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"Our Minds Coming Together"

Supporting Youth Mental Health in a First Nations Community with Traditional and Mainstream Approaches: The Role of Collaboration in Ensuring Program Success

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Background, Challenges & Need for Solutions

The 1990 Oka Crisis impacted First Nation Communities across Canada.

In response, the government agreed to provide enhanced funding for mental health services.

Children and Youth

Within Territory, a number of children and youth referred to medical clinic due to behavioural problems at school:

- Children playing war, violent art work at home and at school;
- Youth experiencing increased racism in non-Aboriginal schools;
- Attempt/suicides in the community increasing on a yearly basis.

The Success of Traditional Medicine.

Our Goal, Objectives & Vision

Goal

To Develop a Mental Health Program to:

- **Build upon traditional** interdependent and reciprocal extended family **relationships and community social structures**;
- **Promote the experiential knowledge of the First Nation community** and its respective mental/health practices and programs;
- **Build partnerships** and promote collaboration.

Objective

- **Provide an understanding** of well-being from the First Nation cultural perspective **of self, family, and community relationships**;
- **Demonstrate the value of using First Nation' cultural resiliencies** as a means to influence mental/health program and policy making.

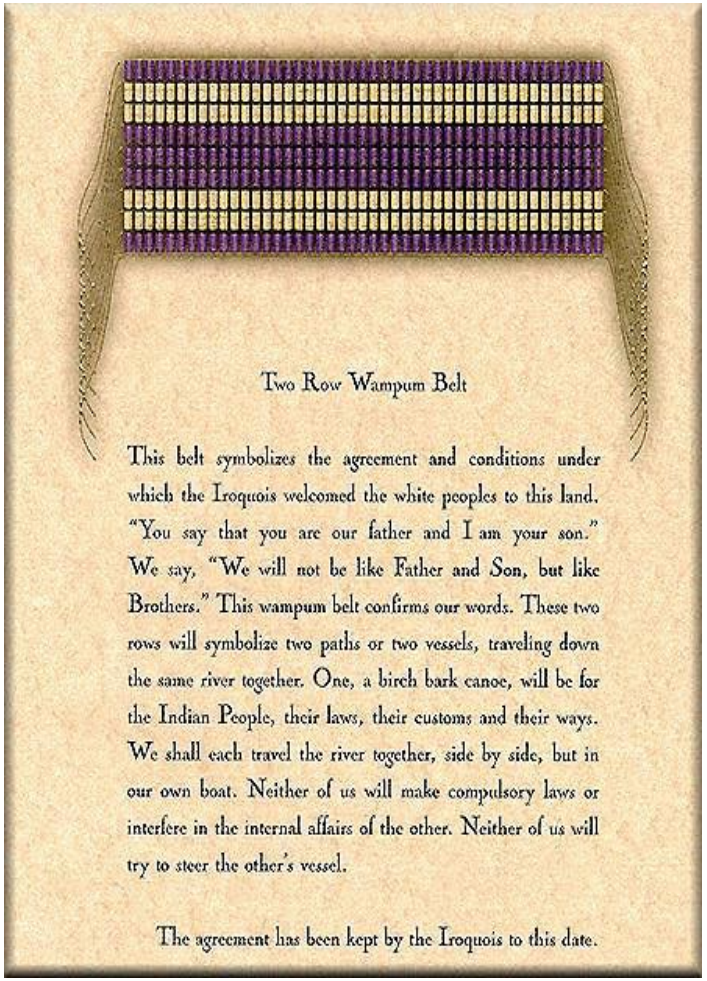
The Challenge

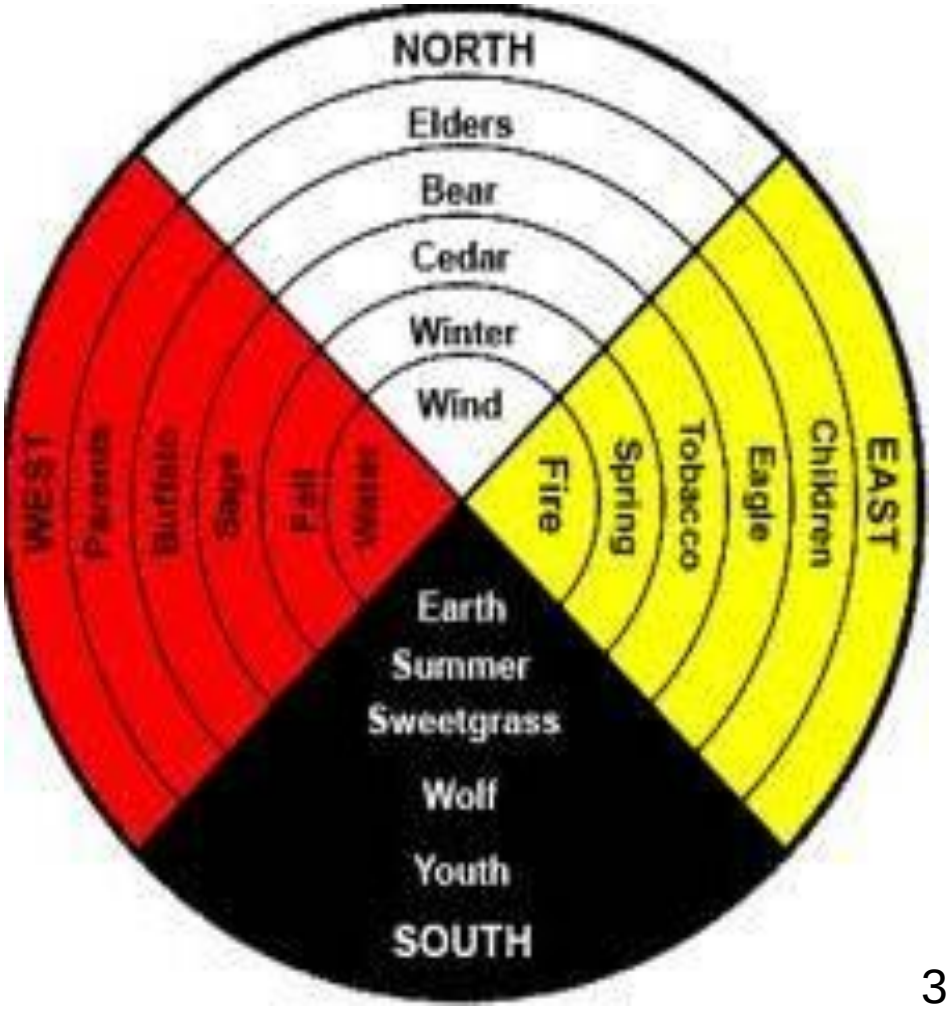
- **Resiliency is value-laden**;
- Presently, policy/program making for First Nation Peoples is **characterized by mainstream norms and values.**

Vision

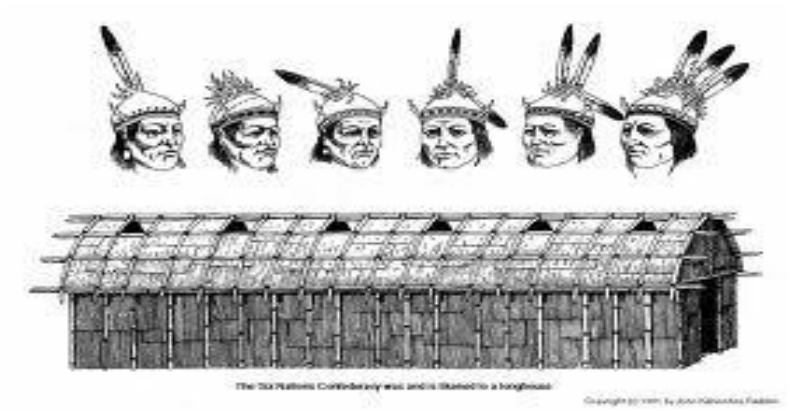
To empower and strengthen the resiliency of First Nation Peoples so that economic and social opportunities are accessed regardless of family socioeconomic background.

Relationship based on Kahswentha
Wholistic Health based on Medicine Wheel





Community Protocol - Self-Determination



Program Staff & Contract Clinicians

- Shake, Rattle & Roll
- Unevaluation & *The Big Question*

Traditional

- Medicine Peoples, Faithkeepers
- **Clan Mothers,** Chiefs
- Iroquois Confederacy Seneca, Tuscarora, Cayuga, Onondaga Oneida, Mohawk

Band Council (Canada)

- Band Council Portfolio Chief
- Band Council Chiefs, District Chiefs
- **Community,** Director of Health

Tribal Council (USA – New York State)

- St. Regis Mohawk Tribal Chiefs

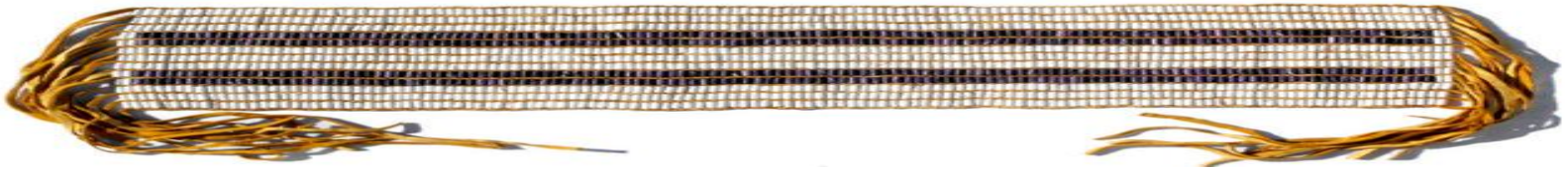
Ontario Ministry of Community and Social Services

CLSC Quebec

United Nations – UNESCO

Algonquin and Iroquoian Confederacies

Collaborative Journey in Native Mental Health



First Introduction

- **Royal Ottawa Hospital, leadership and the expression of cultural identity;**
- **Children's Hospital of Eastern Ontario, mapping out the model (challenges to follow).**

Creating Partnerships

- **The Feast;**
- **Elders, Clan Mothers, Chiefs and Directors;**
- **Touring the Territory.**

In the Spirit of Friendship

- **Diverse Expectations.**

Building the ARC

- **Akwesasne, Royal Ottawa Hospital;**
- **Children's Hospital of Eastern Ontario.**

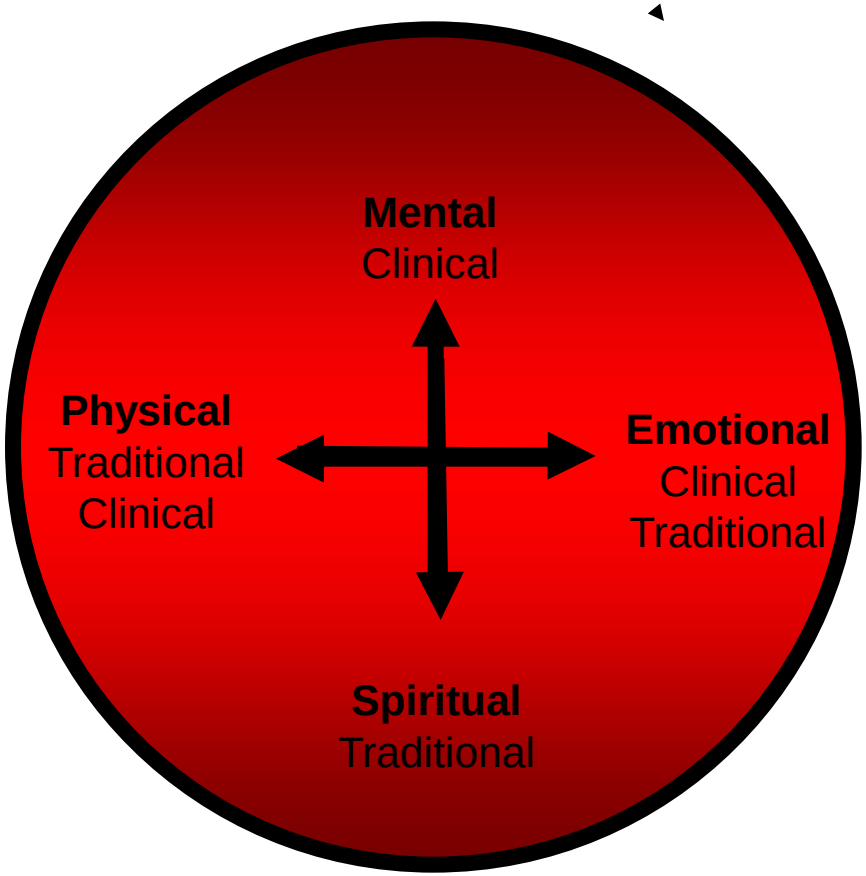
Collaboration: An Opportunity to Strengthen Mental Health Practice

Mental Health Medical Model
Individual

Mainstream or Indigenized

Traditional Medicine
Community

Seers, Ceremonies, Hands on Healers, Herbal Medicines, Traditional Teachings



Kahswentha

Collaboration to design and deliver:

- **Community-based assessment, diagnostic and holistic treatment services;**
- **An Aboriginal biopsychosocial assessment tool;**
- **Tele-health services.**

The Kahswentha Agreement signed in 2000:

- **Mohawk Council of Akwesasne (Canada), St. Regis Mohawk Tribe (U.S), Mohawk Traditional Government, the Royal Ottawa Hospital and Children's Hospital of Eastern Ontario;**
- **Establishment of satellite offices located in Ottawa;**
- **Non-Aboriginal psychiatrists, psychologist, psychometrist and native clinicians work collaboratively to deliver culturally competent assessments and diagnoses;**
- **Traditional medicine practitioners remain in Territory;**
- **Clients are able to choose traditional and/or mainstream clinical services**.

Kahswentha Agreement

Akwesane, Royal Ottawa Hospital, Children's Hospital of Eastern Ontario (ARC) formally acknowledged:

- Traditional healers will not conform to mainstream processes;
- Traditional healers will undertake ceremonies according to traditions;
- Traditional healers have control over the design, development and implementation of their services when interfacing with mainstream human services;
- Traditional services will not be segregated, alienated or compartmentalized as add-on services to mainstream;
- Traditional healers will be afforded the same resources and materials equal to their mainstream program counterparts in the delivery of services according to their needs e.g. office supplies/wood for sweatlodge;
- Traditional healers working schedules will be flexible according to ceremonial processes.

Considerations for Assessing Aboriginal Youth

Connection to Political Context

- Impacts of residential schooling; assimilation experiences of parents, caregivers;
- Loss of cultural identity through assimilation and westernization.

Connection to Self

- Mental, emotional, spiritual and physical self;
- Balance and harmony are required to become contributing members of their community (interdependent and reciprocal society);
- Illness is an imbalance between the individual, and his/her community;
- Experiences and personal meaning to patients;
- Non verbal communication.

Connection to Family

- Aboriginal family and community systems i.e. parenting paradigms in nuclear family, extended family, clan, tribe, nation.

Connections to Community

- History – past, present and future intersections;
- Affiliations in the Aboriginal and non-Aboriginal community;
- The land, people, the non-physical world and connections;
- Basic human needs - housing and shelter, crowding, clean water and sanitation, exposure to communicable diseases, access to proper nutrition;
- Environmental risk assessment – firearms and other weapons, hunting, ATV's, snowmobiles, gasoline, chainsaws.

Thomas

- 13 year old male living with mother, cousin and 2 younger brothers. Father is not involved in his life;

- Living in the Ontario area of Akwesasne Territory but attends school in New York State. Previously attended a school in the Territory – about half his schooling was in the Mohawk language;

- Referred to the Kaswentha program for assessment of aggressive behaviour at home and school. Struggling in school academically – some behavioural issues continue at school and home. Bullied by non-Aboriginal peers at school. Behind in language arts most likely because of the focus on maintaining competency in the Mohawk language;

- From psychiatry - Diagnosed with ADHD with some ODD features. From a Traditional healing assessment several recommendations involving the family, community and specific healing ceremonies.

Thomas

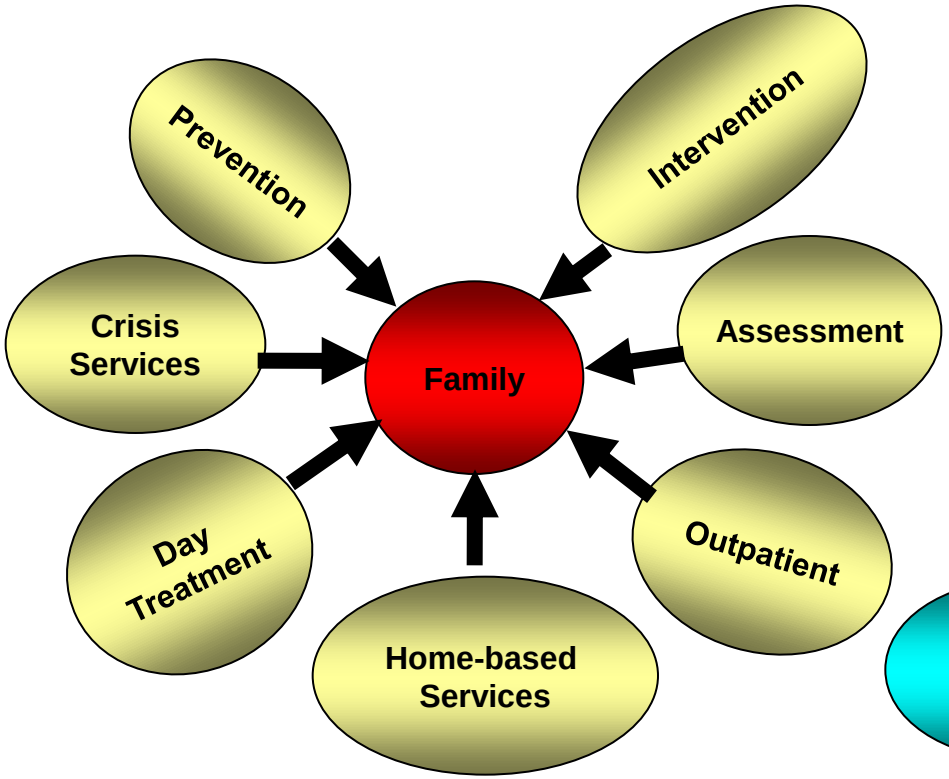
- Started on Concerta 36 mg per day with good response. Small stature – likely constitutional but requires close monitoring for side effects of methyphenidate

- Through discussions with mom and Traditional healers patient connected to community resources – playing lacrosse, swimming lessons, Youth group in the Territory. Mom enlisted involvement of several relatives – uncles and cousins as well as community Elders to provide supervision and engage in offering several traditional healing approaches – sweat lodges, and ceremonies.

ISSUES

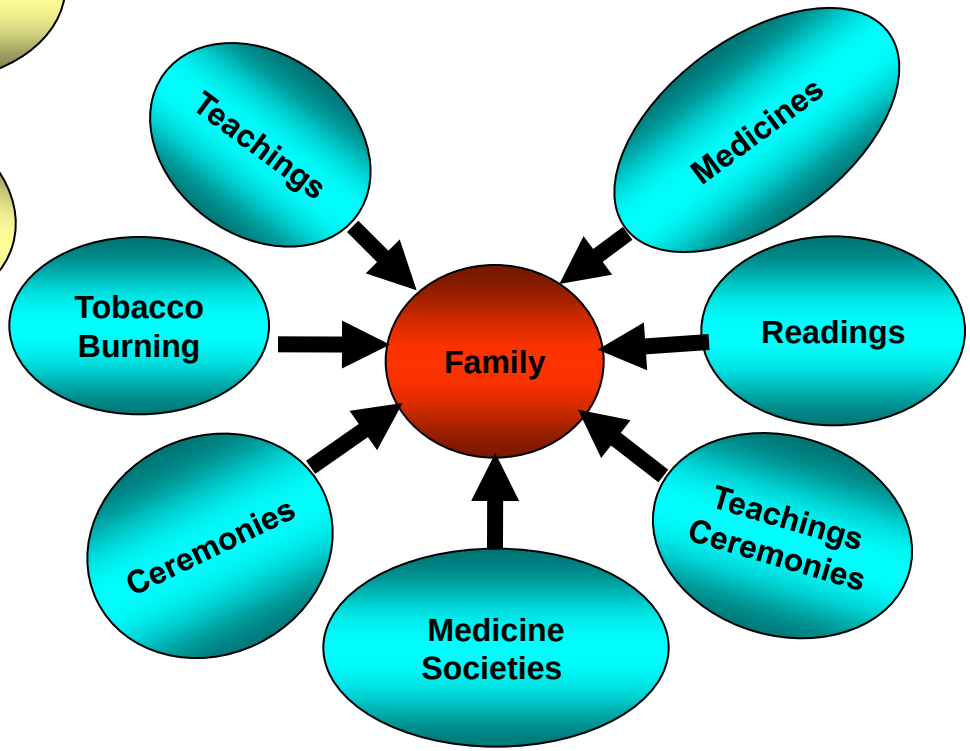
- Mom has history of intergenerational sexual abuse – ambivalent about her parenting;
- Family reluctant to access mainstream medical services – suspicious and distrustful of the system;
- Challenges with borders and identity re: citizenship and residency.

Traditional & Clinical Services



Clinical Services

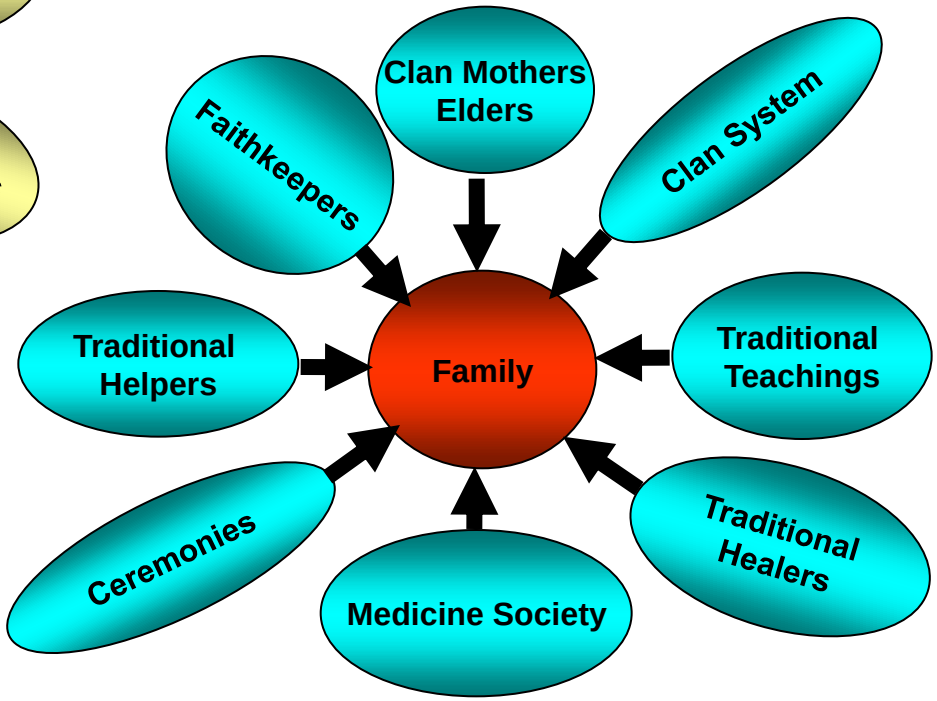
Traditional Services



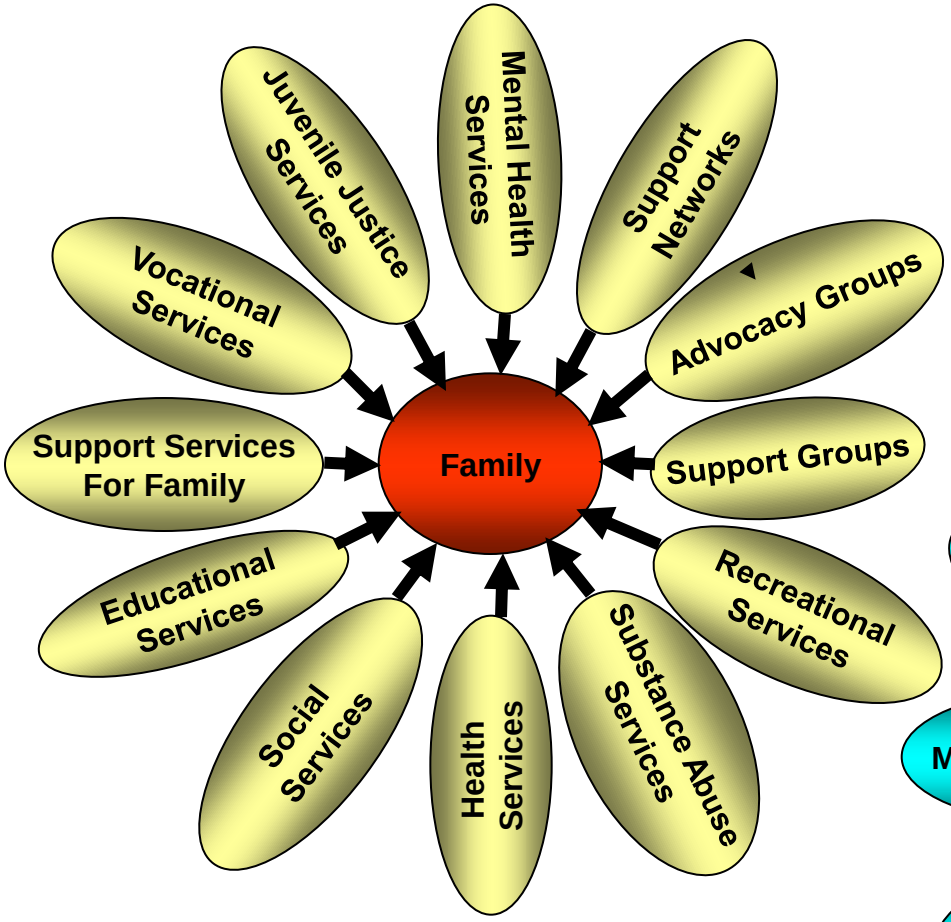
Traditional & Clinical Service Frameworks

Clinical Service Framework

Traditional Service Framework

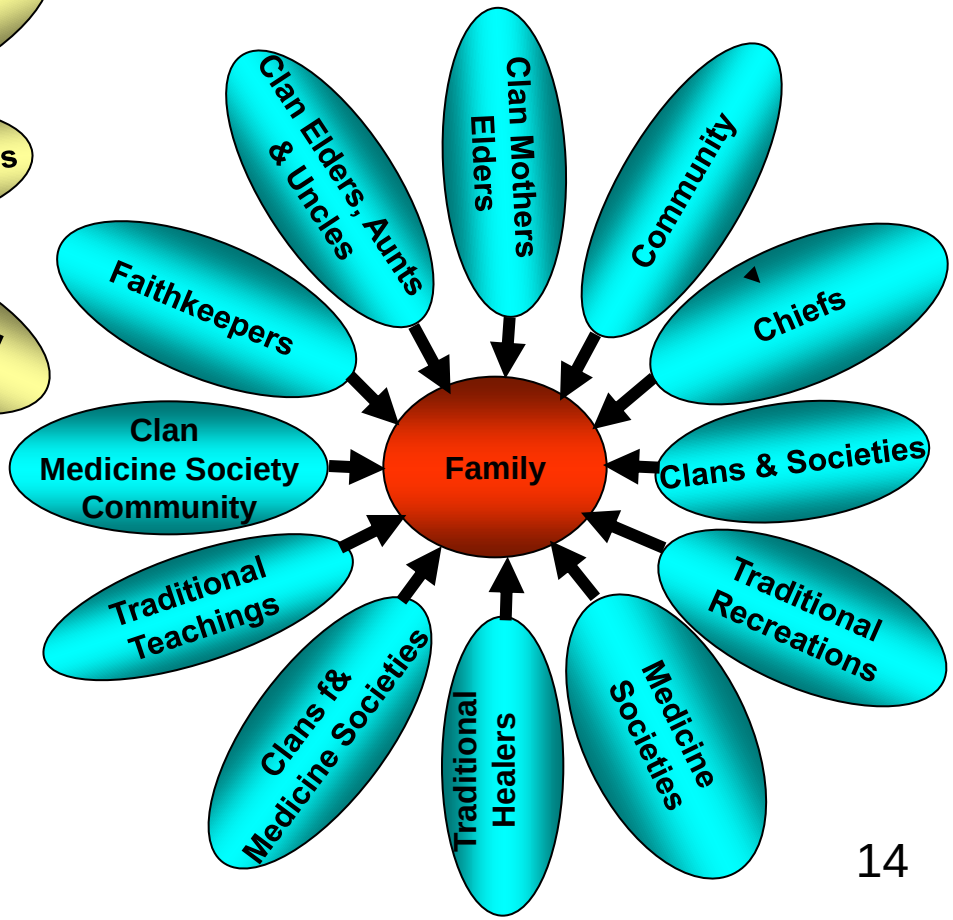


Traditional & Clinical Service Networks

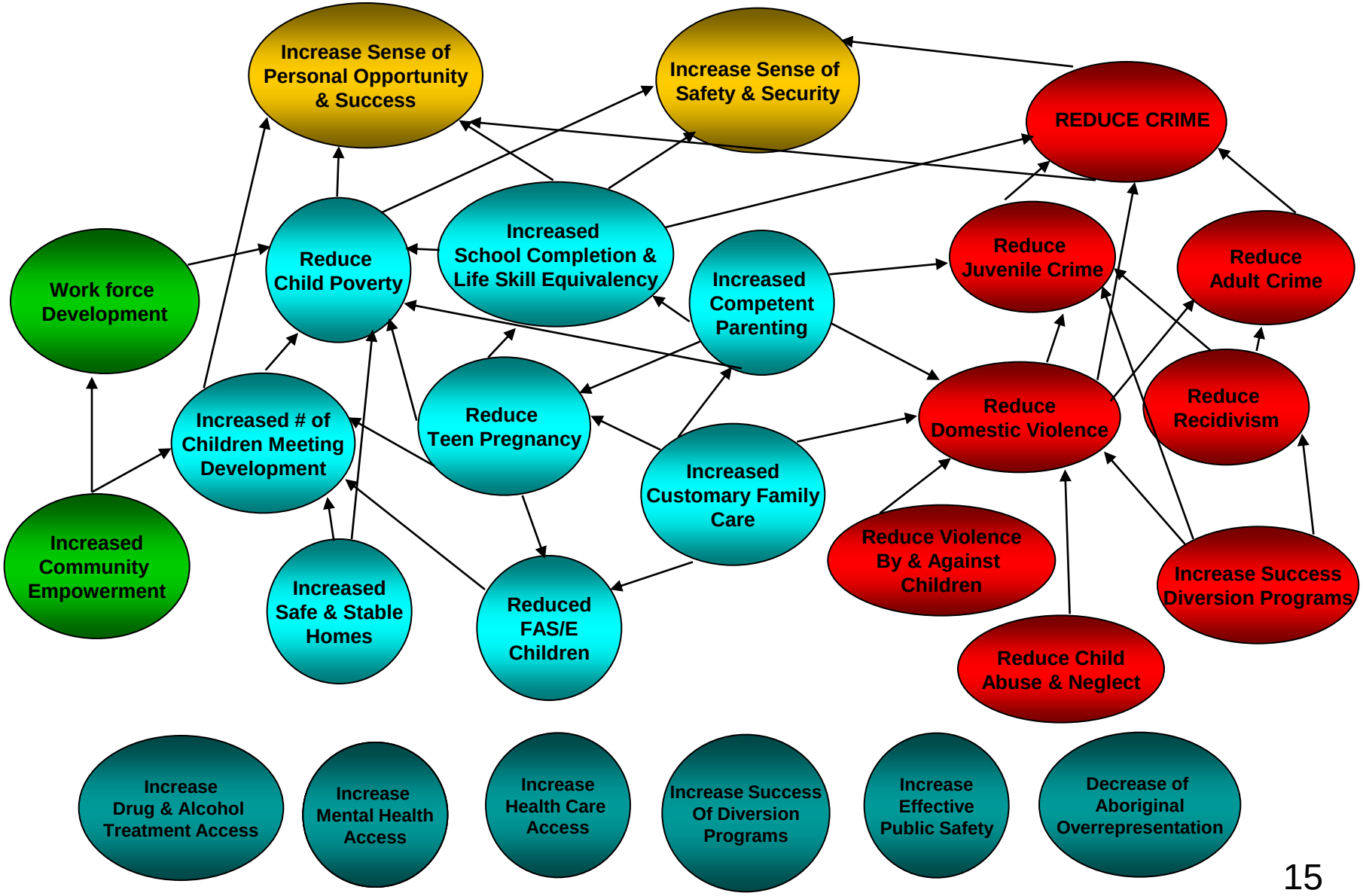


Clinical Service Networks

Traditional Service Networks



Collaboration: Community Impact and Well-being



Collaboration - Community Impact

Pro-Active Program Services

- Amalgamation of three programs – one stop shop;
- Enhanced accountability to community, contract clinicians commence maintaining files;
- Two tiered professional status gradually eliminated;
- First Nation expertise acknowledged and implemented;
- Contract clinicians gradually replaced by community clinicians;
- First Nation clinicians become techies;
- Cross pollination of Mental Health practice with Hospitals increases support and trust in services;
- Collaborative services getting at root of problem quickly, reducing client churn and increased client satisfaction.

The Community

- Program salary dollars remain in community;
- Increased number of First Nation clinicians;
- Increased level of community expertise;
- Increased program reach in community;
- Community crisis reduced – i.e. Young Offender stats - benefits from increased services;
- Increased number of community members seeking services, who previously refused.

Community Program Staff

Before

- Considered as paraprofessionals – second to contract clinicians;
- Traditional knowledge and practice, at the furthest periphery of services, sometimes challenged by non-aboriginal expertise “as putting clients at risk”
- Majority with Community College and/or Associate Degrees**.**

After

- Considered experts in the realm of Native Mental Health;
- Traditional practitioners receive recognition- practice–tiered ‘professional status’ eliminated;
- Community staff providing consults to First Nation Territories outside Quebec and Ontario;
- Majority of workers return to school graduating with BSW and MSW degrees;
- Increased professional opportunities and choice;
- Increased social and economic **autonomy.**

Community Collaboration

- **Be clear** about the purpose or goal of collaboration, community members will specify their health-related concerns that need action to promote and protect health;

- **Become knowledgeable** about the community in terms of its economic conditions, *political structures, norms, values*, demographic trends, history;

- ***Build trust*, establish relationships**, consult with formal and informal leadership, seek community organizations, respect their lead roles to mobilize the community;

- **Acknowledge self-determination** is the right of the community; a program that is run and controlled by individuals or groups who are members of the community;

- **Respect community diversity**. Awareness of the various cultures and other factors of diversity must be paramount in community collaboration approaches;

- **Acknowledge *community identified* strengths and assets**, develop capacity and resources and action to sustain community collaboration; **be flexible** to meet the changing needs of the community;

- **Do not assume the community will undertake program evidence-based research and or program evaluation** – the greater traditional medicines are practiced within a community, the greater the unlikleness of research and evaluation. **Communities are likely to ensure First Nation principles of Ownership, Control and Access (OCA) are in place should research/evaluation be undertaken**;

- **Be Informed - Consult - Be Involved – Collaborate and *EMPOWER.***