First Nations Mental Wellness Continuum Framework

Report of the Ontario Regional Discussions

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Section I: The Context

INTRODUCTION

Community mental health leaders, the Assembly of First Nations (AFN) and Health Canada’s First Nations and Inuit Health Branch (FNIHB) are engaging in a collaborative process to describe and develop a First Nations Mental Wellness Continuum Framework.

The framework development process will establish:

- An understanding of existing mental health and addictions programs as well as the context and constraints by which these are being provided;
- A snapshot of program strengths and critical gaps;
- Initial indications and identification of emerging priorities and areas for development.

The intention is to propose a broad and wholistic framework of mental wellness services that builds on community strengths and explores avenues to better organize resources, in order to strengthen existing mental wellness programming for First Nations communities. The framework will serve as a resource to communities wishing to realign their mental wellness programs and services according to their own priorities and at their own pace. It will also inform government programming at both the provincial and federal levels.

This report sets out the results of two informative dialogue sessions with key stakeholders and partners in community mental health service provision held in Ontario Region in late May and early June, 2013.

BACKGROUND – OVERVIEW OF THE ONTARIO REGION

Ontario Region is the largest region of the First Nations and Inuit Health (FNIH) regions in Canada with 133 First Nation communities representing the largest regional First Nation population with over 90,000 people registered.

Ontario Region is further divided into four Zones as follows:

1. Moose Factory Zone (MFZ) – 6 First Nations communities with a population of 6,864 (7.6%)
2. Sioux Lookout Zone (SLZ) – 34 First Nations communities with a population of 19,505 (21.6%)
3. Southern Ontario Zone (SOZ) – 28 First Nations communities with a population of 38,688 (42.9%)
4. Thunder Bay Zone (TBZ) – 65 First Nations communities with a population of 25,044 (27.8%)
Ontario has the highest number of remote First Nations communities with 25% of communities accessible only by air year-round, or by ice road in the winter\(^1\). FNIHB classifies accessibility as follows:

1. Remote isolated community: no scheduled flights, minimal telephone or radio services, no road access (represents 12% of communities)
2. Isolated community: scheduled flights, good telephone services, no road access (represents 22% of communities)
3. Semi-isolated community: road access greater than 90 km to physician services (represents 22% of communities)
4. Non-isolated community: road access less than 90 km to physician services (represents 44% of communities)

There are several special issues to consider in the Ontario Mental Health System:

1. Multiple ministries have jurisdiction for mental health in Ontario, resulting in fragmentation of services for individuals and their families.
2. Local Health Integration Networks (LHIN) split Ontario in 14 regions which do not align with FN territories. LHINs have not begun to address First Nations mental health and addictions services provision. Only some LHINs have engaged with First Nations communities.
3. There are severe mental health and addictions as well as primary care provider shortages in Northern and rural areas of Ontario.

\(^1\) Stats are from [http://www.aadnc-aandc.gc.ca/eng/1100100020284/1100100020288](http://www.aadnc-aandc.gc.ca/eng/1100100020284/1100100020288)
Regional Discussion Session

In order to reflect the diverse realities and perspectives of the First Nations population, dialogue sessions were conducted in the Ontario Region. The first of the two sessions was conducted on May 29-30, 2013 in Toronto with approximately 35 attendants. The second session was held on June 5-6, 2013 in Thunder Bay in northwestern Ontario with approximately 45 attendants. Most of the participants were First Nations frontline mental health workers supported by several leaders and Elders.

The sessions were organized with the support of two political organizations:
- Union of Ontario Indians (Toronto session)
- Nishnawbe Aski Nation (Thunder Bay session)

Prior to each of the meetings, participants were asked to participate in an online poll to identify the most pressing issues in their area. This was done to ensure that the session discussions would focus on all of the identified issues in each region. A discussion document describing the most relevant issues in First Nations mental health and addictions was prepared and sent to participants just before the event. (Appendix A)

During the sessions, participants identified critical gaps, best practices and needed supports for their geographic area during group work. Different techniques used to elicit information on these topics included: large plenary discussions; a modified “Knowledge Café” format (small groups of participants rotated their discussions through various topics); flipchart work to gather success stories. These techniques enabled the groups to discuss eight major topics in the area of mental health and addictions derived from the discussion paper in a collaborative and efficient manner. The major topics were:

- Children and Youth Mental Wellness and Addictions
- Early Identification and Intervention
- Coordination and Continuity of Care
- Specialized Services and Community-based Care
- Crisis Response
- Community Capacity and Support
- Community Development, Promotion and Prevention
- Cultural Safety, Competency and Knowledge

The daily flipchart notes were transcribed and provided back to participants at the start of the second day for verification. Furthermore, a presentation was made with a summary of the previous day’s key discussion points. This allowed participants an opportunity to clarify and elaborate any points made on the previous day and to ensure that the final report accurately reflects the important themes raised by the participants. A detailed overview of activities and group discussion topics was provided in the meeting agenda which is provided in Appendix B and C.
Findings of the Dialogue Sessions

**Key Definition Related to the Mental Wellness Continuum**

Participants described Mental Wellness as holistic and encompassing well-being in all areas of the social determinants of health. It ensures support through the life cycle for different stages of healing and wellness. The approach is characterized by the necessary supports for the individual, the family and the community. Culture is at the core of mental wellness. A mental wellness continuum is envisioned to contain the following components:

*Figure 1: Mental Wellness Continuum Approach*
CRITICAL GAPS IN MENTAL HEALTH AND ADDICTIONS WITHIN THE CURRENT SYSTEM

A mental wellness continuum as envisioned in the previous section has not been realized in First Nations communities. There are substantial gaps in available services in the mental health sector in Ontario and First Nations face additional geographic, cultural and cross-jurisdictional access barriers. This is compounded by significant health disparities, which are often even more extreme in remote communities.

Many rural and remote First Nations communities have no access to mental health and addictions services beyond health promotion.

During the dialogue sessions, detailed gaps were identified under the following key themes:

1. Children and Youth Mental Wellness and Addictions
2. Early Identification and Intervention
3. Coordination and Continuity of Care
4. Specialized Services and Community-based Care Crisis Response
5. Community Capacity and Support
6. Community Development, Promotion and Prevention
7. Cultural Safety, Competency and Knowledge

These high level themes were selected based on a review of the current literature, previous work done to develop the First Nations Mental Wellness Continuum Framework as well as an advance poll of feedback regarding mental health priorities sent to invited participants.

The specific gaps under each of these headings are detailed further in summary notes from the two dialogue sessions. They are included in Appendix D.

A brief description of consistent themes under each of the headings across both dialogue sessions is provided in the following section.

1. Children’s and Youth Mental Wellness and Addictions

In both dialogue sessions, it was clear that mental health counselling and treatment services are needed to address the specific needs of children and youth both in community based settings and school settings. Thunder Bay participants also highlighted the critical need for additional youth treatment beds, and safe, structured environments and culturally appropriate spaces for children and youth.

In particular, participants spoke to the need to equip teachers and education staff to identify mental health issues and for protocols to ensure referral to and coordination of services in school settings.

Moreover, it was noted in both dialogue sessions that such interventions and treatment should engage the whole family and incorporate traditional and cultural wellness approaches.
In the Toronto dialogue session participants made special note of the need for assessments, clinical tools and processes which are culturally based and wholistic allowing for assessment in the context of the family. This gap was also identified under the heading of Early Identification and Intervention.

Both dialogue sessions touched on the need to be cognizant of the dangers of labelling without adequate clinical and cultural assessment resources and the potential misdiagnosis of children and youth. Related to this, participants strongly advocated for non-pharmaceutical treatment options for treating children and youth wherever possible.

Lastly, the lack of resources to manage transitions in services that children and youth qualify to access over time was strongly voiced in both sessions. Gaps are created by the nature of age specific funding streams, services and treatment location that exclude children and youth in certain age brackets from services they may have qualified for previously.

The need to bolster parenting support, prevention and promotion was mentioned in both sessions as well as increased resources support for culturally and spiritually based interventions.

2. Early Identification and Intervention

In order to address early identification and intervention gaps participants identified the need for a number of new mechanisms and service pathways.

For example, written protocols are needed to appropriately connect mental health services with schools where the early identification services are needed. This gap is also described under the heading of Children’s and Youth Mental Health.

Participants frequently linked early identification and intervention gaps implicitly to children and youth. Age categories for service eligibility are generally too narrow and may restrict access by youth and therefore limit service transitions at critical junctures in the life course. In the Toronto dialogue session, participants described the ages between 6 and 12 as particularly vulnerable. They noted the danger of labelling children without the required assessments and even applying pharmaceutical or medical therapies when much less invasive interventions should be offered. This was a theme strongly echoed in the Thunder Bay dialogue session where participants emphasized approaches to reach and engage children and youth which should include reinforcing the culture, language, identity, family connections, connections with elders and ceremonies. Clearly, there is a need to reframe funding so that services can be coordinated to appropriately address the needs of children, youth and their families as an early intervention measure.

Early identification also requires that stigma around mental health and help seeking behaviour in communities be addressed as well as fear and mistrust of authorities such as Children’s Aid Societies. Greater community awareness and understanding of child welfare protocols, rights and roles is needed.
A critical gap was also described in early intervention and support for individuals and families affected by FASD. In the Thunder Bay dialogue session, participants described a need to expand the services for FASD beyond just those who are alcohol affected to those impacted by addictions, as children are born with what appears as a “Fetal Addictions Spectrum Disorder”. They require services to deal with their specific set of physical and mental health problems.

In the Toronto dialogue session, services aimed at babies born to substance-abusing mothers, through their childhood was highlighted as a need to address the “second generation” impact of substance abuse in communities. These services are currently particularly needed as these children enter daycare and schools.

Early identification and intervention is however not limited to children and youth as it can refer to the need across a spectrum of issues such as depression, psychosis, dementia as well as other mental illnesses. In fact, particular mention was made of a critical need to reach out to elders and seniors to identify their service gaps as they may have their own unique mental health service and care needs.

Lastly early identification and intervention also requires a closer link to crisis response services within communities.

3. Coordination and Continuity of Care

Coordination and continuity of care is hindered in a number of critical ways as noted by dialogue participants in both Toronto and Thunder Bay.

A lack of services or programs within communities to provide case management is further compounded by large geographical distances between communities and available external services. If services are accessible, cultural safety, coordination of care, discharge and transitions between external services and community is often a weak point. Lack of protocols, training around appropriate health information sharing amongst on and off reserve agencies and providers to facilitate coordination was also mentioned as an impediment. Similarly, policies and program mandates are currently not designed to encourage inter-agency or on-/off-reserve collaboration. This is, for example, particularly notable with respect to the NIHB crisis counselling program.

In the Thunder Bay dialogue, special mention was made of the fact that continuity of care does not often happen beyond immediate crisis situations when outside services are “parachuted” into the communities. (This gap will be described in greater detail in the next section.)

Resources are needed to build the capacity for continuity of care within communities so that the focus can change from one that is reactive to proactive over the long term. In particular, in this region, culture was described as an essential thread enabling continuity of care and improved outcomes over the longer term. Funding resources and mechanisms to better support this process were highlighted as a need.
Lastly, at a system level, the dialogue participants in the Thunder Bay session described the need to clearly delineate continuity as well as gaps in children's mental health between the provincial and federal agencies so that services can be appropriately planned and accessed within the context of this continuum or framework.

4. Specialized Services and Community-based Care

An essential point which was highlighted in the Thunder Bay dialogue session was that there aren't just “gaps” in specialized care or community based care in communities in this region but rather there are either no, very few or very limited services of this nature beyond federally funded crisis counselling and community based prevention promotion services in these communities.

The situation varies across the province however. In the Toronto dialogue session, a critical gap identified in specialized care entailed early psychosis intervention and “assertive community team” type services.

On reserve treatment beds and enhanced treatment services are needed and include increased number of mental health counselling sessions or addictions treatment cycles for clients where these are indicated. Concurrent disorders training for community workers was also described as a need.

Specific “cycle of life” services such as geriatric mental health was mentioned as a critical gap in the Toronto dialogue session.

Trauma informed services, training and mechanisms for dealing with trauma were also described in the context of specialized care needs at the Toronto dialogue session.

Apparent in the Thunder Bay dialogue session was a clear shift in thinking about “specialized care” in which communities view traditional and cultural healing approaches as their own form of “specialized care” or “community based care”. This would imply a need to revisit funding mechanisms to extend traditional healing services as eligible services.

Community based care in some of these communities would need to be built from the ground up as there presently is very little in this regard. Interagency collaboration would also need to be improved according to session participants.

A specific gap mentioned was transitional housing for individuals returning from treatment. Such a “step down” environment and associated programming was also mentioned in the Toronto dialogue as a service gap.
5. Crisis Response

Apart from a lack of resources in general, it was noted earlier that, crisis response in communities generally precipitates a flood of resources, providers, agencies and authorities in some communities during the critical time. One of the issues mentioned, is that there is frequently poor coordination between these services and the community affected and there is little left in place once the crisis passes leading to poor continuity of care and Band-Aid solutions.

Lack of capacity building in communities and sustained community crisis planning is evident across many of the communities represented at the two dialogue sessions. Critical Stress Debriefing and Critical Incidence Stress Management (CISM) training was mentioned in both sessions as a need in this area.

A lack of safe places within communities was highlighted and support for community workers impacted by crisis was mentioned as a critical gap.

Recognizing and empowering natural and traditional helpers was described as an issue. Currently, the only funded services to support those in need of mental health support in many communities seem to be NIHB crisis counselling. However this funding stream does not recognize cultural or traditional healing ways as eligible for support.

Within the system itself, communities identified an impending “crisis” occurring when the Indian Residential School Survivors (IRSS) program funding ends. Current programs and services are not adequately resourced to service these clients.

In the Thunder Bay dialogue session, a critical gap also identified included training to equip workers to address both mental health and addictions concurrently as well as additional emphasis on prevention and promotion to effectively prevent community crises.

6. Community Capacity and Support

Beyond some form of core curriculum for mental health training, as noted in the earlier section: Crisis Response; there is a clear lack of capacity building in communities for suicide and crisis according to Thunder Bay dialogue participants. This theme was echoed in the Toronto dialogue where participants spoke of the need for training of this nature as well as support for workers affected by trauma and crisis.

While virtual training and support for workers was highlighted as a need in both sessions, amongst Thunder Bay participants the added caveat is that this form of training, support, case management or supervision must also be culturally competent and ideally provided by those who understand the communities’ history, context and current realities.

Described in both sessions was the clear need for every mental health and addictions worker to have access to:

- Clinical supervision; appropriate supervision for front line workers
• Ongoing professional development and training
• Regularly scheduled debriefing (support for workers)

Within the Toronto dialogue session, discussion also centred on the need for policies and procedures to guide front line workers, appropriate compensation, community and leadership support for mental health and addictions services and an ability to reduce community program “silos” through more flexible funding arrangements at the community level as well as via improved collaboration and coordination.

7. Community Development, Promotion and Prevention

Community development is a longer term approach to building community wellness via the needed continuum of services in a responsive, culturally appropriate, community driven process. Implicated are resources and mechanisms needed for:

* Opportunities and processes to ask individuals and communities how they envision services
* Coordination and leadership to accomplish this work and to involve the whole community
* A way to bring separate plans for each different agency or program mandate together around common aims and to support the necessary linkages and collaboration in an ongoing, sustainable basis
* Development of comprehensive plans encompassing education, prevention and promotion
* Funding mechanisms and support for community healing
* Community crisis planning, team and ongoing support as a sub-element of community development

A clear underpinning of a community development approach is that it be strongly rooted in community cultural ways meaning that services and resources are adapted or designed with the culture and community in mind.

Promotion should emphasize family and cultural values, teachings and linkages to cultural identity and language as was noted earlier. There is a clear need for mechanisms to transmit teachings and knowledge to children and youth. Participants spoke about the need to explore various accessible mechanisms including social media, the school setting, community role models and mentors.

In terms of prevention, the approaches must be carefully crafted and sensitized to ensure that it does not simply bring greater awareness or “glorify” an issue, especially amongst vulnerable or at risk youth, in particular those ages 9 - 13. Examples mentioned included mixing prescription drugs, suicide, bullying and other issues.
Thunder Bay participants also expressed a need for more information about the long term impacts of such treatment approaches as methadone and suboxone. Prevention should also extend to harm reduction such as needle drop off locations in communities.

8. Cultural Safety, Competency and Knowledge

A central tenet described in both dialogue sessions is that cultural safety, competency and knowledge are concepts which can only be defined by individual clients and communities. Thus, a critical gap or need is the community designed and lead processes by which these definitions are elaborated, accepted and agreed upon within communities.

Another key gap entails the need for cultural competency amongst all service providers. Training for external providers to ensure that they are trauma informed, culturally safe and competent based on community realities, needs and aspirations is needed. As well, service agreements with external agencies and providers should make cultural competency of services and providers a requirement.

It cannot be assumed however, that within communities, all First Nation mental health and addictions workers are culturally competent. Therefore support to facilitate cultural safety/competency training and learning opportunities for community workers is also needed.

As a community development approach and to support mental wellness promotion such opportunities should also extend to community members especially youth to affirm and transmit cultural knowledge.

In particular, in the Thunder Bay dialogue session, a “best practice” as identified by communities in this region, includes cultural camps in which elders, youth and families come together on the land to share and learn more about the language, teachings and original ways of the people.

Appropriate funding to support these types of camps as well as to appropriately compensate knowledge holders is needed.

There is also a need for research about the interface of clinical and cultural approaches and how this is best supported.
Successes and Promising Practices

In the dialogue sessions, participants were asked to describe their community’s strengths and successes in relation to what interventions or approaches are working and factors they feel contributed to these successes.

In the Toronto dialogue session, these were characterized according to each of the following topic areas:

1. Children and Youth Mental Wellness and Addictions
2. Early Identification and Intervention
3. Specialized Services and Community-based Care
4. Coordination and Continuity of Care
5. Crisis Response
6. Community Development, Promotion and Prevention
7. Cultural Safety, Competency and Knowledge
8. Community Capacity and Supports

Specific examples were shared in each of the above-mentioned categories. Plenary discussion of each, shaped a picture of what constituted and contributed to these community-defined successes.

Foremost, the strong and growing revitalization of culturally-based approaches to First Nations health and mental health is an overarching success in Ontario.

Successful approaches were identified as supported by the following main factors:

- Collaboration and Cultural and Community Appropriateness
- Community Designed & Driven
- Partnerships
- Responsiveness
- Community Strengths
- Wholistic and Culturally Based

A full listing of all notes from the discussions are in Appendix E. This section provides key themes as well as concrete program examples.

Children and Youth Mental Wellness Interventions

A key theme arising in the examples of children and youth mental wellness intervention relates to the “strengthening of identity, connection and resilience”. Some examples included:

- Engaging youth in peer to peer interventions – e.g. Building capacity and training youth in SafeTalk
• Building resiliency through experiential land based intervention – e.g. Outdoor adventure leadership experience involving a youth canoe trip on the water in Wikwemikong
• Youth wellness programming – e.g. Mistatim Medicine Horse Youth Program

Strongly reinforced elements of successful programming included experiential, land based activity, linkages to history and community character, responsible risk taking and learning amongst peers. These elements are exemplified in the following case study example:

Best Practice Example – Wikwemikong Outdoor Adventure Leadership Experience

“The Outdoor Adventure Leadership Experience is a best practice approach to promote resilience and well-being for Wikwemikong’s youth. This intervention has been tested and has been proven to be statistically significant in effectively improving psychological resilience among Wikwemikong youth, aged 12-18. Leaders from Wikwemikong collaborated with Laurentian University researchers to develop, implement, and evaluate an OALE program. Trained staff coordinated ten-day canoe trips in the traditional territory of the youths’ community, beginning in Wikwemikong Unceded Indian Reserve on Manitoulin Island in Northern Ontario. The Outdoor Adventure Leadership Experience Presentation has proven to be effective in building capacity and resiliency in participants as the experience allows participants to reconnect and build relationships. Participants are provided with opportunities to find their own answers in their life with this strength based approach to wellness. This experience integrates health and wellness in a natural environment which encompasses our history and provides hands on experience of living off the land. The mental wellness is promoted experientially through culturally relevant outdoor adventure excursions. The Wikwemikong Leadership Manual teaches us to recognize that we have the ability to make a real difference in our own lives and the lives of others; emphasizes the importance of connection to aboriginal roots and culture; discover our own personal vision as a leader in the community; cultivate persistence to pursuit success; practice skills to enable us to work effectively with others. The use of the seven grandfather teachings has been incorporated into the Wikwemikong Leadership Manual therefore conference participants will learn how these practical teachings have been used experientially and leaving a lasting impact on the individual. The use of cultural initiatives and connecting this learning with the natural environment demonstrates the positive influence this will have on the wholistic well-being of the individual. “

Early Identification and Intervention - Children and Youth Mental Wellness Assessment
Key themes in children and youth mental wellness assessment include “collaboration” and “cultural and community appropriateness”. Some specific examples described included:

- Agreement to use a common assessment tool across the region i.e. Children and Adolescents Strengths and Needs (CANS) to help coordinate services between First Nations and agencies
- Collaborative tables – e.g. Simcoe County Aboriginal Capacity Building Circle for culturally appropriate assessment of youth
- Culturally appropriate tools - Development of a culturally appropriate Aboriginal child’s health and wellbeing measure

Reaching and engaging across disciplines, sectors, organizations and providers in order to undertake wholistic assessment was a recurrent refrain. Importantly, however, development of culturally appropriate assessment tools was described as a program success. A case example was shared as follows:

_Best practice example - Aboriginal Children’s Health and Well Being Measure_

“The ACHWM is a newly developed tool that is ready for implementation for First Nation’s youth between the ages of 8-18 years. Integration of Aboriginal Traditional knowledge and western academic research enhanced ACHWM ability to track and improve health outcomes in our communities. This culturally relevant tool has been developed by First Nation’s youth for First Nation’s youth. The ACHWM assesses the emotional, spiritual, mental and physical health of youth in First Nations communities. Determining how aboriginal children conceptualize health and well being and what the best questions are to help children express health and well-being is what inspired the ACHWM. Opportunities to assess the relevance of the ACHWM to First Nations that are culturally and geographically diverse as well as developing new partnerships are part of the future of this culturally appropriate measurement tool.”

Specialized Care and Community-based Care

A central theme in this area based on the examples described would be “Responsiveness” in terms of understanding what a community’s true gaps are and then addressing these accordingly. This is evident in the examples provided as follows:

- Addictions Recovery Supportive housing program – “a step down” from treatment to ease transition to own home environment
- First Nation Early Psychosis Intervention Program
- Supportive Housing Unit on reserve for mental health and addictions
• Enahtig Healing Lodge offers a 10 day residential trauma recovery program and a 21 day residential sexual abuse recovery program, using culture based therapies
• Community-based concurrent disorders treatment program
• Telehealth for northern isolated communities
• Raising the Spirit Mental Wellness Team (this will be described more fully in community capacity and support)

Examples described covered a range of mental wellness and addictions service needs and certainly implied comprehensive, community driven planning and implementation processes. More can be learned from documenting such examples and sharing across communities.

Integration and Coordination of Care

A key contributing factor described in the integration and coordination of care includes “Partnerships” with other service providers such as traditional healers and with agencies and organizations such as hospitals.

• Integrative approaches – e.g. a partnership to involve a traditional healer in psychiatric assessment
• Cross sectorial Domestic Assault Review Team with various agencies (counselors, probation, shelters, justice, crisis)
• Developing protocols with all local hospitals for emergency treatment of suicidal community members

Clearly, protocols for sharing information, policies for effective implementation and competencies in inter-professional care are an important requirement implicit in this area.

Crisis Response

In keeping with the integration and coordination of care, the theme of “Partnerships” was repeated and reinforced in the area of crisis response. Examples described included:

• Training of First Nation community members & staff in crisis response and planning; crisis response teams trained and on call
• Critical incident response teams – reduces impact of trauma
• Resource listing of all key crisis contacts provided to all households & health professionals; used by counselors when working with clients
• 24/7 crisis response service – partnership with community child and family services, addictions services, mental health and ECD workers
• Mobile crisis line
Given the myriad of services and partners which must be engaged when crisis arises, such examples speak to a level of collaborative planning that can only be effective if sustained over a longer term approach which is more proactive than reactive.

**Community Development**

Community development examples described, shared a common underpinning or foundation which is built on “Community strengths & partnerships” as noted below:

- Youth and Elder Centre
  - Youth and elder conference – opportunity to learn from each other
  - Traditional teachings and ceremonies
- Youth Camp – Tetu Lake
  - Traditional and cultural teachings
  - Mentoring programs (bullying, healthy life styles)
  - Land based activities → trapping, fishing, hunting, prep work
  - Partners → social services, chiefs and council, elders, Health Canada, youth, Kenora Chiefs Advisory

These specific examples highlight community creativity in devising programs and bringing together partners, funding, and activities to achieve important outcomes in community development and wellness.

**Mental Health Promotion**

Creative “wholistic, culturally based” activities encompassing physical, emotional, mental dimensions of health form the basis of effective mental health promotion within communities.

- Exercise programs
- Artisan exploration program
- Writing exploration program
- Heritage week – traditional activities leading up to community Pow Wow
- Annual canoe trip on north channel
- Weekly drumming practice
- Traditional health promotion
- Education / promotion of identity/ spirituality/ mental health/ emotional and physical health
- Regalia making and beading

The range of examples underscore and reinforce how communities view mental wellness as wholistic. Programming and funding envelopes must reflect this view rather than narrowly restrict focus to “mental health” related program activities.
Capacity Building

If any theme could be described it would be recognition of a “diversity of approaches” in effective community capacity building in mental wellness as evidenced by the examples shared:

- Raising the Spirit Mental Wellness Team - capacity building and support to front line workers in 10 FNs
- Enyonkwanikonhriyohake Program - mental wellness, addictions, child and youth, adult, elder wellness counseling, advocacy and support
- Mental Health First Aid, ASIST, SafeTalk and non-violent crisis intervention
- FNWACB– certification/recertification
- OTN connected for ability to provide support to other communities, train our own staff
- Indigenous Trauma Recovery on line training through St. Elizabeth Health Care First Nations training

One example shared as a best practice included the “Raising the Spirit” Mental Wellness Team which emphasizes working with community mental health providers to provide training and development in specific areas of expertise and cultural knowledge; as well as team debriefing and support which is often a missing element at the community health staff level.

Best practice example – Raising the Spirit Mental Wellness Team

The “Raising the Spirit” Mental Wellness Team is an innovative project involving the collaboration of a specialized consultative team of professionals from social work, psychology, traditional knowledge and healing, concurrent disorders and psychiatry. The team works with community mental health and addictions workers in addressing complex needs in addictions and mental health in ten area First Nations. The goals of the project are to improve access to needed specialized services where gaps exist, enhance knowledge, skills and capacities of community workers, provide support via a team approach of consultation, clinical supervision, coaching and mentoring as well as to build and strengthen bridges between traditional and mainstream approaches to wellness. This team is very effective at achieving its goals and enhances the overall well-being of the participating communities.

Culturally Competent Services

An essential underpinning amongst the examples described regarding culturally competent services, included recognizing and utilizing “community knowledge” to devise or design programming interventions. Examples included:

- Traditional family services for children in care
- Culturally based concurrent disorders program
• Fasting / sweat lodge teachings and on the land activities in spring and fall
• Services of Elders Healers in community
• Clinical mental health services developed with FN community members who understand local culture, history and traditions
• Use of traditional advisors with clients who may be experiencing psychosis
• Community staff collaborate with specialists to provide cultural/community context.

Participants asserted that processes to uncover community held understandings of cultural and traditional knowledge is the starting point to designing programs incorporating and applying this knowledge.

Moreover, in the area of **strengthening cultural knowledge and competency**, “partnerships with education and other stakeholders” is recognized as an important mechanism to promulgate an approach which is culturally informed and sensitive. Such efforts could start in educating the public within school settings on through to professional training institutions according to the examples shared:

• Delivery of mental health curriculum to on reserve schools for kids in Kindergarten to Grade 12 – based on Ontario curriculum; teacher resources using community specific traditional knowledge and cultural ways
• Delivery of a First Nations mental health presentation to psychiatric residents in their final year at McMaster
• Building cultural competency amongst medical students at Northern Ontario School of Medicine
• Partnership with Toronto Central LHIN & OFIFC. Cultural competency training mental health & addictions for non-Aboriginal service providers

These examples again, are predicated on partnership delivery approaches.

Lastly, **sharing cultural knowledge** must also take place within communities and their own health service settings and amongst their community members. The examples described are ones which reflect approaches that are “Community designed & driven” as noted below:

• Strengthening cultural identity – e.g. Whitefish Bay Model & Lac la Croix - connecting youth to elders, land and ceremony through family centred, cultural camps
• Culture camps teach life on land; are wholistic, & community based, family centred, proactive approach to strengthening wellness & identity

These are wonderful examples again that link family, community, land and historical connectedness, embed spiritual and wholistic approaches and reflect knowledge, teaching and practices that are uniquely defined by each and every community involved. Program funding, policies and mandates must provide the latitude to support such approaches.
Strengthening Existing Resources

In order to build a mental wellness continuum, new funding streams must be developed and existing funded programs reoriented or refined.

While participants strongly asserted the need for new, additional resources to address the wide range of gaps, they also provided suggestions as to how existing funding resources could be strengthened in order to be more flexible and responsive to the true areas of need. In answer to the discussion question, “How can funding models be adapted to improve services in First Nations communities?” dialogue session participants shared the following:

1. Review NIHB crisis counselling policy

A program policy review around eligible services should be undertaken to support services and an approach which is more reflective of individual, family and community needs in mental health counseling. A review of how this funding stream is operationalized in other provinces, will be beneficial to inform policy changes in Ontario. Based on participant feedback, changes in policy should reflect the following:

- Inclusion of cultural and traditional approaches
- Facilitation of family-centered approaches
- Providers and service models should be competent in trauma informed approaches to mental health and addictions
- Focus on culturally safe services
- Encourage and support linkages to community mental health services in a team approach
- Focus collection and appropriate sharing of mental health and addictions service and client information inform community planning

2. Children and Youth Mental Wellness

This is a priority area of services which, while gaining greater attention and resources, must reflect a more coordinated and comprehensive approach across the jurisdictions, partners and funding sources implicated if it is ever to be effective. In particular, there should be:

- Closer coordination between federal & provincial funding bodies
- Clear expression of children and youth mental wellness priorities and funding stream in federal framework
• Identification and elimination of gaps between jurisdictions

3. Flexible transfer funding

Dialogue session participants spoke to the need to support and encourage communities to be more self-determining in their overall approach to community wellness. This would entail:

• Allowing communities the latitude to determine their own program priorities and design programs and services accordingly
• Providing fair and equitable resources for cultural and traditional approaches to service provision
• Considering a needs based approach to service development
  • Addressing the unique needs of remote communities who lack access to many services; and recognizing that remote communities often have greater needs

4. Support existing models

There are a number of community defined “success stories” including programs such as cultural camps which communities have described as working well. Program funders should find ways to provide funding or continue funding these instead of reinventing new programs.

Healing lodges have been a source of defining and developing indigenous health and wellness practices yet many are about to lose funding. Dialogue session participants strongly encouraged an openness to find ways to continue funding these needed centers and their programs.

5. Human resources

An area that participants also remarked on included the area of mental health and addictions human resources. Efforts at recruitment, retention, career promotion and ongoing professional development cannot be overlooked. In particular, participants spoke to clear needs in the areas of:

• Salary and wage parity for service providers who provide services on reserve
• Recognition of the difficulties in recruitment and retention of human resources especially in remote and northern locales
• Development and support of clinical supervision models, ongoing capacity building and professional development; regularly scheduled debriefing
Implementation Factors:

Dialogue session participants described a number of essential policy orientations and structural frameworks required as a backdrop for and effective mental wellness framework:

1. Support effective community driven, inter-agency and cross-sectorial collaboration and planning:

It is clear that especially in rural and northern contexts, a wide range of community based & specialized services are not accessible. Improved collaboration can only be realized if such services which span the continuum are, in fact, available.

Moreover planning by different agencies based on their own mandates does not effectively link or collaborate across organizations or with communities. This is particularly evident, during crisis where a clear lack of coordination between agencies and services as well as a lack of continuity beyond the immediate community crisis occurs.

Resources must be better coordinated to sustain and support communities in their long term planning of community based services and to foster interagency collaboration where needed.

2. Services need to become adaptable to meet actual community needs and priorities:

Across both dialogue sessions there was recognition that the array of existing programs, designed for different times, issues, needs and community capacities must now be revisited. There was strong assertion that the “system” should adapt to the community and cultural needs expressed meaning that community needs and aspirations must inform federal and provincial policies and program priorities. This is currently not how programs and services are developed. Instead, communities are required to react and adapt to funding and program priorities which form part of the available system.

3. Advocate for government wide coordination to address social determinants:

A dimension of the mental wellness continuum discussion returned time and again to the fact that the framework can only be supported if mental health and addictions are addressed within the context of social determinants of health. Issues related to community infrastructure, housing, education, economic development and other sectors are impacting all aspects of individual, family and community mental health. Collaborative approaches must be developed to include all of the relevant sectors if community wellness is to be supported in the long term.

Therefore a “whole of government”, “whole community”, cross sectoral, cross- departmental approach is required to address mental health and addictions.
4. **Cultural safety and cultural competency:**

Culture must be at the heart of any proposed mental wellness continuum framework yet there are currently few program supports to develop culturally safe care for First Nations clients and their families with mental health and addictions issues. Programs and services need to be reflective of community cultural and traditional approaches and offer choices to clients. Session participants offered the following guiding principles for programs and services within a mental wellness framework:

- Cultural safety is determined by client and community
- Cultural competency is a qualification needed by all agencies involved as well as service and program providers
- One cannot assume all First Nations organizations are culturally safe
- More community lead research is needed to develop appropriate integration models for clinical and cultural approaches
- Service agreements should make cultural competency of service providers and staff a requirement (including NIHB providers; governmental staff)
- Appropriate compensation model is needed for cultural knowledge keepers who provide services

5. **Leadership must be nurtured to support a mental wellness continuum and framework and to advocate for the necessary resources:**

Specific support is required from leadership in the Ontario area. Leaders must be apprised and supported in order to help foster:

- Strong advocacy for improved coordination amongst all jurisdictions;
- Ensuring collective community voices are heard;
- Ensuring closer alignment of the system with community needs;
- Advocating for adequate and appropriate funding models

Community leaders can also:

- Demonstrate their support for community development approaches
- Express clear declarations of their community aspirations i.e. “wellness as an inherent right of all people”
- Ensure accountability with regard to community developed strategies and plans e.g. 2010 Grand Council Treaty 3 comprehensive healing strategy
Key Recommendations

The recommendations in this section are at high level recommendations, which is a reflection of the great variation in access and funding of services in First Nation communities in Ontario. Operational level recommendations will need to be developed in various geographic regions in Ontario and be designed to reflect specific program components of the continuum. Overall guiding principles for the recommendations are:

*Move away* from piece meal funding and reporting, reactive services and band aid solutions.

*Move towards* a commitment to address the continuum of First Nations mental health and addictions needs;

**Recommendation 1: Develop Flexible Approaches**

There is variation in local capacity for clinical mental health and cultural approaches as well as geographic access to specialized services provided in larger centres. Many rural and remote First Nations have currently no access to mental health and addictions services beyond health promotion. This has resulted is an ongoing and increasing state of crisis for some First Nations, especially those in remote areas. The development and re-orientation of services requires flexible and regionally tailored solutions that respect and build on the current realities of the diverse First Nations across Ontario.

The diversity of the needs of the various areas in Ontario are clearly reflected thought the report and in particular in Appendix D: Critical Gaps Toronto and Thunder Bay Session.

**Recommendation 2: Build on the Successes of Current Programs**

It is very encouraging and much can be learned from current initiatives that are working which point to promising practices for mental health and addictions. First Nations communities are highly motivated to take on the development and implementation of additional, culturally-based services. However, realistic funding commitments are now required to address mental health and addictions issues in culturally and community appropriate ways. There must be a commitment to move away from band aid solutions towards a systems level change.

Successful programs that should be considered for further funding and development are provided in this report in the section entitled *Successes and Promising Practices* as well as Appendix E: Build on Successes. (Additional programs may exist, these program descriptions should not be considered as exhaustive.)
Recommendation 3: Address LHIN/ Inter-Ministry/ Provincial and Federal jurisdictional barriers

To realize sustainable improvements in the area of mental health and addictions, crippling LHIN/ Inter-Ministry/ Provincial and Federal jurisdictional barriers require immediate attention. As it may require time to develop sustainable multi-partite planning tables, interim measures are urgently needed to respond to the current crisis situation. Interim planning tables involving First Nations communities should be struck in order to address the development of mental health and addictions services now.

The barriers that should be most urgently addressed are provided in this report in the section entitled Implementation Factors as well as Appendix E: Build on Successes, "What are critical the success factors?"

Recommendation 4: A Mental Wellness continuum will require a wholistic approach to be effective

An effective Mental Wellness continuum approach cannot be composed of piece meal collection of services. Instead, participants advocated strongly for the design of a continuum or framework reflective of the following important service orientations:

- Life course approach
- Family approach
- Culturally-based, strengths-based approach
- Continuum of services approach

The specific areas for development of this wholistic approach are provided in this report in the section entitled Findings of the Dialogue Sessions (Key Definition Related to the Mental Wellness Continuum and Critical Gaps in Mental Health and Addictions within the Current System); Successes and Promising Practices; and Appendix E: Build on Successes.

Recommendation 5: A Mental Wellness continuum will require a commitment to address complex and wide-ranging First Nations mental health and addictions needs.

A broad range or continuum of services are required which are linked to and supportive of each other. These would include:

- Promotion, prevention, community development
- Early identification and intervention
- Crisis response
- Treatment services
- Capacity building and support for workers
• Coordination of care
• Culturally safe tertiary treatment services
• Support and Aftercare

There must be movement from a discrete “programs and services” approach to a “system” approach informed by the dimensions, elements, principles and guidelines as expressed by all dialogue session participants. Services require approaches that are life course-based, family-based, culturally-based and strengths-based. The diagram provides the visual representation of this concept (as provided in the Key Definitions section of this report):

Recommendation 6: A realistic Mental Wellness Continuum will require enhanced funding commitments for some geographic areas

Many communities have access to few or no services to address the complex issues faced by their community members. For these communities, re-arranging of funding envelopes will not likely be sufficient to address mental health and addictions, due to the high need for services. A wholistic, well-conceived and designed culturally safe continuum is needed, built upon existing strengths and success stories. Piece-meal and band aid solutions which have not been effective in the past will not likely work in the future.

This conclusion is well supported by the extensive gaps described in this report and in particular in Appendix D: Critical Gaps Toronto and Thunder Bay Session.
Recommendations for Next Steps in the Process:

Both dialogue sessions were very well attended by influential and knowledgeable community workers and professionals and engendered insightful, proactive discussion. There was strong optimism that this is the right time, climate, and interest matched to community readiness, will and capacities which can now effect the needed change aimed at improving community mental wellness.

Health Canada regions can now support the development of an appropriate framework or continuum responsive to the Ontario Regional dialogue by:

• “Listen” and acknowledge what has been shared; in many instances these are not new messages.

• Feedback, clarify, and articulate results of regional and national level dialogue via clear and transparent processes involving all stakeholders and disseminated to all participants.

• Advocate strongly for regional needs at federal discussion and decision making tables.

• Ensure communities have ongoing “touch-points” into the process as it unfolds with ample opportunities for refinements, clarifications and validation.

• Coordinate on an ongoing and consistent basis with provincial partners and ensure they are included in the process as the framework or continuum is being developed.

• Share results of the dialogue with partners and stakeholders and offer opportunities for feedback.
# Appendix B: Meeting Agenda Toronto

*Ontario Region First Nation Mental Wellness Continuum*

*Dialogue Session Agenda*

*Wednesday, May 29th 8:00 am – 4:30 pm, Thursday, May 30th 8:00 am – 1:00 pm*

_Courtyard Marriot, 475 Yonge St._

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### Wednesday, May 30th, Yonge Room

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>8 am</td>
<td><strong>Coffee/Refreshments</strong></td>
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<tr>
<td>8:30 am</td>
<td>Welcome</td>
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<td></td>
<td>Opening prayer</td>
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<tr>
<td>8:45 am</td>
<td>Remarks: National Framework Development, Building on the activities of Mental Wellness Advisory Committee</td>
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<tr>
<td></td>
<td>Dr. Brenda Restoule</td>
</tr>
<tr>
<td>9:00 am</td>
<td>Introductions – acknowledging one another’s strengths, capacities and experiences</td>
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<td></td>
<td>“Who will you carry”</td>
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<td></td>
<td>Mariette Sutherland, Marion Maar, meeting facilitators</td>
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<tr>
<td>9:30 am</td>
<td>Overview of agenda, orientation to “Knowledge Sharing Tables”</td>
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<tr>
<td>9:35 am</td>
<td>Knowledge Sharing Tables - Critical gaps:</td>
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<td>1. Children and youth mental wellness services</td>
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<td>2. Coordination of care</td>
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<td>3. Specialized care needs; community based services</td>
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<td>4. Early identification and intervention</td>
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<td>5. Crisis response, crisis services</td>
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<td>6. Community development, health promotion and prevention</td>
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<td>7. Community level capacity and support</td>
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<td>8. Culturally safe practices/cultural competency/cultural knowledge</td>
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</table>
|            | **Affirming designated topics – Are these the right priority topics for our discussion?**  
<p>|            | <strong>What common service gaps across Ontario region must we design around?</strong> |
|            | Knowledge sharing tables - Groups will move from table to table describing how these critical needs or service gaps manifest within their communities. Groups will also reflect on ways these gaps represent opportunities in the development of the framework. |
| 10:30 am   | <strong>Coffee/Refreshments</strong>                                               |
| 10:45 am   | Continuation of Critical Gaps discussion via Knowledge Sharing Tables  |
| 11:30 am   | Plenary Discussion                                                     |
|            | Review of Knowledge Sharing Table results                             |
|            | Building consensus around key themes                                   |
| 12:15 pm   | <strong>Lunch break – on own</strong>                                               |</p>
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| 1:00 pm  | A strengths based continuum – using the same Knowledge Sharing Table format, groups will describe how communities have built strengths and unique approaches in each of these areas. *In Ontario region, what has worked? What innovative or creative practices have emerged? How can we learn from what others have done?*  
1. Children and youth mental wellness services  
2. Coordination of care  
3. Specialized care needs; community based services  
4. Early identification and intervention  
5. Crisis response, crisis services  
6. Community development, health promotion and prevention  
7. Community level capacity and support  
8. Culturally safe practices/cultural competency/cultural knowledge |
| 2:30 pm  | **Coffee/Refreshments**                                               |
| 2:45 pm  | Plenary Group Discussion  
Review of Knowledge Sharing Tables results  
*What key strengths can we build on in a national mental wellness continuum?* |
<table>
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<th>Time</th>
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| 3:30 pm | Small group work – two groups will be formed to discuss questions in relation to two distinct aspects:  
*What are the critical factors which have supported these successes?  How can more of these be cultivated in a new framework?  
*What structural supports are needed?*  
*Within communities:  
  - Human Resources  
  - Capacity building  
  - Knowledge exchange  
  - Research, data, surveillance*  
*In the external context  
  - Jurisdictional issues  
  - Policy and planning environment  
  - Sectorial collaboration  
  - Data, research, surveillance*  
| 4:00 pm | Group Reports                                                        |
| 4:30 pm | • Wrap up of day’s achievements  
  • Overview of next day’s agenda |

**Thursday, May 31st, Alexander A and B**

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8 am</td>
<td><em>Coffee/Refreshments</em></td>
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<tr>
<td>8:30 am</td>
<td>Opening prayer</td>
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<tr>
<td>8:45 am</td>
<td>“Who I’ve carried”</td>
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<tr>
<td>9:00 am</td>
<td>Presentation of previous day’s highlights – Mariette Sutherland, Marion Maar</td>
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<td>Time</td>
<td>Activity</td>
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<tr>
<td>10:00 am</td>
<td>View from a community perspective, a critical lens from the field – “How questions”. Based on day one themes and highlights; three groups will form to discuss:</td>
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<td><strong>Realignment of priorities, funding, resources:</strong></td>
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<td></td>
<td><em>How can the scope of existing federal, provincial, territorial and community level programs be redefined to meet the gaps above?</em></td>
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<td><em>How can the ways in which communities receive funding be adapted to improve services?</em></td>
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<td><em>How can existing resources be better leveraged through partnerships, cultural competency, and relevancy?</em></td>
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<tr>
<td>10:00 am</td>
<td><strong>Collaboration/coordination:</strong></td>
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<td></td>
<td><em>How do existing services at the community level collaborate? Can this be done differently?</em></td>
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<td><em>How can existing systems at the F/P/T level coordinate better with existing services at the community level?</em></td>
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<td><em>What are the specific opportunities for strengthened coordination - with which partners?</em></td>
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<td></td>
<td><strong>Cultural safety, competency, knowledge</strong></td>
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<td></td>
<td><em>How can clinical and cultural supports link better?</em></td>
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<td></td>
<td><em>How can programming and service providers be more culturally safe and competent?</em></td>
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<tr>
<td>10:45 am</td>
<td>Coffee / Refreshments</td>
</tr>
<tr>
<td>11:45 am</td>
<td>• Overview of accomplishments</td>
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<tr>
<td></td>
<td>• Your mental wellness continuum highlights</td>
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<td></td>
<td>• What you can expect to happen next</td>
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<td></td>
<td>• Nomination of a “raconteur”</td>
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<td></td>
<td>• Feedback, evaluation</td>
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<tr>
<td>1:00 pm</td>
<td>Closing prayer and acknowledgements</td>
</tr>
</tbody>
</table>
Appendix C: Meeting Agenda Thunder Bay

Ontario Region First Nation Mental Wellness Continuum
Dialogue Session Agenda
Wednesday, June 5\textsuperscript{th}, 8:00 am – 4:30 pm, Thursday, June 6\textsuperscript{th}, 8:00 am – 1:00 pm
Valhalla Inn

**Wednesday, June 5\textsuperscript{th}**

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td><strong>Coffee/Refreshments</strong></td>
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<tr>
<td>8:30 am</td>
<td>Welcome, Opening prayer</td>
</tr>
<tr>
<td>8:45 am</td>
<td>Remarks: National Framework Development, Building on the activities of Mental Wellness Advisory Committee Dr. Brenda Restoule</td>
</tr>
<tr>
<td>9:00 am</td>
<td>Introductions – acknowledging one another’s gifts and experiences</td>
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<tr>
<td></td>
<td>“My community’s strengths”</td>
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<tr>
<td></td>
<td>Mariette Sutherland, Marion Maar, meeting facilitators</td>
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<tr>
<td>9:30 am</td>
<td>Overview of agenda</td>
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<td>Time</td>
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<tr>
<td>9:45 am</td>
<td>Discussion group activity – four groups will form to discuss key questions related to the following:</td>
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<tr>
<td></td>
<td>1. Children and youth mental wellness and addictions services</td>
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<td></td>
<td>2. Coordination of care; continuity of care after treatment</td>
</tr>
<tr>
<td></td>
<td>3. Specialized care needs; community based services</td>
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<td></td>
<td>4. Early identification and intervention</td>
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<td></td>
<td>1. <em>What are the critical needs or service gaps within these areas in Northwestern Ontario communities? How do these gaps represent opportunities in the development of the framework?</em></td>
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<td><strong>AND</strong></td>
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<td>2. <em>In the Northwestern Ontario region, what has worked in each of these areas? What innovative or creative practices have emerged? How can we learn from what others have done?</em></td>
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<tr>
<td>10:30 am</td>
<td><strong>Coffee/Refreshments</strong></td>
</tr>
<tr>
<td>10:45 am</td>
<td><strong>Group Sharing</strong></td>
</tr>
<tr>
<td>11:30 am</td>
<td><strong>Plenary Discussion</strong></td>
</tr>
<tr>
<td></td>
<td>Review of small group sharing - key themes to build into the continuum or framework</td>
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<tr>
<td>12:15 pm</td>
<td><strong>Lunch break – on own</strong></td>
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<td>Time</td>
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<tr>
<td>1:00 pm</td>
<td>Building the continuum – using the same format as in the morning, four new groups will be formed to discuss these following topics.</td>
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<td>5. Suicide, crisis response, crisis services</td>
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<td></td>
<td>6. Community development, health promotion and prevention</td>
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<td></td>
<td>7. Community level capacity and support</td>
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<td>8. Culturally safe practices/cultural competency/cultural knowledge</td>
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<td>AND</td>
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<td></td>
<td>2. <em>In the Northwestern Ontario region, what has worked in each of these area?</em> <em>What innovative or creative practices have emerged?</em> How can we learn from what others have done?</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Group sharing</td>
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<tr>
<td>2:30 pm</td>
<td><strong>Coffee/Refreshments</strong></td>
</tr>
<tr>
<td>2:45 pm</td>
<td>Plenary Group Discussion</td>
</tr>
<tr>
<td></td>
<td>Review of group sharing – key themes</td>
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<td><em>What gaps, opportunities, key strengths and best practices should be incorporated in a national mental wellness continuum?</em></td>
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<td>Time</td>
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<tr>
<td>3:30 pm</td>
<td>“Ideas roundup” What specifically is needed to support a strong mental wellness continuum and its implementation? What needs to happen, be in place or be developed? Participants will be provided an opportunity to circulate around the room where eight different charts with the following headings will be placed. Participants will be asked to describe on the flipcharts, specific supports, changes or enhancements they feel are needed in each of the following areas:</td>
</tr>
</tbody>
</table>
|         | **Within communities:**  
|         |  - Human Resources  
|         |  - Capacity building  
|         |  - Knowledge exchange  
|         |  - Research, data, surveillance  
|         | **In the external context:**  
|         |  - Jurisdictional issues; program funding issues  
|         |  - Policy and planning environment  
|         |  - Sectorial collaboration  
|         |  - Data, research, surveillance  
| 4:00 pm | Group Review and discussion – “Ideas Roundup”  
| 4:30 pm | - Wrap up of day’s achievements  
|         | - Overview of next day’s agenda  

**Thursday, June 6th**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>8 am</td>
<td><strong>Coffee/Refreshments</strong></td>
</tr>
<tr>
<td>8:30 am</td>
<td>Opening prayer</td>
</tr>
<tr>
<td>8:45 am</td>
<td>“What keeps me going in the work I do”</td>
</tr>
<tr>
<td>9:00 am</td>
<td>Presentation of previous day’s highlights – Mariette Sutherland, Marion Maar</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
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<tr>
<td>10:00 am</td>
<td>View from a community perspective, a critical lens from the field – “How questions”. Based on day one themes and highlights; three groups will form to discuss:</td>
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<td></td>
<td><strong>Realignment of priorities, funding, resources:</strong></td>
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<td>How can the scope of existing federal, provincial, territorial and community level programs be redefined to meet the gaps above?</td>
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<td>How can the ways in which communities receive funding be adapted to improve services?</td>
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<td></td>
<td>How can existing resources be better leveraged through partnerships, cultural competency, and relevancy?</td>
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<tr>
<td>10:00 am</td>
<td><strong>Collaboration/coordination:</strong></td>
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<td></td>
<td>How do existing services at the community level collaborate? Can this be done differently?</td>
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<td>How can existing systems at the F/P/T level coordinate better with existing services at the community level?</td>
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<td></td>
<td>What are the specific opportunities for strengthened coordination - with which partners?</td>
</tr>
<tr>
<td>10:45 am</td>
<td><strong>Coffee / Refreshments</strong></td>
</tr>
<tr>
<td>11:45 am</td>
<td>- Overview of accomplishments</td>
</tr>
<tr>
<td></td>
<td>- Your mental wellness continuum highlights</td>
</tr>
<tr>
<td></td>
<td>- What you can expect to happen next</td>
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<td></td>
<td>- Nomination of a “raconteur”</td>
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<tr>
<td></td>
<td>- Feedback, evaluation</td>
</tr>
<tr>
<td>1:00 pm</td>
<td>Closing prayer and acknowledgements</td>
</tr>
</tbody>
</table>
Appendix D: Critical Gaps Toronto and Thunder Bay Session

Children and Youth Services

<table>
<thead>
<tr>
<th>Critical Gaps – Children’s and Youth Mental Wellness and Addictions</th>
<th>Northwest and Northeast Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>South and Northeast/Central Ontario</td>
<td>More prevention</td>
</tr>
<tr>
<td>• Assessments – clinical tools, culturally based, wholistic assessment in context of family</td>
<td>* Safe spaces to talk/share</td>
</tr>
<tr>
<td>• Coordination/services in school setting</td>
<td>* Treatment in communities</td>
</tr>
<tr>
<td>Training for school based staff</td>
<td>* Culturally appropriate, spiritually based interventions</td>
</tr>
<tr>
<td>• Transitions, age definitions problematic</td>
<td>* Teachers need training to identify mental health issues; more resources/services in schools</td>
</tr>
<tr>
<td>• Labels, behavioural vs mental health</td>
<td>* Transitional housing</td>
</tr>
<tr>
<td>• Bullying programs - lateral violence programs</td>
<td>* Youth treatment beds (suicide)</td>
</tr>
<tr>
<td>• Non pharma alternatives needed</td>
<td>* FN on-reserve treatment facility</td>
</tr>
<tr>
<td>• Parenting support; Engagement with families; single parent/blended family complexities</td>
<td>* Structured environment that is safe; culturally appropriate in the region</td>
</tr>
<tr>
<td>• Must link to early identification/intervention</td>
<td>* Need to be alert for misdiagnosis eg schizophrenia which may in fact be solvent abuse – better understanding of issues</td>
</tr>
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</table>

Early Identification and Intervention

<table>
<thead>
<tr>
<th>Critical Gaps – Early Identification and Intervention</th>
<th>Northwestern and Northeastern Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern, Northeastern, Central Ontario</td>
<td>Need to be alert for misdiagnosis eg schizophrenia which may in fact be solvent abuse – better understanding of issues</td>
</tr>
<tr>
<td>• Written protocols needed to appropriately connect with schools</td>
<td>* Teachers need training to identify mental health issues; more resources/services in schools</td>
</tr>
<tr>
<td>• Age categories too narrow – should be 12 - 25</td>
<td>* To reach children and youth, need to reinforce:</td>
</tr>
<tr>
<td>• Service gap (15-19) – reframe funding; coordinate services to families</td>
<td>* Culture</td>
</tr>
<tr>
<td>• 6-12 vulnerable years, issues around labeling children; non pharma/non-medical therapies needed</td>
<td>* Language</td>
</tr>
</tbody>
</table>
• Fear of child welfare/CAS/"duty to report" is a barrier to early intervention; greater awareness/understanding of child welfare protocols needed
• Ongoing support to reduce stigma in discussing or seeking care for mental wellness
• Early intervention/support needed for FASD
• Services aimed at drug abused babies, toddler/pre-school age
• Closer link to crisis response
• Early identification across spectrum – dementia, depression, psychosis
• Outreach to seniors who are reluctant to access services or care

* Identity
* Family connections
* Connections with elders
* Ceremonies in communities
* But also recognize that there are different spiritual frameworks and faiths

**Coordination and Continuity of Care**

<table>
<thead>
<tr>
<th>Critical Gaps – Coordination, Continuity of Care</th>
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</thead>
<tbody>
<tr>
<td>South and Northeast/Central Ontario</td>
</tr>
<tr>
<td>• Limited services on reserve/territory; services off reserve sometimes not culturally competent/safe</td>
</tr>
<tr>
<td>• Lack of coordination on FN; as well as inter-agency; and with hospitals etc.; no discharge plans</td>
</tr>
<tr>
<td>• Privacy laws impede coordination; lack of understanding of circle of care – training needed; standardized protocols for info sharing needed</td>
</tr>
<tr>
<td>• Repeating story/trauma; confidentiality concerns in small communities</td>
</tr>
<tr>
<td>• NIHB counsellors, private practitioners – policy review of eligible services/linkage to community service, access to aggregate data to inform planning</td>
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land; wholistic, community based, family centred, protective not reactive

Specialized Care Needs, Community-based Care

<table>
<thead>
<tr>
<th>Critical Gaps – Specialized Care Needs, Community Based Care</th>
<th>South and Northeast/Central Ontario</th>
<th>Northwest and Northeast Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Early psychosis intervention</td>
<td>• Few/very limited specialized care services accessible to communities</td>
<td></td>
</tr>
<tr>
<td>• ACT teams on reserve</td>
<td>• Traditional services and Elders recognized as “specialized care” along with mainstream specialized services; need funding mechanisms to support these services</td>
<td></td>
</tr>
<tr>
<td>• On reserve treatment beds</td>
<td>• Need to build community based services as there are none</td>
<td></td>
</tr>
<tr>
<td>• Concurrent disorders training</td>
<td>• Need to improve interagency collaboration</td>
<td></td>
</tr>
<tr>
<td>• Longer treatment services (sessions, cycles)</td>
<td>• Need for transitional housing for people who are returning from treatment centres.</td>
<td></td>
</tr>
<tr>
<td>• Cycle of life services (geriatric mental health)</td>
<td>• Trauma informed services, training, mechanism for dealing with trauma</td>
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<tr>
<td>• Trauma informed services, training, mechanism for dealing with trauma</td>
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Crisis Response

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<thead>
<tr>
<th>Critical Gaps – Crisis Response</th>
<th>South and Northeast/Central Ontario</th>
<th>Northwest and Northeast Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “systems crisis” support for what happens when programs end eg IRS</td>
<td>• Lack of resources in general</td>
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<tr>
<td>• Current crisis counseling does not recognize cultural supports</td>
<td>• Lack of training in Critical Stress Debriefing and Critical incident management</td>
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</tr>
<tr>
<td>• CISM specialists in community are needed</td>
<td>• Lack of coordination amongst all providers/programs/jurisdictions during crisis</td>
<td></td>
</tr>
<tr>
<td>• Community Crisis Response planning – opportunities to learn from otherFNs</td>
<td>• Lack of continuity of care after the crisis or suicide</td>
<td></td>
</tr>
<tr>
<td>• Support for workers impacted by crisis</td>
<td>• Lack of capacity building in the community to deal with crisis over a longer term - gap in community development</td>
<td></td>
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</tbody>
</table>
resources
* Lack of safe places in the community
* Lack of prevention and early intervention
* Need expertise on concurrent disorders MH and A
* Empower, recognize and resource natural helpers, traditional helpers

Community Capacity and Support

<table>
<thead>
<tr>
<th>Critical Gaps – Community Capacity and Support</th>
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</thead>
<tbody>
<tr>
<td><strong>South and Northeast/Central Ontario</strong></td>
</tr>
<tr>
<td>• Core curriculum of training is needed</td>
</tr>
<tr>
<td>• Appropriate supervision for front line workers</td>
</tr>
<tr>
<td>• Policies, procedures to guide workers</td>
</tr>
<tr>
<td>• Virtual training and support for workers</td>
</tr>
<tr>
<td>• Support for workers affected by trauma/crisis</td>
</tr>
<tr>
<td>• Reduce community program “silos” (eg NNADAP, BHC/BF, CHR, CHN)</td>
</tr>
<tr>
<td>• Community support is needed for MH and A – BCR, vision, strategy</td>
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<tr>
<td>• Appropriate compensation for workers</td>
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Community Development, Prevention and Promotion

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<thead>
<tr>
<th>Critical Gaps – Community Development, Prevention, Promotion</th>
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<tbody>
<tr>
<td><strong>South and Northeast/Central Ontario</strong></td>
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<tr>
<td>• Seems to be the focus, whereas the gaps are in services, treatment etc.</td>
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</table>
• Needs to be culturally appropriate  
• Identify and remove barriers to access; reach out to more vulnerable  
• Adapt mainstream resources to culture and community

they want  
* Coordination - who will do this and how to involve the whole community?  
* Separate plans for each different agency or program mandate; need linkages and collaboration  
* Need a comprehensive plan focused on education/prevention  
* Support community healing  
* Community crisis planning, team and ongoing support

<table>
<thead>
<tr>
<th>Promotion</th>
<th>Prevention</th>
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</thead>
</table>
| • Promote family and cultural values; Protection of children; Family intervention  
• Education, values, teaching;  
• Identity  
• Mechanisms to transmit teachings/knowledge to children and youth  
• Appropriate use of social media  
• Use other areas to build knowledge and pride – schools  
• Using positive mentors and role models (burnout) | • Sensitized education/awareness which won't compound the issue or problem eg mixing drugs  
• Harm reduction eg. needle drop off in communities  
• Address gap for 9-13 year olds  
• Encourage use of traditional medicines  
• Knowledge of long term impacts of treatment (eg methadone, suboxone) are unknown |

**Cultural Safety, Competency and Knowledge**

<table>
<thead>
<tr>
<th>Critical Gaps – Cultural safety, competency, knowledge</th>
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<tbody>
<tr>
<td>South and Northeast/Central Ontario</td>
<td>Northwest and Northeast Ontario</td>
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</table>
| • Cultural safety is/must be determined by client  
• Cultural competency is a qualification needed by agencies/providers  
• Communities need a process to determine this for themselves  
• Cannot assume all FNs and organizations are culturally safe  
• More research needed – clinical | * Need community based processes to define cultural safety, competency and knowledge  
* Need training for external providers to ensure they are trauma informed, culturally safe and competent based on community realities/needs/meaning |
and cultural approaches
- Service agreements should make cultural competency a requirement
- Appropriate compensation for cultural knowledge keepers

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<tr>
<td>• Mechanisms to transmit</td>
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</tr>
<tr>
<td>teachings/knowledge to children</td>
<td>• Knowledge of long term impacts of treatment (eg methadone, suboxone) are unknown</td>
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<tr>
<td>and youth</td>
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</tr>
<tr>
<td>• Appropriate use of social media</td>
<td></td>
</tr>
<tr>
<td>• Use other areas to build</td>
<td></td>
</tr>
<tr>
<td>knowledge and pride – schools</td>
<td></td>
</tr>
<tr>
<td>• Using positive mentors and role models (burnout)</td>
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Appendix E: Build on Successes

WHAT HAS WORKED?
The following are meeting notes from flip charts and group presentations in response to the following questions:

- In Ontario region, what has worked?
- What innovative or creative practices have emerged?
- How can we learn from what others have done?

1. Children and youth mental wellness services
   - Youth counselor goes to all 5 local schools (elementary and high school) to meet with students from our community. Also pow wows in schools and cultural presentation to all interested students
   - Partnered with the YMCA in which they provide a free outreach program implementing such initiatives as “Catch”
   - Partnership with CPRI and SOAHAC for a psychiatric assessment with traditional healer involved
   - Partnership with communities in SW Erie ST Clair to deliver children’s programs with a cultural base looking at building cultural identity and resilience
   - Delivery of life cycle mental health services covering children youth adults and geriatric in one office to support ease of transition between services
   - Training youth (15 plus) in safe TALK to help identify their friends at risk of suicide and know how to intervene
   - Outdoor adventure leadership experience. Ten day canoe trip builds capacity and resilience in First Nation youth
   - Aboriginal children’s health and wellbeing measures that seeks to identify needs of children ages 8 to 18 → wiki health centre and Laurentian University
   - Aboriginal child/youth mental health/Addictions workers
   - Strengthening families program (14 weeks)
   - Peer mentoring training
   - Child youth mental health initiative – outreach/school support
   - Mistatim Medicine Horse Youth Program. Unplugs youth from electronic devices and brings youth together in week long camps which reconnects youth to land (rough camping) ceremonies and work with horses. using equine therapy> In Simcoe county.

2. Coordination of Care
   - In Simcoe County, a number of collaborative tables were struck that dealt with specific issues/ie. children & youth. Collaborative tables included First Nations, Metis and mainstream agencies. Example: ACBC (Aboriginal Capacity Building Circle) which lead to the development of a culturally appropriate assessment tool for children and youth. Other tables meet to work together on child welfare & education.
   - M’Chigeeng First Nation Methadone Program
   - NP Onsite/Nurse practitioner x few days monthly
• In depth team planning of who is providing what service(s), what gaps exist, and development of yearly workplans as a team
• Had “Domestic Assault Review Team” with various agencies (counselors, probation, shelters, justice, crisis)
• Electronic medical record across all health programs governed by PHIPA for privacy and a governance policy for documentation standards
• Developing protocols with all local hospitals for emergency treatment of suicidal community members
• Agree to use a common assessment tool across the region i.e. CANS tool (Children and Adolescents Strengths and Needs) to help coordinate services between FNs and agencies.

3. Specialized care & community based services

• Community based concurrent disorders treatment program
• Raising the Spirit Mental Wellness Team providing specialized services in 10 First Nations on Manitoulin
• Psychological consultation and direct intervention from Noojmowin Teg HC
• Psychiatric Consultation
• Enahtig Healing Lodge provides a 10 day residential trauma recovery program. And a 21 day residential sexual abuse recovery program, using culture based therapies.
• Telehealth for northern isolated communities
• Land based healing using traditional activities to promote healthy lifestyles
• NSTC’s Mental health caseworker for those diagnosed with mental illness
• Delivery of Addictions Recovery Supportive housing program on reserve for individuals dealing with addiction, in recovery, needed in community support – ideally “a step down” from treatment before returning to their original home that may still be a using environment
• Delivery of FN Early Psychosis Intervention Program
• Supportive Housing Unit on reserve for MH & A

4. Early identification and intervention

• Basic intake done and referral to appropriate service in a timely manner. Support and Advocacy provided in the interim.
• Secured funding for the delivery of our own early intervention in psychosis program, Very important due to spirituality and how closely it can resemble and be misinterpreted as psychosis. Important to know appropriate traditional resources to assist.
• Teaching families especially youth and young parents about the necessities and importance for attachment and emotional regulation for babies and infants.
• Awareness of impact of attachment disorders as it affects children
• Reinforcing the importance of love and strengths building for infants and children
5. Crisis response – Best Practices

- Mobile crisis line
- 4 Counties Crisis Centre is training staff on reserve to respond to clients in crisis in a safe manner to get appropriate supports
- Critical incident response teams – reduce impact of trauma
- Beausoleil FN trains community members in crisis response. Developing a plan.
- FN Crisis Response team with trained FN community members, scheduled on call.
- Ambulance team – paramedics
- 2 Crisis listings completed and given to all households each year (July & December). This listing is also given to all health professionals, and is used by counselors when working with clients
- 24/7 crisis response service provided in partnership by community child and family services, addictions services, mental health and ECD workers

6. Community level capacity and support – Best Practices

- Raising the Spirit Mental Wellness Team provides capacity building and support to front line workers in 10 participating First Nations
- Enyonkwanikohonriyohake Program covers mental wellness, addictions, child and youth, adult, elder wellness counseling, advocacy and support
- All health and social programs in own building = easier access
- Mental health First Aid Training
- Applied Suicide Intervention Skills Training
- FNWACB – certification for addictions & recertification. Also Health Canada’s yearly financial incentive for certified workers.
- Clinical supervisor for counselors
- Staff trained to deliver Mental Health First Aid, ASIST, SafeTalk and non-violent crisis intervention

- OTN connected for ability to provide support to other communities, train our own staff
- Indigenous Trauma Recovery on line training through St. Elizabeth Health Care First Nations training

7. Community development, health promotion and prevention

Community development:

- Youth and Elder Centre
  - Youth and elder conference – learn from each other
  - Traditional teachings and ceremonies
- Youth Camp – Tetu Lake
  - Traditional and cultural teachings
  - Mentoring programs (bullying, healthy life styles)
  - Land based activities → trapping, fishing, hunting, prep work
  - Partners → social services, chiefs and council, elders, Health Canada, youth, Kenora Chiefs Advisory

Health Promotion:

- Exercise programs – staying Active
- Baseball leagues, floor hockey
- Weight loss programs → ADI
- Walking programs → walk track
  - → treadmills bikes weight machine
- Artisan Exploration Program → self esteem. Problem solving, socialization, creativity, homework, getting along with others, sharing, humour, helping one another, some traditional projects
- Writing exploration program → self esteem, strengths, life story reviewed, problem solving, challenge, creativity, socialization
- “Heritage WK” traditional activities for one week before the community pow wow
- Delivery of metal health curriculum to on reserve schools for kids in K to Grade 12 – based on Ont curriculum for teacher benefit but using our own traditional knowledge and community specific intervention
- Deliver a FN mental health presentation to psychiatric residents at McMaster – usually in final year
- Annual canoe trip between FN’s on North Channel, including making of canoe paddle
- Weekly drumming practice
- Traditional health promotion
- Education / promotion of identity/ spirituality/ mental health/ emotional and physical health
- Regalia making and beading

8. Culturally safe practices/cultural competency/cultural knowledge

- Cultural competency teaching medical students (Northern Ontario School of Medicine) and residents (McMaster University)
- Traditional family services (kids in care)
- Culturally based concurrent disorders program
- Healthy Elders – complete list of these not necessarily age based
- Fasting / sweat lodge teachings and on the land activities in the spring and fall
- Services of Elders Healers in community
- Development of our own clinical mental health services with FN community members who understand our culture, history and traditions
- Use of traditional advisors for clients originally suspected of experiencing psychosis
- Having community staff sit on specialist sessions without clients to provide cultural backing/explanations. Having someone aware of client situation.
- Partnership with TC LHIN OFIFC. Cultural competency training mental health and additions service providers – non-aboriginal
- Raising the spirit mental wellness team provides culturally relevant capacity building and support front line workers in 10 participating FN
- Community wellness and cultural coordinators work in all program in the community ensures cultural sensitivity
- Healing lodges that are about to lose funding. These have been a source of defining and developing indigenous health and wellness practices
- FNIHB (Rose Sones) cultural competence training for federal government staff. B.C. health authority, indigenous cultural competence on line training currently being adapted for Ontario Health Care providers
- Language and cultural component included in the programming and services
- Getting Elders Advisory Circle together to establish guidelines (i.e. self regulation) to ensure safety and integrity of traditional healing practices
- E.g.: traditional healers forum held at RAM FN in March 2013

**WHAT ARE CRITICAL SUCCESS FACTORS?**

The following are meeting notes from flip charts and group presentations in response to the following questions:

- What are the critical factors which have supported these successes?
- How can more of these be cultivated in a new framework?
- What structural supports are needed?

**Human Resources within Communities**

- Grow your programs – training for NP
- Stable funding
- Sound recruitment strategy
- Pay competitive benefits comparable salary grids
- Accommodations
- Retention and succession planning\worker exchange programs opportunities
- Getting community to see role/limitations/boundaries of workers

**Capacity Building within Communities**

- **Assistance to meet provincial standards ex RSW; psychotherapist regulations may impact FN**
- Supporting staff mental health emotional health
- Self care policies
- More support for traditional providers
- Taking care of our own, relearning how to live if programs didn’t exist
- More opportunities to network knowledge share, problem solve
- Support individual training needs
- Creative health promotion , take it out of the health centre
- Showcase what you have:
  - Staff and their experience
  - Program linkages
  - Community members
- Partnerships for staff, for dollars – scope of services offered

- **Clinical:**
  - Having the space – offices
  - Supervision

**Knowledge Exchange within Communities**
• Train the trainer program e.g.: Safe Talk, ASIST, Mental health First Aid
• Telemedicine telehealth, telepsychiatry
• Webinars, easy access
• Sweat lodge keepers – valuing the knowledge and experience, skills, gifts of one another
• Knowledge of customs, traditional practices etc. and then applying this experiencing, doing it
• By acknowledging role models, helpers through celebrations
• Welcoming home ceremonies – belonging, pride
  o Residential school survivors, CAS, children
• Importance of linking Elders with youth and children. Elders to tell stories teachings, e.g. creation, to teach morals, values, e.g., seven grandfather teachings → teachings are informal
• Creating and Elders council;
• Communication via newsletter’s e.g. how to approach an Elder for help
• Making medicines - hands on teaching
• Lots of anecdotal examples of how powerful traditional medicines are
• Feasts – recognizing the presence of spirits

Research, data, surveillance within Communities

• Inputting programs on a computer (using Outlook)
• OCAP compliance (ownership, control, access, possession
• Regular compilation of current population growth
• Our own trends, needs strengths

External Context:

Sectorial Collaboration in the External Context:

• New ways of working in the communities. Organize more in the individuals journey rather than diagnosis. → Education/Awareness to community members and staff (working together)
• Respecting the individuals world view and cultural religious experiences being flexible in approaches Circle of Care concept for caregivers (staff)
• Determine a common goal within the sectors
• Common language, mutual understanding for betterment of families and community

External Context – Jurisdictional Issues; Policy/Planning Environment

• Disconnection
• Funding flexibility is needed in the new mental wellness continuum (ie allow communities to decide how they want to use resources to respond to need)
• Framework flexibility
• M of H / LHINs educate these organization/people on responsibility to deliver services to FN communities
• Overburdened by reports/language – simplify reports
• Include FN @ the table from the front lines [when developing policy or plans]
• Visit FN communities and spend time on reserve
• Forecasting with FN [to plan for future needs]
• No understanding of what FN communities really do
• Prov/Fed policy analysts should have direct experience in FN as a requirement before hiring/+ include as part of training can MOH access federal cultural comp. course??
• Develop a relationship
• Be clear and direct
• Government needs to increase Transfer Payment Agreements with FNs (eg MCYS) right now they are not considering any new TPAs leaving many FN unable to access this type of service or program
• M of H have direct agreement with FNs rather than through LHINs (some FNs don’t engage with LHINs due to fiduciary responsibility)
• Realignment (moving $ from one place to another takes political will)
  o LHIN
  o Prov
  o Fed Depts (can take years to influence realignment)
• NNADAP process looked upon as a good model to influence change
• Question: Is there the will to make changes?
• Through our contributions and this collaboration what is the likelihood of it becoming real?
• Difficult to make the case for services and need without data
• Yet there is no mechanism to link service data to FN identity or Ab identity

Data, research, surveillance in External Context
  • Principles of OCAP
  • Is it relevant, what is it used for?
  • Reporting tools to reflect the work that is being done
  • Measuring outcomes that are important to the community
  • What does success look like
  • Finding ways to reduce stigma of being Aboriginal and accessing services (of self identifying as FN/Aboriginal\indigenous etc.)
  • Data sharing agreements are needed (e.g.: OCAN agreement does not reflect OCAP)