inter-relationships between families and communities.
- Teaching "culturally good ways" as a way of life.
- Modelling resilience.

Lessons from the literature

Although a great deal of historical, anthropological and archaeological evidence suggests that First Nations peoples were healthy at the time of contact (Mussell & Stevenson, 1999), the current health of Aboriginal Peoples has fallen well below that of the rest of Canadians (Health Council of Canada, 2005). A 1993 Canadian Medical Association news release urged the federal government to "acknowledge that the degree of ill health among Canada's Aboriginal population is unacceptable and take immediate and specific measures to improve it."

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

- The crude mortality rate for First Nations is higher compared to Canadian and available provincial rates. The four leading causes of death in First Nations are injury and poisoning, circulatory diseases, cancer and respiratory diseases.
- Lung cancer is the most common type of cancer for all Aboriginal people, followed by prostate and colorectal cancer for men and breast and colorectal for women.
- Tuberculosis is still evident in the First Nations and Inuit populations. The prevalence of tuberculosis in Nunavut is the highest in Canada.
- Diabetes is steadily rising in First Nations and Inuit populations and is much higher in the former group.
- Sexually-transmitted infections such as genital chlamydia and HIV are higher in First Nations and Inuit populations as reported at the national and provincial/territorial levels.
- More First Nations, Inuit and Métis smoke. The teenage smoking rate for Aboriginal Peoples is higher than the Canadian average.
- According to the National Aborginal Health Organization, major depression is a problem in First Nations.
- Inuit Tapiriit Kanatami has named mental health and suicide prevention as the number one health concern for Inuit.
- Obesity rates in First Nations are twice as high compared to the rest of the Canadian population.
- Many older First Nations and Inuit adults do not receive needed home care services.

- A large percentages of inmates in the prairie region are Aboriginal. This population is eight times more likely than other Canadians to be incarcerated (Hylton, 2002).
- In Nunavut, over 31 cases of rickets, a condition caused by low levels of Vitamin D, have been diagnosed since 1999 (Health Council of Canada, 2005).
- Data from health studies and surveys carried out in Canadian Aboriginal populations from the 1970s to the 1990s suggest iron deficiency anemia affects many Aboriginal infants, toddlers and children in Canada, both urban and rural (Moffatt, 1995).

"Aboriginal people are more likely [than non-Aboriginals] to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social, and emotional illness, injury, disability and premature death" (RCAP, 1996, Vol. 3, Sec. 3, p. 1).

For some First Nations youth, home is not a safe place to find respite and healing. Instead, too many First Nations homes are places of violence and too many young people are exposed to violence. Family members facing various stresses are less able to provide a safe haven that meets their children's needs (Health Canada, 2003a).

For Canadian Aboriginal Peoples as a whole, accidents and violence, often involving alcohol, are leading causes of morbidity and mortality. Physical disease, violent death and substance abuse are all linked to social problems--especially loss of community, social support and shared meaning in life--and resultant psychological and emotional problems (Kirmayer et al, 2000; Young, 1988).

Persistent socioeconomic inequities and continued marginalization have taken a toll on the mental health of many Aboriginal people. Although they suffer many of the same mental health problems as the general population, their rates of mental health problems such as suicide, depression, substance abuse and domestic violence are significantly higher in many communities (Mussell et al, 2004). The overall mental health status of Aboriginal Peoples is markedly worse than that of non-Aboriginal people by almost any measure (Kirmayer et al, 2001).

The overall prevalence of psychiatric disorders among American Indians has been estimated at between 20-63% of the adult American Indian population. In a clinical case study from the Inuit of Northern Quebec, of 100 consecutive cases referred for psychiatric consultation, the single most common DSM-III-R diagnosis was major depression with melancholia (Kirmayer et al, 1994).

All First Nations age groups up to 65 years were at an increased risk of suicide when compared with the general Canadian population. In Canada, the rate of suicide among First Nations people aged 10 to 44 years was roughly 2.1 times the rate for the general

population (27.9 deaths per 100,000 population as compared to 13.2) (Health Canada, 2003c). Suicide occurs roughly 5 to 6 times more often among First Nations youth than non-Aboriginal youth in Canada (RCAP, 1995). There is clear evidence of a relationship between First Nations youth suicide and the community's control in the following areas: self-government, land claims, education, health services, cultural facilities, and police and fire services (Chandler & Lalonde, 1998). Although comprehensive information is lacking, there is wide variation in suicide rates across different First Nations communities (Kirmayer et al, 1994).

Health and mental health problems are closely related to colonial policies on the part of the Canadian government that have left Aboriginal Peoples marginalized and oppressed. Given the history of colonization, spin-offs such as addictions, violence and suicide in Aboriginal communities can be seen as outcomes of many layers of assaults on identities, culture and world view (RCAP, 1996). Mental health problems have to be located within the context of intergenerational trauma and grief due to extensive losses of land, culture, language and livelihood, and the legacy of residential schools (Wesley-Esquimaux & Smolewski, 2004).

The impact of residential schools included the disruption of family structures and interference with the natural transmissions of cultural teachings (Wesley-Esquimaux & Smolewski, 2004) that were strongly family and community based at contact.

Among the consequences we see today are stressed Aboriginal communities, and, too often, the absence of a clear set of values, beliefs and strategies necessary to guide people in their efforts to cope with the stressors. When physical and emotional safety and security are lacking, fear, anxiety, and anger build. These are states in which it is very difficult for people to act in caring, rational ways, to learn, to be reflective, and to create understanding both of themselves and their world necessary to bring about positive change.

Contemporary health services of most First Nations normally use a predominantly Western medical approach due to the absence of traditional healing practices and/or lack of funding to support traditional health and healing practices. A medical approach is commonly viewed as the primary way to deal with clinical depression, however, this minimizes traditional healing practices. Depression, suicidal ideation and other mental health and emotional as well as spiritual dilemmas are often linked to many factors, and therefore treatment should be supported equally by biomedicine and traditional healing approaches (Health Canada, 2003b).

Holistic integration of health services (physical, emotional, mental and spiritual) is lacking, as is the integration of health in relation to social services, education, etc. There is fragmentation, segmentation and stove-piping of services, that is, they are provided

through various federal and provincial departments and funding is allocated separately (Health Canada, 2003b).

Mental health services for Aboriginal Peoples have generally been deficient, due to:

- Absence of a national mental health system that makes services available and accessible to First Nations, Inuit and Métis peoples
- Lack of professional services available in remote and rural Aboriginal communities
- Lack of familiarity and understanding of Indigenous knowledge, values, and belief systems on the part of policy makers, programmers, and providers
- Failure to recognize loss of culture as a major cause of personal, interpersonal and community trauma
- Lack of Aboriginal persons educated and trained in health disciplines
- Many agencies/organizations offering components of mental health services with minimal co-ordination between them
- Few examples of collaborative mental health care 'best practices'
- Treatment of the people as objects of life, generation to generation, that fostered social and economic dependence, ill health and other difficulties
- Historical absence of focus on self-care and self-determination in context, making these very important goals today
- Failure to resolve underlying causes of ill health and other problems, for example, viewing use of alcohol as the problem, not as a symptom of unresolved personal issues often connected with personal losses.

Collaborative models and initiatives

"Dialogue can be thought of as the threads of communication that bind people together and prepare them for reflective action. Dialogue links people together through discourse and links their moments of reflection to their moments of action" (Shor, 1992: p. 86).

Due to the history of distrust that has characterized relations since contact, successful collaboration and partnership building between First Nations, other Aboriginal Peoples and non-Aboriginals takes work and a conscious effort to connect mentally, emotionally and spiritually.

Four principles of partnership building are featured in the Royal Commission on Aboriginal Peoples (1996) reports:

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Mutual recognition: Aboriginal Peoples will be regarded as original caretakers of the land, and Canadians are here to stay because they also love the country. Recognition is important to achieve better working relationships within and between Aboriginal communities.

Mutual respect: We do not respect another person if we are unwilling to acknowledge that s/he has something to teach us. If we do respect one another, we engage in sharing which allows us to meet some of our emotional and intellectual needs for survival and personal growth.

Sharing: The model of a top-down relationship depicts a relationship Aboriginal Peoples are tired of and need to change. In a reciprocal relationship, each party leaves the meeting with something more than what s/he had when first coming together. Sharing and discussing experiences can contribute significantly to processes of individual and social change.

Responsibility: This affirms the need to embrace challenges rather than ignoring or denying them, and to work together to develop responses and strategies to address them effectively.

New paradigm collaboration approach

In the new paradigm collaboration model, traditional and biomedical practitioners would work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing (RCAP, 1996).

This model calls for new and/or modified roles and responsibilities of community-based health personnel, family, peers and other social groups serving as therapeutic support for the consumer to gain the most from therapy. In many communities today, the paid workers are the major supports for the consumer. Under the new model, increased levels of involvement on the part of peers, family and other members of an individual's support network is desired for best outcomes.

New paradigm collaborations are being developed in several Canadian settings. One example is the integration of traditional Native cultural teachings offered by a Native elder working alongside Western-trained psychotherapists, at the Centre for Addiction and Mental Health, Aboriginal Services, in Toronto.

See Appendix B for descriptions of other positive practice initiatives.

Key elements and fundamentals of collaborative mental health care

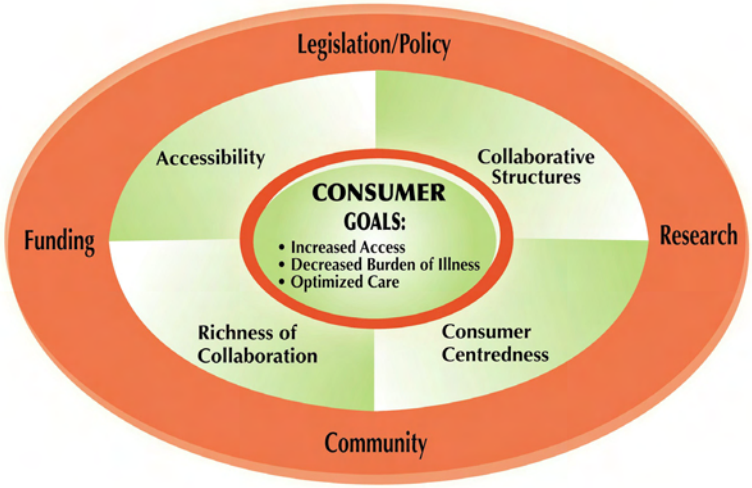

Figure 1 Framework for collaborative mental health care

Accessibility

- Lack of control of, and professional participation in, health care are barriers to access.
- A legacy of colonization, discrimination, and marginalization may deter consumers from presenting themselves to health care services for care. Part of this legacy is lack of familiarity with the written word and medical jargon, especially the ability to 'make meaning' of prescriptions and related oral and written guidance.
- Many urban Aboriginal people utilize hospital emergency rooms, rather than family physicians, for primary care. Why this occurs is not understood and is now being researched.
- Access to health care can be challenging for rural and remote Aboriginal community members. It can require travel by air to the nearest town that provides the necessary services.
- Many Aboriginal people living in rural and remote communities lack access to comprehensive health care, including mental health services. In these and other First Nations communities, membership often relies upon the Community Health Representative for guidance and assistance. Larger First Nations may have a registered nurse on staff as well.
- There is a lack of follow-up for individuals returning to home communities after interventions.

Collaborative structures

- There are few examples of collaborative Aboriginal mental health care initiated by primary or mental health care providers.
- Collaboration may be initiated by Aboriginal communities or by government agencies to deal with failed past practices.
- There is limited to no evidence of psychiatry services integrated physically into family practice clinics for Aboriginal consumers.

Richness of collaboration

- New Zealand models of collaboration include consumers, providers and researchers (Maori/Indigenous Health Institute, Christchurch School of Medicine and Health Sciences, University of Otago, Christchurch, New Zealand).
- Centre for Addiction and Mental Health, Aboriginal Services, Toronto has ongoing knowledge transfer between mainstream mental health providers and Aboriginal therapists, and between therapists and Aboriginal elders.

Consumer centredness

- It is essential to include Aboriginal communities in the planning of mental health services to ensure appropriateness and accessibility of such services.
- Active involvement of consumers in health planning is advisable.
- Due to past colonial history in the relationship of health providers and consumers, active involvement of Aboriginal community members becomes more important in order to avoid past mistakes in service delivery models.
- Advisory groups, consumer representatives and consultation processes are useful.
- The fundamental needs of individuals, families and communities such as clean water, adequate housing, equal educational opportunity, access to effective health care and recreational facilities, have to be addressed before people can move on to building their capacity at other levels (Barron, 2004).

Policies, legislation and regulations

- There is no systematic and organized national mental health program that makes services available and accessible to Aboriginal Peoples.
- It would be valuable to develop a National Mental Health Framework for Aboriginal Peoples in Canada.
- There is an ongoing lack of clarity regarding responsibility of federal or provincial governments for provision of comprehensive mental health care.
- At the national and regional levels (system-wide), existing mental health services (e.g., access to assessment, consultation and treatment) are inadequate and poorly integrated. Resource distribution is not equitable or consistent.

- There is a lack of affirmative action by community leaders, senior staff and opinion leaders to promote effective use of mental wellness resources when they are available, or to work to obtain quality mental health, healing and treatment services when they are not available.
- To strengthen mental health in the Arctic, the challenge must be approached holistically and with consistent, long-term, interrelated policies and programs. Economic opportunities, adequate and effective housing, improved education, gender equity, actions to protect the environment, and attention to justice issues call for a strong holistic approach which needs to reflect the unique circumstances, culture and needs of Inuit communities (Dickson, 2005).
- Frameworks exist in other countries: New Zealand, for example, guarantees sufficient and appropriate mental health services (Ministry of Health, 2002).

Funding

- Funding for Aboriginal health care is neither consistent nor comprehensive.
- Stable funding for mental health services would significantly improve service delivery.
- Funding for mental health projects within the Aboriginal community tends to be project based through initiatives (such as Brighter Futures and others) rather than core funded, and the budget is determined by population.
- Project-based funding that requires submission of detailed written proposals usually places communities with greatest need at a disadvantage because they often do not have the competencies available and accessible within their membership and cannot afford to hire personnel with these skills.
- Funding mandates do not respond to communities in crisis; some communities have had to go to the media and present themselves as pathological to get support.
- Funding must be sought for new collaborative initiatives from a variety of sources, including federal and provincial/territorial governments, and Band Council/Tribal Council budgets.

Evidence-based research

- Evidence supporting 'best' and 'most promising' practices has yet to be developed.
- There are no known tools that are consistently used for assessment, monitoring and evaluation of this population and that would be applicable to primary health care/mental health care.
- Research focusing on the unique traditional lifeways of the many and varied cultural nations among Canada's Aboriginal Peoples has not begun. Because of this, there is little available information regarding evidence-based cultural practices.

Community needs

- Active community participation in planning of mental health services through advisory groups, community consultation processes and formation of partnerships that would elicit and honour input from Aboriginal Peoples is highly recommended.
- Capacity-building in mental health service delivery within the Aboriginal community continues to be a priority in order to increase the numbers of competent staff available.

Planning and implementation

- There is a shortage of Aboriginal mental health care professionals and of health care professionals available for rural and remote Aboriginal populations.
- Some care providers are not adequately trained or prepared.
- Training in Aboriginal realities and mental health issues for non-Aboriginal mental health providers, including family physicians, psychologists and psychiatrists, would support collaborative strategies where mainstream and traditional Aboriginal medicine are involved.
- Training in Aboriginal realities and mental health issues for allied health professionals, such as nurses and dietitians, would also support collaborative strategies.
- Training for Aboriginal leaders, senior health, social and education personnel and key community members to familiarize them with mental health, wellness and treatment matters is recommended.
- Training for traditional Aboriginal elders in mental health issues and care has been carried out and is being suggested as a useful collaborative technique (Centre for Addiction and Mental Health, Aboriginal Services Program, Toronto).

Key issues for consideration

1. ***Understand the current state of Aboriginal health***
   Aboriginal people are more likely [than non-Aboriginals] to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death (RCAP, 1996).

2. ***Understand the nature of Aboriginal health problems***
   For Canadian Aboriginal Peoples as a whole, accidents and violence, often involving alcohol, are leading causes of morbidity and mortality. Physical disease, violent death and substance abuse are all linked to social problems—especially loss of community, social support and shared meaning in life—and resultant psychological and emotional problems (Kirmayer et al, 2000; Young, 1988).

3. ***Understand Aboriginal mental health***
   Persistent socioeconomic inequities and continued marginalization have taken a toll on the mental health of many Aboriginal people. Although they suffer from many of the same mental health problems as the general population, rates of mental health problems such as suicide, depression, substance abuse and domestic violence are significantly higher in many communities (Mussell et al, 2004). The overall mental health status of Aboriginal Peoples is markedly worse than that of non-Aboriginal people by almost any measure (Kirmayer et al, 2001).

   Mental health problems need to be located within the context of intergenerational trauma and grief due to extensive losses of land, culture, language, livelihood and the legacy of residential schools. The impact of residential schools included the disruption of family structures and interference with the natural transmissions of cultural teachings (Wesley-Esquimaux & Smolewski, 2004).

4. ***Recognize the high rates of suicide***
   The rate of suicide among First Nations is more than twice the rate of the general population. All First Nations age groups up to 65 years are seen to be at an increased risk of suicide when compared with the general population.

5. ***Consider new paradigm collaboration approaches***
   In the new paradigm collaboration model, traditional and biomedical practitioners would work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing (RCAP, 1996).

New paradigm collaborations are being developed in several Canadian settings. One example is the integration of traditional Native cultural teachings offering by a Native elder working alongside Western-trained psychotherapists at the Centre for Addiction and Mental Health, Aboriginal Services, in Toronto. The Centre supports ongoing knowledge transfer between mainstream mental health providers and Aboriginal therapists, and between therapists and Aboriginal elders.

6. ***Planning and implementation***

Training in Aboriginal realities and mental health issues for non-Aboriginal mental health providers, including family physicians, psychologists and psychiatrists, as well as for allied health professionals such as nurses and dietitians, would support collaborative strategies where mainstream and traditional Aboriginal medicine are involved. Training for traditional Aboriginal elders in mental health issues and care has been carried out and is being suggested as a useful collaborative technique.

7. ***Policy making***

It would be valuable to develop a National Mental Health Framework for Aboriginal Peoples in Canada. There is ongoing lack of clarity regarding the responsibility of the federal or provincial government for provision of comprehensive mental health care. Frameworks exist in other countries, for example, in New Zealand, sufficient and appropriate mental health services are guaranteed (Ministry of Health, 2002).

8. ***Recommendations***

- Development of a national Aboriginal mental health strategy, including elements of primary, secondary and tertiary care, would enhance attempts at collaboration.
- Engagement of Aboriginal communities in developing a community-based approach to collaborative mental health care is essential.
- Establishment of unique training programs for Aboriginal front-line mental health workers is a priority. Community capacity and control are central to future success.
- Inclusion of Aboriginal health status and health issues in the undergraduate curriculum of Faculties of Medicine, and in the training of family physicians, psychiatrists, psychologists, social workers, nurses, dietitians and other health care and health-related professionals is strongly recommended.
- Research focusing on the unique traditions, knowledge and history of Canada's Aboriginal Peoples is needed to guide the establishment of evidence-based best practices in shared mental health care.
- Support for convening those now working in the few collaborative mental health care projects for Aboriginal individuals/communities would enhance knowledge-sharing and translation.

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Appendix A: Consultation process

Consultation was largely limited to members of the Expert Panel (composed of representatives from across the country) and their colleagues and networks. The Expert Panel and the communities initially consulted concluded that because the Aboriginal communities across Canada are so diverse, to consult with a limited number of communities would be inappropriate.

Appendix B: Positive practice initiatives

The following are brief descriptions of collaborative health care initiatives in Canada specific to Aboriginal Peoples.

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Dilico Ojibway First Nations

- Mental health for 13 First Nations.
- Family physicians, nurse practitioners and mental health clinicians collaborate.
- Psychologists and psychiatrists available on consultation basis.
- Telepsychiatry with specialists from the Hospital for Sick Children (Toronto, ON) and local hospitals.
- Assessments adapted to employ First Nations perspectives.
- Funded by First Nations Tribal Council.

Muskiki Mental Health Program

- Mental health services to 5,000 First Nations people on reserve.
- Counselling and other services incorporate Medicine Wheel teachings.
- Traditional co-ordinator--medicine healer three times/year.
- Funding by Native Community Healing and Wellness, through transfer funds from FNIHB and seed funding from Provincial Department of Health.

Waadiziwin (health is in our hands) Health Access Centre, Mental Health Program, Fort Frances, Ontario

- Serves local First Nations, fly-in services, off reserve and Métis.
- Interdisciplinary team, including family physicians, nurse practitioners, mental health workers, FAS/FAE co-ordinator, traditional healer, etc.
- Psychologist and psychiatrist available on consultation basis. Clients must travel up to 2 to 4 hours for service.
- Funding is from Ontario Ministry of Health and Aboriginal Healing & Wellness Strategy.

Faculty of Nursing, University of British Columbia

Identification, development and implementation of research topics addressing Aboriginal Peoples. Involves members of the Aboriginal communities at all stages of the work.

Centre for Indigenous Peoples' Nutrition and Environment (CINE), McGill University

CINE was created in response to a need expressed by Aboriginal Peoples for participatory research and education to address their concerns about the integrity of their traditional

food systems. Deterioration in the environment has adverse impacts on the health and lifestyles of Indigenous Peoples, in particular nutrition as affected by food and food traditions.

Appendix C: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist – An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

Primary health care - An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres. Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

CIHI	Canadian Institute for Health Information
CCMHI	Canadian Collaborative Mental Health Initiative
FAS/FAE	Fetal Alcohol Syndrome/Fetal Alcohol Effect
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders (3rd ed. revised)
FNIHB	First Nations and Inuit Health Branch
INAC	Indian and Northern Affairs Canada
RCAP	Royal Commission on Aboriginal Peoples
WHO	World Health Organization

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2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

1. Barriers and strategies
2. A framework
3. Annotated bibliography
4. Better practices
5. Canadian initiatives
6. A policy review
7. International initiatives [unpublished]
8. Health human resources
9. Mental health prevalence and utilization
10. Interprofessional education
11. Aboriginal mental health [unpublished]
12. The state of collaborative mental health care

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