Many Hands ...One Spirit

Promising Practices in First Nations and Inuit Home and Community Care —Mental Health Services

Production of this document has been made possible by a financial contribution from Health Canada, First Nations and Inuit Home and Community Care Branch. The views expressed herein do not necessarily represent the official policies of Health Canada.

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ABOUT THE CANADIAN HOME CARE ASSOCIATION

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.

For more information, visit www.cdnhomecare.ca

Foreward

In 2010, the Canadian Home Care Association worked with the First Nations and Inuit Home and Community Care Program to identify and highlight promising practices in regions across Canada. The final report, "Mind, Body, Spirit", was disseminated to a large audience of home care stakeholders and elicited excellent response and interest from home care programs across Canada.

As a continuation of the journey to build awareness and enhance home and community support, this report, "Many Hands…One Spirit", was commissioned by the First Nations and Inuit Home and Community Care (FNIHCC) Program. The report highlights some of the many unique practices in First Nations and Inuit communities across Canada and showcases promising practices in mental health and home and community care service delivery. We anticipate that the response to these practices will be equally enthusiastic and are delighted to be involved in this important knowledge dissemination work.

The initiatives described in this report focus on the contribution of the home care team to the mental wellbeing of their clients. The programs demonstrate how communities build upon their strengths and engage the efforts of many individuals to work harmoniously towards a goal of improving health and wellbeing for all. The report title "Many Hands...One Spirit" is reflective of the collaboration required.

The initiatives that are presented share a common focus of engaging many individuals to enhance home and community based services in order to provide holistic programs that address mind, body, emotions and spirit, while preserving culture and respecting traditional ways. Integration, collaboration and awareness are themes that emerged, reflected through values of respect, love, harmony, balance and wisdom.

The Canadian Home Care Association (CHCA) extends congratulations to the Regions for their successes in integrating mental health to home and community care service delivery. It was a privilege and honour to work with the dedicated individuals who are engaged in home care every day and to learn about their challenges and successes within their communities. We are grateful for the stories and for the time and effort provided by countless individuals to support the development of this document.

The CHCA hopes that this compendium will serve to stimulate discussion and facilitate connections between and within the regions. We encourage readers to use these practices as a resource for staff that experience similar circumstances and want to draw on the knowledge of others.

Nadine Henningsen
Executive Director
Canadian Home Care Association
October 2011

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AWARENESS

THE FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM (FNIHCC) provides home and community care services to vulnerable people in First Nations and Inuit communities including to those who are elderly or disabled, or who have chronic or short-term acute care needs. It allows people to remain in their communities, close to home with their loved ones for as long as possible. FNIHCC includes client assessments, case management, home care nursing services, home support services (e.g. personal care services and home management), in-home respite care, and access to medical supplies and equipment. Included in the FNIHCC program framework as supportive service elements are mental health services for long-term psychiatric clients and clients experiencing mental or emotional illness. The Assembly of First Nations (AFN) has identified mental health as an issue that must be addressed and the AFN health policy on mental health is examining the accessibility of mental health services for First Nations. FNIHCC is committed to ensuring quality care is delivered safely and effectively. Quality improvement initiatives are encouraged at all levels of the program.

The home and community care services are delivered by educated and certified health workers at the community level and supported by home care nurses. Home and community care nurses provide an extensive array of services such as teaching health to clients and informal caregivers, health assessments, medication management, wound management and other nursing treatments. Case management is a critical function to meeting client care needs and includes coordination of hospital-to-home discharge planning, initial and ongoing assessments, consultation with other health professionals, care conferencing and establishing linkages with other health and social services such as mental health services.

The following compilation of best practices and promising approaches in community mental health service delivery with the First Nations and Inuit Home and Community Care Program highlight the partnerships, collaboration and linkages that have been established either formally or informally. This compilation is a resource for capacity building between interdisciplinary teams and promotes the possible and effective collaboration between these two disciplines.

Collaboration

THE ESSENCE OF THE FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (FNIHCC) program is partnership, working together to leverage the contributions of many to achieve wellness. Aligning physical, mental, emotional and spiritual health is a collaborative endeavour and requires the participation of many partners. Central to the team is the client and family whose active engagement as equal partners is required in order to effectively collaborate on the realization of care goals.

Collaboration amongst partners involves better communication, improved teamwork, sharing of clinical care responsibilities, joint educational programs and/or joint program and system planning. Engaging members of the health care team within the First Nations and Inuit community, the resources and wisdom of the Chief and Council, and the provincial health system partners, is vital to achieving significant and lasting improvements. Clients experience better, more comprehensive care. The community is enriched through enhanced service and the performance of the health systems (provincial and First Nations and Inuit) increases when partners offer complementary services and mutual support.

The following promising practices reflect efforts to engage clients and families, bridge sectors and address professional boundaries and responsibilities so that the many contributions of the team and the community can achieve an independent spirit.

OSOYOOS INDIAN BAND
MENTAL HEALTH INTEGRATION INITIATIVE

Collaboration with provincial resources to deliver enhanced mental health care

KEY INFORMANTS:

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Paul Edwards, *Mental Health Therapist, South Okanagan Mental Health Services, Interior Health, British Columbia*

Background

The Osoyoos Indian Band (Nk'mip) is a First Nations community with a population of 512 members. The majority of the Band lives on the Osoyoos Indian Reservation. A young community, 50 percent of the total membership is under the age of 25 years. The Band's land mass consists of 32,000 acres situated in the south Okanagan between Gallagher Lake (11 km north of Oliver) to the east side of Osoyoos B.C. close to the U.S. border.

The community provides socio-economic services for its membership, including Band administration, health, social development, education and human resource programs. The Band is governed by a five member Chief and Council who are responsible for the acquisition and oversight of all areas of service delivery and economic development activities.

The Osoyoos Indian Band (OIB) has provided socially based programming for its membership for approximately 35 years, and has developed both the human resource and capital capacity to provide consistent and high-quality socio-economic services. The Band employs a 17-member social/health services team, and has a fully operational health/social services facility, the Nk'mip Resource Centre. The centre provides a multitude of social/health related programming including Home and Community Care, which involves client assessment, care coordination/management, home support services, and access to medical supplies and equipment.

Absent from the health programs was support for individuals with mental health needs which meant that staff, including home care staff, offered service to the best of their ability but often felt limited. A mental health therapist from Interior Health's South Okanagan Mental Health Services visited on request and had achieved some success with individuals, but there was recognition that more support was required. The issues facing clients and families dealing with brain injuries, drug-induced psychosis and emotional/trauma are vast and impact every facet of the community. For the acute/chronic clients there must be a traversable course of services and resources that they and their families can access.

With half the OIB membership under the age of 25 and at high risk for mental health problems, the Health Services Department, with the support of the Chief and Council, undertook to improve knowledge, education and support in the community. They reached out to other health system stakeholders to explore the development of a comprehensive and seamless service delivery model for mental health services so that clients and their families could achieve a level of life skills and personal independence.

In 2008, the partners applied to the Aboriginal Health Transition Fund (AHTF) Integration Project for funding to launch the Osoyoos Indian Band Mental Health

The young population has the highest risk for head injuries due to accidents/violence, and drug/alcohol induced psychosis.[i] [ii]

PROJECT PARTNERS:

South Okanagan Mental Health Services–Interior Health
One of the five geographically based health authorities established in 2001, it is responsible for ensuring publicly funded health services are provided to the people of the Southern Interior.

Okanagan Nation Alliance (ONA)
The tribal organization that provides governance, administrative and technical support to the seven bands of the Okanagan Nation, and deals with issues related to land, resources, health, education, child protection and other tribally relevant issues.

Nk'mip Resource Services
A multi-faceted health/social services facility that provides a one-window service delivery model for the members of the Osoyoos Indian Band. The OIB Chief and Council provide the managerial oversight for the health, social development and human resources team leaders.

Kelowna Friendship Centre–Aboriginal Mental Health Support Services
A non-profit centre that provides support to First Nations within the greater community by providing social, health, education and cultural programming.

Integration Initiative as the foundation for the development of a strategic and sustainable mental health framework between the Osoyoos Indian Band, the Nk'mip Resource Centre, Interior Health, and other mental health support services within the south Okanagan.

The goal of the initiative was to have a fully integrated and culturally relevant mental health program based on the stated needs of the Osoyoos Indian Band membership and transcending the settings of health care. This would include the development of a framework agreement that articulates:

- The services/resources available for clients and their families;
- The identification of education/awareness prevention programs for children, youth and families;
- The development of a mental health crisis intervention/management model;
- A comprehensive consultation process that is inclusive of the Osoyoos Indian Band health care personnel, initiative partners and other supporting mental health organizations.

Implementation

Critical to the approval of the initiative was the collaborative nature of the approach, making it consistent with "Tripartite First Nations Health Plan". An in-depth consultation with the OIB community, partner agencies and other mental health organizations was undertaken in order to identify existing relationships and responsibilities, and to explore opportunities to integrate existing mental health service delivery mechanisms.

EDUCATION

The Team Leader of Interior Health South Okanagan Mental Health Services, in collaboration with the Health Services Coordinator, developed an educational program for staff. Staff from all programs within the Nk'mip Resource Center, from receptionist to clinician, and from each of the partner organizations, participated. This allowed for shared learning and created opportunities for casual contact between aboriginal and non-aboriginal service providers. The program consisted of six half-day sessions covering a range of relevant topics. The curriculum included:

- Recognizing a Mental Health Problem
- Psychosis
- Depression and Mood Disorders
- Anxiety
- Personality Disorders
- Substance Abuse

The Mental Health Therapist notes that "when Band members reach out for help, it is important to respond quickly. Establishing the connection is vital and starting therapy when the person is ready is critical. Even a phone call helps."

The session leaders included 'Mental Health and Substance Use' staff that was actually providing services to individuals with the disorders discussed. The presenter was the individual with whom the Band staff would be working with in delivering service. This led to a more personal connection between Band staff and service providers. It triggered immediate referrals to a Mental Health Service and instantly strengthened the linkages with the health care team in Osoyoos.

On the last day, OIB individuals focused on cultural issues within their community. They spoke of the effect of the residential schools and the manner in which their people prefer to cope with issues. Interior Health brought about 30 staff to this session which was extremely valuable for the participants and appreciated by the OIB.

The evaluations of the educational program were highly favourable and participants reported that they established working relationships and connections that were previously non-existent. Participants valued hearing the experience of others, the discussions about psychiatry and native culture, and expanding their knowledge base. They felt that the program helped to remove the stigma associated with mental disorders.

Dedicated Staff

The funding also allowed the Nk'mip Resource Center to hire a Mental Disorder/Brain Injury (MD/BI) Specialist for eight hours per week. The role of the MD/BI Specialist was to provide community–based and specialized services that enhanced the health and capacity of clients and their families dealing with mental disorders and/or brain injury. A member of the Nk'mip Resource Team, and under the supervision of the Health Services Coordinator, the MD/BI Specialist was responsible for coordinating services and working with internal/external service providers. The MD/BI Specialist's primary objective was to create a comprehensive service delivery plan that would foster increased capacity and independent living, including the provision of education and support to clients, families and community. The MD/BI Specialist provided the support through the coordination of cultural and recreation programs that offer an alternative to substance misuse.

With the MD/BI Specialist and the Mental Health Therapist from Interior Health, working together in the community, individuals started to come forward with their issues and the home care staff had a resource on which they could depend. Initially, those who were seen by the team were very complex–people with longstanding issues that in many instances had been incorrectly handled or referred to the wrong system (e.g. addictions or justice).

THE TRIPARTITE FIRST NATIONS HEALTH PLAN

A 10-year agreement between the First Nations Leadership Council representing the BC Assembly of First Nations, the First Nations Summit and the Union of BC Indian Chiefs and the Government of Canada and the Government of British Columbia that defines principles that underpin the system of health services in the province. These include: meeting the identified health priorities of the community, enabling access to quality services, coordinating with other community-based service delivery agencies, linking with provincially based agencies, assigning accountability and control to First Nations, and enabling the creation of a collaborative environment in which partnerships and joint planning can occur.[iii]

MD/BI SPECIALIST DUTIES:

- Provide assessments of clients medical and support needs in conjunction with members of the health care team.
- Provide assessments of family/support system.
- Provide assessments of home/living environment.
- Provide referral of clients to Interior Health, Brain Injury Society, Nk'mip Health and Social Services when required.
- Develop on-going communication linkages with client and family/support systems.
- Provide life skills training to clients.
- Coordinate and facilitate integration of clients into the community.
- Coordinate and deliver client–based substance abuse awareness and prevention programs.
- Participate in health team meetings, Council meetings, community meetings and other inter/intra-agency meetings/events as required.
- Liaise with staff members of various community agencies.

The health care partners developed a support system for families, enabling them access to resources and services, which is vital to their wellbeing. Families can take advantage of the support system regardless of whether or not their loved one is receiving active care.

Key Success Factors

Introducing new services and staff to a small health care team can be challenging and potentially disrupt the equilibrium. The health care team believes that the success of the mental health service was a result of the following factors.

Community Presence–Members of the Osoyoos Band were not typically comfortable booking appointments off-reserve. The preference was to seek help, often by "drop-in" from those that they know and trust. Staff needed to be available, flexible and ready to respond when the moment was right.

Community leadership–The Chief and Council were, and continue to be, supportive of health and social issues as a priority. This strong leadership is enormously helpful to the practitioners and enables them to be more effective in their jobs. Chief and Council communicated the importance of the initiative to the Band members and urged employers to work with the Nk'mip Resource Center to accommodate jobs for those ready to return to work. Home and community care staff supported the job re-entry by visiting the work site weekly and responding immediately when managers called with concerns.

Community support–The community was supportive of the mental health initiative, respecting that it is a sensitive yet vital issue. Under the leadership of the Chief and Council, a number of issues including housing were addressed, affording those on the road to recovery a safe environment.

Community collaboration–The collaboration between partners was vital. It has proven to be critical to have health and social services working closely together for the clients at the Nk'mip Resource Center (as opposed to the traditional silos present in so many communities).

"Co-managing works for the clients and the community in a very beneficial way."

Lessons Learned

As a result of the journey to integrate mental health services into the broader health care offering at Osoyoos, a number of lessons were learned about how the members of the community, including the health team, perceived those with mental illness.

- Too often, individuals are stereotyped and assumptions are made that the aboriginal's problem is an addictions issue when there are underlying mental conditions that are treatable. Consequently a criminal justice solution may be sought rather than more appropriate health care treatment.
- Failure to fill prescriptions may not be an issue of "compliance" but rather the result of an inability to afford the medication. Physicians in the provincial health system may be unfamiliar with the medications covered by Federal non-insured health benefits and unknowingly write prescriptions that are not included.
- There is greater openness to support from the provincial health team when staff are respectful, patient and willing to provide care within the First Nation's community.
- It takes time to gain trust.
- It is most effective to work through the Band structure and resources and support their initiatives and autonomy. Care is taken to use the limited resources effectively. The strength of the health care team is in their ability to identify manageable issues that can collectively be addressed.
- The sense of community amongst First Nations is a powerful source of strength and healing for individual Band members and the Band as a whole.

Conclusion

A model for mental health services has been established. The Nk'mip Resource Center staff, the Chief and Council, and the OIB members all have a greater awareness of mental health disorders and feel that they are better resourced to support their clients. They are more confident in their partners and continue to work collaboratively.

The funding was not extended and as a result the Mental Disorder/Brain Injury (MD/BI) Specialist position was terminated. The Health Services Coordinator has been able to allocate some of the Department's funding to have a MD/BI Specialist visit monthly. As a result of the strong interest within the Interior Health Authority to develop improved health care to First Nations people, the Mental Health Therapist has been able to continue to visit weekly. He carries an average caseload of seven on the OIB reserve and has five members who visit him offsite at his office. The Mental Health Therapist brings special qualities to his role within the program—he fits in and is respected by the Band, counted on to be present and available, and comfortable with people "dropping in".

The goal of the Osoyoos Indian Band Mental Health Integration Initiative has been achieved. Mental health services are integrated as part of the overall health care provided by the Nk'mip Resource Center – in clinic and/or at home. Comprehensive and quality services for clients, families and the community at-large are being realized.

The Result of Many Hands

Brian, a middle-aged man, with late onset schizophrenia struggled in the small OIB community. His behaviour was at times threatening and sometimes extremely paranoid. He became unreliable and as a result was terminated by his employer. Without an income and because of his frightening behaviour he lost touch with his family and community. This downward spiral resulted in Brian's admission to a psychiatric unit off-reserve. Once he was stabilized, the OIB Health Department, with the help of the MD/BI Specialist and Mental Health Therapist, was able to support Brian's re-entry to the community. Staff worked with his employer to accommodate a safe return to work. The team agreed to see Brian weekly to support his progress and provide his medication. Brian, who had become an outcast, and previously would not have had access to people who understood his condition, was accepted by his community and supported. He was reunited with his children and rebuilt his reputation and standing in the community.*

**Name was changed to protect identity*

[i] Global status report on alcohol and health, retrieved on June 10, 2011 from http://whqlibdoc.who.int/publications/2011/9789241564151_eng_Consequences_p58.pdf

[ii] Centers for Disease Control and Prevention National Center for Injury Prevention and Control (2010) Traumatic Brain Injury in the United States, Emergency Visits, Hospitalizations and Deaths 2002-2006

[iii] Retrieved on April 20, 2011 from http://www.health.gov.bc.ca/library/publications/year/2007/tripartite_plan.pdf

KAINAI HOME CARE
BRIDGING GAPS AND BENEFITING THE COMMUNITY

The value of a Medical Social Worker on the home care team

KEY INFORMANTS:

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Background

The Kainai (Blood Tribe) is located in southern Alberta and is the largest reserve in Canada, encompassing 544 square miles of territory. The Blood Tribe is a part of the Blackfoot Confederacy. The Blood people speak the Blackfoot language. Agriculture is the primary industry as well as gemstone mining, house construction, oil and gas development, small business and tourism.[i] The Tribe has a population of approximately 11,000 members living on and off-reserve.

The Blood Tribe Chief and Council manage the long-term economic, social and environmental interests of the Tribe. They work with community agencies to address the health and wellness of the Tribe members and to support those dealing with the negative effects of residential schools. This includes historical trauma that is affecting community wellness. Research suggests that the impact of residential schools has negatively affected the following social determinants of health: income, education, employment, social status, working and living conditions, health practices, coping skills, and childhood development.[ii] Cultural loss is also considered a significant determinant of health and wellbeing in a First Nation community.[iii]

Since 1984, the Blood Tribe has authorized the Blood Tribe Department of Health Inc. (BTDH) to regulate and administer medical and health services in the community. The BTDH operates in accordance with the principles of Kainayssini (a declaration by the elders of the Blood Tribe) which include a health by law passed by Chief and Council. The BTDH is committed to the development of a 'Continuum of Care' for the delivery of services to its community members. The Continuum of Care philosophy reinforces the common goal of all programs—the provision of high quality integrated and coordinated services. This approach allows for the integration of Blood cultural traditions and complements a holistic view of treatment.[iv]

As an important component of the BTDH, the Kainai Home and Community Care Program provides home nursing and personal support services to eligible Blood Tribe members throughout their life. The mission of the Kainai Home and Community Care program is to achieve and maintain wellbeing and personal independence in a self sustaining community. Services are provided to enable individuals, particularly those with frailties of aging, to remain at home for as long as possible. Home care services include: nursing, social work, occupational therapy, respite, whirlpool bath, foot care, diabetes clinic, health promotion and transportation for home care services only. To be eligible, members must live on-reserve and be assessed by the Home Care Nurse to have a need that can be met through the home care program.

The majority of clients receiving home care are being managed for acute and chronic wound care. Diabetes and musculoskeletal conditions are also prevalent amongst the home care clientele. More than 90 percent of home care clients are 55 years of age and older. The home and community care team has an average of 80-90 clients on service throughout the year. Nursing services provided by home care include diabetes monitoring, wound management, teaching/education, palliative care, foot care, vitals monitoring, medication review and oversight.

There are 26 staff on the home care team, including the Home Care Coordinator, Health Care Aide Supervisor, Registered Nurses, Licensed Practical Nurses, health care aides, an occupational therapist, medical drivers and a Medical Social Worker. The Medical Social Worker is a unique position and has proven to be very effective in supporting the health care team, particularly when client psychosocial issues interrupt the medical care for which they have been admitted to home care.

The Medical Social Worker is also called upon to intervene when staff is concerned that the home environment may be interfering with the therapeutic plan of care. As part of their assessment and case management role, when the nurses recognize that social issues are disrupting the provision of care, a referral is made to the Medical Social Worker. This role must not be confused with social workers employed by Blood Tribe Social Services. The Medical Social Worker in home care does not provide funding, or address housing issues but will liaise with the Blood Tribe Social Development team where necessary.

When client needs are intense and/or prolonged, the Kainai Wellness Centre is available to provide support and counselling to community members. The Centre has a wide range of programs to support those with mental health and addictions issues. The success of the Wellness Centre is in large part a result of having a First Nations psychiatric nurse in charge who understands the cultural issues and can speak the language. Having established a rapport and trust in the community, the non-native staff that have been recruited to the team are more readily accepted. The other key feature is the relative isolation of the centre. As a standalone facility in a highly accessible and yet private residential area of the community, clients feel less exposed when they visit.

The Medical Social Worker in Home Care

The role of the Medical Social Worker is to assess the psychosocial functioning of patients and families and intervene as necessary. Interventions may include connecting patients and families to necessary resources and supports in the community; providing psychotherapy, supportive counseling, or grief counseling; or helping a patient to expand and strengthen their network of social supports. Medical Social Workers typically work on an interdisciplinary team with professionals of other disciplines (such as medicine, nursing, physical, occupational, and speech therapy).[v] Medical Social Workers' skills in providing counselling and working effectively with families and/or with intergenerational caregivers can have an impact on the clinical outcomes, quality of life and use of the health system.

A case for support for the addition of a Medical Social Worker to the home care team was made to senior management of the Blood Tribe Department of Health and the position funded in 2004. The Medical Social Worker within home and community care is a unique role in Alberta. There are very few such staff integrated as members of the home care team in programs across the province.

At BTDH, the Medical Social Worker, under the direction and supervision of the Director of Home Care, provides service/care to home care clients and their families by applying professional social work practice standards. Interventions may include connecting clients and families to necessary resources and supports in the community; supportive counseling, or grief counseling; or helping a client to expand and strengthen their network of social supports.

Supporting a Grieving Family

Steven, a 60-year-old man who had lived in the community all his life wanted to remain in his home as he battled cancer. As his condition deteriorated, the home care team increased the support so that Steven could realize his wish to die at home. While his children and grandchildren were supportive of Steven's decision, they struggled to cope with the impending loss. Through the efforts of the Medical Social Worker and the rest of the home care staff the family was supported in their grief and past habits of seeking refuge in drugs and alcohol were avoided. Steven died peacefully surrounded by his family.*

**Name was changed to protect identity*

More specifically, the Medical Social Worker:

- Assists individuals and their families to cope with the psychosocial effects of illness, disability and the aging process.
- Teaches and encourages clients and families to relearn former skills of daily living or master patterns of adaptation to compensate for lost abilities, as related to social work.
- Coordinates and, where applicable, chairs case/family conferences.
- Confers with and shares information with the multidisciplinary health care team, as appropriate, to ensure a continuum of care.
- Liaises with other health care facilities, community and government agencies and utilizes such resources in formulating and implementing discharge/after care plans.
- Plans discharge or referral of clients when appropriate.
- Advocates on behalf of clients and their families.
- Completes a comprehensive psychosocial assessment of referred clients.
- Maintains client records with thorough and precise documentation of all interventions related to the client.

The Medical Social Worker accepts referrals primarily from the Home Care Nurses. Nurses may request the Medical Social Worker to support a client who is palliative; suspected of being in an abusive situation; or refusing treatment, for example. The Medical Social Worker's interventions are for counseling (not therapy) and are typically on a short term basis only. Those needing therapy and/or longer term support are referred (with client permission) to the Kainai Wellness Centre or provincial programs off site. Some clients prefer the greater anonymity of off-reserve programs.

The current Medical Social Worker on the home care team is registered and masters prepared. She serves as an active member of the Assessment and Placement (A&P) Committee which determines through the InterRAI MDS assessment, those eligible for placement at the Kainai Continuing Care Center. She also serves as a regular member of the hospital discharge planning team at the Cardston General Hospital and is available as needed at other neighbouring hospitals in order to support a plan of care prior to a client's discharge back to the community.

In working with the neighbouring hospitals, a rapport has been established and strengthened, and, as a result, patient care planning is enhanced. Hospital staff is able to clarify resources that are available on the reserve and work with the Medical Social Worker to establish a smoother transition for the patient at discharge. Conversely, the team can help the Medical Social Worker to sort out provincial services that would be helpful to clients, for example, working with a client who requires subsidy in order to be admitted to a long-term care facility off-reserve.

The numbers of people on the Medical Social Worker's caseload have steadily increased over the years. The needs of the clients seen are numerous and diverse. Responding to these needs with compassion, respect and patience is an important element of the care.

Sometimes it is a matter of "being there" and being willing to listen. It is always important to be the advocate for the individual, asking the medical team to provide more information and posing questions on behalf of the client.

Counselling Helps Client Cope

Sheila was a 32-year-old woman with progressive muscular degeneration. Her frustration with the failings of her body made her angry, demanding and often irrational. Because of physical limitations, her ability to care for herself and her home deteriorated and yet because of her fierce independence she would not accept help. When crises occurred, she would be admitted to hospital and stabilized only to return and repeat the cycle. Counselling by the Medical Social Worker helped Sheila to begin to examine the root cause of her situation. She was helped to find a new direction and path to helping herself cope and retain her dignity. Ultimately this enabled the home care team to be more effective in the provision of the care plan and led to a more stable situation. When the time came for Sheila to transfer to supportive housing, she was ready and able to see this as a positive step for her.*

**Name was changed to protect identity*

Key Success Factors

The role of the Medical Social Worker is supportive and is grounded in understanding the client's emotional and psychosocial issues. The approach taken by the Medical Social Worker on the Kainai home care program has been key to the success of the role. The attributes that contribute to the success are:

- Openness and receptiveness to people.
- Speaking the language–particularly important to, and appreciated by, the elderly.
- Being a team player.
- Patience.
- Good interviewing skills.
- Being a First Nations person—has been particularly important to understand the cultural nuances in order to support care delivery.
- Experience within the health care system.
- Having a network of peers (Alberta Health Services Social Work Team) for purposes of consultation and education.

Outcome

Positive cultural identity has been linked to resilience and mental health among diverse populations, and while more research is needed to understand the linkages between cultural loss and poor health outcomes—such as mental health problems, drug and alcohol abuse, and sexual risk taking[vi]—the integration of mental and physical care through the home care team is positive. The Kainai home care team believes that they are more effective with their clients as a result of their efforts to integrate social and medical care through the addition of the Medical Social Worker. The team is better able to fulfill its mandate to provide holistic care, considering the person through physical, mental, emotional and spiritual perspectives, all of which are inter-related and cannot be separated or addressed in isolation. The Medical Social Worker has become an effective bridge between home care, the Wellness Centre and other members of the health care team within BTDH and with the provincial provider partners. Through the support of this role, the home care staff is able to support clients with their medical care at home, and where appropriate, safely transition them to other care settings.

Next Steps

The demands on the Medical Social Worker continue to grow and it is envisioned that a second staff member will be needed in order to fill the unique needs within home care. An added benefit would be the opportunity for the colleagues to consult and support one another—a strategy that could be extended to the social workers in the BTDH social services. The Medical Social Worker will be instrumental in plans to engage staff and the community in understanding and addressing elder abuse, particularly financial exploitation, which is sometimes evident to the home care team. It will be important that all the programs within BTDH work together to tackle this crucial issue.

Conclusion

Good health is a balance of physical, mental, emotional, and spiritual elements. The interaction of all four contributes to a healthy person and the neglect of one causes health to suffer in all areas.[vii] The Kainai home care program has typically been structured on a medical model, with the focus on interventions to help people with their physical disease. By introducing the Medical Social Worker to the home care team, the home care program is better able to provide holistic care and contribute to good health for members of the Blood Tribe now and in the future, fulfilling the vision established by the Chief and Council and through Kainayssini.

i Retrieved on May 5, 2011 from http://www.btdh.ca/
ii Kinnon, D.(2002). Improving Population Health, Health Promotion, Disease Prevention and Health Protection Services and Programs for Aboriginal People. National Aboriginal Health Organization, p10
iii Ibid
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INDIAN BROOK
LINKING PHYSICAL & MENTAL HEALTH CARE

Home Care and a supportive Chief and Council are a winning combination

KEY INFORMANT:

Terry Knockwood, *RN, Home Care Coordinator, Indian Brook Home and Community Care, Nova Scotia*

Background

The Indian Brook First Nation is administered and governed by the Shubenacadie Band Council which consists of the Chief and twelve Councillors. Indian Brook is the second largest First Nation community in Nova Scotia. It is a Mi'kmaq First Nation Community and is one of four settlements belonging to the Shubenacadie Band. Indian Brook is located south west of Truro and is the largest land settlement (12.13 sq km) of the Shubenacadie Band. There are approximately 1,200 on-reserve members of Indian Brook. The median age is approximately 26 years.[i]

In Nova Scotia, a Tripartite Forum, representing the province, the Mi'kmaq First Nations and the government of Canada, serves to strengthen relationships and resolve issues of mutual concern affecting the 13 Mi'kmaq communities in the province. One area of focus is health care and, as such, community consultations have been undertaken to address the health priorities of Mi'kmaq people in Nova Scotia. Mental health has been repeatedly raised as an issue and, most recently in the 2008 consultations, was rated as the number one overall top priority with addictions and substance abuse ranking as the second highest priority.[ii]

The challenges in Nova Scotia regarding mental health that were reported through the community engagement sessions, youth web surveys, and health system web surveys in 2008 include:

- Access to services (e.g., lack of on-reserve services; transportation challenges; wait times; knowledge of available services).
- Service delivery (e.g., mental health application forms for services external to the reserve are only easily accessible to those with Internet access; after-hours services are not available; confidentiality concerns; lack of standard policies/procedures).
- Lack of funding, infrastructure, and human resources to deliver mental health and addictions services.
- Need for culturally-safe prevention and treatment services.
- Individual factors/stigma (e.g., people are in denial or too proud to seek help).
- Absence and/or awareness of resources specifically for youth.[iii]

While not actively engaged in the provincial 2008 consultations, many of these concerns were identified by the Community of Indian Brook through their participation in a qualitative research initiative that was undertaken to identify the gaps, barriers and successes/solutions associated with mental health services in Mi'kmaq communities in Nova Scotia. In their published analysis, the researchers indicated that efforts to address mental illness in Mi'kmaq communities had been proposal driven or crisis oriented.

They identified the need for community-based, culturally appropriate, coordinated and sustainable services.[iv] The Home Care Coordinator, who had previous experience in the education system, was acutely aware of the oftentimes hidden mental health and substance abuse that affected the members of the community. The Home Care Coordinator recognized the linkage between mental, physical and spiritual health and saw the opportunity to leverage home care to better support those with mental health needs in order to keep them safe in their communities.

Integrating Home Care and Mental Health

Health care at Indian Brook is delivered through the Community Health Centre and includes: Public Health, Wellness Programs, the Home Care Program and access to a dentist. Individuals must travel off-reserve to access a physician in a neighbouring community, about 10 minutes away by car.

The health care team members in Indian Brook have strong linkages with the Colchester East Hants Health Authority, which is responsible for managing and delivering a wide range of services to the 73,000 residents of Colchester County and the Municipality of East Hants.[vi] Acute care and non-acute (such as out-patient therapy) services are accessed through the Colchester Regional Hospital in Truro.

The Indian Brook Home Care Program is a federally funded program to provide home support services for on-reserve community members. The program mandate is to provide services to assist clients to stay in the community, decrease hospitalization and prevent admissions to alternate care facilities. The home care program provides ongoing support in the form of nursing assessments, medication monitoring, physical care, support for activities of daily living and socialization. There is a total of 15 staff to provide home care services for the community and the program is managed and overseen by the Home Care Coordinator. The nursing staff provides case management, client assessment, direct nursing services as well as supervision of continuing care assistants and home support workers. The continuing care assistants manage personal care including bathing, and transfers (e.g. to and from wheel-chairs); and the home support workers provide home maintenance and light housekeeping. The Home Care Coordinator reports that of the 75 clients on the home care caseload, 14 have a confirmed mental health diagnosis.

Mental health issues that are not addressed impact the community on several levels. The social impact may translate to crime and violence; there are economic impacts when people cannot work; and, emotionally, there is more stress and anger within the community. The Home Care Coordinator, who lives in Indian Brook, has witnessed firsthand the challenges in the community in trying to help those with mental health care needs.

These include:

- Limited access to services.
- Availability of culturally appropriate services.
- Stigma and denial related to mental health issues.
- Mindset of delivering care when people are in crisis.
- Absence of health promotion programs and awareness/education about mental health issues.

In part, because of her passion, and because of the realities of working in a small rural community, the Home Care Coordinator and Indian Brook Mental Wellness Coordinator (referred to as the Wellness Coordinator) have established a strong working relationship in order to deliver comprehensive holistic care. The Mental Wellness team is responsible for administering and delivering mental health services to Indian Brook community members and their families. Services include counselling (individual, family or group), support services and/or referrals to treatment centres.

SCHUBENACADIE FIRST NATION MISSION [v]

Shubenacadie Mi'kmaq First Nation leadership will respect, honour and protect our treaty rights now and forever.

Honouring the past.
Respecting the present.
Envisioning our future.

VISION – SHUBIE FIRST

S-SOVEREIGNTY
H-HONOUR
U-UNITED
B-BUSINESS
I-IDENTITY
E-EQUALITY
F-FIDUCIARY
I-INDEPENDENT
R-RESPECT
S-STRENGTH
T-TREATIES

Leading the way and putting our people first.

By building stronger linkages between the home care staff and the Mental Wellness team, a number of positive outcomes are realized for both the clients and the staff. The health care teams recognize the duality of physical and mental care. When the needs of the individual as a whole person are addressed, the team know they can make a difference in the lives of their clients, often enabling the client to remain at home. Recognizing and embracing the fact that their work as practitioners overlaps, staff strive to offer consistent and complementary service.

A challenge that the members of the health care team undertook collectively was to improve the follow-up service for those discharged home post hospitalization for mental health issues. They also wanted to do more within the community to keep people with manageable mental health issues at home and, where possible, prevent avoidable facility admissions.

Accessing a Variety of Mental Health Programs[vii]

In order to improve the health care programs on reserve, the home care program strengthened its linkages with the mental health resources within the District. Specifically, home care staff learned about the Community Psychosocial Rehabilitation and Support Service (COMPASS) program, Mental Health First Aid, and, worked more closely with Addiction Services. They also undertook to establish stronger connections with neighbouring in-patient facilities in order to allow better exchange of information at discharge back to the community, or upon admission.

COMPASS is "a voluntary program for adults with complex/serious mental illnesses that interfere with their daily life." Conditions treated through COMPASS include psychosis and mood disorders. COMPASS is provided through the Health Authorities including Colchester East Hants. The team is comprised of psychiatrists, nurses, social workers and occupational therapists who provide a variety of services including: individual support in the home, community or clinic; goal and skill development; wellness education; problem solving and support; recreation groups; advocacy; access to community resources; crisis support; and relapse prevention.[viii] The home care team in Indian Brook recognized the value of this program for clients in the community and began to make regular referrals to the team in Truro.

MENTAL HEALTH FIRST AID (MHFA) training course was developed to help people provide initial support for someone who may be developing a mental health problem or is experiencing a mental health crisis. The MHFA program aims to improve mental health literacy, and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague. The program teaches how to:

- Recognize the signs and symptoms of mental health problems.
- Provide initial help.
- Guide a person towards appropriate professional help.[ix]

The MHFA course is a requirement of home support workers in Indian Brook and to date, 85 percent of staff has completed the training.

ADDICTION SERVICES is a program funded by the Nova Scotia Department of Health and Wellness to help those who are harmfully involved with alcohol, gambling, tobacco or other drugs. A range of services are provided across the province through the Addiction Services offices in Nova Scotia's District Health Authorities and the IWK Health Centre . Addiction Services offers free, confidential prevention and treatment resources and services to anyone affected by addiction; provides policy makers with the information they need to protect and promote the health of Nova Scotians; and, ensures that Nova Scotians across the province receive the highest standard of service that meets their needs.[x] The home care staff leverages this program by making regular referrals to the office in Elmsdale which is about 18 kilometres from the reserve.

Home Care Team Identifies Addiction

An elderly woman, Jean, has multiple chronic conditions – diabetes, congestive heart failure, arthritis and hypertension. She lives at home and wants to remain there for as long as possible. Because of her complex physical conditions, Jean has been on the home care program for a number of years. The home support workers often found her to be drowsy and minimally responsive. Initially, it was thought that this was a reflection of poor glucose control. However, the Home Care Coordinator determined that Jean has serious addictions that had not been identified or acknowledged. Recognizing this primary problem resulted in a shift in Jean's care plan, the focus has become monitoring and managing Jean's addictions. Home care staff continues to visit and provide supportive care primarily related to her mental health. This service is essential to keeping Jean safe at home.*

**Name was changed to protect identity*

The home care team also established linkages with the Canadian Mental Health Association (CMHA) Nova Scotia Division. CMHA staff from the Colchester/East Hants County Branch in Truro conducted in-service education programs that instructed staff on a number of programs including:

- CLUBHOUSE - a program that provides a work ordered day and includes programs that are aimed at improving life, work, social and recreational skills. It is provided through a partnership arrangement with the CMHA.[xi]
- COMMUNITIES ADDRESSING SUICIDE TOGETHER (CAST) - An initiative of the CMHA – Nova Scotia Division and funded by the Nova Scotia Department of Health Promotion and Protection to assist communities in building their capacity to prevent suicide.[xii]
- CHANGING MINDS - a CMHA program based on the premise that mental illness is more challenging to understand than other kinds of illness because its symptoms are changes in thinking, feeling and behaviour; and that mental illness can be more readily understood when the person is known as an individual impacted by the illness. The program consists of eight modules generally offered in four half-day sessions. It is designed for people who come in contact with persons with serious mental illness in the course of their work or daily lives.[xiii]

Another program offered with the Colchester-East Hants area is Training, Recovery, Empowerment & Employment Services (TREES). TREES is a support program that helps mental health consumers to improve their quality of life by assisting them in gaining independence through work.[xiv]

Collaboration and Partnership – Making a Difference

Accessing a variety of mental health programs in addition to a collaborative approach to care were key foundational pieces to realizing the goal of keeping people safe at home. As a first step, the home care team was encouraged to be more aware of the potential for undisclosed mental health problems. They learned that often the physical symptoms that they were addressing could indeed be manifestations of a mental health condition. A person-centred approach to care was adopted and reinforced through a greater understanding of the need for home care staff to embrace holistic care—interact with clients and be prepared to provide support as issues unfold.

Where previously the stigma associated with mental illness often caused individuals to consciously hide their condition, the openness by the home care staff to considering mental health issues amongst their clients led to more disclosure. The client works together with their family, the physician, Wellness Coordinator and Home Care Coordinator in order to determine the type and amount of service that will address the presenting needs, both physical and mental.

This collaboration has led to some creative solutions. For example, the two pharmacies that serve Indian Brook have agreed to put prescribed medications in blister packages without a physician's order and without the client being charged for this service. Blister packaging is a system of sealing medication doses into single containers in order to improve adherence and monitoring of prescribed medications. The simple strategy has proven to be a highly effective way of helping clients to manage their medications and readily recognize when medications are missed, potentially leading to relapses.

Outcome

By working closely with the broader health care team, both on and off-reserve, the home care program has been able to support more people at home in the community. The clients with primary mental health concerns continue to receive home care services, even when their physical symptoms are under control. The health care team knows that without the collaborative approach and flexible service, most clients would be re-admitted to a facility off-reserve at a greater cost to the system, but more importantly, at a significant price to the client's quality of life.

Home Care and Mental Health Care – Team Collaboration

Tom, 36, suffers from schizophrenia. He was diagnosed at the age of 17 and has struggled to remain at home. His erratic behaviour resulted in an inability to retain a job and be entrusted with the care of his children. As a result, he and his partner were estranged and for years Tom was in and out of hospital, group homes and shelters. The medication that effectively treated his condition could only be given by a registered nurse. As a result of the collaboration of the home care and mental health team an arrangement for weekly nursing visits was made. This has meant that Tom, who had been in hospital for many months, was able to move home. He has acquired a part-time job and is rebuilding his relationships in the community.*

**Name was changed to protect identity*

Staff reports compelling examples:

- Client has remained out of hospital for four years.
- Client admitted herself to hospital only once in the past four years when she recognized a need for medication adjustment.
- Client has remained at home for three years as a result of home care visits for medication administration.

These outcomes are achieved because the health care team and the Band work to collaborate and recognize the importance of their partnership. The Band uses other sources of revenues to subsidize the home care program so the visits can be made to those with mental health issues. Staff participates in additional training in order to have the confidence to provide good mental health care and staff also spends the necessary time to provide clients with the support they need to work through their mental health issues.

The home care program accepts that clients with mental health needs are home care clients for the long term. The imperative is not to discharge but rather to keep these individuals on program with a minimal amount of support. As a consequence, clients know that they always have access to home care and that services can be increased when needed.

To facilitate communication, the clients with mental health needs are provided with the Home Care Coordinator's cell phone number so they can reach her right away. The Home Care Coordinator and Wellness Coordinator stagger their vacation schedules to ensure safe coverage for all home care clients. Personal commitment is a key ingredient to the success at Indian Brook. While maintaining the professional boundaries, there is a unique commitment that emerges when one delivers health care within an individual's home. Home care staff typically enjoy a great amount of flexibility to plan their work at times that are mutually convenient for themselves and the client. This model of delivery provides professional satisfaction and works for clients, particularly in a small community such as Indian Brook.

Conclusion

Physical and mental health are inextricably linked. The health care team serving Indian Brook is committed to treating the person as a whole, and as such are actively working together to access the various programs on and off-reserve to provide the right mix of care that keeps people at home. The belief is that "by linking with other programs [the community] gets a better home care program". Personal commitment, a supportive Chief and Council, and the many hands of the health care team are a winning combination for Indian Brook.

[i] Retrieved on July 11, 2011 from http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-594/details/page.cfm?Lang=E&Geo1=CSD&Code1=1208014&Geo2=PR&Code2=12&Data=Count&SearchText=Indian%20Brook%2014&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=1208014

[ii] Horizons Community Development Associates. 2008. Exploring Health Priorities in First Nation Communities in Nova Scotia. Tripartite Forum Health Working Committee

[iii] Ibid

[iv] Vukic, A., Rudderham, S., Martin Misener, S. A Community Partnership to Explore Mental Health Services in First Nations Communities in Nova Scotia Can J Public Health 2009; 100(6):432-35.

[v] Shubenacadie First Nation Band vision retrieved from http://www.indianbrook.ca/

[vi] Retrieved on Aug 15, 2011 from http://www.cehha.nshealth.ca/reference

[vii] These programs are in addition to those supported through Health Canada's First Nation and Inuit Health program in the Atlantic Region, such as the National Native Alcohol and Drug Abuse Program; the Brighter Futures Initiative; and the Building Health Communities programs.

[viii] Mental Health and Addictions Strategy Project – April 4, 2011

[ix] Retrieved on July 4, 2011 from http://www.mentalhealthfirstaid.ca/EN/Pages/default.aspx

[x] Retrieved on July 12, 2011 from http://www.gov.ns.ca/hpp/addictions/

[xi] http://www.novascotia.cmha.ca/bins/content_page.asp?cid=284-294-296-318&lang=1

[xii] http://www.novascotia.cmha.ca/bins/site_page.asp?cid=284-682-698-2623-1584&lang=1

[xiii] ibid http://www.novascotia.cmha.ca/bins/site_page.asp?cid=284-682-698-2623-2625&lang=1

[xiv] http://www.treesproject.org/

Integration / Linkages

MENTAL ILLNESS AFFECTS THE MIND, BODY AND THE SPIRIT. First Nations and Inuit share a common understanding of wellbeing or wellness as coming from a balance of body, mind, emotion, and spirit. The integration within each person can most effectively be supported through the integration of the services and supports provided by the health team and community

Integration is defined as "bringing parts into a whole". From a health system perspective this typically refers to removing the "silos" and improving the coordination of services. Concepts central to integration in health care include: across the continuum, coordination, complementary, seamless, unification and system.

Integration is not an outcome but rather a process, or strategy, to achieving specific outcomes, primarily a better and more comprehensive care experience and improved clinical outcomes. Integration occurs at various functional levels - policy, functional, and clinical; and most importantly, it occurs for each individual through a holistic approach to health. First Nations and Inuit health care programs across the country recognize and strive to integrate mental, physical and spiritual care. Within the First Nations and Inuit Home and Community Care (FNIHCC) Programs, efforts to strengthen the integration of mental and physical health are a clear priority.

The promising practices described in this section reflect the active engagement of many stakeholders to build a needs-based continuum that is seamless, harmonious, and responsive for clients. The practices demonstrate the recognition that physical and mental health is inextricably linked and show how health care providers integrate their efforts by working together – engaging many hands - in order to provide holistic comprehensive care.

BATTLEFORDS TRIBAL COUNCIL INDIAN HEALTH SERVICES INC.

Seeking harmony and balance through mental health and home care

KEY INFORMANTS:

Laurie Ironstand, *Director of Home Care Services, Battlefords Tribal Council Indian Health Services, Saskatchewan*

Jean Wright, *Wellness Support Nurse, Home Care, Battlefords Tribal Council Indian Health Services, Saskatchewan*

Background

Battlefords Tribal Council (B.T.C.) Indian Health Services is a First Nation owned and operated health service organization governed by a board comprised of the seven Chiefs of the Battlefords Tribal Council First Nations: Little Pine, Lucky Man, Mosquito, Moosomin, Poundmaker, Red Pheasant and Sweetgrass.[i] The communities of the Battlefords Tribal Council remain one of the regions committed to maintaining language, culture and spiritual practices.

B.T.C. Indian Health Services provides a comprehensive array of health and social services:

- Public health services, including prenatal and postnatal care, delivered through community health clinics.
- Addiction services that include counselling for both youth and adults.
- Health promotion and planning.
- Youth suicide prevention/awareness.
- Home care services that include the provision of supports for persons with chronic disease, including emotional illness.
- Head Start, a preschool program offering support to parents and their young children.
- The Indian Residential School Support Program, a program that offers ongoing emotional support.
- Dental program.
- Battlefords Family Health Centre provides primary health service with physicians and nurse practitioners through a partnership with Prairie North Regional Health services. (Prairie North Health Region is one of Saskatchewan's 13 health authorities.)

B.T.C Indian Health Services has a staff complement of 125 and serves 5,000 people on-reserve in seven communities. In addition, the health team provides health care to off-reserve members who request it.

The organization's vision is to create an environment where all children are born to healthy supportive families and communities which honour traditional cultural values and promote independence, self-determination, and participation in community life.

The need to protect and maintain cultural, spiritual and social practices is essential to ensuring social, mental and emotional wellbeing and is vital for the continued existence of the native family system. This approach and philosophy is a source of great strength and it is acknowledged that this accepted wisdom must continue to be stimulated and nurtured.

HOSPITAL LIAISON SERVICE

This service provides liaison and cultural support for First Nations and Métis people and is administered by a home care team member working within the hospital (Battlefords Union Hospital, Battlefords District Care). The duties of this position include connecting patients to hospital and community services; translating and explaining procedures to patients; bridging the cultural gap between staff and patients; arranging and coordinating transportation, meals, equipment orders, etc; discharge planning assistance; and client/family support in emergency room crises.

Addressing the increasing incidence of substance abuse, addictions, and other mental health problems is priority for staff at B.T.C. Indian Health Service. A number of assessments highlighted this requirement.[ii] One of the foremost needs consistently identified was for Mental Health Services and Therapy, with the most frequent recommendation being for an increase in Mental Health staff to provide ongoing services in the seven communities.

The B.T.C. Indian Health Services Mental Health Needs Assessment conducted in 2001 indicated that community mental health issues tended to be overlooked and in extreme cases ignored. While many individuals would independently choose to seek the necessary resources, 40 percent of respondents felt they had no access to service. (110 respondents)

A review of B.T.C. Indian Health Services data showed that in 2003 approximately eight percent of Battlefords Union Hospital admissions that were assisted by the Hospital Liaison were because of mental heath needs. The 2003 Assessment identified the need for:

- On-reserve counselling for clients with grief and coping problems.
- Improved linkages and referrals with off-reserve services, and other First Nations organizations.
- Support and guidance for nurses who provide emotional support.
- On-reserve support and follow-up for the chronically ill.

Barriers to service accessibility included a lack of information, a lack of transportation, inadequate finances, isolation, conflicts, lack of cultural sensitivity, lack of specialized services, lack of flexibility in appointment times (one hour versus traditional counselling timeframes) and also lengthy waiting lists for counselling and outpatient treatment.

Home care staff provided follow-up for people with chronic mental health issues but struggled to address the high needs of this population. The requirement was for someone with expertise in mental health care, who knew the Mental Health Act, the system, and nature of provincial services to get involved in the First Nations communities.

Applying Principles & Values to Client Care

Drawing on the research, that demonstrated the effectiveness of a broad range of community based treatment and prevention and health promotion initiatives[iii], the B.T.C. Indian Health Services undertook to develop a framework that supports service delivery. The framework reinforces B.T.C.'s client-centred and community-based care philosophy and describes the elements and resources required to keep clients in the community and decrease admissions to facilities off-reserve.

The framework demonstrates the development of families and community as partners in treatment and rehabilitation. It also allows for treatment plans to integrate holistic and traditional approaches to mental health and treatment models. The four key elements in mental wellbeing are addressed:

- Physical care
- Psychological factors
- Social factors
- Spiritual factors

Medical transportation to and from the First Nation community tries to meet the general needs of all the passengers using the service that day. It is sometimes difficult for individuals to commit to an appointment at a specific time, and as such clients are occasionally wrongly reproached for failing to adhere to their discharge plan.

The resources that need to be in place in order to link the elements of mental wellbeing are:

- Housing—affordable and appropriate.
- Transportation and mobility—enabling access to services and people.
- Services—community resources with capacity to meet needs.
- Income—opportunities to make a living.

The framework serves as a touchstone for the B.T.C. Indian Health Services providers, as well as the community at large, to understand and support the care requirements of those with mental health needs. Client-centered service delivery addresses barriers to care and enhances health outcomes.

Taking Steps to Meet Mental Health Needs

The B.T.C. Indian Health Services home care program is comprised of a staff of 22 that supports individuals living on-reserve to remain in their homes with the assistance of family and community members. The approach is client focused, encouraging independence and family involvement while respecting and supporting the client's rights, values and beliefs.

The home care team utilizes registered nurses, a dietician, a diabetes health educator as well as home health aides in the assessment and long-term management of chronic health conditions in the community. This model of health care delivery is one where client participation and self care management is delivered in partnership with a multi-disciplinary team, the family and the community.

Over the years, the home care team had noticed that clients living in the community with chronic health conditions were also experiencing symptoms of emotional illness. To address this identified need for ongoing emotional support, the Wellness Support Program was introduced. Through home visiting, a caring relationship was established with clients so they could begin to address their emotional health issues. Other mental health services were also offered to address the emotional health needs of the client while respecting their desire for intervention and treatment.

In addition to supporting the mental health needs of clients with chronic health conditions, it was anticipated that programs for youth would also be a priority, because of the high incidence of overall illegal drug and alcohol use in this population. Many of these young adults had been showing signs and symptoms of psychosis resultant to marijuana and other illegal drug use.

The provision of mental health services in Saskatchewan is a provincial responsibility. All mental health service is administered under the direction of the Mental Health Services Act. The health care facilities for inpatient and outpatient care function within the jurisdiction of the province. Saskatchewan is organized into eight mental health regions. Obtaining health services for the profoundly mentally ill person experiencing symptoms of persistent mental illness can be almost impossible without a nurse, one who is well versed on the provisions with the Mental Health Services Act to advocate.

The justice system has a role to play in accessing treatment at the Mental Health Centre for those persons in need of care supervision and control for their own protection and welfare, and /or the protection and welfare of others. Safety for family members, both young and old, living in the home is often a huge concern when a member of the family is experiencing symptoms of a psychosis, or a profound mental illness. Discharge planning and facilitating the involvement of the family in the case conference at the Mental Health Centre is vital in giving the family a voice, communicating to the psychiatrist and other Mental Health Team members the significance and the impact that the mentally ill person has had on the family. Discharge planning and follow-up in the community can be influenced by family involvement in the case conference. Once the patient is discharged and leaves hospital, implementing the discharge plan becomes very important. Home visiting is crucial to sustaining the release and the wellbeing of the client. The Wellness Nurse monitors the overall health of the client, provides medication (for example injections), ensures medication compliance, and assesses for symptoms of illness or side effects from the prescribed treatment.

ADDITION OF A COMMUNITY WELLNESS NURSE

A key element of the Wellness Support Program was the introduction in 2004 of a Community Wellness Nurse reporting to the Home Care Director. The purpose was for the Nurse to focus on providing support for the emotional and psychological stresses of the community members of all ages using a family centred approach. The development of the duties and responsibilities evolved from the community and health care team feedback.

The Wellness Nurse is responsible to provide mental health assessments, counselling and case management services to persons living within the B.T.C. Indian Health Services First Nations who are experiencing emotional and mental health problems. The Wellness Nurse provides follow-up care and support for clients who have experienced an acute mental health episode or have a long-term mental health condition. The Nurse works closely with clients and their families to assist with reintegration and stabilization in the community.

Home visits from the Wellness Support Nurse provide the family with greater opportunity to have access to the Nurse, to gain information and insight into the illness afflicting their loved one, and make it possible for increased awareness in a greater number of family members. It provides opportunity for the Nurse to gather additional feedback from the family as to how they perceive the family member to be functioning and coping.

The Wellness Nurse serves as a single point of access for individuals with mental health needs. She works within a multi-disciplinary and intra-agency team including long-term mental health support, crisis mediation and management; critical incident stress debriefing; and, suicide intervention education for communities and staff members. The caseload for the Wellness Nurse has grown steadily and she currently manages approximately 100 clients with 25 of them being followed for long-term chronic mental health needs. The Nurse collaborates with the Home Care Nurse in each community to plan and coordinate care. The goal of treatment for clients on the Wellness Support Program is not to discharge but rather to provide an accessible system of care. Most interventions involve several sessions over a number of days and long-term follow-up is often required. The Home Care Nurse and Nurse Supervisor can authorize additional service when needed.

As a member of the home care team, the Wellness Nurse is able to assist staff in addressing mental health-related concerns and clients benefit from the strong connection through prompt access to service. The home care program offers flexibility in services so when clients are in crisis or have concurrent physical issues, additional home care from a team that knows them can be provided. The Wellness Nurse is responsible for advancing the Community Mental Health Program for B.T.C. Indian Health Services and assists in building linkages with other services, including corrections, probations, the magistrate and rehabilitation hospital.

Outcomes

The Wellness Support Program addresses the gap in on-reserve community mental health services. As with any new program, it took time for the health care team and the clients to recognize the value of the Program. It quickly became evident that the continuity between mental health services and community is enhanced through the linkages developed between the Hospital Liaison and the Wellness Nurse. Together they created a consent form for sharing of information between mental health agencies and B.T.C. Indian Health Services. Formal written and telephone communication links and processes were established.

Other initiatives have been undertaken, including working with physicians regarding concerns of prescription drug abuse, and developing a protocol for communication with the emergency departments in order to improve the follow-up in the community for persons who are seen for suicide attempts and released.

The Wellness Nurse reports a drop in the suicide rate in the communities served by B.T.C. Indian Health Services. While it is difficult to directly attribute this drop to the new program approach, it is believed that through the greater insight and awareness and attention to mental illness, the role of the Wellness Nurse is making a difference.

The addition of the Wellness Nurse to the B.T.C. Indian Health Services health care team is unique. In the past, the important services provided by the Wellness Support Nurse were only accessible through the provincial health care program. This new role has reinforced the vital need for providing these services in the local community in order to meet the requirements of those persons living in a First Nations community suffering from mental illness. The Wellness Support Nurse also advocates on behalf of clients and provides guidance to successfully navigate the often complex mental health care system.

Today, the Wellness Support Program is an integral component of the B.T.C. Indian Health Services. As a home care service, the Program fundamentally works to achieve a supportive and enabling system that keeps people safe and independent at home in their community.

Community awareness and appreciation for those with mental health needs is being realized as individuals are becoming more open and understanding of the irrational fear and stigma related to mental illness. There is greater awareness of the symptoms of mental illness, treatment options and acceptability of accessing support. Mental health is accepted as a community issue.

Key Success Factors

The Wellness Support Program has been successful as more clients are seen in their communities and are not required to leave for treatment or be placed in a facility off-reserve. The success can be attributed to the following:

- The program is community based operating within the home care program.
- The Chief and Council governing the Battlefords Tribal Council Indian Health Services are supportive and encourage the communities to participate in the program.
- The Wellness Nurse has experience and understanding of the way of First Nations people.
- The approach is person-centred, working with people from their starting point.

Conclusion

Many of the mental health issues and illnesses are a result of unresolved grief and trauma and aging. It is necessary for qualified and effective professionals to provide mental health counselling and therapy services. Only through counselling and therapy, be it contemporary or traditional approaches, can these issues be addressed, processed, released and resolved. The Wellness Support Program is a model of success providing services in the community while linking with the provincial programs through the regional health authorities. The next anticipated step is to work with system partners to build community–based supportive housing on-reserve, an important resource to addressing the elements to wellbeing reflected in the client centred framework for mental health care in the community.

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[ii] The B.T.C. Indian Health Services Home and Community Care needs assessment 2001; Eagles View B.T.C. Indian Health Services Mental Health Needs Assessment; Home Care Nurses Focus group 2003; Joe Barnes Needs Assessment; Hospital Liaison 2003-04 Stats Report.

[iii] Smyth,M. (2000) The home treatment enigma. BMJ. 2000 January 29; 320(7230): 305–309.

SAGKEENG FIRST NATION
ADDRESSING SERVICE GAPS
For persons with disabilities

KEY INFORMANTS:

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Background

Sagkeeng First Nation is an Anishinaabe (Ojibway) First Nation located approximately 120 kilometers northeast of Winnipeg, Manitoba. Situated on the southern tip of Lake Winnipeg, Sagkeeng has a land mass of 91 square kilometers and a registered population of more than 6,000—approximately 3,000 live on-reserve.

Sagkeeng First Nation is a thriving and developing community, focused on instilling and maintaining a sense of respect and pride in the traditional Anishnabe culture. The community's vision for Sagkeeng First Nation's future is one of hope and expectation. Some of the major services within the Sagkeeng community include three schools (Elementary, Junior and Senior High Schools), several community stores, a health and wellness centre, employment and training services, day care, Child and Family Services, an arena multiplex, fire hall and First Nations police service. The Sagkeeng Home and Community Care Program provides a number of services to community members with disabilities. These services include assessment, home support, meals, personal care, home nursing, respite, referral and access to equipment and supplies. They are provided to community members who are assessed to have a physical and/or functional need that is greater than what the family/informal caregiver can meet, and whose needs can be met in a safe and affordable manner through the home care program.

In Sagkeeng First Nation, the health care providers and local partners are committed to improving services so that individuals are able to access quality care in their home communities. With this goal in mind, the community identified a number of concerns including service gaps, jurisdictional disputes and a lack of integration of services for those with disabilities living on-reserve. One particularly vulnerable population group that the health partners identified as requiring better support was those persons with severe mental illness. Prevalence rates in Sagkeeng were similar to those in the general population, however, the health partners identified a need to establish appropriate supports within the community in order to enable this group to live safely and facilitate their transition from a mental health facility to the community.

To meet this challenge, and with funding support from the Aboriginal Health Transition Fund (Health Canada, 2007), the health partners devised a plan to address the service gaps for persons with a wide range of physical and/or mental disabilities, by assessing the nature of the gaps, determining community readiness for change, and developing closer collaboration with local provincial services to eliminate or reduce some of these service gaps. The partners anticipated that a more effective, collaborative and integrated approach to care would lead to improved quality of life for persons with disabilities, while enabling them to remain in their home community. In addition to ensuring access to appropriate services and support, the intent of the partners was to de-stigmatize those with disabilities.

The Genesis of a Program

The Sagkeeng Health Centre developed and submitted a proposal to The Aboriginal Health Transition Fund. Referred to as the "GAPS Project", the goal was to:

- Address the special needs of people with disabilities in a more comprehensive, coordinated and effective way.
- Ensure fair and equitable access to support, treatment and assessment services to First Nations persons living with disabilities across the lifespan, regardless of on- or off-reserve residence status.
- Establish a means to deliver on-reserve health and social services according to best practice standards.
- Reduce and/or eliminate inequities and gaps in service between on- and off-reserve target populations.
- Establish a system of closer collaboration and integration of health and social services, within the community and between provincial and federal services.

The GAPS Project targeted a wide range of populations including:

- Children with special needs.
- Persons with severe and persistent mental illness.
- Adults with cognitive/ developmental delay (vulnerable persons).
- Adults with severe disabling physical limitations.

The timing was opportune. In Manitoba, provincial programs at every level were, and are, striving to achieve an integrated approach to planning and service delivery and break apart long-standing silos within health and social services. This philosophy of integration and collaboration was a fundamental element in stakeholder engagement, with GAPS Project partners encompassing a broad base of stakeholders:

- Sagkeeng Health Centre staff, in particular the mental health/wellness program and the Home and Community Care Program, were active partners in this two-year project, ending late 2010.

Other partners included:

- Sagkeeng First Nation community leaders and elders.
- Sagkeeng Social Service Agency.
- The three local schools.
- George M. Guimond Care Centre, a 30-bed long-term care facility located on-reserve.
- North Eastman Health Association (NEHA).
- Manitoba Family Services and Housing.
- Association for Community Living.
- Winnipeg Regional Health Authority (WRRHA) programs including the Child Development Clinic; Assertive Community Treatment: At-home Initiative (ACT) and Program for Assertive Community Treatment (PACT) teams.

Implementation of the Program

The goal of the program was to address service gaps for First Nations persons with disabilities living on-reserve as compared to those living off-reserve, and design improved ways to provide services to persons with disabilities.

The first step in achieving this goal was to establish an Advisory Committee to provide direction and oversight for the GAPS Project leads. This Advisory Committee was tasked to review and revise processes and develop protocols as required throughout the Project.

The next step was to build upon the health care providers' knowledge of current services and gaps, and validate these assumptions with those affected. This was achieved through the development and implementation of a survey to assess need and engage clients and their families in interactive conversations. The survey was

JORDAN'S PRINCIPLE

Jordan River Anderson, a young child living on the Norway House Cree Nation, was born with complex disabilities and medical problems that posed significant challenges for his family and the First Nation community health services. Although the appropriate community-based services were available for him, they were expensive and the federal and provincial governments could not agree as to who should pay for these required services. While these arguments continued, Jordan passed away in hospital at the age of four. The federal government passed a motion in December 12, 2007 known as the Child First Principle or Jordan's Principle which declares that any government must pay for the needs of cases like Jordan and then resolve the payment issues later.

comprised of 84 multilayered questions to capture community members' experiences in areas such as education, housing, employment, income and financing, transportation, activities of daily living, community living and health and social service accessibility and adequacy, including identification of jurisdictional barriers. The survey was administered by home care staff (unrelated to the Project for neutrality) and a total 54 surveys were completed with Sagkeeng members living both on- and off-reserve.

From the mental health perspective, it was evident that there were limited resources for individuals living on-reserve. Respondents noted that mental health support was only available for shorter grief therapy; there was no funding for cognitive assessments by psychologists; no mental health crisis stabilization unit in the region; and no service for alcohol induced dementia in home care. The home care program provided service when and where resources permitted; however, the focus was primarily on the 'medical' aspect of care, i.e. medication administration (injections) or treatment for physical issues. The current approach to mental health care was not coordinated or formalized. By contrast, the off-reserve services were numerous and included day services, residential programs, community mental health workers, crisis intervention, vocational support, housing and social and recreational programs

Over a two-year period (November 2008 to December 2010), the partners jointly identified a number of strategies that would bring appropriate programs to Sagkeeng. New protocols or pathways of service allocation involving Project partner organizations were constructed. A training plan was developed and workshops for community and partner organization staff were planned. To address the needs of individuals living with mental disabilities and those with complex health and mental health needs, innovative approaches including PATH (Planning Alternative Tomorrows of Hope), PACT (Program of Assertive Community Treatment) and ACT (Assertive Community Treatment) were examined to see what components of these proven and effective strategies could be adapted for the Project.

PATH (Planning Alternative Tomorrows of Hope)[iv] is a planning tool that helps individuals and their families plan their future using pictures and symbols to reflect their aspirations and feelings. Individuals define and picture their life and incorporate the steps necessary to realizing their goals. For those with severe/profound cognitive disabilities, family members and others who know him/her best, assist with the development of the PATH. The PATH includes:

- Understanding the person's current state.
- Identifying people to enrol in order to help realize the individual's goal(s).
- Ways to build strength or capacity, for example knowledge or skills to acquire.
- Committing to the first step—taking action.
- Planning the next three months.
- Mapping out the next six months.
- Ongoing plan reviews and updates.

People living with mental illness have the right to obtain the services and supports they need. Without proper treatment and support, individuals often cycle in and out of facilities or into repeated homelessness. Individuals with severe and persistent mental illness require supported/transitional housing, and intensive case management as a building block to recovery[i]. In addition, they require guidance, advocacy and structured support to successfully live in the community.

The technique inspires and makes those with disability and their needs more visible, highlighting their aptitudes and ambition to live their lives as others do. It was envisioned that this process could also be of benefit to persons with severe and persistent mental illness, as it could help focus services for such persons to their individual, unique needs and aspirations, and could also help to alleviate some of the stigma they face in the community.

Individuals with severe and persistent mental illness can be frightening to the community and are often, shunned and isolated. By introducing appropriate programming, these individuals will have a greater chance of being accepted and understood by their community.

The Program of Assertive Community Treatment (PACT) is an outreach-oriented comprehensive community treatment, rehabilitation, and support service designed to meet the needs of people with severe and persistent mental illness. The service is provided to participants in their homes, at work, and in community settings and includes attention to both mental health needs and basic needs of daily living. Services enable participants to regain stability, take steps towards recovery and achieve personal goals. PACT is appropriate for a select portion of the population of people with mental illnesses and is particularly suitable for individuals with psychotic disorders who have continuous high-service needs indicated by:

- High use of inpatient psychiatric services.
- Frequent use of medical services.
- High use of emergency and crisis services.
- Residing in hospital or a supervised community residence, but could live more independently if intensive services were provided.[v]

The Assertive Community Treatment team, known as ACT, is one part of the Mental Health Commission of Canada's 'At Home/Chez Soi' Project, providing culturally-relevant and sensitive programming to homeless people with severe and persistent mental illness from both a client strength and harm reduction perspective. The lifelong intensive community support elements of PACT have been customized to have a First Nations cultural sensitivity. The ACT team is made up of a multi-disciplinary group of mental health professionals. Regardless of individual disciplines, the team shares equal responsibility in assisting participants through their recovery. ACT is currently a pilot study and control-group research project. Preliminary anecdotal evidence shows significant success.[vi]

Sagkeeng hopes to model local services for persons with severe and persistent mental illness after these programs, by closely collaborating with the programs for shared clients, and by establishing formalized links between local services and programs, and at times by pooling resources and adapting policies and mandates, to address the needs of this client group.

Adults living with a mental disability (those with a lower IQ and needing help with daily living) are considered vulnerable persons.[ii] The disability is manifested prior to the age of 18 due to a condition present at birth or an illness or acute trauma during childhood, not being caused by a mental health disorder. Under the Vulnerable Persons living with a Mental Disability Act (Government of Manitoba, 2010)[iii], Manitoba Family Services provides support services including residential services, counselling, day services, vocational training and life-skills programs. However, access to these services is not available to vulnerable persons living on-reserve.

To support continued integration of local services, an Inter-Agency Collaboration Agreement was developed, using a 'case management' approach. The partners agreed to collaborate and share resources as required, providing appropriate, fair and equitable, effective services to affected community members/ families. Any member of the Inter-Agency team can bring forth cases for discussions, provided that formal written consent from the community member/ family has been obtained.

The process:

- A case manager is assigned for each client.
- A detailed and individualized needs assessment is performed with the individual client and their family (if appropriate), using assessment tools specific and appropriate to the type and degree of disability.
- The case manager is responsible for seeking information (potentially by accessing off-reserve resources or agencies) to determine specifically what services the individual/family would have access to if living off-reserve.
- A detailed, specific, individualized goal/service plan is developed.
- The plan is shared with inter-agency partners and a collaboration process is agreed upon.
- The case manager is responsible for coordination and facilitation of team meetings and to ensure that the service plans are documented, evaluated and updated regularly and as client/family needs change.
- Service plan modifications are agreed upon by the applicable parties, documented and formally endorsed by the parties involved.
- Once local resources have been coordinated and maximized, the assigned case manager reviews the service plan with the client/family. If additional supports are required that are not available locally, the case manager will approach the appropriate off-reserve resource or service agency to formally request specific contributions based on individual needs. The Council representative advances any identified need for program protocol changes to the council, which addresses the need with the funders.

The hope was that the Inter-Agency Case Management Team Model would continue beyond the two-year term of the Project to improve inter-agency collaboration to address service needs for clients and families with complex needs. Currently, this is accomplished by leveraging the established Inter-Agency Meetings taking place on a monthly basis, supported and endorsed by Chief and Council. By including the GAPS Project, the community leaders became involved in understanding individual cases thereby, strengthening the collaboration, service integration and partnerships with local and external resources. A Protocol Agreement and Oath of Confidentiality was developed and signed by all parties and a Band Council Resolution is under development to ensure that this process is sanctioned and validated by Chief and Council.

RECOMMENDATIONS TO SUSTAIN THE MODEL

Local capacity building A level of mentorship support and guidance should be provided to guide the practitioners.

Project leadership Knowledgeable leaders with experience in the community should be retained to champion the work.

Community support The Protocol Agreement endorsed by the Sagkeeng Chief and Council is an important demonstration of support for integration within the community.

Collaboration The Inter-Agency Case Management Committee reflected the will of community programs and external service provider organizations, to work together to improve services. The formalization of the agreements was a significant accomplishment. Ongoing cross-jurisdictional policy work will be critical to ensure continued success and a continued focus on the needs of the disabled.

LESSONS LEARNED

- It takes time to gain trust—people are cautious about sharing personal information with the health team.
- Clients recommend focus groups and other small participatory gatherings, rather than large community surveys, as a more effective way to gather information and assess need.
- Engagement and active participation in program development and leadership of individuals/their families with disabilities is important to assure relevance and priority setting.
- It is challenging and takes work to change the silo mentality and break down the barriers within and across systems, organizations and service providers.
- Pervasive stigma highlighted both the need for awareness raising and de-stigmatization of disabilities and the need to look at cultural relevance more closely.
- More cultural programming, training and perspective would have helped the provincial partners and assured the Sagkeeng team of the commitment to Band ways.

Outcome

This Project was successful in developing an Inter-Agency Case Management Team model where Program Managers and a Band Councillor meet on a monthly basis to discuss mutual clients, collaborate on care plans, explore ways to integrate their services, and adopt cost sharing measures to ensure that service gaps are addressed. There is improved trust between programs and agencies locally and across jurisdictions. A range of formal and informal agreements with external service providers have been established, delivering a commitment to offer previously unavailable or difficult to access services to the First Nation target groups. Others have committed to continuing work with the First Nation in a mentorship role and to assist with case planning. The health care team, including the home care staff, is better supported with a range of services with which to collaborate in order to better serve those with mental illness.

Conclusion

The Project has come to an end and the leaders have been redeployed. Without the resources of the Project, the mandate to continue to drive the initiative has waned, however, the Sagkeeng Wellness and Home and Community Care Program are committed to working to adapt and develop new approaches and overcome jurisdictional obstacles in order to address individual client needs on a by-case basis. Families with complex needs require a case manager dedicated to coordinating their needs, advocating and negotiating for them, and managing the services. Designated space is needed to help meet the needs of disabled community members, where they can be with others, feel included and valued. Building on the success of the Project, the partners envision achieving the following outcomes:

- Improved quality of life and client satisfaction.
- Reduced morbidity and mortality for target population.
- Reduced use of acute care services for respite needs and/or for supportive services that would be best deployed in the community.
- Increase in number of disabled persons who can remain in or return to their home communities despite complex care/support needs.
- Improved service delivery to target population, decreased stress/distress (including family caregivers).
- Community priorities and local needs and culture are clearly incorporated into program development.

Service Collaboration Increases Stability

Jack, 26, was diagnosed with schizophrenia, developmental delay and co-occurring substance use. He was in a cycle of crisis care and homelessness. Single and with no immediate family, Jack lived on the street and occasionally with distant relatives. Jack had problems following his medication program which triggered his socially unacceptable behavior. Individuals like Jack require lifelong, intensive support. Through service collaboration among partner agencies, Jack has enjoyed increased periods of stability and reduced episodes of hospitalization. The provision of permanent housing with ongoing, intensive support would be a major factor in supporting ongoing stability for Jack, and for others like him. . This has unfortunately not yet been accomplished, but remains a major long-term goal.*

**Name was changed to protect identity*

[i] North Eastman Health Authority (2004). National Homelessness Regional Homelessness Fund: Needs Assessment, unpublished.
[ii] The Vulnerable Persons Living with a Mental Disability Act (VPA): The Family Guide. Retrieved from http://www.gov.mb.ca/fs/assistance/spd/vpa_family_guide.html on June 26, 2011
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[iv] Created by Marsha Forest and Jack Pearpoint, from Inclusion Press Inc.
[v] Retrieved from http://www.wrha.mb.ca/community/mentalhealth/files/PACT-English-Mar07.pdf
[vi] Retrieved from http://www.mountcarmel.ca/programs/community/ACT.php

WALPOLE ISLAND
THE MENTAL HEALTH COMMUNITY COMMITTEE

Making a Difference in Community Mental Health Services

KEY INFORMANTS:

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Leslie Jenkins, *Social Worker, Canadian Mental Health Association – Lambton-Kent Branch, Ontario*

Background

Walpole Island First Nation of the Council of Three Fires at Bkejwanong (where the waters divide) has been home to aboriginal people for over 6,000 years and has remained an "unceded territory". It is comprised of six islands and surrounding waterways with a land base of approximately 58,000 acres. The community is located at the base of the St. Clair River, downstream from Sarnia, Ontario.

Walpole Island delta is home to the largest wetland eco-system within the Great Lakes system and is known for its rare flora and fauna. The local economy is highly diverse, rich and dependant on the bounty of the land and its fruits. The lands and waters support recreation and tourism. As the southernmost reserve in Canada, Walpole First Nation citizens still support their families through "hunting, fishing, trapping and guiding activities which are central to the economic base and cultural integrity".[i]

The total band membership is approximately 4,000 with an on-reserve population of over 2,100. One Chief and 12 Councillors, with an infrastructure of 30 band departments, govern the First Nation.

There are approximately 653 housing units on the reserve. The community is challenged with a constant housing shortage fuelled by a growing population. Unemployment and social assistance rates are high. There is a preschool and an elementary school on the reserve. Children leave the community to go to high school in one of the neighbouring communities; however the number of graduates remains low.

The population is relatively young: 28.3 percent are 17 or younger, 54.8 percent are between the ages of 18 and 54, and 17 of the population is over the age of 55.[ii] There are approximately 60 children classified as children with special needs, as a result of birth anomalies, addictions, disease and handicaps.[iii] Approximately 5 percent of the population on-reserve is known to the health care team as having mental health and/or addictions issues.[iv]

50 percent of residents on Walpole Island do not have a family doctor[v] and accordingly access care from a variety of programs and services on and off reserve. In one neighbouring hospital, two percent of visits in 2010-2011 were for mental health needs. The diagnostic categories included: addictions (36 percent); anxiety disorders (28); depressive episodes (8 percent); acute stress (7 percent); panic disorder (3 percent).[vi] Readmission rates are high with 41 percent coming from Walpole Island community members; alcohol, depression, anxiety and opioid use being the primary reasons[vii].

HOME AND COMMUNITY CARE (HCC) PROGRAM - SERVICE OBJECTIVES

- Provide a single access point for both health and support services for individuals needing home and community care.
- Integrate health promotion goals and practices in care plans and in the provision of care.
- Provide clients with a holistic, consistent, comprehensive and client-centred assessment of need, utilizing other health disciplines when required.
- Teach clients, families and other community members to provide care to promote self-reliance and efficient use of resources.
- Coordinate services required by clients, including assisting clients to gain access to related services to meet identified needs.
- Evaluate policies, standards and indicators, always striving for continuous quality improvement.

Walpole Island First Nation provides health programs and services consisting of the Community Health Centre, Home and Community Care, and the Community Service Program. These operate autonomously and all report to the Health Committee which is authorized by the Chief and Council.

The Community Health Center team focuses on health promotion and prevention and provides services to band members who live on the Island. Off-reserve band members can receive care at the Centre as well.

The Home and Community Care (HCC) Program aims to safely preserve and maximize a community member's ability to remain as independent, as long as possible, at home. In supporting client independence, the Program works with the family to encourage and facilitate the important role they fulfill.

The Community Service Program is a mental health and addictions education and prevention program. There is no withdrawal management or treatment for addictions on Walpole Island. The Community Service Program primarily refers clients to off-island services.

Recognition of the need within the Walpole Island community and the value of leveraging and aligning the health care offered on-reserve with that of the provincial system was the catalyst for action. It was clear that collaboration needed to improve and a new model of working together needed to be developed in order to better respond to those with mental health needs.

Creating Cross-System Collaboration

The Walpole Island Home and Community Care (HCC) Program provides service to approximately 400 individuals per year. There is 19 staff:

- A Program Coordinator is responsible for the overall operation of the program, the budget and the HCC Program staff. The HCC Program Coordinator is part of the local Health Management Team that offers a forum for communication and networking among the existing three Walpole Island health programs (Community Health Centre, Home and Community Care, and the Community Service Program).
- A Nurse Case Manager who conducts home visits for assessment, follow-up and care planning and works with the community health service providers as part of the provincial home care program (Community Care Access Centre), assisting in education, prevention and care planning related to chronic disease management in the community.
- Sixteen support staff, including Personal Support Workers, Home Support Workers and others who provide supportive care in the home.

The Program Coordinator and Nurse Case Manager work collaboratively with members of the health care team, both on- and off-reserve, to carry out the client needs assessment, care planning, coordination of services, provision of planned

Community Care Access Centres are the local organizations established by the Ministry of Health and Long-Term Care to provide access to government-funded home and community services and long-term care homes.

A MATTER OF BALANCE

Traditional medicine uses a holistic model of wellbeing through the integration of emotional, physical, mental, and spiritual aspects of being. It is based on the understanding that man is part of nature and health is a matter of balance. The belief is that the human body is an organism with self-healing and strong recuperative capabilities which, when maintained properly, is capable of ongoing health and longevity. Where disease does exist, a Traditional Healer aims to correct both the internal and external imbalances for the patient. In First Nations cultures, healing is the process of bringing aspects of one's body-mind-spirit to a deeper level of inner knowledge that leads to integration and balance. First Nations traditional healers do not claim to cure the disease, but work to facilitate the body's own recuperative powers using traditional medicines and ceremonies.[viii]

services, referrals for medical supplies and equipment, evaluation of client care plans and the client's response to the care provided. A client care plan is developed, with the assistance of the client and family members. The plan identifies a nursing diagnosis and the nature of the services required to maintain independent living. Referrals are made to the appropriate service providers for treatment and/or supportive care, for example, the CNIB, the Canadian Mental Health Association (CMHA). The essential services for clients are delivered in response to a client assessment process that generates a client care plan which is used as the tool to coordinate a seamless web of service—a holistic continuum of care for the client.

The Program has a strong working relationship with the Erie St. Clair Community Care Access Centre (CCAC) which delivers home nursing services and funds the Walpole Island team to deliver additional home support care.

The Program Coordinator and the Nurse Case Manager accept referrals from Community Health Centre Nurses, Physicians, Nurse Practitioners and community members. A home visit is arranged to complete the assessment. Based on the results of the client assessment and development of a plan of care, the Nurse Case Manager recommends provision of the following services:

- Administration of prescribed medications and monitoring of compliance.
- Chronic Disease Management.
- Monitoring of vital signs and blood glucose.
- Follow-up on early discharges from hospital (medical, surgical, emergency, psychiatric, pediatric).
- Education of client, family /caregivers and home support workers.
- Referrals to local community health nurses to address education and prevention needs.
- Therapeutic diet support.
- Supervision of the home support workers.

The Program Coordinator and the Nurse Case Manager have implemented a number of supportive services to complement and enhance the clinical programming. Professional services are contracted when the need arises, with special emphasis on grouping together clients, families and caregivers with similar service and educational needs. Workshops are provided to meet the educational needs of the client, their family and the community. For example, the need for grief support counselling was identified and supports put into place. Currently the Health Centre and the Home Care Program work collaboratively to provide individualized bereavement support to members of the community. A group counselling session for those recently bereaved is held once a year.

MENTAL HEALTH PARTNERSHIP COMMITTEE MEMBERSHIP

- Canadian Mental Health Association (CMHA) – Sarnia-Lambton & Chatham-Kent
- ACT Team – St. Joseph's Health Care
- The Way Out Counselling Services – a private counselling service
- Walpole Island Services – Mental Health & Addictions, Health Centre, Home & Community Care, Social Services, Police Service

Home-based services for long-term psychiatric clients are provided collaboratively by the Nurse Case Manager, Canadian Mental Health Association, the ACT Team, psychiatrist and traditional healers if the client wishes.

Building on the culture of collaboration and recognizing the need to improve and increase the care in the community for those with mental illness, the HCC Coordinator initiated an invitation to partner organizations serving individuals with mental health and addictions to form a Mental Health Community Partnership Committee. A number of organizations answered the call and agreed to work together. The purpose of the committee is to provide a venue for mental health service providers in neighbouring Chatham-Kent and Sarnia-Lambton to network and communicate with the Walpole Island First Nation health care team. The goals are to:

- Develop an understanding of available services.
- Develop an awareness of available educational resources.
- Integrate the services of the two counties based on the location of the client's primary care.
- Enable care planning through presentation of client specific case studies.

To date, the participants have:

- Provided each other with regular updates regarding their respective organizations and programs.
- Used each meeting time for education on matters related to the provision of mental health care.
- Developed a process and protocol for streamlining access to mental health services for clients, eliminating the duplication and confusion that often arose for clients who were uncertain as to which off-reserve community resource to access.
- Improved the communication (with client permission) regarding care in order to improve consistency.

The Partnership Committee meets four times per year. The importance and value of the meeting is such that attendance is between 90 and 100 percent for all meetings. The educational component of the meetings is very popular and addresses relevant issues. The participants leave the meeting equipped with a presentation and information to share with their staff and often, because the individuals at the meeting are those engaged in the delivery of services, with a better understanding of how to work to improve care. Some of the topics presented include: intergenerational trauma, post traumatic stress, grief recovery, the Assertive Community Treatment team (ACT), and traditional healing.

The Committee also works to address health system issues. The perception that First Nations people being admitted in emergency departments were not getting the same treatment as non-Natives was addressed through dialogue with the hospitals and discussion at the Committee.

Treatment Accepted through Team Collaboration

Steven a 35-year-old man with severe mental illness had been a longstanding patient of the mental health system. He began to complain of pain which was initially dismissed as being a ploy to access narcotics. However, the home care team, in collaboration with the primary care physician was able to persuade him to accept treatment for his addiction. Once stabilized, the persistent pain was identified as being related to back injury. Steven was referred to a pain clinic and began to develop strategies for coping. He has remained in the community through regular support from home care and continues to be seen by a psychiatrist and the Canadian Mental Health Association and his family physician.*

**Name was changed to protect identity*

Outcome

A major accomplishment of the Mental Health Community Committee has been the development of relationships with Walpole Island Home Care Program and health professionals from the provincial system. These relationships have facilitated the identification of the mental health needs of the First Nation population on Walpole Island and improved the ability of the providers to effectively deliver care. For example, a Walpole Island community member with advanced mental health needs was able to stay in his home with the support of the Nurse Case Manager and the ACT Team.

The participants have a greater understanding of the resources that each has to offer. Together standardized referral processes and documentation have been developed. Clients now access mental health services in the community in which their primary care clinician practices and this simple step has improved the communication and coordination of care.

Physical and mental health is inseparably linked and, accordingly, health care providers must integrate their efforts in order to provide holistic comprehensive care. The high incidence of diabetes on Walpole Island is coupled with depression and, for some, more complex mental health issues. Through the recent efforts to better collaborate, such as services from the CMHA, clients are remaining at home with support for their physical needs and mental health issues. There is a greater tendency for team members to contact each other in order to identify resources for clients, problem solve care needs, and access a range of services that will support a durable discharge and good care for the individual in their home community. Service coordination has been enhanced. Hospital admission and emergency presentation have been appropriately avoided. Personal Support Workers are more confident in their abilities to help those with mental health needs.

Conclusion

The process of relationship building takes time. Mental health and addictions services for Walpole Island are a priority—for the Walpole Island Health Committee and for the Erie St. Clair region known as the Local Health Integration Network (LHIN). The Mental Health Community Committee has successfully begun the process of strengthening linkages. It is envisioned that others, including the CCAC and regional hospitals will join the Committee as regular members. Ultimately, it is a matter of many hands helping each other for the benefit of the clients.

[i] http://www-personal.umich.edu/~ksands/Warpole.html
[ii] From Meg Connelly, RN, BScN, Home and Community Care Coordinator, Home and Community Care, Walpole Island First Nation
[iii] Ibid
[iv] Ibid
[v] Chatham-Kent Community Health Centres Interim Report on the Use of Community Engagement Funds. Submitted by Chatham-Kent Community Health Centres Steering Committee, 2008
[vi] Committee Presentation by Paula Reaume-Zimmer, Director, Mental Health and Addictions and Emergency Services. May 2011
[vii] Ibid
[viii] Retrieved from http://www.suite101.com/content/first-nations-traditional-healing-a100329 and http://www.fnhc.ca/index.php/initiatives/community_health/traditional_medicine/

Awareness

THE STIGMA OF MENTAL ILLNESS IS A BARRIER TO CARE AND WELLNESS FOR too many. Within the First Nations and Inuit Home and Community Care (FNIHCC) programs it is recognized that greater awareness of the potential for mental health issues is required. Too often the mental health of individuals is overlooked and as a result, the other domains of wellness—physical, emotional and spiritual—are compromised. Being open and receptive is critical to creating an environment in which individuals can feel comfortable disclosing their mental health issues to their health care team. Fostering community awareness and recognition of the unique needs and aspirations of those with mental health challenges can also help to alleviate the pervasive stigma.

FNIHCC programs work with provincial partners to increase access to programs for their clients. By working together—engaging many hands—access to care is improved and cultural context better understood so that stereotyping and assumptions about client behaviours do not compromise care for treatable mental conditions.

Central to achieving improved access is respect and caring for individuals and the choices they make. It requires understanding that past experiences may contribute to behaviours and choices in the present. Without judgement, members of the health care team recognize the right of all persons to be informed and supported to acquire health care. The following practices reflect efforts to achieve a heightened awareness of both client needs and services that are available in order to create a state of wellbeing for each individual.

KITIGAN ZIBI
DEVELOPING A DEEPER UNDERSTANDING

For the mental health needs of the elderly

KEY INFORMANTS:

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Background

Kitigan Zibi (also known as River Desert, and designated as Maniwaki Indian Reserve No. 18 until 1994) is a First Nations Reserve of the Kitigan Zibi Anishinabeg First Nation, an Algonquin band. The reserve is bounded by the Eagle River along its west side, by the Desert River on the north side, and the Gatineau River on the east side. On the south-west, it borders the town of Maniwaki in the Outaouais region of Quebec. Having an area of 175 square kilometres, it is the largest Algonquin Nation in Canada, in both area and population.[i] There are approximately 2,600 community members.

The geography of the reserve poses unique challenges for the delivery of community based care as there are 13 large fresh-water lakes and approximately 29 smaller lakes and streams located throughout the territory; forest covers much of the reserve. Many services and programs are available to the community members including: an elementary and secondary school, day-care, community hall, community radio, health centre, police department, and youth centre.

Since the establishment of the reserve, Kitigan Zibi has worked to obtain autonomy for the administration and delivery of their health and social service programs. An Advisory Council has been established to facilitate increased community input and involvement in the coordinated and planned delivery of health and social services. The goal is to enhance the mental and physical wellbeing of all community members. The vision is to provide the highest quality service, achieving compliance with health standards and respecting the fundamental rights and freedoms of individuals.

The Kitigan Zibi Anishinabeg Health and Social Services Advisory Council believes that in order to enjoy a healthy lifestyle, one must live in balance and harmony with their mind, spirit, body and environment, which are the basic components of traditional holistic healing practices. This foundational principle and the pragmatism borne from limited resources and a "semi-isolated" designation have contributed to an integrated comprehensive approach to health care in the community.

Kitigan Zibi Health and Social Services staff provide high quality services designed to achieve physical and mental health and wellbeing within the community, with sensitivity to the particular needs of women, children and the elderly. The focus is on reducing health concerns and addressing underlying causes while striving to maintain and/or restore family systems. When mental health and/or substance abuse counselling needs arise, the services of a psychologist or substance abuse counsellor through the Mental Health and Substance Abuse Addictions Counselling teams is offered. However, the priority for the mental health services is the youth. Kitigan Zibi Health and Social Services staff recognized that new strategies were required in order to help individuals, particularly the elderly with dementia, live at home with the appropriate community-based services.

An Integrated Approach to Care

As an integral component of the Health and Social Services team, the Home and Community Care (HCC) Program has evolved over the past 10 years. The program has incorporated two sources of funding, Indian and Northern Affairs Canada (INAC) and Health Canada, and has integrated services in order to improve the overall wellbeing of those served.

The HCC Program funded through Health Canada encompasses services to support activities of daily living for those unable to manage on their own. Services are enhanced by the INAC funds which are targeted for the provision of supplemental services, such as snow shovelling, wood piling and heavy cleaning. Support for elders is also provided through a community meal offered every week (except during summer months) and transportation is provided to facilitate access. This service demonstrates respect and caring by the community for their elders and provides socialization that is critical to wellbeing. The community lunch, which 45 to 80 elders attend, provides a forum for consulting with elders and informing them of matters pertaining to the community.

Through integration of resources, the Kitigan Zibi has established the Kiweda Group Home for semi-autonomous persons. The group home has a total of 12 beds, including a number of respite, or short stay beds, for individuals post acute care or in crisis. This short-term option provides families with the necessary relief from the ongoing care responsibility and can be the crucial service to enabling sustainable family support for their elders. The Supervisor of Kiweda works closely with the HCC team to determine the best allocation of the group home beds.

Typically the HCC team provides home care evaluations, care coordination and scheduling, heavy cleaning, home visits, foot care clinics, and community prevention education support (a drug prevention framework). There are two nurses: a home care coordinator responsible for overseeing a team of personal support workers and a registered nurse responsible for elderly clients, many of whom have mental health needs and require more intensive care and follow-up. The home care team has approximately 62 clients receiving home care services weekly; more than half (27 men and 8 women) are followed for mental health support.

MENTAL HEALTH KNOWLEDGE– SHARING AND LEARNING

The increasing number of elderly and rising numbers of home care clients with dementia was a catalyst for education and awareness of the etiology of 'hard-to- serve' clients. The challenges of providing care for individuals with dementia were exacting a toll on home care staff and families. While they wanted to be supportive and keep their elders at home and in the community, home care staff and families struggled with the unpredictable and often irrational behaviours of those with dementia.

It was becoming increasingly difficult to provide care, and it was sometimes unsettling, for staff who did not know how to intervene most effectively. Sometimes they thought their actions were helpful and other times were afraid that they were exacerbating the situation. They wanted to better understand issues such as hoarding, which could be a sign of depression; addictions (especially those denied by clients because they are due to prescribed medications); the turmoil of residential school survivors; or other conditions that might explain the needs of their elderly clients. Staff needed an opportunity to explore their own reactions and feelings.

The Past Explains the Present

Sensing the frustration and impatience of those trying to help her, an elderly woman, Jean, explained why she will never go to the Community Health Centre. As a child, Jean and her sister were instructed by their parents to take their little brother to see the doctor. It was in the 1930s and at that time a physician from Indian Affairs visited periodically, setting up his clinic in a small shack across town from where Jean and her family lived. The girls brought their brother to the doctor who, after a cursory examination, directed the girls to hold their brother still on the table. The doctor sliced open the boy's eye and things went horribly wrong. While, Jean and her sister held down their brother, he bled to death.*

**Name was changed to protect identity*

Dementia is a syndrome consisting of a number of symptoms that include loss of memory, judgement and reasoning and changes in mood and behaviour. These symptoms may affect a person's ability to function at work, in social relationships or in day-to-day activities.[ii]

A special education session, *Dementia and Caregivers/Managing Difficult Clients*, was convened, primarily for personal support workers in the home care program. A Mental Health Clinical Nurse Specialist (CNS) from Health Canada was retained to lead the session at which 19 staff attended. The objectives were to provide an overview of the aging process and explain the dementias and behavioural disorders that can be disturbing and alarming to the community and health care team.

The education program reviewed a variety of dementia, including Alzheimer's disease, vascular dementia (stroke), alcohol-induced dementia, and Wernicke/ Korsakoff's syndrome (thiamine deficiency). Participants discussed the many potential problems associated with dementia that were of concern to the home and community care team including:

- Medication management.
- Daily activity limitations.
- Agitated behaviours.
- Mood disorders.
- Poor nutrition.
- Falls.
- Safety.
- Legal competencies.
- Care at the end of life.
- Institutionalization.

The seminar provided an opportunity for staff to learn about a wide range of mental health issues in the elderly. They learned about the isolation that the elderly experience, and how isolation impacts the aging process. They also examined the causes of isolation. The intent was to increase awareness so that the home care team could understand the rationale and importance of current strategies to support the elderly. Workshop attendees reviewed the fundamental causes of the different types of isolation—physical, social, spiritual and mental-emotional.[iii]

Physical isolation can occur as a result of:

- Geographic isolation.
- Lack of transportation.
- Poor physical health.
- Inadequate housing.
- Poor diet.
- Physical inactivity.
- Mobility problems.
- Limited access to health care.

Social isolation can occur as a result of:

- Lack of information about program and services.
- Lack of home care and home supports.
- Lack of support services.
- Weak family, social and community networks.
- Lack of participation in recreational, social and community activities.

Spiritual isolation can occur as a result of:

- Inability to observe religious and spiritual practices (lack of access and opportunity).
- Loss of meaning and purpose in life.
- Loss of sense of connectedness and belonging to something larger than oneself.

Mental–emotional isolation can occur as a result of:

- Mental disabilities.
- Low self-esteem.
- The impact of cultural change on the status of elders.
- Difficulties accepting aging.
- Communication problems with family or community health workers.
- Ageism, sexism or racism.
- Stress.

The workshop also included education about depression and delirium. It was acknowledged that there is a high prevalence of depression in elders that cannot be ignored. Sometimes it manifests as dementia. Screening and assessment tools were reviewed and staff was introduced to a self-care guide that instructed on the use of cognitive and behavioural methods to overcome milder forms of depression. Those with more serious forms of depression (as per the Geriatric Depression Scale) would require medication and/or cognitive behavioural therapy (CBT).

Temporary changes in cognition, such as delirium and agitation, were reviewed and linkages between physical and mental health explained. Older males with sensory deficiency, dementia and/or depression will be predisposed to altered cognition. An infection, electrolyte imbalance, or pain could precipitate irrational behaviours. Being able to work with individuals calmly and address the underlying causes is vital to achieving high quality physical and mental health wellbeing.

Staff was instructed on interventions to effectively support clients with delirium and/or agitated behaviours. They reviewed appropriate documentation.

LESSONS LEARNED

The day was very successful, with high ratings given for material and trainer. Staff felt valued as they were able to talk about the challenges of working with aggressive clients and developed strategies that would be effective. In the words of participants:

"I will be understanding and listen more to the client."
"Now I know that I am not alone with these challenges."

Everyone recognized the value of setting time aside for sharing ideas and discussing challenges and the decision to continue to learn and work as an integrated team was appreciated. It takes many hands working together to achieve physical and mental health and wellbeing for the community members.

In addition to the special education session, staff at Kitigan Zibi Health Services is coached to understand and acknowledge the experiences that may be contributing to the behaviours they witness with the elderly. They are encouraged not to personalize behaviours, but rather to recognize where the elder's "hardened coping skills" may originate. Often there are lived experiences that have a profound impact on a person's life and manifest in what may appear to be illogical or irrational behaviours. In sharing stories and being more aware of the past influences on the behaviours of the present, the health care team appreciates the need to accept and provide services that enable people to stay at home.

GERIATRIC VITAL SIGNS

AUTONOMY
INTEGRITY OF THE SKIN
NUTRITION
ELIMINATION
COGNITIVE STATUS
SLEEP [IV]

Creative Solutions for Complex Issues

The HCC team has increased its awareness of the mental health issues of the elderly. They recognize the linkages between physical and mental health and through their strong working relationships with the broader health care team are developing effective strategies for care around the client and their family, strengthening their ability to remain at home.

The Health Service relies on the wisdom and guidance of the Kitigan Zibi Anishinabeg Health and Social Service Advisory Council and of the Kitigan Zibi Chief and Council. It is the Chief and Council that find ways and means to provide the support when service requests or needs are outside of the program limitations set by the funding authorities. As a result of the collaboration across the health team and within the community, and the evolution of home and community care over the past 10 years, those living on-reserve are better served today than in the past and are more often able to remain at home, despite health-related frailties.

The staff at Kitigan Zibi Health Services recognize the need for additional nursing support, particularly in the area of geriatric mental health. There is a need to have expertise in helping the elderly as issues from their past surface. Ideally, they would recruit a First Nations expert so that culturally specific issues could be more appropriately developed. The team would also like to offer more service so that higher needs clients could be supported to die at home.

When the resources to support a client who wishes palliative care at home are mobilized, staff believe they have made a meaningful contribution to the community and the mental health of the family. In recognizing and addressing mental wellbeing of the client, the family and the community as integral to the provision of health care, the Kitigan Zibi Health Services staff has eroded the silos of care to the benefit of the community as a whole.

[i] Kitigan Zibi Anishinabeg Member Community Page. Algonquin Anishinabeg Nation Tribal Council. http://www.anishinabenation.ca/eng/comm_kitiganzibi_en.htm. Retrieved 2008-09-17.

[ii] From the in-service presentation, Dementia and Behavioural Disorders, presented by Dominque Boucher on April 13, 2011

[iii] Ibid

[iv] Ibid

KWANLIN DUN
SERVICING THE COMMUNITY

Flexible, responsive programs

KEY INFORMANT:

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Background

Kwanlin Dun First Nation has 1,130 members of Northern and Southern Tutchone origin and some members of Tagish origin located in and around Whitehorse.[i] There are no reserves in the Yukon. Programs funded by the First Nations and Inuit Health Branch (FNIHB) flow directly to First Nation communities which work with the Yukon Government to deliver health and social services.

The vision of the Kwanlin Dun First Nation (KDFN) Health Department is a community that is healthy, family centered, and self-sufficient; a place where cultural values are respected and motivated people pray, work, and play together. In the pursuit of health program and service delivery excellence, the Health Department is committed to improving the quality of life of the community by adopting a collaborative, holistic and culturally appropriate approach to wellbeing.

The KDFN Health Centre is the only First Nation operated Health Centre north of the 60th parallel. The Centre employs 19 staff and provides service to approximately 1,600 First Nations and Non First Nations people living in the area. The Health Centre is also unique in its integration of programming that forms a continuous stream from pre-birth to death. The focus of services is client-centered and reflects the unique needs of clients as defined by their age and health status. Some program initiatives include: health promotion activities, maternal and child health activities, chronic condition screening and management, and traditional knowledge sharing with on-the-land activities (rabbit snaring, trapping). Healthy Aboriginal Adult and the Injury & Illness Prevention programs are delivered by nurses and Community Health Representatives (CHRs). Consultants and other professionals may be brought into the community from time to time to provide special services and information and to deliver programs.

The KDFN Home and Community Care Program delivers nursing and support services to elders and others requiring ongoing case management for chronic conditions, palliative care or other medical situations. The team includes one nurse, a nurse manager and two Elder Health Support Workers, who provide clients with a consistent, comprehensive and client-centered assessment of need and home and community services, with the HCC Team liaising with the Yukon Territorial Government (YTG) home care program to access additional health services such as therapies when required.

The objective of the Home and Community Care Program is to improve the quality of life for community members by promoting resilience, motivation and independence. The program encompasses an array of services including home visits, assessments, surveillance, and managed referrals. Personal care, home support, socialization, nursing, advocacy, and linkages/referrals to other community support services are the cornerstones of the program. Referrals are accepted through the Home and Community Care Nurse. Client assessments, and care plans are developed in

The Elder Health Support Workers have either Community Health Representative or Nursing Home Attendant training, terms for the education of unregulated staff. Both certifications are directed at working with health care providers to deliver personal and supportive care, promote wellness, protect health and prevent injury and illness. The former is focused on community settings and the latter on nursing homes.

collaboration with the client. The Home and Community Care Nurse also coordinates access for clients, who have no family physician, to the KDFN medical doctor who runs a clinic twice a week.

Reducing isolation is a goal of the KDFN home care program and, accordingly, socialization is an important component of services provided. Active and inactive clients remain connected to the program and are included in social initiatives such as berry picking and outings. Wellbeing and appropriate nutrition are also elements of the socialization approach and are supported by the Meals on Wheels program which offers hot meal delivery twice weekly.

The majority of clients are elders, who, by virtue of the services they require, have the closest contact with the Elder Health Support Workers (EHSW). The EHSWs take clients to appointments, provide foot care, pick up and drop off prescriptions and offer companionship. As a part of the health care team, they relay any client concerns immediately to the nurse or manager. This close and regular contact exposes staff to the challenges that their clients face, and fosters a level of trust that often leads to clients revealing mental health concerns ranging from depression to multiple psychiatric and substance abuse problems. As a result of these experiences, EHSWs indicated a desire to increase their knowledge and skills in responding to these situations in an appropriate and therapeutic manner. Specifically, they wanted education and training to heighten their awareness of when clients are reaching out for help, and direction in how best to respond and support the individual in accessing help.

Approaches to Community Mental Health

Addressing the mental health needs of the community has been a priority for the KDFN Health Department. The Wellness program served the community for many years through general health counselling, substance use and addictions counselling, youth outreach counselling, group programs, Indian Residential School support, traditional teachings and on-the-land camps and activities. As a result of resource restructuring, the program ended in 2010.

Recognizing the important role of the EHSWs, the KDFN Home Care Program funded the staff to complete the Applied Suicide Intervention Skills Training (ASIST). ASIST is a two-day, skill-building workshop that prepares professionals, unregulated staff, volunteers and family caregivers to provide suicide first-aid interventions. The ASIST training teaches how to identify and respond to people who have thoughts of suicide. The program provided staff with a framework for handling conversations with clients and accessing assistance in a way that is respectful of the client and adheres to safety commitments. While not mandatory, this program continues to be strongly encouraged by the KDFN Home Care Program. The Health Centre funds the training and staff is paid to attend.

Psychosocial first aid is a modular approach to providing psychosocial and emotional help to victims of traumatic events. Participants in the Psychosocial First Aid Program are taught how to assist individuals and families in the immediate aftermath of a tragedy or community catastrophe. It ensures that individuals who work with survivors of a calamity can help victims manage initial distress, identify coping actions that assist the person to recover, and mobilize resources for interpersonal support. [ii]

A Mental Health Team – Introducing Community Clinical Counsellors

While other resources such as an alcohol and drug treatment program were in place, the KDFN health care leadership group recognized that a comprehensive mental health team with trained counsellors was needed to effectively support mental health services in the community. In response, a team of four Masters prepared clinical counsellors was recruited. The counsellors are supervised by a PhD prepared psychologist. Initially clients were reluctant to deal with strangers, but now the counsellors are well regarded and accessed by the members of the community. The team provides daily services and, although there is no official on-call at night and over weekends, some individual clients are able to access a counsellor in an emergency or crisis.

The mental health team accepts self-referrals and those from the health centre and home care staff, as well as from the community. As integral members of the health care team, the mental health team is aware of the services that are available through the KDFN Health Department and will make referrals to support the individual's total health care needs. They collaborate with other members of the health care team where appropriate, while respecting the client's privacy. In order to facilitate confidentiality, the mental health workers will meet clients wherever they are most comfortable including at home.

The presence of the mental health team has served as an important resource to the KDFN health care team through the provision of support and guidance. The Kwanlin Dun community had experienced 21 deaths in 2010, including both natural and preventable deaths. While a number of respected elders passed away from natural causes, many of the deaths were a result of the long-term effects of excessive alcohol consumption and/or drug use. Furthermore, a young adult committed suicide in 2010, an event that is very rare in this community.

In response to these unfortunate events, the mental health staff recommended that all 19 staff attend a two-day Psychosocial First Aid program. Conducted by two external consultants, the program provided staff with knowledge on strategies to support both the psychosocial and emotional needs of clients. Apart from being an excellent team building exercise, the training helped clarify the work of the clinical counsellors and ensure that all the health care team members were better prepared for any mental health situations that may arise with clients in the community. The Kwanlin Dun also provides free access to the local Employee Assistance Program to support staff members in dealing with the stress and mental health pressures of their work.

A Partnership Approach

The mental health issues facing the Kwanlin Dun community are complex, chronic and potentially avoidable. Many individuals suffer from a functional mental illness brought on by abuse of drugs and alcohol. Once afflicted, it becomes increasingly difficult to access treatment and/or sustain a care plan and the condition, if unmanaged, makes the individual unemployable and often homeless.

In an effort to provide insight into the challenges faced by clients in the community, KDFN hosted a site visit of the Health Centre for a number of Whitehorse General Hospital staff. The purpose was for hospital staff to gain a greater understanding of the circumstances of patients and the difficulties and barriers they face in accessing health care services in the community. The site visit has resulted in improved collaboration. There is now better contact and sharing of information between the acute care and community health care staff, particularly for individuals who are admitted in the emergency room from the community. This partnership has facilitated ongoing care.

The Many Hands of a Supportive Community

John, a middle aged male, had been hospitalized for a number of years because of multiple serious mental health issues. In spite of his situation, John was encouraged to visit with family in his home community. The Health Centre was notified of his pending return and advised that he would require supervision. John's situation presented a number of challenges for the Health Centre. Without a family doctor, medication management was a challenge. His family was not comfortable being responsible for his care and was concerned about being able to support him financially. A team approach was required to meet John's needs. The KDFN Home Care program assumed the care management role for John. Home visits were initiated for ongoing assessment and medication monitoring. The Health Centre doctor became John's primary physician. John was assisted to ensure that he maintained his appointments at the Health Centre. His family was aided with funding from the Yukon Government to support his living expenses. John was introduced to a local initiative that helps people with disabilities to find employment and contribute to their community.*

John continues to live in his home community and, with ongoing support by the Home Care team, is compliant with his treatment regime.

**Name was changed to protect identity*

Providing mental health services and support for individuals in the community is always a challenging undertaking and is worse when individuals are homeless. The KDFN Home Care Program provides transportation for individuals so they can return to the hospital for follow-up appointments; however this service is only available if individuals have a home address, further disadvantaging the homeless. To address this situation, the KDFN Home Care Program is launching a new initiative in partnership with the Salvation Army and Yukon Territorial Government Health and Social Services. The partners are opening a clinic at the Salvation Army which is readily accessible to the homeless in Whitehorse. The clinic will initially offer general nursing care, wound care, foot care, assistance with medications and case management support to access additional health and social services. The partners currently predict that the clinic will service 5 to 10 clients per week and anticipate that it will take time to build awareness of the program and to reach maximum capacity.

The KDFN Health Centre also supports the No Fixed Address (NFA) Outreach Van which started as a mobile community outreach program aimed at meeting a variety of health, safety and social needs to a specific sector of the Whitehorse community. Based on the Harm Reduction model, the program reaches out to street-involved youth and adults who are unable to, or choose not to, access existing health services. Staff provide health education and on-site care to clients related to wound management, sexual health, vein care and infection prevention. They also liaise with the broader health care team and advocate on behalf of their van clients for appropriate services.

Making an Impact

Social inclusion and fostering independence is not only a goal of the KDFN Home Care Program, it is also a key service goal for those with mental illness. The home care team works closely with First Nations and territorial partners to provide appropriate services to enable individuals to live safely in their homes and to be independent and engaged in their communities. Health care practitioners recognize that many hands (individual, the community and society) are involved in the lengthy recovery process. This approach requires both health and social services and can be achieved through supportive programming and collaborative engagement.

Conclusion

Mental and physical health is intricately linked and integral to a holistic approach to wellbeing. The KDFN Home and Community Care Program is actively pursuing new approaches to their services and to the way in which they partner in order to effectively contribute to the health of their community. The Program actively looks for creative ways to overcome barriers and help the clients become self-reliant, confident and healthy.

Constant Support Encourages Strength

A middle aged female, Sheila, was well-known to the KDFN Health Centre. She had a long history of alcohol and drug use, triggered as a result of childhood abuse. Her husband also suffered from addictions and for a number of years they had repeated admissions to the health system at times of crises. Once they established a connection with a mental health counselor, the couple overcame their addictions together. Sheila continued to struggle with depression and suicidal ideation and was supported through the KDFN Home Care Program for ongoing monitoring and support. The Program was a constant for her and she knew that she could access additional support when her condition started to escalate. This approach allowed Sheila to maintain balance for a number of years until her husband developed a serious neurological condition with a grim prognosis. The home care team increased their services and referred her for additional support from the mental health team. Through the assistance of home care and Sheila's active involvement, her husband was able to remain at home until the end of his life. She became stronger as her husband's needs increased. She assumed more responsibilities and became a source of strength for her family.*

**Name was changed to protect identity*

[i] http://www.justice.gc.ca/eng/pi/rs/rep-rap/2003/rr03_vic3/fig2l.html
[ii] http://www.jibc.ca/course/cism201

Canadian Home Care Association
canadienne de soins et services à domicile

www.cdnhomecare.ca