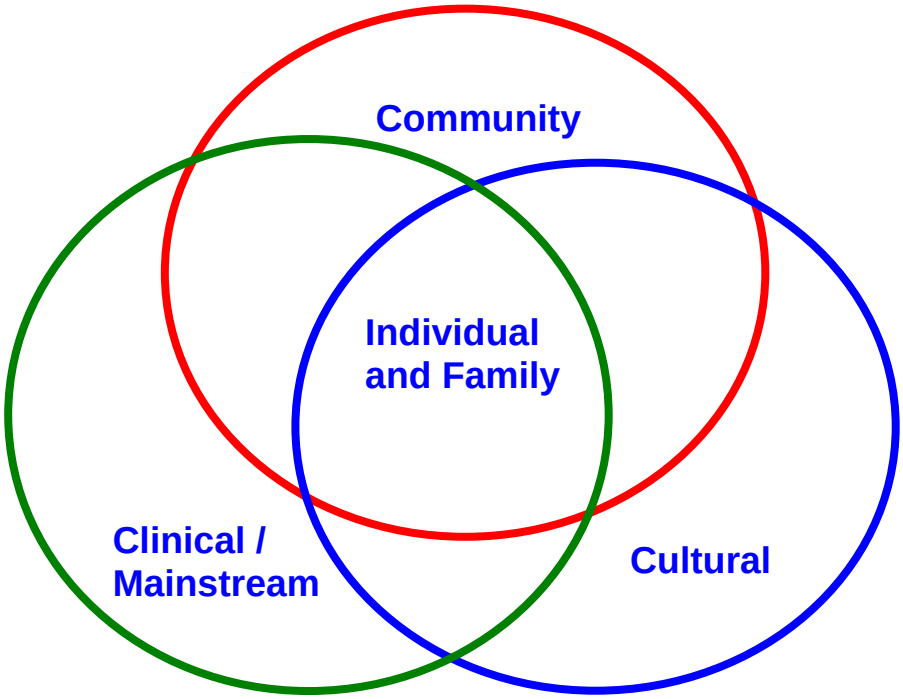
MENTAL WELLNESS TEAMS

Community of Practice Workshop

First Nations & Inuit Health Branch
Health Canada



November 30th - December 2nd, 2010
Ottawa, Ontario

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HISTORY

In 2007, as a part of the National Anti-Drug Strategy, the Government of Canada committed $30.5M ($9M ongoing) over 5 years for First Nations and Inuit communities to enhance the quality, effectiveness and accessibility of addiction services. This funding includes an investment of $4.2 million over 5 years for Mental Wellness Team (MWT) pilot projects ($1.1M ongoing).

Health Canada's work in the area of mental wellness is informed by the Mental Wellness Advisory Committee (MWAC), established in 2005. MWAC includes all major partners with a role in First Nations and Inuit mental health and addictions policy and programming.

MWAC developed a strategic action plan to improve mental wellness outcomes and to inform First Nations and Inuit mental wellness policy and program development. The five priority goals of the Strategic Action Plan for First Nations and Inuit Mental Wellness include:

- Coordinated continuum of mental wellness services
- Disseminate and share knowledge about promising traditional, cultural and mainstream approaches
- Support and recognize the community as its own best resource
- Enhance mental wellness and allied services workforce
- Clarify and strengthen collaborative relationships

Concept

MWTs are community-based, client-centered, multi-disciplinary teams that provide a variety of culturally safe mental health and addictions services and supports to First Nations and Inuit communities. Mental wellness teams are owned, defined and driven by the community and include Aboriginal traditional, cultural, and mainstream clinical approaches to mental wellness services, spanning the continuum of care from prevention to after-care.

The MWT concept supports an integrated approach to service delivery (multi-jurisdictional, multi-sectoral). Given Federal/Provincial/Territorial/Aboriginal jurisdiction, participation and commitment of provincial services/agencies/authorities is important.

MWT Model/Pilots

The goals of MWTs are closely aligned with the MWAC Strategic Action Plan and support a flexible approach to programming which involves balancing of evidence from cultural, community and clinical spheres, centred on individual, family and community needs. Eight MWTs in six regions are under development: British Columbia, Ontario, Quebec, Manitoba, Saskatchewan and Atlantic (which includes one Inuit-specific MWT). In most cases, the work of these pilots is premised on already existing programming. An example of this includes the highly successful project with Nuu-chah-nulth Tribal Council in B.C., which has oriented services to address youth suicide prevention by using cultural and clinical methods to identify root causes and solutions. Further, the communities chosen for the MWT in Quebec had already been implementing pilot projects developed by the communities and supported by the Ministère de la Santé et des Services Sociaux du Quebec for the past 3 years.

Evaluation

The First Nations and Inuit Health Branch (FNIHB) has developed guidelines for the evaluation of the MWT pilot projects, in partnership with the MWT pilot communities and the University of Ottawa. A participatory approach to evaluation will be used as a way to more fully engage First Nations and Inuit in the process. The evaluation framework will be designed to accommodate the varying community approaches to MWTs and the different stages of pilot initiation and development.

Partnership Opportunities

The collaborative nature of MWTs provides an avenue for Federal/Provincial/Territorial partnerships and formal linkages with the Mental Health Commission of Canada (MHCC) to build a network of services for Aboriginal people living on and off reserve. MWTs can fill gaps in the continuum of care and increase community access to mental wellness services for First Nations and Inuit communities across Canada. This could be accomplished through a collaborative network of federally-funded MWTs for people living on-reserve and provincially-funded MWTs for First Nations and Inuit living off-reserve.

THE COMMUNITY OF PRACTICE WORKSHOP

A major component of the MWT pilot projects is to bring the teams together to promote the exchange of knowledge and experiences through the sharing of promising practices at the community level. This workshop report is a summary of the second opportunity the MWTs gathered to network and share valuable learnings.

The MWT Community of Practice Workshop was held in Ottawa, Ontario from November 30th to December 2nd, 2010. The agenda can be found in Appendix A *(note: due to time restrictions, some changes were made to the agenda during the workshop).*

The objectives of the MWT Community of Practice Workshop were as follows:

- Advance the implementation of the MWT pilot projects and facilitate the achievement of results;
- Provide a forum for the exchange of promising practices and lessons to understanding what works in First Nations and Inuit communities;
- Support capacity development and learning in specific areas relevant to the MWT pilot projects;
- Develop common indicators for the evaluation of MWT pilots;
- Facilitate communications on MWTs.

The MWTs participating in the Workshop included:

- Mapping the Way Mobile Multidisciplinary Mental Wellness Clinical Team (Nunatsiavut)
- Maliseet Nations Mental Wellness Team (Atlantic)
- Tui’kn Partnership Mental Wellness Team (Atlantic)
- Projet en mieux-être mental (Québec)
- Raising the Spirit Mental Wellness Team (Ontario)
- Anishinabe Mekina Mino-Ayawin Mental Wellness Team (Manitoba)
- White Raven Healing Centre Mental Wellness Team (Saskatchewan)
- Quu’Asa Wellness Project (British Columbia)

Day 1 (November 30th, 2010)

The three day MWT Community of Practice Workshop was opened with a traditional prayer offered by Elder Perry McLeod-Shabogesic of Wikiwemikong, Ontario.

FNIHB Welcoming Address - Kathy Langlois

As the Director General of Community Programs, FNIHB, Kathy warmly welcomed all participants to the Community of Practice Workshop in Ottawa. In welcoming the mental wellness teams from across the country, she stressed the importance of networking and supporting each other in this initiative.

Kathy provided a brief history of the mental wellness initiative within FNIHB and referred to the vision and the five key goals listed below:

Vision:

Support for a multi-disciplinary team approach that would fill gaps in the continuum of care and increase access to comprehensive, client-centered, culturally-safe, community based mental health and addictions services in First Nations communities.

Key Goals:

- Coordinated continuum of mental wellness services;
- Disseminate and share knowledge about promising traditional, cultural and mainstream approaches;
- Support and recognize the community as its own best resource;
- Enhance mental wellness and allied services workforce;
- Clarify and strengthen collaborative relationships.

Kathy further stated that the definition of a mental wellness team is defined by the community and the teams are owned by the community.

Kathy concluded her talk by emphasizing the need for workshops to focus on 'what works' in the area of First Nations and Inuit mental wellness.

Keynote Address – Patrick Dion

The first keynote address was presented by Patrick Dion, Government Director on the Board of Directors for the Mental Health Commission of Canada (MHCC). Mr. Dion provided a brief history of the MHCC concentrating on their mission of improving the mental health of the seven million Canadians that have a mental illness. He further stated that research has shown that Aboriginal people in Canada have poor mental health. He elaborated on the work of the Commission with the focus of hope, support and solutions through the report "Out of the Shadows at Last".

Key areas of Mr. Dion's talk included the following points:

- Cultural safety is an integral part of innovative approaches to healing;
- "Opening Minds" is an initiative to tackle the stigma of and attitudes towards mental health. The major barriers are talking about it and seeking treatment for it. Attitudinal change is the goal of this initiative;
- Homelessness and mental illness is a priority for the MHCC;
- Bill Mussell has been the chairman of the First Nations, Inuit and Métis Advisory Committee. The priority of this Committee has been cultural safety;
- "Mental Health First Aid Program" – a MHCC initiative to teach people mental health first aid techniques until health experts can be found and treatment can be attained. To date, 31,000 "first-aiders" have been trained;
- MHCC's initiative on Aboriginal mental health first aid is moving forward as a national program;
- MHCC is creating a "Knowledge Exchange Center" to facilitate transforming knowledge into action.

For more information on the MHCC, please see their website:
http://www.mentalhealthcommission.ca

Keynote Address – Dr. Laurence Kirmayer

The second keynote address of the day was offered by Dr. Laurence J. Kirmayer, MD, Division of Social and Transcultural Psychiatry, McGill University.

Dr. Kirmayer presented a substantial keynote filled with valuable information on mental wellness in the Aboriginal communities.

Highlights of Dr. Kirmayer's keynote include:

Mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of equity, social justice, interconnections and person dignity - Joubert and Raeburn, 1998.

General principles for mental wellness teams include:

- Accessibility;
- Cultural safety;
- Community engagement;
- Diversity;
- Evidence-based;
- Recruitment;
- Training;
- Retention;
- Responsiveness.
- Networking is a crucial function of mental wellness services in the community.

World Health Organization (WHO) Social Determinants of Health and Wellbeing include:

- Cohesion;
- Control;
- Connectedness;
- Autonomy.

WHO Quality of Life is measured by:

- psychological dimensions (memory and self-esteem);
- social relationships;
- environment (physical safety and security);
- home environment (financial resources);
- availability and quality of health and social care.

Limits of the wellness approach include:

- reducing illness and promoting wellbeing are both important goals for mental health programs and services;
- those who suffer from severe mental illness or those who have common mental health problems with co-occurring substance use disorder may need specific interventions beyond those that are commonly found as part of wellness approaches.

Unique Situation of Aboriginal Communities:

- complex jurisdictional arrangements result in significant gaps in coverage and ambiguities or conflicts about responsibility;
- diversity of Aboriginal communities in terms of culture, language, geography, lifestyle and the scale and configuration of communities;
- high prevalence of specific types of problems like suicide or substance abuse;
- the practical dilemmas posed by serving many small communities that are remote from urban areas, including the shortage of trained professionals or other helpers, time pressures on workers living in a small community, emotional demands of working in one's own community and the difficulty of ensuring confidentiality in communities;
- the pervasive impact of the history of collective trauma and loss;
- the key role of cultural identity in community revitalization and in insuring the safety and competence of health services;
- Problems in service delivery including services provided in response to crises, services are segmented, fragmented and lack continuity of care over time, financial stability of projects is uncertain.

Components to community based resources and healing include:

- community members owning and defining their problems and solutions;
  projects employing local people and training them in community development skills and processes;
- establishing a local committee to participate in all aspects of the community development process;
  building trusting and respectful partnerships.

Components to improve access and responsiveness of mental health care include:

- identify, monitor and disseminate information about effective models of services and partnership that improve service responsiveness to Aboriginal people;
- develop and implement programs that strengthen maternal and child health programs with a focus on culturally appropriate family and parenting skills;
- improve linkages across all services and sectors to ensure collaborative responses and needs-based mental health care;
- build a skilled group of mental health workers able to provide mental health and social and emotional well-being services within the Aboriginal community controlled health services.

Dr. Kirmayer closed his keynote emphasizing areas of focus for mental wellness in communities. These four areas include:

- Youth and families;
- Developing Aboriginal community controlled health and wellness services;
- Improving access and responsiveness of mental health care;
- Improving the coordination of resources, programs and initiatives.

He also emphasized the need for capacity building in the community while relying on words of wisdom and experience that emanate from the community.

Panel Discussion: Solutions to Challenges

Many teams identified experiencing similar challenges with the planning and implementation of mental wellness teams. Some of these challenges included evaluation, recruitment and retention, and team work. Sustainability was also identified as a challenge and is covered more extensively in the panel discussion entitled Strategies for Sustainability. The following teams presented their experiences and suggested solutions for these challenges.

Mapping the Way Mobile Multidisciplinary Mental Wellness Clinical Team – Nunatsiavut

The presentation was given by Mary Mayo – consultant, Zita White – project coordinator, Mary Sheppard – clinical manager and Peggy Baikie – Evaluator.

Mission Statement:

To strengthen and improve the mental wellness and social health of Labrador Inuit and Innu through culturally appropriate mental wellness and healing programs and services. A community development perspective will be fostered by advocacy and collaboration.

The four communities served by the Mapping the Way MWT are:

- Natuashish
- Sheshatshiu
- Hopedale
- Nain

The project officially started September 1, 2010 with staff orientation, public relations and acquiring clinical and prevention resources.

Evaluation:

- Challenge: Burden of data collection on team members;
- Solution: Work with the team to find the balance of data needed and workload.
- Challenge: Keeping up with the volume of data-extracting lessons and transforming them into action;
- Solution: Systematic collection and review, identifying responsibilities, involving the team in the development.

Recruitment and Retention:

- The team discussed their strategy for recruitment and retention. It includes:
- Steering committee established a hiring committee;
- A recruitment initiative was launched;
- A targeted outreach strategy generated interest;
- Partner flexibility and creativity was encouraged.

Sustainability:

The team's strategy for sustainability includes:

- Partners have committed temporary and/or permanent funding as well as in-kind contributions;
- It was time consuming to identify other potential funding sources and to submit proposals;
- Partnership creativity and flexibility was required in budgeting and human resource practices;
- Some partners are already seeking additional funding to sustain and support the project;
- Sustainability is dependent on partners and communities' needs and inputs.

Quu'Asa Wellness Project – British Columbia

The presentation was given by Anita Charleson-Touchie - Counsellor and Ray Seitcher – Elder.

Ray and Anita presented a cultural approach to their work as the mental wellness team with Nuu-chah-nulth people on the west coast of Vancouver Island. Their philosophy is 'Hish ook ish Tsa walk' or 'everything is one and all is interconnected'. The Nuu-chaa-Nulth team operates from a foundation of culture. Their emphasis is on connection and re-connection with culture through celebrations with song, healing through cedar, dance, promoting healing, sharing food, sharing strengths, promoting family support and modeling healthy behaviour.

Teamwork:

- value of relationships;

- value of family;
- focus on strengths;
- use of language, practices, protocols, rituals and ceremonies;
- share a spiritual understanding;
- sense of humour;
- focus on relations not time – go with the flow;
- flexibility.

The team emphasizes staff wellness with particular attention paid to:

- access to clinical supervision;
- quarterly team meetings;
- annual meetings and self care;
- debriefing opportunities;
- self care plans for staff.

When working with communities the team focuses on:

- networking with frontline community workers;
- understanding community strengths;
- understanding the uniqueness of each community;
- understanding where community is at.

The team focuses on the following team work principles:

- understanding staff skills;
- understanding staff abilities;
- understanding staff approach;
- understanding that we have our tool boxes ready.

Challenges:

Ray and Anita discussed the challenges they experience as a MWT:

- Conflicts in culture and values;
- High staff turn over rates in communities;
- Workers bring in their own issues;
- Isolation of communities creates less opportunity to fill roles;
- Follow-up;
- When networking and working as a team on events, work can be stalled for fear of stepping on toes;
- Networking can be challenging when a common goal is not shared;
- No understanding of other programs' goals – how can you use what you don't know is there?;
- Lack of resources.

Working as a Team: The Joy and the Grief

The presentation was given by Dr. Pippa Hall, Clinical Scientist in Palliative Care, Elisabeth Bruyere Research Institute

Dr. Hall began her presentation speaking to the issue of suffering and the four dimensions that require addressing. Within suffering she related to the four dimensions of:

- Physical – disease management
- Psychological – emotions
- Social – cultural aspects
- Spiritual – existential

Dr. Hall emphasized the need for team work as no one person can address these complex needs alone. In mental health it is necessary to work with all four dimensions therefore a team approach is required.

The presentation examined the differences between working as a group and working as a team. She described team as:

- Shared leadership roles;
- Individual and mutual accountability;
- Specific team purpose;
- Rewards collective work products;
- Meetings include open-ended discussion and problem solving;
- Effectiveness measured through team's deliverables;
- Discusses, decides and does real work together.

Dr. Hall further elaborated on teamwork in health care as the sum of resources, organizational structures, individual willingness and capacity to collaborate. She emphasized the need for collaboration in the delivery of health care particularly where all four dimensions require attention.

She discussed the 6 steps to the clinical care model used in palliative care. The six steps are:

- Assessment;
- Information sharing;
- Decision making;
- Care planning;
- Care delivery;
- Confirmation.

When all four dimensions are being addressed, it takes a team to provide the best possible care especially when the 6 steps of the model are followed.

- Who do you need information from?
- Who needs to know what you think/do?
- What are your resources now?
- Is this something that you:

- Do alone (uni-professional)?
- Co-operate with others, but not share complex decision-making (multi-professional)?
- Collaborate with others (interprofessional)?

She spoke further on the competencies involved in collaboration: Communication, Collaboration and Roles and Responsibilities. See Appendix B for "Competencies for Effective Collaborative Team Practice Checklist."

Dr. Hall completed her panel presentation by identifying 4 key competencies for teamwork:

- Willingness to collaborate;
- Communication;
- Respect;
- Trust.

Maliseet Nations Mental Wellness Team - Atlantic Region

This presentation was given by Theresa Bartlett-Chase, mental health nurse.

Panel Discussion: Strategies for Sustainability

Two MWTs presented their lessons learned with engaging partners and other strategies for sustainability.

Theresa began her presentation discussing the challenges involved with First Nations accessing mental health services. She stated that there are many gaps in the Atlantic region for First Nations. The team is working on the following areas to work toward sustainability of services:

- First Nations and non-First Nations have to work together – a First Nations cultural day for all staff is held to create further understanding;
- Building bridges is a key focus;
- Regular communication between all parties is paramount;
- A flowchart has been developed where services are available with contact names and numbers;
- Involve provincial health authorities from the beginning;
- Did a needs assessment with provincial agencies to determine what they want to learn about First Nations to form the foundation of in-service workshops;
- One to one time with non First Nations agencies is important to secure support and assistance for the team;
- A psychiatrist works with the team;
- Lesson learned: educate provincial counterparts to inform them what is happening and not happening in First Nations communities;
- Strategy for sustainability includes involving all services, regular dialogue, exchange of ideas, planning and moving forward.

Anishinabe Mekina Mino-Ayawin Mental Wellness Team – Manitoba

This presentation was given by Sylvia Meilleur, Program Manager.

Sylvia gave a brief history of the working relationship between the MWT and Correctional Services Canada (CSC). The objective of building the relationship was to learn and understand each others' initiatives and what services maybe available to assist with the integration of Aboriginal offenders back to their community. Various meetings were held with key stakeholders and programs within CSC to begin the collaborative effort.

The areas of collaboration include:

- Awareness and knowledge of each program to be presented to the community frontline workers by the CSC program staff and vice versa;
- The objectives of the Regional Health Services Release Planner are to enhance transition of care back to the community; work with parole officers for a more holistic approach; and to educate the community and/or family;
- Information sharing between the MWT and the Aboriginal Reintegration Team that focuses on the continuum of care;
- Both CSC and the MWT are sharing training events on mental health, including effective intervention and tools;
- Mental Health first aid training for the CSC healing lodge staff.

The next steps for relationship building between the MWT and CSC are:

- Jointly drafting integration process and protocols;
- Drafting a communication plan;
- Updating the heads of Health Canada, First Nations and Inuit Health and CSC;
- Continue to be involved in each others' training schedules.

Sylvia shared the following strategy for sustainability with CSC:

- The support and interest of upper management in both organizations has been secured;
- All are working to achieve a common objective – to clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federally funded and provincially or territorial funded programs and services;
- Reaching out to non-traditional stakeholders to assist in overcoming challenges;
- There is a shared responsibility and concern for the client/offender;
- Aboriginal offenders' success upon release is based on participation in spiritual and cultural awareness activities as well as programs preferably delivered by Aboriginal people and support from family and community;
- Protocol and procedures are to be developed collaboratively with CSC program staff and the MWT site coordinator for discharge planning and continuum of care;
- All involved must commit and be willing to continue to work on the best ways to ensuring offenders and their communities are safe and healthy.

Lessons Learned from Day 1

The end of the first day gave the MWT Workshop participants the opportunity to discuss the information presented that day. Participants identified the following lessons learned from the presentations:

Topic	*Discussion*
Solutions to Challenges	• Recruitment and retention – develop recruitment and retention strategies to build capacity of workers in the community. • Open dialogue and discussion – Respect where everyone is at. Rise above issues and disagreements. Keep an open dialogue among the team particularly around sensitive issues. • Cultural competency – have insight into the community ways of knowing and doing things. • Respect – for community uniqueness and diversity. • Partnerships – with open-to-new-ideas people in different organizations. • Clinical teams – bringing the teams together to collect input and opinions towards shaping the work; to rely on each other; to learn from each other and to foster relationships. • Mental health forum – hosting to increase visibility and awareness. • Steering committees – meetings rotated to help ensure communities are participating and staying active. • Communication – use of different forms to ensure everyone stays informed. • Chief and Council – keeping them informed on a regular basis so they understand the work and to engage them to take initiative to help resolve issues that arise in the community. • Focus – on client needs and priorities • Development of action plan – include community needs, external partners with emphasis on community empowerment. • Family – involve in client treatment. • Capacity Building – team and community. • Traditional healing – incorporate throughout the work.
Teamwork	• Having a common goal. • Celebrating success and strengths of the team. • Incorporating traditional practices and customs. • Emphasis on self-care of the team • Learning from each others' successes and challenges. • Know your communities. • Cultural sensitivity when working with various groups and stakeholders. • Clarification of roles and responsibilities. • Developing a vision statement for the team. • Communication amongst the team is critical. • Transparency is important for the team and community. • Learn to deal with conflict on the team. • Use of healthy humour on the team. • Build and focus on healthy relationships. • Incorporate team building activities.
Strategies for Sustainability	• Have ownership and control over program/team particularly the process and resources. • Collaboration with key stakeholders. • Cohesiveness and commitment within the team.

	• Community commitment to the project. • Building capacity within the community and team through enhancement of skills. • Focus on relationship building. • Use the education system to create First Nations workforce for communities. • Build case management and care facilitation within the community. • Use the natural culture of the community. • Learn from similarities, differences, struggles and challenges. • Focus on what works and what does not work. • Team members support for each other. • Use of a memorandum of understanding. • Ensure equity of funding – on par with provinces. • Networking with linkages with both internal and external partners. • Encouraging community volunteerism. • Ensure the work is built into the governance of the community. • Communication as a key element to sustainability. • Consistency in team leadership. • Adequate resources. • Strategic planning. • The incorporation of understanding and awareness of history and culture in approach to community and mental wellness. • Ensuring a strong foundation and framework to support the team and its work. • Recognition of contributions by all. • Build and focus on respectful relationships. • Commitment to the work and the team through a dynamic approach that includes clear lines of communication. • Strong traditional values and beliefs. • Infrastructure that meets the needs of the community and the team. • Being open to change by embracing new approaches. • Creating an environment to 'go the extra mile'.
Other	• Flexibility – have the ability to change direction when necessary or required by working together. • Geography – the ability to adapt to diverse and changing community/client needs. • Information sharing and continued education – to raise awareness externally with Health Authorities and other partners to get a better understanding of the realities that First Nations communities deal with on a regular basis. Can be accomplished through informal networks with external stakeholders and within communities. • Creativity – being creative in the way the service is delivered, utilizing different activities and different ways to engage communities. • Culturally acceptable services – to not only focus on cultural safety but culturally acceptable clinical services based on the natural culture of the community. • Connection – with off-reserve and provincial services to better meet the needs of the clients. • Empowerment – of the community and clients served. • Networking with other MWT teams

Day 2 (December 1st, 2010)

Day 2 began with a Sunrise Ceremony led by Perry McLeod-Shabogesic. The day focused on panel discussions on cultural safety and community development.

Panel Discussion: Cultural Safety

MWT pilots and outside experts presented on their lessons learned with developing and/or providing culturally safe services, tools, policies and programs.

White Raven Healing Centre Mental Wellness Team – Saskatchewan

Presentation by Murray Ironchild - Traditional Advisor, Rob Kirk – Psychologist, and Chelsea Millman - Student.

White Raven Healing Centre is located at the All Nations Healing Hospital in Fort Qu'Appelle, Saskatchewan. The focus is Cultural and Counselling Programming. White Raven Healing Centre is a program under the authority of File Hills Qu'Appelle Tribal Council.

Mission Statement:

- To promote guiding principles that will encourage open communication with all individuals, families and communities. Our primary focus is to provide traditional and conventional therapeutic counselling designed to address the legacy of inter-generational impacts of residential schools and unresolved trauma and family violence.

Vision:

- To provide client centered mental health and addictions programming that integrates the best of mainstream therapeutic techniques with traditional First Nations healing practices to provide a holistic approach to heal from past traumatic experiences and current psychological issues.

Mandate:

- To provide holistic counselling programs in a safe, culturally sensitive environment to assist individuals, families and communities in healing trauma and to maintain emotional wellness. The Centre operates within a First Nations culturally appropriate, community specific frame-work, utilizing the principle of empowerment to promote and facilitate individual and collective development.

The therapists use a wide range of counselling techniques in a culturally appropriate manner (i.e. mainstream techniques are altered to include elements of culture), including:

- Cultural/Spiritual Services;
- Counselling/therapeutic Services;
- Addictions Counselling: Alcohol, Drugs and Gambling;
- Indian Residential School Support Program;
- Research Project "Culture Heals";
- Crisis Program;
- Mobile Trauma Treatment Program;
- Promotes sharing and understanding of First Nations culture and its
- philosophies;
- Assists First Nations people in continuing the traditions of oral teachings;
- Ensures the opportunity to integrate First Nations philosophies, beliefs and healing ways into a clinical setting.

Two Traditional Advisors (male and female) are available within the Centre, or clients may choose to bring their own ceremonialist to the Centre. On request, ceremonies are available to clients in the hospital and their families, and to clients in the community. On a weekly basis, the Elders Helper assists in hosting sweats for women, men and youth in the Winter Lodge, located just outside the facility. Cross-cultural teaching is provided within the hospital for Non-First Nations staff and surroundings schools and communities. An Elders Suite, a separate suite with a bedroom, full kitchen and washroom, is used for the comfort of visiting Elders.

Following their team presentation on the MWT, Rob Kirk, the team's psychologist, gave a presentation on trauma, including a description of the biological processes and risk factors associated with trauma.

Rob explained that on a biological level, what we need to do to address trauma is quiet the fear response (amygdyla) so we can talk to the rest of the brain. We need:

- Safety;
- Calm;
- To extinguish irrational beliefs;
- To establish positive beliefs about self;
- Provide restorative experiences;
- Learn to walk forward in our lives.

Rob described Client-Centered Elder Counselling, Spirituality (Ceremony, Medicine), and Restoration of Cultural Identity as three key elements of care offered at White Raven.

Chelsea Millman presented on the team's research project entitled: Culture Heals. The purpose of the research was to develop evidence of the efficacy and veracity of 'culture' in use at a First Nations healing centre focused on assisting mental health and addictions clients. Phase One of this research project aimed to define how Traditional Helpers define the term 'culture', as well as how clients at the White Raven Healing Centre view the role culture has played within their healing journeys. Phase Two of this research project was designed to follow the progression of participants healing journeys from the time they were first interviewed.

One important implication of the research is the creation of a training series that could allow front-line workers to address each of these three issues. The goal of these workshops is to train service providers on ways in which they can adapt the services they currently offer to make them more culturally appropriate as well as to take an inter-disciplinary approach to case management. The series is comprised of three modules. These include: Cultural Competency; Trauma (in First Nations communities); Multidisciplinary Mental Wellness Teams and the Circle of Care.

A Critical Cultural Perspective in Health Care: Cultural Safety

Vicki Smye RN, PhD, Assistant Professor, University of British Columbia's School of Nursing presented on her work and research in cultural safety within the health care and mental health systems.

She began her presentation discussing assumptions that can be made in cultural safety:

- Cultural knowledge belongs to the people from that culture – we do not become "experts" in another culture;
- Structural change is essential to shifting power imbalance and to integrating 'cultural safety' into practice;
- Our ideas about culture are strongly influenced by recent historical events, today's political climate, and expanding patterns of globalization.

Vicki outlined elements of many existing cultural sensitivity models:

- Directs nurses to focus on traditions, values, beliefs, and life-ways as the primary facets of culture;
- Culture is made up of fixed sets of characteristics that belong to a particular group;
- Focus on knowing lists of cultural traits;
- Can lead to "narrow understandings of culture".

The problem with cultural sensitivity:

- Diverse groups appear as the same;
- There is a risk of stereotyping and "othering" that erases the complexity of human identity and experience;
- It draws our attention away from the wider social, historical and economic contexts that shape peoples lives – it enables us to overlook the influence of the burden of history, and social and structural inequities.

When becoming culturally competent in practice, we need to:

- Think about how we are conceptualizing 'culture';
- Move beyond a narrow view of cultures;
- Notice the blind spots we may be missing.

In looking at culture as relational, a critical cultural perspective is necessary. This includes:

- Examining beyond shared beliefs, ethnicity or nationality;
- Situated within a social, political and historical context (consider the social determinants of health);
- A process that happens between people and within and between groups of people – it is created and lived – it is dynamic.

In researching cultural safety, Vicki examined what the Maori in New Zealand had initiated that called attention to health inequities and the need for relational practice that begins with respect and acknowledgement of the unique features of peoples lives that shape/influence health and health care – values, beliefs, attitudes and social features such as age, class, gender, ability, sexual orientation and so on – to social and structural inequity.

Dr. Smye defined cultural safety as: a critical cultural lens to shift attention from the 'culture' of the 'other' to the culture of health care and structural inequities and power relations that shape health care and health and our relationships.

She further stated that cultural safety:

- Is both a process and an outcome;
- Includes actions which recognize, respect and nurture the unique cultural identity of those we engage with to safely meet their needs, expectations and rights;
- Is defined by the recipient of care.

Cultural safety also demands we ask a series of moral questions about benefits, risk and justice and that we think 'critically'.

In relation to clinical practice, there are 4 key areas we need to pay attention to:

1. Cultural safety begins with the health care provider;
2. The client's reality provides the first window to understanding;
3. Power dynamics are addressed;
4. Health policy and practice benefits patients/clients, families and communities.

In working with communities, Vicki quoted an Elder:

"*That traditionally when people were ill, you went to their bedside because you bring the good medicine. You are the good medicine. And that's really what you're supposed to do . . . and that just by being with the person you bring them medicine.*"

Vicki discussed the place to begin is with the notion of critical reflexivity. This includes:

- Self knowing, self-reflection – a consciousness of self;

- Recognizing our own influence, and influences of and within social, political and cultural contexts;
- Goal of social transformation.

In concluding the presentation, Vicki spoke of the following in relationship to cultural safety:

- People bring their unique experiences and culture to the health care experience;
- There is a need to consider many different perspectives and sources of knowledge in policy and practice;
- Providers need to engage relationally to provide culturally safe and effective care for clients – to understand relationship beyond a 1:1 encounter to the contextual features of people's lives that shape health and health care.

Maliseet Nations MWT - Atlantic Region

This presentation was given by Veronica M. Wolf Eagle, Project Coordinator.

Veronica began her presentation discussing how the Maliseet Nations is working towards a culturally relevant philosophy of practice for the MWT. This involves placing the DSM IV on the Medicine Wheel or Circle of Life teachings.

Veronica expanded on the use of the two practices:

The DSM IV Circle of Life Medicine Wheel begins clockwise in the East with a Social work relationship of theory, model and framework for intake. Next in the South comes the fire of transformation to develop an assessment from information gained. In the West, our emotions on the river of life create movement so that an intervention is made. The North involves interaction which is a physical process between the person providing services and the one seeking services.

The DSM IV allows the journey to continue around the medicine wheel in a counter clockwise manner:

- Axis I: Clinical Disorders and other conditions for focus of clinical attention is in the South and is related to the fire of a person's spirit;
- Axis II: Personality Disorders and Mental Illness are in the East, the place for the mind;
- Axis III: General Medical Conditions are in the North, the place of the physical;
- Axis IV: Psychosocial and Environmental Problems occur in the West;
- Axis V: Global Assessment of Functioning is in the Center and place of Vision.

We receive in a clockwise manner and let go in a counterclockwise manner. Indigenous people work clockwise following the cycle of the rising and setting of the sun and moon. Western philosophy is counterclockwise.

The sign for infinity is a clockwise and counter-clockwise manner. Therefore, although the methods between Native People's and non-Natives flow in opposite directions, they combine together into the universal shape of the infinity sign.

The medicine wheel and the DSM IV do a dance between clockwise and counter-clockwise perspectives. The two philosophies have been combined for a best practice of cultural appropriateness. The need for diagnosis indicates that there is an imbalance occurring so therefore services are sought to assist a person to find the answers within the tools to walk the path of life. The MWT walks with clients to find empowerment and to recognize their own inner strength.

Panel Discussion: Community Development

Projet en mieux-être mental – Québec

This presentation was given by Rejean Vallières and Barbara Bouchard.

The MWT from Québec Region is responsible for:

- Service to two communities in the Abitibi region who were already implementing provincially funded front line social services for the past 3 years;
- Working collaboratively with the provincial system;
- Enhancing mental wellness services currently available to First Nations communities by increasing accessibility and ensuring service continuity;
- Consultant hired to ensure community development process is followed;
- Research working group to develop an evaluation model for the project;
- Services offered include training, clinical supervision and treatment;
- The team will conduct assessments and service referrals at the request of primary care workers, social services, community organizations, detox centers, schools, any secondary services and clients.

The community development approach is based on:

- The individual and collective capacity to take control, regardless of the problems experienced by the individuals and communities;
- Improving the situation in the communities requires the community to take responsibility (leaders and population);
- The Aboriginal communities are in the best position to act to ensure that the implemented services are culturally-appropriate, respond to local priorities;
- A conception of the health and social problems recognized both in Quebec and in Canada (health determinants);
- An action plan with multiple targets:
- Treatment;
- Prevention – promotion;
- Collective interventions on the living conditions, the social, economic, political and cultural structures that foster or hinder community wellness;
- Individuals as well as the community as a whole.

A bottom-up approach rather than a top-down approach:

- Communities taking responsibility for piloting the intervention;

- A mobilization process among the population and community players to elaborate the state of the situation, the possible solutions and the intervention priorities and maintenance this mobilization;
- Action priorities - interventions that come from and are determined by the community;
- Concerted action between the players from both inside and outside of the community;
- Support from the partners (Health Canada, MSSS, FNQLHSSC) in the planning, set-up and implementation steps (rather than for the determination of the contents of the action plan and the interventions to be implemented).

The team outlined several challenges related to the community development approach, including but not limited to: shifting from a top-down approach to a bottom-up approach; recognizing and valuing community expertise; implementation process takes time; going beyond prevention–promotion activities that target individuals in order to act upon the social structures; conserving energy for prevention-promotion despite the enormous pressure for treatment; streamlining the community's existing services, particularly with the first-line social services and the NNADAP agents; and gaining support from the band councils and their involvement in actions that foster the mental wellness of the communities.

Raising The Spirit Mental Wellness Team - Ontario Region

This presentation was given by Mariette Sutherland, Program Coordinator.

Program Vision:

- To enhance capacity at the community level to address needs associated with addictions, mental health and concurrent disorders in ways that reflect the culture, attitudes and philosophies of the participating First Nations communities.

Project Aims:

- 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;
- Build and/or strengthen bridges between traditional and mainstream approaches to wellness;
- Improve health outcomes through community engagement and community driven design and development of this project.

The team used a consultative approach to begin the process of establishing the MWT. It involved the following:

- Meetings with First Nations to obtain support and BCRs;
- Consultation occurred with 10 communities to reaffirm interest and support; to engage communities in the design of the project; to better define needs, gaps, community strengths and aspirations; and to seek input for the steering committee;

- Consultation process also involved a literature review for environmental scans. There were community consultations and key informant interviews held. Other consultations included Elders, community workers and the education sector;
- The steering committee membership was completed in March 2009.

The Developmental challenges for the MWT included:

- Financial;
- Communication with First Nations and leadership;
- Leadership engagement;
- Staff changeovers;
- Research fatigue within communities;
- Team recruitment;
- Capacity differences within First Nations;
- Steering committee participation.

What worked for the MWT:

- Comprehensive community engagement process;
- Strengthening bridges among First Nations communities and partner organizations;
- 'Champions' who persevered;
- linkages with First Nations and Inuit Health of Health Canada;
- Traditional approaches to mental wellness.

Factors contributing to success are:

- Social capital within and among First Nations and Health Canada. A track record of collaboration;
- Cultural bonds – language, culture, kinship etc.;
- Strong political alliances amongst Tribal Councils and PTO's;
- Service delivery alliances and referral patterns;
- Existing mental health capacity.

The Raising the Spirit MWT offered advice to others wishing to establish a similar program:

- Projects need 'champions' or 'bulldogs';
- Community engagement is ongoing. Leaders and stakeholders may change;
- Assess community readiness, build on community strengths and what is already in place;
- Build evaluation in to the process from the beginning;
- Keep it manageable;
- Establish governance model right away;
- Develop partnerships – 'invite the neighbours'.

The approach to evaluation the team uses includes:

- Evaluation committee established as a sub-committee of the steering committee with key external resource people;
- Evaluation team selected;

- Evaluation elements include: project development case study; program logic model; academic research partnership; evaluation framework to guide evaluation for the next 2 years; and training for the team to incorporate tools, workplans etc.

Quu'Asa Wellness Project: Completing the Circle – British Columbia

This presentation was given by Simon Read, Director, Nuu-chah-nulth Community and Human Services.

Quu'Asa Project Approach:

- Collaborate with 14 Nuu-chah-nulth First Nations and NTC Mental Health Services;
- Integrate a multi-disciplinary, balanced, culturally sensitive healing approach which includes traditional healing, practices and western approaches for counselling;
- Respectfully provide and exercise client-driven, culturally sensitive, strength based treatment;
- Key elements of Quu'Asa or "the people's way" include:
- Work from strengths, not disease;
- Transformation;
- Connection to place;
- Ceremony.

Simon described how community ownership was fostered:

- Community identified that culture was missing from healing;
- Invited agencies to gathering to assist in providing healing support;
- Community workers decided suitable locations for healing sessions;
- Discussions with community workers to learn needs.

Networking and Sharing

In the afternoon, an opportunity was provided to participants to share what they have learned as MWTs and to provide input or feedback to the topics of the last two days. A world café process was utilized to effectively and efficiently draw the knowledge from each of the workshop participants. Discussions were framed around 6 key questions. The following table summarizes these discussions under the three components of the MWT model:

QUESTION	***COMMUNITY***	***CULTURAL***	***CLINICAL/ MAINSTREAM***
What are key elements for cultural safety?	-Validating programs, activities and tools with the community population. -To participate in and/or host community activities including gatherings. -To know that food, family and	-Including cultural advisors to incorporate traditions including teachings and to adapt mainstream programs to include traditions and teachings.	-Adapting clinical intervention tools to include cultural sensitivity -Sharing of mainstream clinicians practices

	friends are necessary for success in community events. -To know that relationship building takes time. Trusting you are where you are meant to be. Wellness is not based on a schedule. -Understanding of the value of relationships by getting to know the people, their families, the community and their connection to the land and how they are inter-connected.	-Being aware of your own culture, values, beliefs and ways and the impact you have on others. -To be aware of and practice the Seven Grandfather Teachings when working with communities: Respect, Humility, Bravery, Love, Wisdom, Truth and Honesty. -To have an understanding of First Nations and Inuit history including historical trauma, trauma, colonization and grief issues and their impacts on the wellness of people. -Practicing due diligence when opening people up to culture and a healing path. -Using language and wording that is appropriate to First Nations and Inuit populations. -Providing opportunities for participants to learn more of their culture with insights into our values and beliefs. -Use of the holistic approach incorporating personal and cultural values. -An approach that is client guided and not clinician dictated giving the client choice. -Acknowledging individual needs and goal differences. -To practice being nonjudgmental, listening skills, open mindedness, trust, acceptance, self-reflective, self-care, sharing and knowledge transfer.	and views with traditional providers' ways to examine similarities and differences.

		-Balancing health inequities to ensure the client feels you are walking the walk with them.	
What works for community engagement and ownership?	-Establishing a community MWT steering committee to guide policy and to make decisions. -Locating well respected community champions and opinion leaders who are influential in public opinion to support the MWT. -Obtaining a Band Council Resolution to support the MWT. -Recognition of accomplishments by community individuals and staff – both individually and collectively. -Focusing on strengths and successes of the community. Working from a strength based perspective. -Demonstrating responsiveness and accountability for input from the community by making changes and acting on the information you ask for. -Engagement through community consultations, regular communication with the community, implementation/direction based on consultations, involvement of community in decision making, and the facilitation of empowerment. -Building trust in all relationships. -Giving the community permission to accept ownership of their problems and to validate they have the solutions within the community. -Work to engage youth. -Linking the work of the MWT	Ensure cultural safety and sensitivity. -Use of Algoma University's Community Engagement Tool.	

	to existing community initiatives. -Ensuring the goals of the MWT are the same as the goals of the community. -Walking with the community at their pace and level of responsiveness. -Demonstrating that you CARE first. -Ensuring the team is ethical and practices confidentiality. -Education and promotion with Chief and Council, the community and all service providers, internally and externally. -Building equal relationships with external mental health and addiction agencies.		
***What works for achieving buy-in from partners and stakeholders*?**	-Communicate with partners/agencies on a regular basis. -Provide partners with tools and knowledge to achieve openness and understanding. -Outline common links, common goals and benefits with partners/agencies. Establish a joint work plan to achieve the goals. -Develop and implement a public relations strategy for working with partners and agencies. -Focus on working together to reduce redundancy, duplication of services and costs. -Share your data, information and knowledge as a MWT with your partners/agencies. -Celebrate success with your partners/agencies. -Work towards sustainability and longevity with your partners/agencies. -Engage leadership and political influence in building	-Include partners/agencies in ceremonies, cultural teachings and community activities	-Invite non-Aboriginal partners/services to come to First Nations or Inuit communities for exchange of information on what they can offer and to learn about the community. Seek out joint initiatives for collaboration. -Accept that partners can contribute in different ways and at different levels. -Clarify roles and responsibilities among all partners.

	partnerships. -Assist partners to take a risk in working with your team and within the community. -Ensure equality exists in partnerships and joint initiatives.		
What are the gaps in services and how have you addressed them?	-Lack of funding for services especially long term. -Lack of confidentiality. -Recruitment and retention of qualified staff. -Lack of collaboration in services. -High turnover in leadership with Chief and Council. -The impacts of nepotism and politics. -Working to bring services into the community. -Offering training to community members so they are qualified to work in helping professions. -Mobile MWT units who will draw in community resources. -Using the resources from one community to assist other communities. -Utilizing the champions and/or allies to assist in addressing the gaps.	-Accessing traditional and cultural services. -Lack of cultural safety. -Equitable compensation for traditional services. -Providing training in cultural safety and competencies. -Employing more Elders.	-Accessing clinical services. -Accessing clinical supervision. -Lack of aftercare services. -Lack of specialized mental health services. -Lack of provincial resources. -Mainstream services that are mandated to serve First Nations on reserve but do not. -Case management. -Teleconferencing for clinical supervision.

How do you build capacity within the team and the community?	-Training for community members and partners on their identified needs, including team work -Consultation with community and leadership. -Inventory of existing capacity through strengths and asset mapping. -Ability to transfer knowledge. -Clear understanding of team roles and responsibilities. -Identifying areas for growth and education and following up with training. -Promotion of role models. -Involving the whole community to take ownership. -Implementing a process to determine community needs in capacity building. -Celebrating strengths and successes. -Focus on communication with the team and the community. -Ensuring the steering committee members were in a position with the ability to make decisions on programs, policies and finances. -Hosting a mental health knowledge symposium. -Know the boundaries and limitations of the MWT. -Willingness to learn and to teach. -Having common goals, direction and vision with the community.	-Orientation for new Aboriginal and non-Aboriginal staff on culture and traditions. -Mentoring the youth on traditional knowledge, teachings and ways.	-Linking the continuity of care with clinical supervision and consultation. -Ensure territorial jurisdictions for service provision are implemented in cooperation with the MWT. -Education for existing services -Researching all services available and communicating with them. -Networking with services. -Bridge building between services, partners and agencies. -Influence resource and funding allocations.
How do you share the wisdom of your work/ experience with others?	-Interactive knowledge transfer. -Building relationships throughout the community. -Acknowledgement, recognition and celebration. -Lunch and learn activities. -Regular and consistent communication. -Networking as a priority.	-Sharing circles. -Potluck gatherings. -Storytelling -Music, song, dance, puppetry and other children's activities.	-Evaluation framework and reporting. -Partnering with an academic research project. -Hosting an up to date website. -Workshops, conferences and

	-The use of photo voice. -Community gatherings and presentations. -Brochures, videos, posters and newsletters. -Media through radio and TV to communicate milestones, successes and champions/ the use of social media/networking.		meetings. -Developing reports, publishing the work.

Day 3 (December 2nd, 2010)

Day 3 focused on evaluation; however time did not permit for the technical plenary session on developing common indicators for the evaluation of MWT pilot projects which was originally scheduled on the agenda.

Evaluating MWTs

Issues in the Evaluation of Aboriginal Mental Health Programs

This presentation was given by Marion Maar, Ph.D., evaluator for MWT in Ontario region.

In her presentation, Marion focused on evidence-based practice. She explained that evidence-based practice refers to "preferential use of mental and behavioural health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems."

In addition to the collection, evaluation, and interpretation of data, evidence-based practice emphasizes the dissemination of information so that the evidence can reach clinical practice. Therefore, well thought-out and careful clinical planning involves both individual clinical expertise and the best available external clinical evidence in addition to data collected from the individual. However, Marion pointed out that some things (variables) in a client's life are not easily controlled.

Key points from Marion's presentation include:

- In Ontario, regional implementation task forces have adopted recovery as the guiding principle for the reform of the mental health system. The recovery principle's emphasis on constructing a strong sense of self defies quantification and instead challenges policy makers, providers, and others to examine qualitative changes to how mental health services are delivered. (CMHA);
- The culture of mental health practice and evaluation is *not* the culture of the Aboriginal community;
- Current measures are based on mainstream populations and may be ideologically incompatible with Aboriginal worldviews;
- Culturally-based programs often represent local innovation in therapeutic approaches;
- There is a need for the development of new approaches to Aboriginal mental health evaluation (J. P. Gone & C. Alca´ntara, 2007).

Potential future areas of focus described by Marion include:

- Community-based research with robust findings can translate into better mental health programs and policies for Aboriginal people;
- Compared with mainstream and clinical evaluations, frameworks for Aboriginal wellness teams must include a broader perspective than emphasis on individuals and problem-based measures (Weiman, C., 2006);
- Research is also necessary to improve our understanding of the healing experience of Aboriginal individuals and their families; how traditional healing services support

family healing from a holistic perspective, such as decreasing violence in the home, and encouraging healthy parenting; and, how clinical services can best complement traditional approaches;
- Strengths based indicators;
- Participatory approaches to evaluation;
- Measuring various levels (individual, family, community, mental health system).

Marion explained that research on the effectiveness of integrated services must not force traditional healing practices into clinical mental health evaluation models; conventional outcome measures and efficacy research are likely inappropriate. Instead research should explore new indicators of success that reflect the impact of integrated clinical services and traditional healing on the community, families, and individuals (Maar, M. & M. Shawande, 2010).

Measuring Positive Mental Health

This presentation was given by Dr. Samir Khan of the Health Information, Analysis and Research Division of First Nations and Inuit Health Program, Health Canada.

Dr. Khan gave a brief background to the evaluation of mental health. He stated that the prevailing hypothesis among many researchers in mental health assessment has been that:

- The absence of mental illness is the presence of mental health;
- Measures of mental illness and measures of mental health belong to a single continuum.

He further stated that in contrast, Dr. Corey Keyes approach is founded on three observations:

- Measures of mental illness and measures of mental health are two distinct continuums;
- Poorer physical and psychological well-being are linked to anything less than "flourishing" mental health; Only a small proportion of those otherwise free of a common mental disorder are mentally healthy (flourishing).

Dr. Khan discussed Dr. Keyes' development of an assessment tool for positive mental health. The tool measures the frequency with which respondents experienced each symptom of positive mental health. The dimensions of positive mental health are:

- Emotional well-being;
- Social well-being;
- Psychological well-being.

He made note that the two dimensions missing were ecological well-being and spiritual well-being.

In summary, Dr. Khan stated that having appropriate indicators of positive mental health could mean:

- Improvement of mental health care does not need to start as soon as mental illness appears;
- Improving positive mental health would act as a preventative measure, before signs of illness appear;
- Mental and physical benefits could come to those who improve on measures of positive mental health.

Outcomes of Healing

This presentation was given by Dr. Rod McCormick, University of British Columbia.

Dr. McCormick presented findings from his research on outcomes of healing based on his study that was published in 1996. As a result of the research, five healing outcomes emerged based on the 50 Aboriginal people and the 437 critical incidents of what was done and what action was taken to facilitate their healing.

The five outcomes are:

- Cleansing: Refers to the eliminating or getting rid of bad energy, spirits, or emotions and includes outcomes such as letting go, expressing and releasing emotions. Cleansing can occur through a wide variety of means and can apply to physical, mental, emotional and spiritual cleansing. Often what leads to cleansing is the need to express emotions such as pain, anger, guilt, or fear. Much of the practice of cleansing for Aboriginal peoples is expressed in a symbolic way and may not be clearly visible or understood by non-Aboriginal people. Cleansing or expression is extremely important when we consider the amount of unacknowledged, unexpressed pain, guilt, shame, anger etc. that we are carrying as a result of traumatic events.
- Balance: Refers to having attained balance in one's life. It includes outcomes such as attaining harmony, centering and grounding of oneself. The individual attained perspective, meaning in their life, calmness or peacefulness. The individual may also have managed to develop a certain part of him/herself such as the emotional or spiritual dimension.
- Discipline: Through obtaining and exercising discipline, participants reported that they were more in control of their lives. Participants felt more self-control, self-awareness, and self-esteem and felt they were proud of their accomplishments in obtaining discipline. This provided people with optimism and confidence in their abilities to deal with future problems. Learning discipline was and still is an important part of traditional teachings and is often learned through participation in ceremony. Although discipline was represented in primarily in the physical, it also manifested in spiritual, mental and emotional ways.
- Belonging/Connection: In this category the person achieved a sense of belonging or connectedness to something or someone. This category includes outcomes such as connection/belonging to family, community, culture, nature, the spirit world and all of creation. The desired outcome illustrates the collective orientation of many Aboriginal people. The extended family, friends, and members of the community are often seen as a natural support and illustrate the importance of belonging. Similarly, it is seen as desirable to be connected or to belong with nature and with spirituality, and ultimately, to be a part of and belong to all of creation. This belief touches on a broader cultural issue for Aboriginal people because of the historical events of the

past 200 years. The federal government's policy of assimilation has had devastating effects on the unity and sense of belonging/connection for Aboriginal peoples. The government and church tried in a systematic and determined manner to separate Aboriginal people from their culture, language, religion, families, communities, and land. Aboriginal peoples have recognized the overwhelming need to be reconnected and to reclaim what was taken, and are acting to reconnect and strengthen those bonds. The compartmentalized, hierarchical nature of euro-western cosmology clashes with most Indigenous cosmologies and worldviews.

- Empowerment: Colonization and oppression is about stealing people's power and sources of meaning and strength e.g. the land, culture, spirituality, identity, self-esteem, sense of purpose etc. Empowerment is about taking it back. For individuals and communities to be response-able to make positive changes we need to reclaim our power.

Dr. McCormick illustrated the five outcomes through a series of experiential activities that assisted the participants understand the necessity of the outcomes for Aboriginal people seeking healing. He concluded by suggesting that effective healing programs for Aboriginal peoples would invoke empowerment, cleansing, balance, discipline and belonging/connection.

In relationship to evaluation, he provided the workshop with a question asking if the 5 outcomes of healing could assist the MWT pilots in their formation of process and for outcome evaluation.

The workshop closed with a ceremony led by the Elder Perry McLeod-Shabogesic.

WORKSHOP EVALUATION RESULTS

The participants of the 'Community of Practice' Workshop were provided with an evaluation questionnaire each day of the workshop. The following is an overview of what participants stated each day.

Participants identified the following strengths from the MWT Workshop:

- Networking (small group discussions);
- Sharing of information (challenges and successes);
- The cultural presentations (cultural safety).

Participants identified the following areas for improvement from the MWT Workshop:

- Days were too long as agenda was too packed;
- Speakers went over their time limit;
- No food available.

IF YOU WOULD LIKE A COPY OF ANY OF THE PRESENTATION SUMMARIZED IN THIS REPORT, PLEASE CONTACT NANCY-JANE HELFERTY AT:
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APPENDIX A

MWT "Community of Practice" Workshop

November 30th – December 2nd, 2010
Crowne Plaza Hotel
Ballroom "B"
Ottawa, Ontario

OBJECTIVES:

- Advance the implementation of the MWT pilot projects and facilitate the achievement of results;
- Provide a forum for the exchange of promising practices and lessons to understanding what works in First Nations and Inuit communities;
- Support capacity development and learnings in specific areas relevant to the MWT pilot projects;
- Develop common indicators for the evaluation of MWT pilots
- Facilitate communications on MWTs

AGENDA

DAY 1 – November 30th

Opening Prayer – Perry McLeod-Shabogesic
Welcome and Introductions

Rod Jeffries, facilitator (outline of the day)
Kathy Langlois, Director General of Community Programs, FNIHB

Keynote Address:
Patrick Dion, Government Director on Board of Directors for the Mental Health Commission of Canada (MHCC)
Laurence J. Kirmayer, MD

NETWORK BREAK

Panel Discussion (Solutions to Challenges) (MWT pilots and outside expert(s) present on challenges and how they addressed them)

Mapping the Way Project (Nunatsiavut)
Anita Charleson and Ray Seitcher from MWT project in BC
Dr. Pippa Hall, Clinical Scientist in Palliative Care, Élisabeth Bruyère Research Institute
Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for ON MWT

LUNCH

Panel Discussion: Strategies for Sustainability (MWT pilots present on their lessons learned with engaging partners and other strategies for sustainability)

Theresa Bartlett-Chase, Nurse for Maliseet Nations MWT in Atlantic region (accessing provincial MH services)
Sylvia Meilleur, Program Manager for MWT in Manitoba region (working with Correctional Services Canada)
Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for MWT in Ontario region

NETWORK BREAK

- Breakout discussion groups (guided by discussion questions)
- Report back
- Closing

DAY 2 – December 1st

- Sunrise Ceremony (optional)
- Opening

Panel Discussion: Cultural Safety (MWT pilots and outside expert(s) present on their lessons learned with developing/providing culturally safe services /tools /policies /programs etc.)

Rob Kirk, Psychologist and Murray Ironchild, Traditional Advisor for MWT in Saskatchewan region
Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for MWT in Ontario region

NETWORKING BREAK

Panel Discussion (Cultural Safety) continued

Vicki Smye (RN, PhD, Assistant Professor, School of Nursing, University of British Columbia)
Veronica M. WolfEagle, Project Coordinator for Maliseet Nations MWT in Atlantic region (Medicine Wheel tool for DSM IV)
Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for MWT in Ontario region

LUNCH

Panel Discussion: Community Development

Réjean Vallières and Barbara Bouchard from MWT in Quebec region
Mariette Sutherland, Program Coordinator for MWT in Ontario region
Simon Read, Anita Charleson and Ray Seitcher from MWT in BC
Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for MWT in Ontario region

NETWORKING BREAK

- Discussion Circles (guided by discussion questions)
- Report back
- Closing

DAY 3 – December 2nd

Technical Plenary Session: Evaluating mental wellness teams

- Marion Maar, Evaluator for MWT in Ontario region (limitations related to the evidence-based model approach to Aboriginal mental health program evaluation)
- Samir Khan, Senior Research Analyst from National Office (research on positive mental wellness indicators)
- Rod McCormick (research on outcomes of healing)
- Perry McLeod-Shabogesic, Traditional Counsellor/Coordinator for MWT in Ontario region

NETWORKING BREAK

Technical Plenary Session: Developing common indicators for the evaluation of MWT pilot projects

Andrealisa Belzer, Senior Evaluation Advisor from Atlantic region
Angela Fabisiak, Evaluation Manager from National Office
Nancy-Jane Helferty, Senior Policy Analyst from National Office

Breakout discussion groups
Report back

LUNCH

Facilitated breakout groups guided by "Proposed MWT Evaluation Questions"

NETWORKING BREAK

- Report back
- Closing Remarks
- Closing Prayer

APPENDIX B

Competencies for Effective Collaborative Team Practice Checklist

- **Which competencies did you observe in others?**
- **Which competencies did you apply yourself?**

Interprofessional competencies for collaborative team practice	I observed in my team (✓)	I did … (✓)	Comments
Communication *Ability to communicate effectively in a respectful and responsive manner with others.*			
Collaboration *Ability to establish/maintain collaborative working relationships with other providers, patients/clients and families.*			
Roles and Responsibilities *Ability to explain one's own roles and responsibilities related to patient/client and family; and to demonstrate an understanding of the roles, responsibilities and relationships of others within the team.*			
Collaborative Patient/Client/Family-Centred Approach *Ability to apply patient/client-centred principles through interprofessional collaboration.*			
Conflict Management/ Resolution *Ability to prevent and deal effectively with conflict between and with other providers, patients/clients and families.*			
Team Functioning *Ability to support effective team functioning to continually improve collaboration and quality of care.*			

Interprofessional Competencies for Collaborative Team Practice

Communication

Descriptor: *Ability to communicate effectively in a respectful and responsive manner with others.*

- Communicates and expresses ideas in an assertive and respectful manner.
- Uses communication strategies (e.g. oral, written, information technology) in an effective manner with others.

Collaboration

Descriptor: *Ability to establish/maintain collaborative working relationships with other providers, patients/clients and families.*

- Establishes collaborative relationships with others in planning and providing patient/client care.
- Promotes the integration of information and perspectives from others in planning and providing care for patients/clients.
- Upon approval of the patient/client or designated decision-maker, ensures that appropriate information is shared with other providers.

Roles and Responsibilities

Descriptor: *Ability to explain one's own roles and responsibilities related to patient/client and family care (e.g. scope of practice, legal and ethical responsibilities); and to demonstrate an understanding of the roles, responsibilities and relationships of others within the team.*

- Describes one's own roles and responsibilities in a clear manner.
- Describes the roles and responsibilities of other providers.
- Shares evidence-based and/or best practice knowledge with others.
- Integrates the roles and responsibilities of others with one's own to optimize patient/client care.
- Accepts accountability for one's contributions.

Collaborative Patient/Client/Family-Centred Approach

Descriptor: *Ability to apply patient/client-centred principles through interprofessional collaboration.*

- Seeks input from patient/client and family in a respectful manner regarding feelings, beliefs, needs and care goals.
- Integrates patient's/client's and family's life circumstances, cultural preferences, values, expressed needs, and health beliefs/behaviours into care plans.
- Shares options and health care information with patients/clients and families.
- Advocates for patient/client and family as partners in decision-making processes.

Conflict Management/ Resolution

Descriptor: *Ability to prevent and deal effectively with conflict between and with other providers, patients/clients and families.*

- Demonstrates active listening and is respectful of different perspectives and opinions from others.

- Works with others to prevent and deal effectively with conflict.

Team Functioning

Descriptor: *Ability to support effective team functioning to continually improve collaboration and quality of care.*

- Evaluates team function and dynamics.
- Demonstrates shared leadership within the healthcare team that is appropriate to the situation.
- Contributes effectively and meaningfully in interprofessional team discussions.

Reference: Curran, Vernon, Casimiro, Lynn, Banfield, Valerie, Hall, Pippa, Lackie, Kelly, Simmons, Brian,Tremblay, Manon, Wagner, Susan J. and Oandasan, Ivy. 'Research for Interprofessional Competency-Based Evaluation (RICE)', *Journal of Interprofessional Care* 2009; 23(3): 297-300.