

A stylized sunburst graphic in a golden-brown color, consisting of several vertical lines of varying lengths radiating from a central point, with a curved base. The text is overlaid on this graphic.

***COMMUNITY MENTAL HEALTH
HUMAN RESOURCE ISSUES
PERTAINING TO ABORIGINAL
CLIENTS***

The Centre for Rural and Northern Health Research
Lakehead University

COMMUNITY MENTAL HEALTH HUMAN RESOURCE ISSUES PERTAINING TO ABORIGINAL CLIENTS

Submitted to:

*ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE
ONTARIO MENTAL HEALTH FOUNDATION*

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2007

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2007

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Acknowledgments

The authors would like to acknowledge and thank those who gave freely of their time to be interviewed for this study. While they must remain anonymous, as health administrators, program directors and front-line care providers the insights and ideas they shared about Aboriginal mental health services and cultural competency made a central contribution to this study.

We also thank by name the individuals who helped with various phases of the research, locating informants, conducting interviews, and transcribing the results: Cecilia Fiddler, Joan Hardy, Donna Lyons, David Moonias, Christopher Mushquash, Mark Rantala, Diane Savor, and Ellen Yeast.

As well, we wish to acknowledge the financial support provided by the Ontario Ministry of Health and Long-Term Care through the Ontario Mental Health Foundation. The interpretations and conclusions expressed in this study are the authors' alone; no official endorsement by the ministry or the foundation is intended or should be inferred.

Executive Summary

Although imprecisely documented as yet, there is compelling evidence that Aboriginal residents in Ontario carry a heavy mental health burden; one made worse by a lack of appropriate services and culturally competent providers. The latter fact raises a number of questions about the skills and knowledge required to deliver effective mental health care to the province's First Nations, Métis and Inuit people:

- *What clinical skills and cultural competencies are required?*
- *Is there a shortage of culturally competent mental health workers?*
- *Is the training available adequate?*
- *Is there a lack of cultural sensitivity within mainstream services? Is there a need to recruit more Aboriginal workers?*
- *What are the barriers to recruiting and educating them?*
- *What are the federal and provincial roles and responsibilities with respect to delivery of Aboriginal mental health services?*
- *What are the lessons learned about these issues from Canada's other provinces and territories and how might they be applied in Ontario?*

The authors undertook to find answers to these questions by synthesizing information from several sources: (a) a systematic review of 240 Canadian and international studies, reports and websites; (b) community-based interviews with 55 program administrators, supervisors and front-line providers in ten northern and six southern Ontario communities (including urban, off-reserve rural and First Nations sites); (c) interviews with 27 policy makers and implementers from all of the other provinces and territories, as well as the federal government; and (d) a scan of relevant mental health training programs offered by post-secondary institutions in Ontario.

Results

There is a degree of uncertainty about the mental health needs of Ontario's Aboriginal population because no comprehensive epidemiological studies have been done. Indeed, the exact number of Aboriginal residents is unknown, although census figures show that at least 20 per cent of Canada's Aboriginal population lives in the province. Nonetheless, an array of Aboriginal-specific mental health programs exist, sponsored and delivered by the federal and provincial governments, often in collaboration with Aboriginal organizations. Still there are gaps in services, difficulties for clients being transferred from one level of care to another, and restrictions limiting access to various programs. Caregivers, particularly those serving status First Nations or Inuit people, have to understand the complex system of overlapping federal and provincial jurisdictional responsibilities that apply, depending on the clients' place of residence, the programs available, and the criteria determining their eligibility.

A major cause for concern is the lack of mental health workers who are properly prepared and willing to look after Aboriginal clients' mental health needs. Crisis care is usually managed adequately; the real consequences of health human resource shortages become clear, however, when it comes to preventive or follow-up care. Often, there is none and clients tumble back into states of crisis. Or they avoid seeking further attention because of their experiences with culturally insensitive caregivers. It is the same story in the south and the north (albeit health human resource shortages are worse in the latter case), and in cities, rural areas and First Nation communities.

The challenge is to find individuals who are fully qualified, or in other words, both clinically and culturally competent. Aboriginals and non-Aboriginal mental health caregivers tend to locate somewhat differently in relation to the two areas of competence. While it is assumed that Aboriginal paraprofessionals fully understand the importance of culture as a determinant of health, what they lack, more often, are essential clinical skills to meet the needs of their clients. For their part, non-Aboriginal professionals must learn to apply their specialist knowledge within a framework partially constructed from their Aboriginal clients' experiences and cultural expectations. When they fail to take these factors into account or act inappropriately, it deters Aboriginal clients from continuing to use the services offered. Demonstrated cultural competence is increasingly seen as something that should be required for professional certification and accreditation. Yet it is difficult for non-Aboriginals to gain enough cultural knowledge to be truly competent.

Recruitment of more people of Aboriginal heritage into careers as mental health professionals is widely seen as the best way of meeting the dual competency imperative, but it will take a long while to reach sufficiency in this regard. Aboriginal people are inhibited from entering mental health careers by several factors. First, there is a stigma associated with mental health deviations that forms the basis for a general avoidance of the topic. Second, many individuals have unresolved personal issues which they would have to work through before they could help others. Third, the usual western modes of intervention and treatment embody practices that are contrary to traditional Aboriginal beliefs, at least in the eyes of some. Fourth, on a practical level, Aboriginal people are often inadequately prepared academically to pursue careers in mental health. And, fifth, many lack the family, peer and community encouragement to seek the advanced levels of education required to enter the field. Respondents felt these obstacles might be overcome if Aboriginal organizations and communities focussed on the positive aspects of such a career. Suggested strategies included: building on natural helping skills; promoting positive role models among youth and adults; and fostering awareness through career fairs, job shadowing and apprenticeships.

Ontario's Aboriginal education institutes, community colleges and universities offer training at several levels in the health sciences and related fields; although none focus exclusively on mental health, graduates are prepared to take on various roles in delivering mental health services. Aboriginal students continue to face a number of barriers in achieving success, however; these include inadequate preparation, family commitments, financial hardship, lack of academic supports, discrimination and fear that personal success will lead to rejection from their peers and others in their home communities. In the case of professional programs, open to Aboriginal and non-Aboriginal learners alike, there are continuing debates about what constitutes appropriate cultural content and how best to integrate the topic into baccalaureate and continuing education programs. Should it be taught as a separate and distinct module or threaded through various courses? Can it be taught in a didactic manner, or must it involve community-based experiences? In pondering both content and structural dimensions, the message from several interviewees is particularly cautionary: recognize that there are multiple Aboriginal cultures in Ontario and that individuals relate to their heritage in differing ways. The search for cultural definitions can lead to inaccurate assumptions of homogeneity and stereotyping.

In sum, successful Aboriginal mental health strategies are built on the strengths of Aboriginal communities and the providers who serve them. Best practices emerge when organizations delivering mental health take time to listen to communities, nurture consistency in care, support front-line providers and enhance educational opportunities.

1. INTRODUCTION

There is evidence that Ontario's Aboriginal residents suffer deviations in their mental health to a greater extent than others; for example, provincial data in the First Nations and Inuit Health Survey shows that 18 per cent of women and 13 per cent of men met the criteria for major depression, rates which exceed the Canadian average.¹ But they are difficult-to-serve clients. Those living in First Nation communities have few treatment options "on-reserve," and these are usually limited to crisis intervention programs; there is a lack of staff able to offer acute or chronic mental health care. For urban residents the issues are different; they have access to a broader range of services, but in the general health care system – unless they identify themselves as such – their Aboriginal status may not be taken into account in developing plans of care. Moreover, many have a marginal existence in the city and, consequently, may fall through cracks in the network of services. The impediments of both *geographic* and *social* isolation combine against those who live off-reserve in rural areas; local services are limited and seldom oriented to their cultural group.

1.1. Research Questions

Recognizing that Aboriginal Ontarians have a substantial burden of mental health problems, made heavier by the lack of sufficient, culturally appropriate services, Ontario is committed to improving mental health services for its Aboriginal citizens by recruiting more properly prepared community mental health workers – professionals and paraprofessionals, Aboriginals and non-Aboriginals – so that there is better access to competent care for those suffering deviations in their mental health, whether they reside in a city, rural area or remote First Nation community. To inform the development of a comprehensive approach to this issue, the provincial Ministry of Health and Long-Term Care's Mental Health and Rehabilitation Unit, Aboriginal Health Unit, and Allied Health Human Resources Policy and Planning Unit commissioned this study to find out more about the skills and knowledge required to deliver effective mental health care to Aboriginal residents of the province. It undertook to answer eight interrelated questions:

- 1) *What skills and cultural competencies are required to deliver community mental health programs that cross the spectrum of care to Aboriginal Ontarians?*
- 2) *Is there a shortage of culturally competent community mental health workers to meet the needs of Aboriginal people in the province? If yes, how does this shortage affect access to mental health services?*
- 3) *Is the training available to community mental health workers adequate to meet the clinical and cultural needs of Aboriginal clients? If not, what are the workers learning needs?*
- 4) *Is there a lack of cultural sensitivity within mainstream community mental health services that deters Aboriginal clients from seeking and continuing to use these services?*
- 5) *Is there a need to recruit more Aboriginal workers into the community mental health sector? If yes, what are the barriers to recruiting and retaining them? And what strategies will best promote and sustain the choice of community mental health as a career for Aboriginal people?*
- 6) *Are there barriers experienced by Aboriginal people in accessing and successfully completing College or University training in community mental health? If yes, what are they?*
- 7) *What are the federal and provincial governments' roles and responsibilities with respect to the delivery of community mental health programs to Aboriginal peoples in Ontario? What are the implications of any differences in their respective obligations?*
- 8) *What are the lessons learned from other Canadian provinces and territories regarding the delivery of mental health services to Aboriginal communities? How can these lessons be applied in Ontario?*

1.2. *The Study*

Answering these questions involved synthesizing knowledge from several sources: (a) a systematic review of Canadian and international literature; (b) community-based interviews in northern and southern Ontario sites (urban, off-reserve rural and First Nations); (c) interviews with policy makers and implementers in each of the country's provinces and territories, as well as at First Nations and Inuit Health Branch, Health Canada; and (d) a scan of relevant mental health training programs offered by post-secondary institutions in Ontario. All procedures were approved by the Lakehead University Research Ethics Board.

(a) Literature Review:

To identify published literature, both health sector and non-health sector, national and international, a search from database inception to June, 2007 was done using the following electronic database search engines: PubMed, CINAHL, EMBASE, PsycINFO, CBCA, Social Work Abstracts, ERIC, Sociofile, Scirus, Teoma, Google Scholar and INFOMINE. Subscribers of health related listservs, such as CANMEDLIB-L (Canadian Medical Librarians Listserv) and MEDLIB-L (Medical Librarians Listserv), were enlisted to help identify the so-called grey literature -- reports, policy and position papers, and non-scientific articles. In addition, national and international websites for key government and non-governmental organizations were searched, as well as those of Canadian health professional regulatory bodies. This work was done with the assistance of a medical librarian based at the Northern Ontario Virtual Library Program (NOVL). A total of 240 documents were selected for the review, based on their relevance to recruitment and retention of community mental health workers to serve Aboriginal clients, culturally competent training and practice, and locus of service (urban, rural and remote).

(b) Community Interviews:

To document the diversity of ways in which Aboriginal residents of Ontario access mental health care, the study interviewed mental health administrators and staff involved in delivering mental health services in sixteen places, ten in the north and six in the south. Sites were selected which captured a full range of mental health services delivery environments. In the north, interviews were conducted in two remote and four rural First Nations, two non-Aboriginal towns, Sioux Lookout and Kenora, that are principal referral centres; an isolated rural community that serves an adjacent First Nation; and Thunder Bay, which has a large Aboriginal population and

is the region's main tertiary care mental health centre. Because of the interlinked nature of the region's mental health system, in presenting the data it was decided to pool respondents from the northern sites, to capture the full spectrum of services and programs available.

In the south, interviews were conducted in three First Nations, one adjacent to a medium-size city, the other two in rural areas; Parry Sound, which serves rural communities with a high Aboriginal population; and Ottawa, which has a significant number of First Nation, Métis and Inuit residents and many Aboriginal-specific services. Because the southern Ontario sites are geographically removed from one another, they are dealt with as separate entities for purposes of this report. Open-ended interviews were conducted in-person with health administrators and front-line practitioners; the most appropriate individuals were identified in consultation with the programs, facilities and communities involved, and snowball sampling used to identify additional informants. The interviews asked about staffing, cultural competence and training required to meet the needs of Aboriginal clients in various settings (*Appendix A*). Fifty-five community-based mental health program directors, managers, and front-line staff completed interviews. With the exception of three individuals who preferred to have their responses recorded in written notes, all interviews were audio-recorded, with permission, and transcribed.

(c) Provincial/Territorial Interviews:

Since governments are the common source of program funding, the first contacts for interviews in the other province and territories were staff responsible for policies or services in relevant areas (e.g. mental health care, Aboriginal health) at their respective ministries of health. These individuals were invited to participate in an open-ended telephone interview which asked about programs and policies, as well as experiences with the delivery of mental health services to Aboriginal clients in their jurisdiction (*Appendix B*). Using a snowball method of sampling, those interviewed were asked to name at least one other person who might have had experience with some dimension of the issue. Follow-ups with the named individuals provided further leads, to the point of information saturation. Twenty-seven interviews were completed with government policy/decision makers, public sector health planners and service providers; this included representatives from every province or territory outside of Ontario and those delivering federally-supported programs. All interviews were recorded, with permission, and transcribed verbatim to facilitate analysis.

(d) Scan of Aboriginal Mental Health Education and Training Programs:

At the request of the funding agencies, the research plan was augmented to include two open-ended e-mailed surveys, one for administrators and the other for students, at institutions which offer Aboriginal-specific health education programs. Both surveys were distributed to Aboriginal student services coordinators and health education program administrators at Ontario's 56 university, college and Aboriginal institutes. Responses, however, were very weak and did not yield sufficient data to be properly analysed. Follow-up phone calls to educational institutions revealed why this happened; most had not distributed the survey in a systematic manner because they do not have a way of identifying students' by ethnicity. This was disappointing, but did not come as a complete surprise. The inability to identify Aboriginal students at primary, secondary and post-secondary levels has been recognized by the Ontario Ministry of Education,² the Ministry of Colleges, Training and Universities,³ and the Association of Canadian Colleges and Universities⁴ as the major challenge in assessing First Nations, Inuit and Métis education initiatives. To offset this information gap somewhat, we conducted a program scan on Aboriginal-content and Aboriginal-specific mental health training programs in Ontario.

1.3. Data Analysis

The literature was reviewed and clustered according to theme. The analysis of the interviews followed inductive procedures whereby the volume of information collected was reduced by focussing on recurring concepts and their relationships with one another. Specifically the issues examined were: (i) the need for community mental health workers; knowledge and skills necessary for culturally competent practice; adequacy of training available; roles and responsibilities in delivering mental health care to Aboriginal communities; (ii) the delivery of mental health services to Aboriginal communities and how these could be applied to Ontario; and (iii) the factors facilitating or impeding entry of Aboriginal workers into community mental health careers. These issues constitute the analytical framework; collectively they provide what Patton (2001) refers to as "sensitizing concepts" which were used to help organize and analyse interview data.⁵

1.4. *This Report*

For ease of presentation, the results of the study have been organized into three major sections: the first addresses the need for community mental health workers; the second examines cultural competence and access to care; and the third looks at training for cultural and clinical competence. The literature on each topic is included as part of the relevant section, rather than as a lengthy stand-alone chapter. And the report makes extensive use of quotes from the interviews; this is the best way to retain the “tone” of people’s comments and allows the reader to gauge both the speakers’ intentions and the accuracy of the authors’ interpretations. Because the report is organized thematically, insights from the community and cross jurisdictional interviews are included together. As well, since respondents’ comments tend to be quite specific, but at the same time refer to diverse aspects of a given topic, we opted to summarize them in bullet format, identifying the sources in general terms.

2. ***THE NEED FOR ABORIGINAL MENTAL HEALTH WORKERS***

A great deal has been written about challenges --and failures --when it comes to the delivery of mental health services to Aboriginal people. The compelling evidence that their needs often go unmet is found in the widely reported incidence of depression, suicides, violence and substance abuse. Nonetheless, it must be remembered that these conditions are not universal; many Aboriginal communities do well and it behoves researchers to find out why.⁶ One key factor is the extent to which Aboriginal people have access to *clinically* and *culturally* competent mental health care providers.

This chapter looks at the need for mental health workers, both Aboriginal and non-Aboriginal, in Ontario. Doing so requires creating a frame of reference outlining both the need for mental health care (to the extent that it is documented) and the way in which such care is organized for clients in urban, rural and remote settings. The chapter starts with a brief overview of the demographic characteristics of Ontario's Aboriginal population and summarizes the limited information available about the occurrence and causation of mental health deviations experienced by Aboriginal people in the province and elsewhere.

This is followed with a description of the complex and, at times, confusing array of programs available through Canada's federal and provincial (or territorial) governments, depending on a person's Aboriginal status, health condition and place of residence. Finally, the section looks at the admittedly slim data on health services utilization. This is followed by the main focus of the chapter, an analysis of the mental health providers available in various care environments. This reveals that health worker shortfalls exist virtually everywhere – too few people, who are both clinically and culturally competent, are dedicated to serve Ontario's Aboriginal residents.

2.1. *Ontario's Aboriginal Population*

The 2001 Canadian census, the most recent data available,⁷ found that 188,315 Ontario residents identified themselves as being of Aboriginal heritage, whether First Nation, Inuit or Métis.⁸ This number is an underestimation for several reasons. First, seventeen reserves or settlements were not fully enumerated.⁹ In certain cases communities refused to take part as a matter of principle; they do not believe that the Canadian government has the right to take a census of their people. Second, if patterns from the 1996 census repeated, it is likely that a significant number, both on- and off-reserve, did not self-identify as Aboriginal.¹⁰ Smylie notes that some individuals will not reveal their ancestry or claim an Aboriginal identity when dealing with non-Aboriginal census takers, because of "historic, systemic, and attitudinal inequities."¹¹ Third, because this population tends to be very mobile and to be over represented among those who are homeless, an untold number would have been missed in the count.¹² And, four, the status of some individuals who rightfully are Aboriginal is not recognized for various anomalous reasons.

Still, although those known are just one percent of the province's population, it appears that more than one-in-five Aboriginal Canadians are Ontarians. The majority of them live amidst the general population, with only 21.5 per cent residing in some 134 First Nation communities scattered across the province, but concentrated in the north. Of the rest, 61.1 per cent are city dwellers and 17.4 per cent live in rural areas. Compared to the province's population as a whole, because of continuing higher (albeit declining) birthrates, Aboriginal people tend to be younger, with about 46 per cent under 25 years of age.

2.2. *Mental Health Needs of the Aboriginal Population*

Although large-scale epidemiological studies establishing the prevalence rates of mental health problems for Canada's Aboriginal population are not available, data from the 2002-03 First Nations Regional Health Survey indicate that 30 per cent of on-reserve First Nations adults report experiencing depression for two or more weeks,¹³ a rate double that found among the general population.¹⁴ The FNRHS data also shows that 30 per cent of adults reported having suicidal thoughts over their lifetime and 16 per cent had attempted suicide at least once.¹⁵ Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and young adults, with suicides occurring at rates that are up to 10 times the average for the Canadian population.¹⁶

There is no reason to believe that the individuals in Ontario at highest risk of suffering a deviation in their mental health would differ from those in other jurisdictions – people who are homeless, incarcerated, who have alcohol and drug problems, or are suffering the aftershock of a catastrophic life event.^{17 18 19} Such marginalized situations are thought to both feed and reflect upon Aboriginal peoples' mental health status.²⁰ A common root cause of Aboriginal mental health problems, in Ontario and elsewhere in Canada, are the abuses that occurred in residential schools, which not only affect the former students, but also their children and grandchildren.²¹ Reactions to this social and psychological trauma manifest in the form of "dissociation, mood, personality, or behaviour problems, alcohol or other substance abuse, self harm and suicide."²² Moreover, community-based counsellors working with victims are themselves vicariously traumatized by their clients' experiences.²³ A diminished cultural identity, weakened family and community ties, poverty and economic dependence also contribute to mental health problems, especially among children and youth.²⁴

2.3. *Aboriginal Utilization of Mental Health Services*

Although it is possible to describe the Aboriginal-specific mental health programs available, it is often impossible to know where Aboriginal Canadians turn for care. As Smylie and Anderson (2006) explain, Canadian health data does not accurately identify the Aboriginal population nor cover it adequately.²⁵ Census data is incomplete, health surveys have limited coverage, and at a provincial or territorial level, only the four western provinces have systems in place which permit assessments of Aboriginal utilization of health care services. As a result, data on the sources of help used vary considerably.

The most recent data available, from the First Nations Regional Health Survey (2002-03), indicates about one-quarter of the on-reserve population sought emotional or mental health support from a variety of health care providers, as well as family and friends. Most often, they turned to family physicians (23.5%), traditional healers (15.0%), nurses and counsellors (13.1% in each category). Comparatively few people looked to community health representatives (8.9%), social workers (7.8%), psychologists (5.1%), psychiatrists (4.6%) or crisis line workers (2.0%).²⁶ Those who had experienced feelings of depression, sadness or feeling blue, as might be expected, reported somewhat greater utilization of these supports. Individuals with depression had turned to family doctors (31.8%), counsellors (19.7%), nurses (18.6%), traditional healers (17.6%), community health representatives (13.5%), social workers (12.7%), psychiatrists (9.1%), psychologists (8.4%), and crisis line workers (3.6%) for support.²⁷

There is no mental health-specific data for off-reserve Aboriginal populations. However, information about health service utilization generally is instructive. The Canadian Community Health Survey (2000-01), which asked respondents about their use of health care services in the preceding 12 months, confirms that 76.8% per cent of the off-reserve Aboriginal population saw a general practitioner, which is about the same as the non-Aboriginal population.²⁸ Contacts with other health professionals were comparable, with the exception that Aboriginal people were more likely than non-Aboriginals to go to nurses for care.²⁹ Despite the overall similarities, needs remain unmet to a much greater extent among Aboriginal people, both urban (18.8 *vs.* 12.7 per cent) and rural (21.3 *vs.* 12.8 per cent). About 34 per cent of urban and 26 per cent of rural off-reserve Aboriginals report having access to traditional healing and wellness practices in their home communities; approximately seven per cent sought counselling from a traditional healer for physical, emotional or mental health issues.

The Aboriginal Peoples Survey (2001) developed and delivered in partnership with Aboriginal organizations, is comparable.³⁰ This data indicates that more than three-quarters of the First Nations, Métis and Inuit people living off-reserve obtained health care from a health professional within a given year. However, there are significant differences in the extent of contact by region: 75 per cent of Aboriginal people living in urban areas had seen a health professional, while 69 per cent living in rural areas and only 43 per cent living in far northern Arctic regions had done so. People living in remote northern regions where nurses are the principal primary care providers, however, were more likely to have seen a nurse (58 per cent, as compared to 23 per cent of urban and 27 per cent of rural Aboriginal populations). Although about 31 per cent of respondents reported that there were traditional medicines, healing or practices in their community, only about 7 per cent urban, 6 per cent rural and 2 per cent of the far northern populations had consulted a traditional healer about physical, mental or emotional health issues.

2.4. *Aboriginal Access to Mental Health Care*

As noted in the Kirby report (2006), Aboriginal Canadians face a “jurisdictional quagmire” determining which mental health services, programs and initiatives are available to them.³¹ For example, they will have differing access to federal and provincial programs depending on their status,³² their residence on-reserve or off, and their access to the general health services that are available to all residents in the communities where they live.

2.4.1. Federal Programs

First Nations and Inuit people who have status and live in a community located more than 90 km via road from the nearest place with provincial physician services, can access primary care through Health Canada's system of health clinics and nursing stations.³³ These are staffed by extended practice nurses, with supports from physicians *via* telehealth, and monthly physician clinics.³⁴ First Nations people who live on-reserve in both remote and less-isolated locations also can access mental health information and supports through various home and community care programs funded by Health Canada. These programs, managed by First Nations and delivered on-reserve by community workers, include: Brighter Futures, Building Healthy Communities, Aboriginal Fetal Alcohol Spectrum Disorder, National Aboriginal Youth Suicide Prevention Strategy, National Native Alcohol and Drug Abuse Prevention (NNADAP) and the Indian Residential Schools Mental Health Supports.³⁵ Although Health Canada continues to fund community-based primary care and mental health programming, there has been substantial transfer of responsibilities for health care delivery to Aboriginal organizations and communities. To date, 279 First Nations, including 38 located in Ontario, have signed agreements that give them partial or total control of health services that are delivered on reserve.³⁶ In addition, there are 19 agreements that transfer specific community-based treatment programs, as well as some hospitals and tertiary care centres, to Aboriginal control.

Some mental health supports are available through Health Canada's Non-Insured Benefits Program, which is accessible to First Nations and Inuit people with status, regardless of whether they live on-reserve or off.³⁷ Benefits include prescription drugs and the costs of travel to the nearest community for assessment, treatment or referral for short-term crisis interventions.³⁸ The program also will cover fees and travel costs for mental health professionals to deliver services in a remote community, when it is more cost-effective to do so.³⁹ Aboriginal people who lack a status card have limited access to federally supported programs, except for Health Canada's Métis, Off-reserve Aboriginal and Urban Inuit Prevention and Promotion Program. Annually, it supports Aboriginal organizations in delivering between 30 and 40 health promotion projects, many of which have mental health components.⁴⁰

In partnership with the provinces, territories and Aboriginal organizations, Health Canada has supported a number of inter-jurisdictional Aboriginal telemental health initiatives to facilitate assessment and treatment in remote communities.⁴¹ Some of these are used to support training and education for community workers as well.⁴² Development of First Nations and Inuit telehealth networks has occurred slowly, however, because communities lack infrastructure and there are no sources of sustained funding to support the services once they are operational.⁴³

2.4.2. Provincial and Territorial Programs

As outlined in the joint federal-provincial *Blueprint on Aboriginal Health* (2005), most provinces and territories have moved towards integrating Aboriginal health initiatives into primary care. There are differences, however, in the way that that Aboriginal health needs are addressed within the general health care system and, more specifically, in the services and supports for Aboriginal mental health.

While some jurisdictions, such as Alberta⁴⁴, British Columbia,⁴⁵ and Ontario⁴⁶, have established strategic policy frameworks to guide development of Aboriginal health programs, including mental health care, none, to date, have formulated distinctive policies in this area.⁴⁷ The result is a patchwork of programs with Aboriginal-specific mental health content; while some programs are at the provincial or territorial level, most are delivered on a regional basis. In British Columbia,⁴⁸ Alberta,⁴⁹ and Saskatchewan,⁵⁰ for example, regional health authorities are working with First Nations and Métis communities to address the mental health needs of children and youth, through developing dedicated teams of mental health workers, local preventive initiatives, and consultative supports.

Although other provinces and territories have mental health initiatives that serve Aboriginal communities, none have an exclusively Aboriginal focus. Manitoba⁵¹, New Brunswick,⁵² Nova Scotia,⁵³ Newfoundland and Labrador,⁵⁴ and Prince Edward Island⁵⁵ deliver services through networks of hospitals and community-based mental health clinics, with mental health services integrated into primary care in a few locations. The Northwest Territories,⁵⁶ Nunavut⁵⁷ and the Yukon⁵⁸ all have integrated health care systems, with mental health care being provided by community primary care teams, regional assessment teams and telepsychiatry supports. Quebec has developed integrated regional primary care, mental health, and social service systems, built around local networks of community health and social service providers.⁵⁹

2.4.3. Ontario's Aboriginal Mental Health Supports

As outlined in *New Directions: Aboriginal Health Policy for Ontario*, the province has had an Aboriginal health policy in place since 1994.⁶⁰ Although at the present time an Aboriginal-specific mental health policy has not been developed, the provincial Aboriginal Healing and Wellness Strategy (AHWS) include a number of programs which support mental health and wellness.⁶¹ Developed and delivered in partnership with Aboriginal organizations, these initiatives include Aboriginal Health

Access Centres (9 urban centres), which offer primary care, counselling and traditional care, and Crisis Intervention Teams (in 47 remote First Nations), which respond to suicide related incidents or family violence. Other programs, such as Community Wellness Workers (118 First Nations), Health Outreach Workers (14 urban areas), Aboriginal Healthy Babies/Healthy Children Program (160 locations); deliver mental health and wellness programming to Aboriginal families and communities.

AWHS also funds three residential care programs to assist individuals and families recovering from mental health and addictions issues: Shelters For Women and Children (9 First Nations) provides short-term support and aftercare to women and children who have experienced family violence; Healing Lodges (6 First Nations) deliver traditional healing approaches to addictions, assault and family violence; and Treatment Centres (2 First Nations) offer care for Aboriginal youth with addictions. AWHS currently funds an additional 14 mental health demonstration projects that are designed to complement existing services for Aboriginal individuals and families.

Ontario is a partner in two Aboriginal federal-provincial integration initiatives and two Aboriginal-specific telehealth networks, both of which have significant mental health components. The integration initiatives, Meno Ya Win Health Centre in Sioux Lookout⁶² and Weeneebayko Health Ahtuskaywin in Moose Factory,⁶³ involve integration of provincial, federal and municipal hospital, primary care and community health, to establish single-point access to address physical and mental health needs. Both initiatives include Aboriginal-specific mental health services, respectively, NODIN Counselling Services and the Weeneebayko Mental Health Program, which offer outreach counselling, assessments and access to traditional care. Clients requiring more specialized psychiatric care are flown to tertiary facilities located in the larger urban centres of Ontario's mid-north.⁶⁴

Keewaytinook Okimakanak (KO) Telehealth in northern Ontario works in partnership with the NODIN in delivering telemental health to 26 remote First Nations, including assessments, some types of therapy and caregiver education.⁶⁵ An Aboriginal-specific telemental health link also has been piloted to facilitate access to specialized child and youth mental health supports for the Mohawk communities at Akwesasne in eastern Ontario.⁶⁶

2.5. *Jurisdictional Issues*

The Kirby report observation about a “jurisdictional quagmire” notwithstanding, it is clear that efforts are being made to address the urgency of Aboriginal mental health issues, albeit perhaps in an uncoordinated piecemeal fashion. Key informants report experiencing significant difficulties locating appropriate mental health services for their Aboriginal clients. Jurisdictional issues are a significant issue affecting access to care, determining client eligibility for services and funding for programs:

- Generally, service providers get frustrated when attempting to navigate the provincial, territorial and federal systems to acquire the referrals and funding necessary for their clients, since each program has its own eligibility requirements and forms to fill out. A coordinator working in Quebec explains: “Professionals find the system too bureaucratic and don’t want to get too involved. It creates an obstacle in providing services to the communities. The paperwork is inconvenient for the client; there is the provincial stream, the federal stream and the First Nations stream. If we had tripartite protocols, it would solve the problem.”
- Bureaucracy can impede mental health service delivery in Aboriginal communities, particularly for First Nations or Inuit clients who need to access care from provincial mental health systems. There are problems, for example, in finding information about the psychologists who have been approved to deliver services to First Nations clients under the federal Non-Insured Benefits Program. This service gap was identified by respondents in several provinces; as a nurse practitioner working in central Ontario commented: “It would be good to have an updated list because we are never sure if they have gone through the [Health Canada] vetting.”
- Referral processes also became complicated when Aboriginal clients moved back and forth between First Nations or Inuit communities and urban areas, which meant moving between federal and provincial or territorial systems. Coordination of care was difficult, because with the exception of a few integrated care initiatives, there were no protocols for providers to follow when clients moved

between jurisdictions. Speaking about the situation in northern Ontario, a mental health worker said: “A gap that we can run into is when there is an individual that that has family in the town ... and going back and forth; ... nobody wants to take that responsibility of reporting to somebody [in the town] ...where we don’t have access to work.” He believes that confusion about “jurisdictional responsibility” also creates communication barriers, so sometimes “the door doesn’t seem to open when you call.”

- Other informants felt that closer integration between federal, provincial and regional systems of care is needed to support Aboriginal mental health care. A Saskatchewan consultant said: “My sense is that on-reserve providers need to be connected much more closely to the health regions.” An administrator from British Columbia shared similar concerns. He reported that it was especially difficult to serve clients from remote communities, who received most of their primary care through Health Canada and only accessed the provincial system through referrals. Discussing supportive care for Aboriginal clients, a Nova Scotia program director said the need is to “figure out once and for all what the jurisdictional issues are.” She added: “There is just a whole range of unmet needs and a lack of a consistent and coordinated approach.”
- Jurisdictional issues also mean that Aboriginal mental health programs, of necessity, must obtain their funding from a variety of federal and provincial sources, including government ministries, regional health organizations and foundations. Citing his agency as an example, the manager of an Ontario urban-based Aboriginal support program commented: “Indian and Northern Affairs Canada provides a small amount for core funding, Service Canada (HRDC) provides funding for the employment, and Trillium funding for the cultural needs program ... homelessness is federal funding that comes through the city and the Ministry of Community and Social Services provides funding for the violence prevention programming.” Summing up the situation, a program manager from Manitoba said: “We have two systems – one that has federal funding attached and one that is provincial level.” She added that the jurisdictional issue “needs to be looked at because federal and provincial funders don’t even talk to each other.”

2.6. *Aboriginal Mental Health Human Resource Issues*

Any discussion about the mental health human resources serving Aboriginals has to be framed in terms of the care setting, be it urban, rural or First Nation, with relative isolation factored into the last category. In each case it is partly a matter of distinguishing between the *ideal* and the *real* situation (who is available). To some extent, it also involves larger questions about the categories of providers who are generally most appropriate to offer primary mental health care. For example, debates circle around the part that psychiatrists' should play,⁶⁷ or about the increasing reliance on generalist nurse practitioners rather than clinical psychiatric nurse specialists to provide mental health interventions.⁶⁸ Similar discussions centre on the role of traditional healing and wellness practices, which many Aboriginal people prefer to be part of their care.^{69 70}

While acknowledging that shortages of certain categories of health professionals, especially physicians, are an emerging issue in urban areas across Canada,⁷¹ a larger problem faces rural^{72 73} and remote⁷⁴ parts of the country, in which nurses provide most of the care. The situation is particularly dire in remote Aboriginal communities, where persistent nursing shortages sometimes severely restrict the level of services available, including mental health supports.⁷⁵ In remote parts of northern Ontario, for example, it is not uncommon for one-third of the funded nursing positions to be unfilled at a given time. As a result, if they can not attract full-time staff, local health authorities and the First Nations and Inuit Health Branch (FNIHB) are forced to rely on agency nurses to provide vital services, each for a few weeks at a time. One small community had 42 different nurses in and out during a one-year period.⁷⁶ This situation can seriously compromise continuity of care in a system where nurses are the principal primary care providers.⁷⁷

The inadequate supply of health human resources is a matter of long-standing concern to the communities and to the federal government, which has tried numerous ways to fill the shortfall. These include strategies to increase the supply of physicians⁷⁸ and nurses,⁷⁹ along with efforts to attract more individuals of Aboriginal heritage into nursing careers.⁸⁰ In spite of these initiatives, health human resource deficits persist and services vary considerably, with the more remote communities suffering the greatest disadvantage.⁸¹

2.7. *Urban, Rural and Remote Health Care Teams*

The mix of health care providers is largely dictated by geography and community type. In urban centres, even smaller ones, usually there is a diverse array of professionals available to Aboriginal clients, as there are to any resident.⁸² These include specialist physicians and nurses,⁸³ as well as professionals from other helping disciplines like social work. There may also be some indigenous mental health workers, although their presence and use is limited in most cities.⁸⁴ However, despite the options potentially available, urban Aboriginals often go untreated.⁸⁵ In some cases clients may choose not to access care as a result of previous encounters with mainstream health care services that left them feeling diminished or marginalized.⁸⁶ Moreover, the stigma associated with mental health causes clients to ignore conditions, attempt to cope on their own, or opt for care in another centre where they would enjoy greater anonymity, if there is one that is sufficiently close to them.⁸⁷

All residents in rural areas face limited choices locally; it is difficult to recruit and retain mental health professionals in every discipline and specialist outreach programs are expensive to mount.⁸⁸ Because of the scarcity of providers, rural mental health teams often includes people from areas not normally considered to be in the *health* domain, like representatives of social service agencies, educational organizations and law enforcement, since they are the first point of contact for many people in crisis.^{89 90} Clergy also sometimes work with the teams in rural communities.⁹¹ As well, rural outreach teams employ local paraprofessional workers to assist with client identification, support and counselling.^{92 93 94} The latter, however, need adequate supervision and training, as well as help in dealing with emotionally draining clinical encounters.⁹⁵ Practitioners in underserved rural areas often find integrated approaches best because they are easy to manage,⁹⁶ allow more efficient use of resources,⁹⁷ and improve delivery.⁹⁸

As in rural communities generally, the notion of the *mental health team* in remote Aboriginal communities is inclusive, involving nurses, community workers, indigenous healers, Elders, police officers and teachers.^{99 100 101} Nurses play a pivotal role, providing the entry point into the mental health system by making referrals to visiting physicians and regional counselling services.¹⁰² There is increasing reliance on community mental health workers, who deliver local health and wellness supports.^{103 104} Community nurses¹⁰⁵ and outside professionals¹⁰⁶ also recognize that local people who know and understand the community and can help them to bridge the cultural gap are a great help. The mental health team, however, can differ substantially from one First Nation to another, depending on their location, resources and management decisions.¹⁰⁷

2.8. *Community Mental Health Work Challenges*

Those providing mental health to Aboriginal clients often face challenges uniquely linked to the care settings in which they work. Community nurses working in remote or rural First Nations, for example, may find it difficult to maintain separation between their professional and personal life.¹⁰⁸ Their clients are also neighbours.¹⁰⁹ Any efforts they make to keep a degree of social distance between themselves and their clients or, in other words, the boundaries expected by their profession, can be misconstrued as unfriendliness or, worse, a misplaced sense of superiority. The resulting resentment can negatively affect the community members' acceptance of the services offered.¹¹⁰

Community mental health workers also may find themselves, as the Scott-McKay-Bain Health Panel noted, caught between community expectations that are "extremely high, often unrealistic and sometimes in conflict with the expectations of [others on the health care team]." ¹¹¹ In particular their "community well-being work" may be misunderstood by both the community and clinicians.¹¹² So, although mental health workers are trained to counsel families about strategies for maintaining wellness, they are called upon to intervene in crisis situations, for which they may be ill prepared. And NNADAP workers, who deliver community drug awareness programs, find themselves expected to provide case management for people with addictions problems.¹¹³

Despite such role conflicts, there is evidence that paraprofessionals can play a vital role in mental health, particularly in cross-cultural settings. Although there are no systematic Canadian evaluations, an American study found that community health workers increased access to services and successfully promoted shifts in behaviour among ethnic minority women.¹¹⁴ Generic behavioural or mental health workers can be a preferred option for rural residents, if they function with the guidance of a regulated professional (usually from-a-distance because the latter are urban-based).¹¹⁵ ¹¹⁶ They can also be effective supports for children and families requiring community-based mental health care.¹¹⁷ Indeed, a recent Cochrane review of the use of paraprofessionals in the treatment for anxiety and depressive disorders found sufficient evidence to justify recommending further development and evaluation of programs incorporating paraprofessionals.¹¹⁸

2.9. *Mental Health Human Resource Deficits*

If one word were to be chosen to sum up the Aboriginal mental health human resource situation in Ontario, as in the other provinces and territories, it would be *shortages*. By turn the various messages heard from those interviewed came back to one fact --there are too few individuals properly prepared to provide the services needed by First Nations, Inuit and Métis people across Canada. Whether the matter being considered is one of service delivery challenges, maintaining cultural competence, or finding alternative ways to access care, it links in one way or another to the mental health human resources deficit:

2.9.1. Gaps in the Service Delivery System

- Gaps in the mental health service delivery system are becoming more apparent with the growth in the Aboriginal population and a corresponding increase in mental health issues. Front-line providers state they are seeing increasing numbers of Aboriginal clients, the needs of whom can not be adequately met within the existing service delivery system. A professional who worked with several First Nation communities in northwestern Ontario believes “there is a high population of Aboriginal people with mental health issues; it is more and more noticeable, like addictions are having an impact with our youth and their mental health; and we just don’t have the services to provide and we have to network with other agencies to keep up.”
- Those living on the streets in cities present particular challenges. A director from British Columbia says: “We are seeing more and more Aboriginal people that are homeless, not because they have severe mental health disorders, but because they have post traumatic stress disorder and addictions.” He goes on to explain that these clients are usually referred to family physicians, which do not have the resources needed to link clients to supportive care. Indeed, professionals are not always aware of the specific issues which Aboriginal clients are experiencing. A manager from central Ontario observes: “I think they are still under the impression that alcohol is the biggest issue but right now a lot of our people are addicted to pain meds.”

- Services available in urban centres often do not meet Aboriginal clients' cultural needs, particularly if they are in the city solely for treatment. A Nova Scotia program supervisor noted that it is hard for Aboriginal clients to adjust to mainstream services: "You can't take someone away from their community and fit them into the services that we have developed. It doesn't work; the cultures are so very different." This point was echoed by two people in Ontario. A nurse practitioner working with First Nations in southern Ontario pointed out that the nearby cities "have few mental health services that are culturally appropriate for Aboriginal clients ... where the person feels comfortable." Likewise, a manager in Ottawa, talking about Inuit clients, observes: "They need to be here, but the language is a big barrier, so they're not getting quite what they need."
- However, the most serious gaps in services are in rural and remote communities where services are limited or non-existent. An Aboriginal health worker from Thunder Bay emphasizes that "some smaller centres don't have any services at all." The nearest mental health services to her home reserve, for example, were located in a nearby small town, about 90 km away by road, or the regional centre, about 150 km away. Residents of remote communities that were accessible only by airplane or winter road faced even greater challenges in obtaining mental health care. As a program manager from British Columbia observed, the greatest needs were often in "outlying communities, where transportation links don't work, services are limited, and air travel isn't often, especially in winter." In the same vein, a manager of a Sioux Lookout program said: "It's so hard to get [professionals to fly-in communities] to help them and ... after care is really hard we have people out there but it's not easy; the continuum, it's just not there."
- If outreach services cannot be provided, the only other option is for clients to travel elsewhere for care, but that can prove equally problematic if transportation is unavailable or too costly. A mental health worker who served rural communities in northeastern Ontario explained that there was often a mismatch between the transportation available and appointment schedules: "We have a medical van that goes on certain days of the week, so we try to fit things in, but it doesn't always work." A Nova Scotia consultant

confirmed Aboriginal clients from rural communities experienced similar difficulties: “There is no transit in our area, so if they are coming to services here, they have to find transportation; it’s an hour drive.” Although some medical travel costs are subsidized by the provincial or federal governments, not all costs of travel for mental health services are covered. According to a manager working with First Nations communities in Quebec, “There are also financing problems because Health Canada does not give financing [to access mental health services] if it is not a crisis.”

- Faced with long waiting lists to access outreach care, some Aboriginal families made the difficult decision to relocate to cities for specialized services, such as children’s mental health or addictions care. A mental health worker from a remote Ontario First Nation used her personal experience as an example: “I had to leave the community to get my son some help because I couldn’t get anything for mental health.” Another front-line service provider from an isolated First Nation reported that Aboriginal families who relocated often found urban waiting lists were as long as those for outreach care: “Waiting lists are nine months long and they have to come back here because they have a job here, or they have got a house up here.” He added: “Some parents are so desperate; they put these children into care just to get the services.”
- Aboriginal clients who relocate to urban areas, intimidated by the complexity of the mainstream mental health system and unsure about how to proceed, often did not show up for appointments or did not follow through with recommendations to access supportive care. As a mental health program administrator from Alberta commented: “Aboriginal people feel overwhelmed by our system [which is] big and confusing and as a result they don’t access service except for crises. They present at the emergency department when they are suicidal and we provide referrals for them but they don’t follow through.” When clients who are from rural or remote communities return home they face another set of challenges. A front-line supervisor from British Columbia explains: “An individual with drug issues can go to an urban area for treatment, then they can go back to their community, but the support is not there to actually keep them well, so then [they] return into the acute care system.”

- Current funding constraints also have impacts on service delivery. Several informants emphasized that mental health services were “chronically under-funded” compared to acute care services. A manager working for an Aboriginal health organization in rural southern Ontario said: “Mental health in general, looking at the mainstream, is a poor cousin to physical medicine.” Funding that was available on project specific basis also contributed to program instability, because there were no guarantees that funding would continue. As the health director of an Ontario First Nations mental health program commented, one of the major challenges in delivering services was “overall organization of the programs” when each program component was funded “by external agencies.” His organization was currently experiencing shortfalls in funding to train community support workers in “case management and cultural skills.”

2.9.2. Health Human Resource Shortages

- Recruiting enough qualified staff is a widespread dilemma. A mental health manager from Saskatchewan felt that many of the problems in First Nations communities in this regard are similar across the country: “I don’t think the challenges here are any different than any sort of rural area, where you have large amounts of space, few people, and small reserves – all those issues I think contribute.” Recruitment is also a problem that crosses sectors. A Quebec administrator states: “I’ve been working for a while with communities at a social level and I think there is a shortage in social intervention, period. Whether we talk about mental health, alcoholism, drug addiction or violence, there is a shortage of professionals in the communities.”
- Health human resource shortages were thought to be gravest in northern communities, where the only specialized mental health services are those delivered by outreach care teams. However, a steady stream of visiting professionals is problematic in a cultural context that values sustained relationships and sees them as therapeutically beneficial. A mental health worker from a northern Ontario First Nation says: “We are dealing with personnel that do not have a close connection with the community; they might be just

locums coming for a few weeks and they don't really have the opportunity to build any relationship with the population." As a manager from Quebec reported: "When teams of professionals keep changing and you have to retell your story every time, it is hard to deal with."

- Reliance on visiting professionals contributes to perceptions that the care provided is not very effective. A front-line service provider from a First Nation community reports that clients quickly become dissatisfied with professionals "just go into this office and lock themselves in here; next client, next client, you know, and when they are done they just go back to their hotel." An Northwest Territories informant noted that "coming into an office [for] therapy is not a culturally comfortable approach for First Nations [people]." Even in urban settings there are complaints about the amount of contact clients have with therapists. "They see you maybe one hour a day, that's it. Nothing else. Even a couple of hours for five days, it's not adequate" concludes an Aboriginal case manager in Ontario. Of course, such complaints are not unique to Aboriginal clients.

2.9.3. Consequences of Mental Health Human Resource Shortages

- Professionals working in the mental health field are well trained to meet the clinical needs of Aboriginal clients; however, few have the cultural competence necessary to work effectively with Aboriginal people. A front line worker from a First Nation community in the mid-north said: "Most of the mental health workers we see are from southern Ontario and may never have been to [the north] and have absolutely no idea about cultural competence or anything like that and don't understand [that] a lot of traditional values are essential when dealing with things like mental health."
- An interviewee from Quebec felt that cultural competence was especially lacking in specialist outreach teams: "Some professionals working outside of the communities lack the cultural sensitivity, the knowledge of the way of life in communities, the constraints and the factors to be considered in an intervention." Staff turnover on outreach teams also inhibits the relationship building process and the solidification of trust. As a front-line supervisor from Nunavut

observed: “Professionals tend to be very transient ... you’ve always got new people coming and that can sometimes turn people off.”

- As mental health manager from northern Ontario observed, even one negative encounter with a culturally insensitive provider can make Aboriginal clients reluctant to access care. She explained, “Like going into emergency at the hospital is a very difficult thing for some people, when they’ve been treated very poorly.” A key informant from Saskatchewan emphasized that client-caregiver interactions can be “intimidating for people, especially seeing a psychologist or psychiatrist, because the environment is not really aboriginal- friendly.”
- Reluctance to seek care also reflected the widely-held perception that “outside” professionals who are only in the community for a short time are not really interested in their Aboriginal clients. As a supervisor in the Yukon said, “they are only going to be there a little while and then they’ll be gone, so is it worth opening up to this person when they are only there for the pay cheque and then they’ll be gone?” Another manager said, “People are really cynical about that so you really have to prove yourself that you are going to be here and stay here in order to get trust.”
- Aboriginal clients, like the general population, face long waiting lists in order to access mental health care, so they “aren’t getting the services they need, when they need them.” Clients who are placed on waiting lists often become frustrated and simply give up. The manager of a northern Ontario program commented: “When people want to go to treatment, they want to go now; they don’t want to wait; three months later they might change their mind.” Clients who were placed on waiting lists often just “didn’t come back.” Some Aboriginal clients viewed waiting lists as an indicator that they are being denied appropriate care, or even discriminated against (although not necessarily for racial reasons). “They don’t want to wait; they don’t feel like they’re at home; they don’t feel understood” observes an urban southern Ontario service provider. Both situations represented significant deterrents to Aboriginal clients’ seeking and continuing to use mental health services. In the opinion of a New Brunswick program manager, “Waiting time ... is a major hurdle with the delivery of services.”

2.9.4. Difficulty Recruiting Aboriginal Mental Health Counsellors

- Managers are constantly searching to find Aboriginal people to fill clinical roles and in so doing, find themselves in competition with other Aboriginal-specific organizations. As a manager from Thunder Bay explained, the competition for qualified individuals is intense, because “when the Ministry gives funding for a MSW everyone else in the province requires a MSW.” An Alberta hospital administrator concurred that “Aboriginal professionals, who are well-credentialed ... are in high demand.” Moreover, increasingly strict legislation governing mental health professions in some jurisdictions may impact the number of Aboriginal people that are able to work in mental health roles. As a supervisor from the Yukon explained, the clinical qualifications required: “make it even more difficult to hire First Nations people.” A clinician from a rural central Ontario community explains. “Given Bill 171 legislation, it’s becoming more and more regulated and the standards of education required will screen out many people.”
- There were also challenges in locating qualified Aboriginal staff that had experience working with mental health clients. As the manager of an eastern Ontario urban initiative said: “We got people that applied for mental health but they didn’t have any mental health background. They had counselling background, they had addictions background, they had house monitor background, detox background, things on the periphery, but not *quite* mental health worker.” A community mental health program director from Manitoba said that organizations in his area “have posted positions in the past and never had an Aboriginal person apply – there hasn’t been one!”
- In unionized environments, administrators’ freedom to hire Aboriginal candidates can be limited by contractual hiring policies. In Prince Edward Island, a director explained: “Even if we found a qualified Aboriginal candidate they might not even get an interview because you have to hire permanent first and then temporary and then casual.” In Manitoba, an administrator reported that changes in contractual language which limited hiring of casual staff impeded their ability to hire Aboriginal paraprofessionals to meet client

needs: “We used to just match the client with the provider; and we would go out and hire if we felt that was in the best interest of the client. But now we can’t.” Contract language which specified that workers must be bilingual in English and French also represents an impediment in some situations. As a program administrator from New Brunswick said: “Besides Mi’Kmaq they speak mainly English [but] most of the positions are [designated] bilingual essential.”

2.9.5. Limited Access to Telehealth Supports

- Although telehealth is touted as a way of addressing human resource shortages, connecting community-based providers to specialist supports and facilitating continuing education, opinions are divided. Some interviewees have used telemental health to good advantage and are comfortable in using the service for their Aboriginal clients. A northern Ontario children’s mental health professional found that telemental health was an excellent support, because it allowed workers and client families to communicate directly with “experts in Canada in children’s mental health issues, they consult with us or do a session with the child through videoconferencing.”
- Other respondents who have used telepsychiatry for Aboriginal clients, however, felt that it was not necessarily the most culturally appropriate method of consultation. An outreach worker, who delivered services to remote Ontario communities said: “There is a unique thing about First Nations, where they find more healing when you are ... doing face to face counselling rather than looking into a monitor and talking to a machine ... they connect a little bit more.” Similar concerns were expressed regarding Aboriginal people’s use of telephone-based health information or referral services. As a northern Ontario mental health worker said: “You can see them on the phone from that moment the other person’s picking up ... the barriers start right away. And you can see the frustration.” Another northern Ontario worker emphasized the importance of direct contact: “they need to see you face to face, not on the phone or through letters.”

- Reliance on telehealth is constrained by the fact that many remote or rural Aboriginal communities do not have access to the networks; the most isolated communities do not have telephone landlines; others may have insufficient numbers of lines to support televideo-conferencing. Some locations may have the technology but lack sustainable funding to support ongoing operations. Telehealth also can be of limited use, if no mental health workers are available locally to help clients or to implement plans of care. Based on the experience of a Nova Scotia provider: “Without the support in the community, it would never work; it would fall apart. You would have a psychiatrist being asked to see individuals that they don’t know, that haven’t been worked up; [and the specialists] don’t know there is actually someone there to follow up with the recommendations.

2.9.6. Need for Aboriginal Mental Health Workers

- At the same time, there is widespread recognition that mental health organizations need Aboriginal workers to ensure that their Aboriginal clients have appropriate care. A mental health worker from Manitoba shares his personal thoughts. “If I have a problem I don’t go to a psychiatrist or psychologist, I go to my own people. There is a need for more Aboriginal mental health workers. You need to understand the emotional piece of the person.”
- Lack of Aboriginal workers is viewed as a serious deterrent for Aboriginal clients accessing care. An interviewee from Quebec said if there were no Aboriginals on staff in mainstream organizations: “Aboriginals don’t feel represented in the services offered by the system; they feel that the system is not for them which are a barrier.” A director for an organization in Prince Edward Island providing community mental health services felt a lack of Aboriginal workers also contributed to difficulties retaining clients. She said, “It affects holding onto people, like keeping them in the service [because of] the lack of cultural sensitivity.”
- Agencies providing outreach mental health services to a number of First Nation communities have to accommodate the variability in the level of mental health supports from one community to the next.

These can be affected by changes in political priorities, management decisions, or program staff turnover. An Alberta respondent said: “The politics change, the management changes and sometimes we have more supports and sometimes we have less.” Community mental health programs could be staffed with “everything from people with Bachelor of Social Work degrees to people that have absolutely no degrees at all” reported a program manager from Saskatchewan.

- Even when qualified Aboriginal workers are available, community-based agencies often do not have the resources to offer them a competitive salary and benefits package. A coordinator of a Quebec program said: “The shortage of funding is preventing us from improving the services.” Other sectors of the economy draw people away from community programs by making more lucrative officers. A program manager from the Yukon explains: “People will work for a couple of years and then it’s ‘I can get a job at the diamond mine, making easy money, two weeks in, two weeks out,’ – a different kind of lifestyle.”
- An additional challenge is finding Aboriginal staff willing to work in their own communities. They want to avoid situations where they know boundaries are difficult to maintain and where they are expected to adhere to cultural practices that may conflict with professional expectations. A nurse practitioner working with a southern Ontario First Nation explains: “It’s hard on people in the community to talk to someone they grew up with or their neighbour.” A mental health professional from Nunavut said workers “are related to half the people in the community, so it’s difficult for a local person to be direct [in curbing expectations].” Hiring appropriate workers to meet the needs of specific client groups was even more difficult. Talking about her experiences, the manager of a southern Ontario women’s program said: “It’s tough; we have two counselling positions open, because we aren’t willing to fill them with just anybody – we want to fill them with Aboriginal women because that is who our clients are.”

2.9.7. Problems Retaining Community Mental Health Staff

- The demands placed on community mental health staff also made it difficult to retain workers. As a consultant from the Northwest Territories commented, communities often expected that local professionals and paraprofessionals “need to be available 24/7 ... and that’s hard.” Excessive demands contribute to job stress and turnover. A mental health worker from southern Ontario describes how her organization “had about six or seven people turn over” in just four years. Another mental health worker from an Ontario First Nation recounts her personal situation: “I had to go on sick leave ... there was just too much burn out, too many people knocking at my door, even at home, [at] all hours of the night, saying ‘can you help us, our daughter is trying to kill herself’.” Speaking of remote communities, a Newfoundland program manager said: “Most don’t last long; usually less than a year ... they burn out trying to deal with community expectations.”
- Lack of mental health qualifications put community workers at a disadvantage. As a program manager from central Ontario stated: “There’s certain people that have some training and other people that have no training or little training, so the training is inadequate for the needs.” Aboriginal mental health workers, for example, often had not been given opportunity to acquire needed counselling skills: “They have a lot of experience, they know their community very well, but they often do not have a basic training” explains a respondent in a management role from Quebec. Recounting an example from northern Ontario, an administrator said, without needed clinical training, workers do not stay long: “This person had no training and was in over her head. She recently quit, I think, because she didn’t know what she was doing.”

2.10. *Summary*

There is a degree of uncertainty about the mental health needs of Ontario's Aboriginal population, just as there is about the size of that population itself. But this is only because no *exact* epidemiological and demographic measurements have been taken. Nonetheless, a complex array of Aboriginal-specific mental health programs exist, sponsored and delivered by the federal and provincial governments, often in collaboration with Aboriginal organizations.

Still there are gaps in services, difficulties for clients being transferred from one level of care to another, and restrictive eligibility requirements that exclude some individuals from particular programs. The known incidence of certain events, like suicides, is compelling evidence that the mental health needs of Aboriginal Ontarians are great and still unmet in every type of care environment, whether found in an urban, rural or remote setting. One major reason for this is the lack of mental health workers who are properly prepared, both clinically and culturally, to look after Aboriginal clients. Crisis care is usually managed adequately; the real consequences of the shortages become clear when it comes to preventive or follow-up care. Often there is none and clients tumble back into states of crisis.

Given the now recognized importance of cultural awareness and local familiarity, it is not surprising that care models involving informal and/or traditional providers are preferred by clients, whether they are youth¹¹⁹ or adults.¹²⁰ Recruitment of mental health workers of Aboriginal heritage is challenging for a number of reasons, however. Many do not want to work in the very communities where they have the greatest advantage of cultural familiarity – their own – because of the challenge they face maintaining boundaries between their personal and professional lives. The stressful nature of the work and unrealistic demands placed on them, compounded by the lure of other jobs, causes high turnover. There are also structural barriers that restrict the number of Aboriginal hires in mainstream organizations; these include the clinical training and accreditation required, as well as hiring restrictions created by union agreements or mandatory language rules in some work places. So, although recruitment of more people of Aboriginal heritage into care giving roles is widely seen as a solution to a major dilemma --clients avoiding mental health care because of their discomfort in a culturally insensitive system of care – it is not happening yet for various personal and institutional reasons.

3. ***CULTURAL COMPETENCE AND ACCESS TO CARE***

Culture is recognized as a major determinant in the health of Aboriginal Canadians,¹²¹ in part because of its influence on the care they receive.¹²² As for any minority population,¹²³ culture plays a vital role in their mental health, not only in terms of how it is understood, but how people respond to it.¹²⁴ Their cultures shape Aboriginal people's perceptions about what constitutes a deviation in mental health,¹²⁵ and incorporate beliefs that limit the applicability of standard assessment procedures.¹²⁶ These factors, in turn, may influence their interaction with the health care system in ways that undermines the quality of care they receive, a phenomenon common to minority groups.¹²⁷ It is known that Aboriginal Canadians access care less effectively and that they are more intimidated by the health care system.¹²⁸

Consequently, a deep understanding of socio-cultural factors affecting the delivery of health care is essential – in both the practice and policy spheres – to overcome the chronic disparities experienced by Aboriginals.¹²⁹ This chapter explores the notion of cultural competence – what it is, how it affects access to care, and how the health care system and individual care providers can ensure that it becomes a considered part of Aboriginal mental health care in Ontario.

3.1. ***The Need for Cultural Competence***

The likelihood of therapeutic exchanges being positive is enhanced if professionals are able to understand and interpret behaviours according to their patients' cultural frame of reference.¹³⁰ This capacity translates as respect for the inherent worth, uniqueness and dignity of the individual.¹³¹ Its acquisition is the result, not only of professional training and front-line experience, but the innate personal characteristics of the individual providers themselves.¹³²

This need has led, recently,¹³³ to widespread calls for the development of what is commonly called cultural *competence*^{134 135 136} or cultural *safety*^{137 138 139} on the part of health care practitioners, settings and systems. However, there are many definitions of the term *cultural competence*. Some are worded in a straight forward way, such as the following: “the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”¹⁴⁰ But the most frequently cited definition is stated in more complex language: “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.”¹⁴¹

While both systemic characteristics and individual behaviours are encompassed in most definitions,¹⁴² greater attention is paid to the latter, with an emphasis on interpersonal communications and respect for diversity.¹⁴³ Although rooted in concerns about appropriate health care for members of ethnic or racial minorities, cultural competence is now a consideration for other cultural minorities, too, like those whose identity is based on sexual orientation or religious affiliation. The elements that constitute cultural competence for specific populations, including Aboriginals,¹⁴⁴ have yet to be clearly delineated, however.¹⁴⁵

The lack of consensus about terminology is reflected in uncertainty about approaches and their effectiveness.¹⁴⁶ However, Branch and Fraser¹⁴⁷ categorized the techniques usually suggested as follows: (1) interpreter services; (2) recruitment and retention policies of minority staff; (3) training; (4) coordinating with traditional healers; (5) use of community health workers; (6) culturally competent health promotion; (7) including family and/or community members in care-giving; (8) immersion into another culture; and (9) administrative or organizational accommodations. Each is meant to address some aspects of the culturally-based disparities in health care that are seen as a by-product of the diverse, often conflicting values and beliefs found in multicultural societies.

Attitudinal shifts are occurring, however, and these are increasingly reflected in formally stated professional expectations.¹⁴⁸ For example, the importance of cultural competence is recognized in College of Nurses of Ontario practice standard respecting therapeutic nurse-client relationships.¹⁴⁹ Indeed, the need to comply with new legislative, regulatory, and accreditation mandates is now driving adoption of appropriate programs and practices.¹⁵⁰ Another consideration, perhaps more the case in the United States than other places, is fear about liability or malpractice claims over the failure to provide culturally appropriate care.¹⁵¹ Certainly, help in finding

information about traditional healing and culturally acceptable care is increasingly available; for example, a recent paper outlines Internet sources of information on these issues in reference to Native Americans.¹⁵² Other resources, such as the Canadian Collaborative Mental Health Initiative's "Pathways to Healing: A Mental Health Guide for First Nations People," contain practical information to assist consumers, family caregivers and health care providers in understanding Aboriginal mental health issues, cultural contexts, and holistic approaches to care.¹⁵³

3.2. *Absence of Culturally-Appropriate Care*

Aboriginal people who are discriminated against or otherwise marginalized in our society also tend to need,¹⁵⁴ but be ill-served by the mental health care system.¹⁵⁵ Moreover, most cannot remove themselves from situations that trigger their mental trauma.¹⁵⁶ Because they are doubly stigmatized – both for their mental health condition and a second reason, like their race – many do not seek or fully engage in treatment.¹⁵⁷ Relatively recent reviews of the situation among American Indian and Alaska Natives document how stigma is manifest in mental health care, now and in the past.^{158 159} These observations underscore the findings from an earlier report where Alaskan providers from various disciplines talked about their difficulties interacting with clients from a population characterized as being alienated, distrustful and in despair.¹⁶⁰

The absence of culturally-appropriate care is grounded, at best, in a lack of knowledge and ethnocentrism among the dominant majority; at worst, it manifests racism or other forms of prejudice.¹⁶¹ Australian research papers are often quite blunt about the need for cultural competency in mental health practice and the inadequacy of cultural competence training in that country.¹⁶² For example, Fredericks (2006) states that in some cases cross-cultural awareness training is not sufficient; what may really be needed is anti-racism training.¹⁶³ Regardless of the country involved, it is thought that relatively few care providers actually reflect on how actions, even well-meaning ones, might "diminish, demean or disempower the cultural identity and the well-being of the individual."¹⁶⁴ Rather, the goal is to fit all patients into the accustomed care paths and practices, unmindful of the impact on the client or their ultimate compliance.¹⁶⁵ At a system level, health care institutions are sometimes reluctant to introduce programs that would foster culturally appropriate care, due to the financial and time investment required for their implementation.¹⁶⁶

3.3. *Cultural Barriers to Accessing Care*

There was consensus, among those interviewed from Ontario, the other provinces and the territories, that Aboriginal people found mainstream health care organizations intimidating and, as a consequence did not seek care until they were in crisis. Several factors contributed to the reluctance to access care, including feelings of stigma and shame, language differences, communication styles, and a lack of understanding of traditional care practices. Respondents offered numerous examples of the ways in which cultural factors can affect Aboriginal people's willingness to access care:

3.3.1. Stigma and Shame

- Stigma, shame and fear are the most significant cultural barriers to accessing mental health services. A front-line provider from Thunder Bay states: "If we look at the word mental health from the client's perspective, sometimes they feel ashamed of it because it's been stereotyped. People need to realize that it is a sickness." The stigma also means that families and communities are sometimes reluctant to support people who have mental health problems. As a worker from Kenora said, "They are just not comfortable dealing with [it] or they are not ready to deal with it." Managers in Manitoba reported similar concerns: "They are often ostracized from their own community; there is a big stigma involved with accessing [care]." A consultant from Nova Scotia observes "there is still an unwillingness to identify, self-identify or identify a family member of having a mental illness."
- The terms used to describe mental health in some First Nations and Inuit dialects have very negative connotations which discourage people from seeking care or coming back for follow-up. A manager from Nunavut, for example, said that the term mental health worker means someone who "works with people who have no brains, or works on heads." The administrator of a northern Ontario Aboriginal mental health service addressed this issue by renaming the program: "I don't call it mental health problems anymore because they all associate it with schizophrenia and sending you off

to the hospital.” Similar approaches were employed by a southern Ontario program manager, who recommended saying “you just need help, mentally, the way your judgment is and your decision making.”

- The stigma of having a dual diagnosis, mental health along with addiction problems, made Aboriginal people doubly reluctant to access care. A manager from northern Ontario says clients would be more willing to access care “if we were more comfortable as a community around some of these mental health, substance abuse, and addictions issues.” Another Ontario worker feels youth with addictions are especially sensitive to “the stigma, the shame, the guilt, the secrecy of what you are using and how often and where.” A mental health worker from Toronto saw a need to acknowledge that “addictions and mental health are inseparable; they are part and parcel of the same problem.” He added it was important “to get the professionals and people to understand that and not be afraid.”

3.3.2. Concerns about Confidentiality and Privacy

- Concerns about confidentiality and privacy were a serious barrier to care, particularly in small Aboriginal communities, where everyone knows everyone else and keeps close watch on what is happening. As a northern Ontario worker observes, “Some clients are fearful of even using the phone to call a mental health worker because the receptionist will know.” A central Ontario outreach team manager points out that, if you are walking into the health centre on the day the visiting psychiatrist is in town, everyone knows “you’re going for therapy.”
- Aboriginal clients are equally concerned that consultations are not always private, because clinics are short of space. “They’ve come to know what they say can be heard the next day; they don’t trust or they don’t want to readily share with anyone in the First Nations, because they know somebody is going to say something about it” observes an Ontario case manager. Confidentiality problems in the past also discourage people from accessing care. As a worker from a remote Ontario First Nation says: “I sit here in my office, sometimes

all day and I know there are problems out there. A long time ago things were not confidential; they still think it is still not confidential.”

- Fear that families will find out if people go to local mental health services is an equally serious deterrent. A southern Ontario program administrator states: “An Aboriginal person may not use a native service as they may have family working there.” An administrator from Alberta makes a similar observation: “They don’t want their families to find out.” A front-line supervisor from the Northwest Territories remarked this barrier was most prevalent in smaller communities, where people knew the local workers were likely related to them “in ten different ways.”

3.3.3. Trust Issues

- Lack of trust in providers is seen as a significant barrier to accessing care. As a worker from northern Ontario explains: “There are trust issues; if people don’t trust you, they won’t work with you, so we try to ... build relationships where they trust us to help them.” Trust issues may be the reason why some Aboriginal clients are unwilling to approach Aboriginal organizations for care, suggests a manager from Ottawa: “Where there has been no confidentiality kept, where everybody knows their problems, where they’ve been ridiculed or ashamed or even forced off the reserve because of their illness, they don’t have that trust when it comes to their own people.”
- Trust issues are magnified with non-Aboriginal providers because, in the words of a Saskatchewan program director, many non-Aboriginals “don’t understand, don’t have the history, and don’t really get it, basically, in terms of Aboriginal people.” As the director of a mental health program in eastern Ontario commented, mainstream providers often have limited “understanding of intergenerational impacts [and] the trauma Aboriginal people have experienced.” Providers might not understand that clients from communities which have a past history of child welfare issues, for example, have difficulty sharing family problems because they are scared that their children will be taken into care. A front-line

provider from a northern Ontario First Nation reports, “there are always reports done on the family or whatever, and I know that people are scared of that and that’s why they don’t come and say I need help for this.” A counsellor working in Alberta recommends that these issues be addressed early: “They have to be able to trust you. They give you a little bit of information and they watch you to see if you can handle it and how you respond. Are you judgmental? Are you helping? Are you trustworthy? Is this someone I can open up to?”

3.3.4. Language Differences

- Although many Aboriginal people speak English, a significant number are most comfortable using their traditional tongues to convey their concerns and feelings. Language and dialect differences, however, create care challenges, even for Aboriginal providers. A manager in an Inuit organization in Ottawa said: “Even though I’m Inuk, I don’t speak Inuktitut, so if I was providing counselling or anything like that, there’s still a barrier.” An urban Aboriginal mental health worker from northern Ontario had similar experiences: “Cree and Ojibway are totally different languages; that could be a barrier too because some words in Cree are bad in Ojibway and vice versa, so you just have to be careful.”
- Generational differences in use of traditional languages also impeded willingness to access care. As a worker from a remote Ontario First Nation observes: “there’s a language barrier between adults, elders and youth.” She adds that youth who “only speak English” are not willing to approach “older mental health counsellors” who prefer to speak traditional languages. Conversely, elders “who speak their first language first” are not comfortable talking to younger counsellors who often speak “mostly English.” Another worker from a northern First Nation suggests that elders “who only speak Ojibwa, they wouldn’t even apply” for help with mental health problems.

- Interpreter services are used, but even with the best of interpreters, the meaning of words and phrases can be lost. A manager from Nunavut explains: “It’s not always the best because as good as the interpreters are, and we have some excellent ones here, you lose something in the telling of the problem.” Another set of challenges is created when local people are used as interpreters: “The question of language is very problematic because even if you have local people who can act as interpreters, these interpreters are criticized.” This interviewee, a program manager from Quebec, adds that involving local interpreters may discourage use of services, because “clients do not want interpreters to know their problems.”

3.3.5. Cultural Differences

- Aboriginal clients will not use mainstream mental health services in which they lack confidence and may avoid programs that have an inherent cultural bias toward a medical diagnosis and treatment model that does not recognize needs for holistic care. A mental health administrator from rural central Ontario shares his perspective: “It is very much a medical model and it’s very focused on clinical treatment and it may not address what an Aboriginal person is looking for, the spiritual types of treatment.” Similar observations were made by a Manitoba program director: “We meet the clinical needs, but we do it in a western way.” Traditional belief systems see the mental and physical aspects of a person as inseparable. An Elder involved with a mental health program serving First Nations in the mid-north stated, “you work with the whole person; you don’t take anyone apart because you might not be able to put them back together.”
- Clients may also be reluctant to access care for fear that their communications will be misunderstood by non-Aboriginal providers. A program manager from Thunder Bay observes differences in the way sentences are structured and delivered: “I can see some of the turn-taking; it isn’t English turn-taking because the pauses are longer, or cuing, meaning ‘now it’s my turn to speak,’ looks different.” A director from Prince Edward Island observes non-Aboriginal providers also did not understand the cultural

differences that shaped communication, “what’s the normal communication, in terms of personal space and what they talk about and don’t; what’s taboo in their culture.” Aboriginal clients may not be comfortable discussing personal problems or mental health concerns, for example, although their unwillingness to do so may determine what care they receive. A manager from Ottawa says, for example, that his Aboriginal clients “tend not to be very vocal about things that are bothering them; so if a person is experiencing depression, it’s not normal cultural practice for that person to talk about what’s depressing them.”

- Non-Aboriginal mental health professionals, trained to be cautious with humour for fear that it be misunderstood, had difficulty understanding that humour could be healing for their Aboriginal clients. A northern Alberta manager said: “We hear from any of our clients, ‘I wish our therapist will lighten up once in a while!’ And from Aboriginal people we see that there is gentle humour, when people smile and when you know humour is present, you know we are in a good place.” As front-line Aboriginal worker in Thunder Bay pointed out, humour properly applied and appreciated, was a valuable tool in delivering mental health services to Aboriginal people: “You gotta use humour all the time. Anishnawbe are always [joking]. That helps a lot of the time in working with them.”

3.4. Strategies for Overcoming Cultural Barriers to Care

Those interviewed in Ontario and the other provinces and territories gave some concrete examples of strategies that could be used to enhance cultural competence in mental health services, providing suggestions similar to those made in the literature. Their observations speak to four broad areas of knowledge vital to meeting Aboriginal people’s mental health needs: understanding their history, traditional practices and behavioural patterns, as well as their present life situations; acknowledging their preferred styles of interaction and communication and being flexible about service delivery:

3.4.1. Understand Aboriginal People's Past and Present

- Understanding Aboriginal people's past was viewed as a key to understanding their present situation. A front-line Aboriginal worker from Quebec felt that First Nations and Inuit clients experience "the problem of not being understood in our culture." Many non-Aboriginal professionals lack knowledge of historical issues, such as residential schooling and its devastating multigenerational effects on Aboriginal communities and individuals. A program coordinator from a northern Ontario First Nation discusses the interconnectedness of the collective and personal experiences: "Drug abuses, sexual abuse [now] arise from what happened [in the past]." Another front-line supervisor from the Yukon says "the history of abuse in First Nations communities translates into people that are oppressing and abusing each other [now], so there is a low trust in the communities for each other."
- Aboriginal professionals and paraprofessionals also need opportunities to work on personal issues from their own past to be healthy and successful in caring for clients. An Aboriginal worker serving several northern Ontario First Nations comments that some workers are "absolutely not well at all, they are depressed themselves, really wounded from long ago; they haven't dealt with that, so how can you help someone else when you haven't helped yourself?" As a manager from Quebec emphasizes, "The training of these workers should include an evaluation of themselves and their own family in the healing process. We have to be resistant and healthy to work with suffering people."

3.4.2. Acknowledge the Importance of Traditional Practices

- Combining western and traditional practices can be an effective way of delivering mental health services. A front-line mental health worker from a northern Ontario outreach program serving Aboriginal communities believes that "First Nations are now at a point where they can receive both of them and understand both of them and see good components from western philosophy and traditional practices of healing." Recognizing the value of both, a

number of programs strive to have either option available or, ideally, to provide services that integrate the two. The challenge for providers, as a Parry Sound worker notes, is “bridging both worlds – you can’t be in one or the other entirely anymore – it’s simply impossible.”

- Involving Elders and including traditional teachings in the renewal of their spiritual health and mental well-being is very important to many Aboriginal people. They want to reconnect with their heritage as an integral part of their healing journey. Because of this, programs in various locations across Canada now use elders as advisors and include sweat lodges, legends, the medicine wheel and ceremonies rooted in local tribal customs as a central part of care.
- While the importance of having cultural elements in mental health programs is widely recognized, uncertainty may exist about the specific content to include. An administrator from the Yukon points out: “There is a lot of controversy of what is First Nation, if sweat lodges were a part of the culture here or Christian traditions.” A Saskatchewan specialist makes similar observations: “There is also a cadre of Aboriginal people who did not live traditional lifestyles, who are Christian by background and don’t want sweat lodges or any traditional services.” An Alberta supervisor notes difficulty of identifying which Elders are appropriate for particular communities, “Christian or pre-Christian traditions.”
- Making a choice among mainstream or traditional Aboriginal services can be a dilemma for urban Aboriginal people. A manager for an urban southern Ontario service explains: “just because they are native, you can’t specifically herd them off to a native agency; if they are born in an urban centre, they may feel comfortable using non-native services.” A manager working in an Alberta hospital feels that mainstream organizations frequently make the error of assuming that “all the Aboriginal people have the same sort of needs.” He continues: “We also have a lot of people that come through the doors and say, yeah, I’m Aboriginal, but that is not how I want to approach this.” As a Manitoba Aboriginal worker reminds, diversity must be respected: “Aboriginal people are many, many people – we are different but so connected.”

3.4.3. Recognize Aboriginal Communication Styles Are Different

- Mainstream agencies and non-Aboriginal providers need to recognize and accommodate Aboriginal communication styles. The manager from a northern Ontario mental health program, for example, reports her agency found that Aboriginal clients would not answer private questions “over the phone” so they had to switch to workers doing “in home visits” to gather needed information. “Face to face” communications were more culturally appropriate. A southern Ontario city-based worker discussed a strategy he uses to connect with urban Aboriginal people who were mistrustful, to slowly bring them out of their shell: “We were just talking, we were cooking and it just looked like we were chit-chatting. So we would talk about healing, we would talk about abuse, we would talk about education, we would talk about culture, we would talk about protesting, we would talk about anything that was native or cultural oriented and, little bit by little bit, they started coming around, they started asking questions.”
- Aboriginal clients also had different expectations about the amount of “time” that should be taken for a consultation. A non-Aboriginal community mental health worker from southern Ontario area said: “Your time is not their time; I learned that I can’t book one or two hours; I have to be flexible with that.” A social worker serving central Ontario First Nations uses similar strategies: “I tend not to make appointments – just go ahead and visit, do what I have to do.”
- Attempts to establish boundaries within the provider-client relationship, moreover, can be interpreted as rude, because “boundaries are set in a very different way” in Aboriginal communities. Aboriginal clients, for example, sometimes have an expectation that outreach staff will share something of themselves during “visits” in order to “make connections” with clients. A nurse practitioner working with southern Ontario First Nations emphasizes: “You have to share a bit of yourself, if you’re going to get anywhere.” A manager from Alberta also recognized the value in opening yourself up a bit in order to develop a relationship with Aboriginal clients: “Take the time in meetings to connect with

people. That is the balance between formal and informal; people will have to let down their barriers a little bit in order to form those relationships.” A northern Ontario professional agreed that time spent in First Nations communities, talking with people “having tea and bannock,” is well worth the effort, since it strengthens relationships and makes it easier to provide care.

3.4.4. Be Flexible About Service Delivery

- Flexibility on the part of the service providers is an essential element in the provider-client relationship. Aboriginal people often want to access services on an immediate basis; they do not want to make an appointment for a week later, when the urgency of the issue may have dissipated. A manager working in a central Ontario First Nation community explains that many people do not understand that crisis services are limited in the types of care they can provide: “If you are suicidal they usually put you in quickly, but you could wait there up to 48 hours [for non-crisis care] and a lot of people have left, they walked away.” An administrator in Nunavut reports similar problems encouraging clients to follow-up: “They come and see you until they are feeling better and then when they are feeling better, even though they can benefit by follow-up and what have you and they’re like – ‘why should I come, I’m feeling okay now?’”
- Several administrators gave examples of the ways their organizations have adapted to accommodate Aboriginal peoples’ preferences for more flexible care. A manager for an Alberta hospital explained that “no shows” for scheduled appointments need to be understood: “There are many things that affect Aboriginal people ... transportation issues, family issues, whatever, and so we encourage people to keep the clinical file open a little longer and to be a little more accepting of inconsistencies.” Another mental health program administrator in Nova Scotia abandoned scheduled appointments and “strict no-show policies” in favour of a more flexible system that accommodated Aboriginal clients’ needs: “Follow up and outreach works better.”

3.4.5. Hire Culturally-Competent Staff

- Many of the interviewees felt that ideally, they would prefer to ensure cultural competence by hiring Aboriginal staff to deliver services to Aboriginal communities. Some organizations had done so, creating positions for Aboriginal elders, interpreters and cultural support workers. An Alberta program specialist noted that having Aboriginal staff “makes it more accessible for Aboriginal people ... they seem to connect easier, they take the information easier from that person and they are quite appreciative of the support they receive.” A director from British Columbia explains how Aboriginal liaison workers help clients navigate the mental health care system: “We are using people that are living and knowing their culture to ensure that their people are well looked after.” There are, however, few Aboriginal mental health workers and those which are available are in high demand.
- While having Aboriginal staff is preferred, non-Aboriginal staff can provide appropriate services as long as they are culturally competent. “All or most of the frontline providers in First Nations communities that I have met are not [Aboriginal but they have] credibility within those communities as mental health workers” in the opinion of a mental health worker from Cape Breton. Non-Aboriginals who have “experience and life cultural competence” can be very effective. Truly culturally competent non-Aboriginal professionals, however, are difficult to find; as a Quebec manager said: “in terms of specific knowledge of Aboriginal programs and Aboriginal culture, I would say, not many are more than superficially aware.”

3.4.6. Provide Aboriginal-Specific Information during Orientation

- Professionals exposed to general cultural sensitivity training often do not understand how subtle cultural differences impact interventions. From the perspective of an Alberta manager: “Cultural sensitivity training can be very broad-stroked and it can be superficial and it can gloss over ... the differences between an urban Aboriginal population and a reserve population.” Aboriginal

organizations try to bridge the culture gap by giving specific information during employee orientations. A First Nations counsellor from Nova Scotia reports: “We ask professionals we work with to respect the cultural values to be aware of the social and psychological implications that arise when people are confined to reserves and to understand our socio-economic situations.”

- Several informants, however, acknowledge the difficulties of providing adequate cultural competence training for non-Aboriginal staff. A southern Ontario health administrator, looking at her own staff, acknowledges “except for a front-line NNADAP worker, as far as the rest of us, [we have not had] any specialized training at all” on the topic of cultural needs. A program director from British Columbia admits: “We haven’t done a good job of training our mental health staff on Aboriginal issues.” He adds that some progress is being made: “It’s something that we have pushed hard on and health authorities have taken steps ... [so] that issue is much more addressed.”

3.4.7. Ensure Consistency in Care

- Recruiting people who are committed to the work and the place of work is vital --Aboriginal mental health can’t be just a job, with the motivation of just a paycheque. An administrator from the Yukon said the goal is to hire people who are “really committed, their families are here, and they live here.” The director of a British Columbia program says the ideal candidate for a front-line mental health worker position is “an individual who’s already well-linked in and has worked for the band for many years.” Finding such workers and retaining them is a key to program success. In the words of a manager of a Nunavut program: “You need consistent people, [otherwise] ... you may go back to square one [when people leave], rather than following on a continuum [of care].”
- Retaining service providers is suggested as a principal way to improve care. As a northern Ontario front-line worker reports, constant staff turnover “affects the client and understanding the client’s needs because ... the continuance of treatment is not always

there.” A program director from northern Alberta has similar experiences: “When people change frequently [clients] don’t engage with them at all, so when people stay on for a long time that’s who they engage with.” An administrator from Quebec reports: “People come but they do not stay long. Problems are heavy; and the network needs constant stabilization because of the high turnover in First Nations communities, [so] the professional life expectancy is very short.”

3.4.8. Support Front-Line Workers in Aboriginal Communities

- On the issue of employee retention, there was widespread agreement that supports need to be in place to alleviate work related stresses. A coordinator from Quebec says: “If there is no support system and no possibility of relieving some stress, people just quit and the community has to start back from scratch.” A program supervisor for First Nations in central Ontario emphasizes needs to respond to stress promptly: “Our workers are traumatized on a daily basis because of what they have to walk in to, so I make sure they get treated for vicarious trauma.”
- Managers also had to understand cultural differences in work styles. As a Thunder Bay administrator said: “There’s a cultural piece ... how they view time, how they ask for time off ... looks very different than what the system and the structure allows.” Mental health workers also require a degree of flexibility in managing their case loads, to accommodate their client’s concerns about privacy and confidentiality. As a northern Ontario First Nation provider said, some are willing to take phone calls at home, make home visits, do counselling in their own homes and to put themselves on-call for extended hours: “We don’t come into work until 10:00, that gives people that don’t want to come to the office because ... other people see them and it’s like ‘oh they must need help or oh they are in trouble.’ ... So what we do is we stay home ‘til around 10:00 a.m., so if they want to come to the house they do and if they want to phone you they will.”

- Differences in how time is perceived, how policies are viewed and how work schedules are negotiated, however, may be difficult to accommodate within organizations. Funding formulae tend to be structured around scheduled appointments, with dollars to direct clinical care. A northern clinician underscored the difficulty in accommodating more flexible work styles, because the trend was to use caseloads and client contacts as a basis for funding: “The most negative thing about it ... is that they don’t have prescribed, monitored tasks ... that’s a disadvantage for me ... because I do all the reporting ... it’s all computerized and in the future, funding will be based on what you do.”
- Funding formulas often fail to account for culturally competent best practices. One participant from Thunder Bay who delivers services specifically to women reports that such programs are not funded for childcare, despite the fact that providing child care is identified as a best practice in the delivery of services to women. “You can’t offer a women’s program without considering that they are the primary caregivers of children.” As a result she spends time fund-raising to have childcare available so women can access their services. Time invested in fundraising effects other operational aspects of the organization.

3.4.9. Consult With Communities and Clients about Services

- Consulting with communities is a best practice identified by many of those interviewed; to be effective, however, it has to be done at a “pace that is not really fast.” Taking the time to visit an Aboriginal community, getting to know the people that live there, and learning about the struggles they face, all build trust and are important parts of service delivery. On this subject, a program director from Kenora said: “Listening to community members is extremely important they need to be able to say how they want services delivered.” Front-line staff from Parry Sound also reiterated the value of community consultation, advising: “If in doubt, consult with people; ask them what their preference is.”

- Consultation with Aboriginal communities, families and clients reinforces respect and ensures that plans of care are effective. A community worker from northwestern Ontario sums up: “You go into a community and you respect that community where they are at and you help them from there.” A supervisor from the Northwest Territories emphasizes that consultation makes providers aware of the strong family and friendship “connections” which are one of the strengths of Aboriginal communities. An employee of a mental health agency in Alberta says: “Different people see the world in different ways and we have to be open to mutual goal setting and involving the client in his or her own therapy.”
- Consultations often result in partnerships with health care clinics, schools and other community service agencies and, thus, more effective service delivery. A front line worker from northern Ontario said: “We have a pretty good team here, we work with the school, and we work with social services and health and share what we know.” A manager from a government agency in Quebec reports that consultation also improves communication among service providers: “We work to make relationships, partnerships, to make agreement protocols for the transmission of information so that it is more fluid.”
- A provider from the Yukon also attests to positive benefits from developing outreach care in consultation, which is “a really useful way to provide services.” Partnership formation, however, is challenging, as an Alberta manager points out: “We don’t have a funding system that encourages various Aboriginal agencies to actually work together it creates a system that gets people against each other and makes it more difficult for folks to feel comfortable to work as a group and not [feel that] their own mandate or ability to carry on their services [is threatened].”

3.5. *Summary*

Cultural competence – the ability of health care organizations and providers to deliver services that meet clients’ social, cultural and linguistic needs – links in important ways to health care access for Aboriginal Ontarians. Mental health providers need a deep understanding of the way cultural factors shape clients’ experiences and decisions with respect to their health.

Some concerns are shared in common with non-Aboriginal clients, like issues of confidentiality and establishing trust. Others overlap to a certain extent. Stigma, for example, is a cause for anxiety widely associated with mental health, but there is often an additional burden for Aboriginal clients rooted in their cultural group’s beliefs about mental health deviations. As well, there are factors that are uniquely linked to Aboriginal cultural groups; holistic conceptions of well being are one example, and the limitations imposed by terminology, as well as language comprehension, are others.

A number of strategies are proposed to move mainstream mental health care workers toward greater competence in terms of Aboriginal cultures. These include: understanding the collective history of colonization and oppression; acknowledging the value of traditional medicine; and recognizing differences in styles of communication. There are also ways of adjusting service delivery, allowing for greater flexibility for clients, as well as providing Aboriginal-specific orientations and on-the-job supports to those on the front-line.

4. TRAINING FOR CULTURAL AND CLINICAL COMPETENCE

The need for cultural, as well as clinical competence in the domain of Aboriginal mental health is ultimately addressed through education. While intuitively obvious, perhaps, this statement immediately brings to mind two questions. On one hand: how do you attract Aboriginal people – who are assumed to have cultural awareness already – to the field, and encourage their success in clinical programs? On the other hand: how do you train non-Aboriginal clinicians to provide culturally competent care? This chapter addresses both questions in turn. It starts with the issue of recruiting more Aboriginal people into mental health, because this is widely seen as *the* solution to the cultural competence issue. The section includes an overview of relevant professional and paraprofessional programs available in Ontario that are specifically intended for Aboriginal students. Then the chapter addresses the second question, looking at factors to consider in preparing all providers to take account of their clients' heritage when giving care.

In 2004, the federal government announced plans to spend one hundred million dollars over five years to train Aboriginal health professionals.¹⁶⁷ This commitment came nine years after Canada's Royal Commission on Aboriginal Peoples called for intensive efforts to increase the Aboriginal presence in the nation's health work force to 10,000 in ten years,¹⁶⁸ a ten-fold increase. It is anticipated that increasing the presence of First Nation, Inuit and Métis in these roles will foster more culturally competent care and increase their people's willingness to access health services.¹⁶⁹ Of course, while recruiting practitioners of Aboriginal heritage might ameliorate the extent of cultural misunderstandings, this is not guaranteed.¹⁷⁰ Individuals may – or may not – know their own tribe's traditions, but if they opt to practice in other tribal areas might be unfamiliar with local beliefs and customs, like any outsider. Nonetheless, this massive recruiting and training effort, currently unrolling in Ontario, as it is elsewhere in Canada, underscores the timeliness of the two questions posed.

There are no comprehensive assessments of health human resource issues pertaining to Aboriginal care in Ontario.¹⁷¹ Most of the available literature looks at recruitment issues, documenting the negative effects of turnover, and problems of accessing specialist care.¹⁷² Only two sources examine successful health human resource initiatives.^{173 174} And issues surrounding Aboriginal health human resource funding levels, while mentioned frequently, are not explored in depth.¹⁷⁵ With respect to mental health specifically, the focus is on health professionals, especially nurses, who are responsible for primary care delivery in northern First Nations.^{176 177} Relatively little attention has been given to Aboriginal health human resources affecting off-reserve rural and urban populations, including Métis and other non-status Aboriginal people.¹⁷⁹ Only a few articles examine physician preparation,¹⁸⁰ support for family physicians in mental health practice with Aboriginal clients¹⁸¹ and the need for Aboriginal psychiatrists.¹⁸² Other professions have generally been neglected; while several studies discuss general needs for Aboriginal psychologists,¹⁸³ for example, none were specific to Ontario. Some material does look at the use and educational preparation of paraprofessionals in the province.^{184 185}

4.1. *Aboriginal Mental Health Education in Ontario*

A scan was done to find out what training relevant to mental health practice with Aboriginal clients is available in Ontario.^{186 187 188 189 190} It revealed that mental health, *per se*, is not the sole focus of any one program; but a diverse group of preparatory and continuing education programs do address the topic to varying degrees. Worth noting is the number of programs offered through cross-sector partnerships, especially between community colleges and Aboriginal education institutes. Also significant is the extent to which distance education options are incorporated into the mode of delivery, thus enabling community-based mental health workers to upgrade their qualifications with minimal disruption to their employment.

4.1.1. Paraprofessional Programs

Although there are no specific programs designed to prepare Aboriginal students for the field of mental health, there are a range of paraprofessional training programs that give students skills which can be applied in mental health settings. Most are delivered through partnerships between Aboriginal education institutes and community colleges. Some programs offer instruction via distance education

directly to First Nations communities when numbers are sufficient to warrant doing so.

There are six programs in Aboriginal Community Health, also known as Community Services Worker, Indigenous Community Development programs. These two to eight semester programs are designed to train individuals to develop and administer health and human services programming within First Nations or Aboriginal communities. Four are offered by colleges (Confederation, George Brown, Georgian, and Sir Sanford Fleming) and two are offered conjointly with Aboriginal organizations (Confederation/Oshki-Pimache-O-Win, George Brown/Aboriginal Health Centre of Toronto). All incorporate work placements as an integral part of the program.

Students wishing to work as front-line mental health workers can take cultural counselling preparation. Also known as Aboriginal Healing and Wellness Worker, Drug and Alcohol Counsellor, Indigenous Wellness and Addictions Prevention Worker, or Mental Health and Addictions Worker Programs, these two-to-four semester programs prepare workers to develop, coordinate and deliver community health initiatives, such as family violence prevention and crisis coordination. Culminating either in a post-secondary certificate or diploma, such programs are accessible through three colleges and one Aboriginal education institute (Canadore/Seven Generations, Confederation, and Sandford Fleming). The Native Education and Training College in North Bay, a non-profit First Nations career college, also offers Healing and Wellness Counsellor, Social Services Worker, and Youth Worker Programs, which are delivered upon request.

Aboriginal Social Services Worker Programs, including Native Human Services, Native Social Services, Native Child and Family Worker, or Native Youth Worker Programs, prepare students to deliver community-based mental health supports to children, youth and adults. These programs, typically two years in length, are currently available at six locations (Cambrian, Confederation/Oshki-Pimache-O-Win, First Nations Technical Institute/St. Lawrence, George Brown, Sault College, Sir Sanford Fleming, Native Education and Training College). Three of the programs (Oshki-Pimache-O-Win, First Nations Technical Institute and Native Education and Training College) offer distance education options. In many cases, programs are accredited and graduates are eligible for registration as Social Services Workers.

It should be noted, although not unique to Ontario, that concerns exist about the lack of standardization in the curricula offered by various paraprofessional programs ostensibly covering the same area of specialization. Moreover, there are limited options for accreditation and certification.^{191 192} These concerns are emerging as workplace issues because employers are increasingly conscious of their liability for any actions taken by employees.

4.1.2. Professional Programs

Professional programs directed towards Aboriginal students or containing extensive Aboriginal content, are available in the Human Services and Nursing fields. Aboriginal Human Services programs, leading to a BSW degree, are available at five universities (Carleton, Laurentian, Toronto, Ryerson, and Wilfred Laurier). To ensure that programs are directly accessible to learners in First Nations, the Carleton and Laurentian programs have been offered via distance education in partnership with Indigenous teaching institutes (Moose Cree Education Authority and Seven Generations, respectively).

Ontario's Nurse Practitioner Program, which has Aboriginal content and reserved spaces for Aboriginal learners, provides advanced practice education for baccalaureate prepared nurses. Jointly offered by nine universities (Lakehead, Laurentian, McMaster, Ottawa, Queen's, Ryerson, Western, Windsor and York), the program leads to extended-class certification. Graduates work in primary and acute care settings, including Aboriginal health access centres; First Nations health centres on-reserve; provincial community health centres; mental health services; and acute care settings. Post-graduate certificate programs in mental health for RNs and RPNs also are available through nine community colleges (Canadore, Centennial, Conestoga, Durham, George Brown, Humber, Mohawk, Niagara and Northern College). Although none of the latter is specific to Aboriginal mental health, all contain modules on mental health interventions for special populations.

Some Aboriginal-specific mental health initiatives involve workplace training. These sessions are delivered in time-limited workshops, rather than as a course of instruction requiring attendance over an extended period. This makes them more accessible to Aboriginal and non-Aboriginal mental health and addictions service providers. Recent examples include: the Ontario Federation of Indian Friendship Centres' "Health Advocacy Initiative on Mental Health Services and the Mental Health Act;"¹⁹³ the Centre for Addictions and Mental Health's "Continuing

Professional Education Session on Suicide and Aboriginal Peoples;"¹⁹⁴ and the Ontario Centre for Health Promotion's "Summer School on Mental Health Promotion with First Peoples."¹⁹⁵ The Métis Nation of Ontario has also announced a partnership with Providence Care and Queen's University to provide training in suicide intervention and non-violent crisis intervention for mental health workers across the province.¹⁹⁶

4.2. *Aboriginal Recruitment to Mental Health Practice*

Educational programs across health disciplines actively court individuals of Aboriginal heritage. For example, a major Canadian report on Aboriginal nursing¹⁹⁷ calls for increased enrolment of Aboriginal students in programs at the undergraduate and graduate level; needs to which the country's schools of nursing are trying to respond.¹⁹⁸ Some offerings, such as the Native Nurses Entry Program at Lakehead University, are designed to support Aboriginal learners in gaining entry into health professions.¹⁹⁹ Others, like the Ontario's *Grow Your Own Nurse Practitioner* initiative, are designed to increase the pool of Aboriginals in an advanced practice role, among other objectives.²⁰⁰

Increasing the involvement of Aboriginal people in the health sciences depends on two complex processes: *encouraging their interest* and *supporting their education*. While significant efforts are being made on both fronts, they pale against the magnitude of the health human resource gap. For example, although the numbers have since increased by a few, a 2004 enumeration found just 16 Aboriginal-identified medical students and only 12 practising physicians in Ontario, where ideally there should have been at least 375 of them.²⁰¹

Our interviewees had a great deal to say about the factors influencing Aboriginal people's career choices and those that determine their success as students. Respondents who participated in this study, in Ontario and elsewhere, shared their thoughts about what impedes or facilitates interest in health careers among Aboriginal people, as well as the barriers experienced by Aboriginal students in accessing and completing mental health education programs, as well as the strategies which might be used to overcome these constraints:

4.2.1. Preparational Barriers

- Students of Aboriginal heritage have a lower high school completion rate than those from the general population across Canada and this is viewed as a major barrier preventing them from entering mental health careers. “Very few children graduate from high school; very few go on successfully to complete post-secondary education,” according to a person interviewed in Parry Sound. Aboriginal students who are poorly prepared during their early years of education also tend to leave school once they reach higher grades in order to avoid the stress and frustration of failure. A front-line service provider from a remote northern Ontario First Nation, talking about students who go south after grade ten to finish high school, observes: “They seem to fall behind in the first year, first semester ... they sneak out and they say it’s too hard ... instead of saying I don’t understand [and asking for help].”
- Lack of family and peer support discourages Aboriginal students from completing their education. Their parents often have little formal education themselves, so it is difficult for them to help their children with school work. A manager working in Ottawa states: “They don’t get the one-on-one support in the maths, the sciences ... areas where the parents can’t help them.” Lack of peer support was identified as another barrier by a front-line service worker from a northern Ontario First Nation. He feels students: “aren’t being successful because they are getting taunted from other community members that don’t want to see them get ahead and try and hold them back.”

4.2.2. Perceptual Barriers

- The stigma surrounding mental health acts as deterrent for Aboriginal people in selecting mental health careers. A front line worker from a rural community in southern Ontario explains: “Some people think you [must] have a mental health issue if you go into the field.” Other Aboriginal people may be discouraged from a mental health career because of the many challenges that are associated with it. A program manager in the Parry Sound area

believes: “Fear is a recruitment barrier. ‘What will I have to do? How do I handle conflict of interest in the community?’” Such uncertainty quickly translates into disinterest.

- Some people may feel that mental health work, in the Western sense of counselling, is antithetical to Aboriginal cultural norms. An Ottawa manager says: “The idea of sitting at a desk and talking to people and counselling ... is not high on their list [of desirable occupations].” Troubled personal histories can also be a deterrent to choosing mental health careers. A counsellor from Alberta comments: “Having to look at themselves is very traumatic and it is hard to push all that stuff aside and then look at a job that deals with these sorts of issues ... it’s hard.” Recruitment efforts need to focus on the many positive aspects of a career in mental health to overcome the fear and negativity.

4.2.3. Career Demands

- Difficulties and demands of a mental health career are an additional barrier to recruitment. A social worker from Thunder Bay shared her personal experience: “My daughter told me that she would never be a social worker because of me looking burnt out and never being able to enjoy things. We are so overloaded as social workers. That is a barrier – people don’t want a career like that.”
- Mental health workers providing outreach services to rural and northern areas often do extensive traveling as part of their work, which can be strenuous. A rural worker in the north explains “yeah, the hours are very, very long and we are on the road a lot.” A city-based program director also notes that: “the area is underpaid, so mental health workers need better pay.”
- In rural and remote areas, especially on reserve, there are limited or no mental health services for the workers themselves to access. In the field of mental health, debriefing with a trained professional is very important for maintaining workplace health. Nor is there support for an employee with mental health concerns of their own. An employee working in a rural area in southern Ontario points out

that: “There was no EAP for us; like if you are suffering from a mental health crisis; you are not going to talk to your colleagues who then have an ethical obligation to [report the person to their regulatory college]. There is nobody around that you can actually confide in.”

4.3. *Encouraging Careers in Mental Health*

When natural helping skills are recognized in Aboriginal people, they should be encouraged to consider a career in mental health. A number of people believed that working in the mental health field is a gift or a calling and that Aboriginal people who have this gift need to use it. They also need to be supported by family and community to follow a mental health career:

4.3.1. Supporting Career Choices

- Natural helping skills were often viewed as a gift or a calling. As a northern Ontario mental health program manager said, “There are certainly First Nations people who are gifted, and when I say gifted, they are gifted with the ability to learn and understand the person’s body and mind and where it comes from.” An Aboriginal mental health worker from Ottawa summed up this belief: “All my life [people] felt relaxed in coming to me and telling me their problems. I was born to do this, I don’t mean to sound egotistical, but that was my direction in life, I’ve always known in some form or fashion I was going to help people.” She added, “I believe there are a lot of people out there with that gift.”
- Some Aboriginal people do not recognize the strengths they possess, so need extra support for their career choices. A worker from a northern Ontario community shares her observations: “Aboriginal people have a lot of barriers within themselves. We judge ourselves harshly, you know. We look at something and think we can’t do it.” She felt people need to be sustained in their choice of a career: “You got to have strong support [from] family or a counsellor that really

believes in you because it's a struggle, a big struggle when you don't have the support." Another mental health provider who worked with First Nations said: "If gifts are recognized, parents or grandparents or the family members should mould that child to be a success in that particular area."

4.3.2. Ensuring Awareness

- Positive role models are believed to be an effective way to encourage Aboriginal people in their education and career choices. A front-line worker from Kenora gives an example: "We did local success stories young people going to college. And we had posters made and sent out to different communities." There is also a need to identify community role models – youth and adults – to encourage people to think positively about their options. An interviewee from Quebec suggests role models ideally should demonstrate "the desire to work, to be able to get our life together and maintain our commitments." On this subject, a Métis administrator from eastern Ontario recommends Aboriginal organizations should: "Highlight people that are successful. You have to build pride in your culture. When people see that, they see the possibilities for themselves."
- One difficulty in recruiting Aboriginal students is a general lack of career guidance. A counsellor working at a southern Ontario college concludes: "There's no guidance on how to obtain a mental health provider's career." Interviewees feel that career guidance should be started early, ideally while students are in their first years of high school. An administrator from eastern Ontario emphasizes that high school career recruitment materials should also address students' fears that they cannot qualify for post-secondary education: "Aboriginal people don't feel [they will ever qualify] to go off to college or university. The confidence isn't there; it seems like too big of a leap."
- Promotional materials for Aboriginal mental health careers, however, are generally not available. In the opinion of a career counsellor from southern Ontario, "There's a lot of promotion for programs like nurses and personal support workers, but not for

mental health that I know of.” A counsellor from a mid-northern Ontario rural area reinforced this message: “A friend of mine went to a job fair and said, ‘I didn’t see anything that would attract First Nations’.” Recruitment strategies also need to ensure that students living on reserve can participate. “When there is a career fair off-reserve, there is nobody here to take the kids or sometimes it’s not even advertised out here so we don’t know” explains a worker from a road accessible northern First Nations community.

- Job shadowing, mentoring, and apprenticeships are all effective ways of providing exposure to the mental health professions. An interviewee from Parry Sound suggests: “Internships would be a good one; give people more job-shadowing opportunities and give people a chance to explore a career.” A program manager from Ottawa sees a need for “videos and advertising materials targeted at First Nations people” that would accurately demonstrate the realities of mental health work. A northern Ontario mental health worker thought that “apprenticeship programs” with links to recognized educational programs would be beneficial for the communities. Aboriginal organizations also need to make sure that youth are aware of the mental health career opportunities which become available near their home communities. Otherwise, as an Aboriginal program manager from Toronto remarks: “many of our young people leave the reserves, go out and do find success [but] they can’t go back home, because there are no positions there.”

4.4. *Aboriginal Training for Mental Health Practice*

Many Aboriginal learners face a cluster of barriers to successful completion of a program of study in mental health at the college or university level. Important among these are inadequate academic preparation; for example, poor reading comprehension accounted for higher first attempt failures during the foundational years of medical education at the University of Manitoba.²⁰² Other factors include family commitments and financial hardship,²⁰³ lack of academic supports,²⁰⁴ discrimination²⁰⁵ and fear of community rejection.²⁰⁶ The last mentioned concern continues for those who graduate, a feeling that their education alienates them from their heritage, making them unwelcome at home.²⁰⁷ Several of these factors may co-

exist for a given student, with each one magnifying the effect of the others,²⁰⁸ to a point where they overwhelm the person's ability to concentrate on their studies.

Moreover, the academic world is often alienating, seen as committed to a single way of learning and to constant evaluation (which is experienced as criticism or attack).²⁰⁹ Students find little or no support for their cultural identity,²¹⁰ and the well-being and life experiences of Aboriginal peoples are largely invisible in the curricula studied.²¹¹ As is true for students from other racial minority groups,²¹² instructors fail to acknowledge indigenous students' individuality and classroom peers fail to understand their different world view, leaving them feeling isolated and forced to cope on their own.

The literature suggests ways to overcome most of the inhibitors identified, from adequate financial and academic supports²¹³ to improving faculty awareness.²¹⁴ For example, the Pika Wiya Learning Centre in South Australia offers social, cultural, practical and emotional supports to help indigenous students in health related courses.²¹⁵ Some proposed measures focus on changing attitudes among the non-Aboriginal students, thereby creating an atmosphere of tolerance within the learning environment.²¹⁶ However, personal success may also depend on adaptation on the part of Aboriginal students themselves. An analysis of American Indian graduates of a baccalaureate nursing program over a ten year period found that an ability to adjust to the dominant culture, as well as the roles of student and nurse, were key enablers.²¹⁷

4.5. *Barriers to Entry and Completion of Education*

The issues interviewees identified as affecting entry into, and completion of, programs in mental health actually pertain to post-secondary education for Aboriginal people in all fields of study. Moreover, in the case of young people from northern First Nations who must leave their communities for any education above grade ten, the issues often apply to the upper grades of high school as well. This fact is of particular concern because it involves the years when strong foundations for advanced study are normally laid. Aboriginal students who must relocate for education often have difficulty coping with culture shock; they also experienced difficulties in locating funding supports and programs that provide needed cultural competencies:

4.5.1. Coping with Culture Shock

- Many Aboriginal students, particularly those from remote First Nations, must leave their home communities for high school and post-secondary studies. Culture shock occurs on a number of levels, at school, in the residences where students board, and in the larger communities. As a counsellor from a northern Ontario First Nation says, “to take Aboriginal kids and put them in a non-Aboriginal school or home when they are used to everything being Aboriginal – it’s such a culture shock.”
- Students who must relocate to urban centres also face the loneliness and isolation of being away from their families and home communities. A counsellor with a southern Ontario community college explains that these students are doubly disadvantaged: “[They are] isolated from their families and they are not used to the face of urban living.” Similarly, a program manager in Kenora reports: “I’ve had kids that told me: ‘I got so lonely [in the city] I came home’.” At the same time, parties, where alcohol or drugs abound, are a distraction that can quickly become a disincentive. A front-line worker in a remote First Nation observes: “There are kids that have gone away and tried to go to school [but] when they end up in the big world and find out there is lots of booze out there and parties, school becomes less important.”
- Educators and administrators must make an effort to understand the cultural challenges which Aboriginal people face in post-secondary institutions. Students from traditional homes often have difficulty fitting into non-Aboriginal school environments, because their upbringing teaches them that questioning is disrespectful. A manager from Ottawa concludes: “If you were raised up north and you were raised not to bring up questions, not to question things ... those are barriers.” Failure to understand cultural barriers results in situations like the following, related by a southern Alberta supervisor: “So I take a look at the Aboriginal folk that were shy, dealing with complex and probably unfamiliar material, and would probably have been able to offer really rich conversation based on their own experiences, but I never heard a peep and they eventually melted away and never completed the course.”

- It is imperative that Aboriginal students have access to personal and educational supports within the education system itself. In the words of a manager from Quebec, those responsible for program delivery cannot concentrate only on the academic content, but must “integrate support and assistance.” Post-secondary education programs, for example, should provide opportunities for Aboriginal people to do some personal reflection, to make sure that they are personally healthy before they begin to practice. An Aboriginal mental health worker from Ottawa believes: “In order to work in addictions/mental health, you have to be of the nature to look in yourself, to identify your history, your emotional history, your mental history, you have to look at your own abuse issues and that’s hard to do.”

4.5.2. Encouraging Aboriginal Staff to Continue Their Education

- Encouraging Aboriginal staff to continue their education was a priority. Some respondents felt that resources should be put into training highly-skilled professionals. Otherwise, as an Aboriginal worker from southern Ontario warns, there are potential dangers if inadequately prepared staff counsel clients: “It’s all well and good to have a cultural component, but if you don’t know how to intervene properly, you’re hurting and harming more than you’re helping. I’ve heard from my own clients that damage has been done [by] somebody thinking that they were the ultimate counsellor.” She thought that masters-level preparation in social work or psychology should be required for a counsellor position.
- Given the length of time required to prepare professionals and the level of unmet needs, other interviewees saw value in putting additional resources into training front-line paraprofessionals. Sharing his opinion, an Ontario First Nations worker said: “There are so many people that can do great things with people that need the services and they don’t need to have [training as psychologists and psychiatrists] ... I think they should spend a little more money on the front line workers instead ... that would be excellent.” Having educated front-line staff is important when it comes to advocating for clients within the larger health care system. One

northern Ontario program manager said: “[In] a case conference I want my staff to be able to sit there and make demands for our people; I want them to say ‘we need this for this person.’ You can’t do that without education. You have to sit there as an equal.”

4.5.3. Finding Funding

- An important barrier for Aboriginal participation in post-secondary education is a lack of funding. First Nations and Inuit organizations, which control funding for status individuals, have limited amounts available for education, so they have to make difficult decisions about which students to support. As a nurse from southern Ontario observes: “Some give priority to students coming out of high school, so mature students don’t always get the funding.”
- Other students may lose their funding part way through their education. A worker from a First Nation community near Sudbury explains: “I know a few people that have started to go to school and their bands pulled the funding.” In addition, according to a program manager in Ottawa: “When people [go] outside of their region for any length of time, they can become disqualified for funding.” Secure funding was needed to ensure that students could complete their programs.
- Non-status and Métis people do not have access to the post-secondary education funding that is available to status First Nations and Inuit people, making it more difficult for them to go on to advanced studies. A manager working with Métis across Ontario explains: “People are below the poverty line so there isn’t the [personal] money for education and people aren’t even thinking about those kinds of things.” She continues: “There hasn’t been the opportunity for Métis people to go for education. Virtually no funding has come from the federal government [to] Métis people for education.”

4.5.4. Finding Childcare and Other Supports for Mature Students

- Mature students face their own set of challenges, because many of them return to school after they have started families. On this subject, an Alberta program manager says childcare is a major concern: “There are an awful lot of single moms who are kind of regrouping in their lives and trying to get training and also trying to raise families ... [they need] access to readily available safe babysitting arrangements or childcare.” An interviewee from Thunder Bay, who teaches social service worker courses, reports that some of her older Aboriginal students from remote fly-in communities “had to go back home; they couldn’t finish because they were taking care of other things.” Mature students also may need extra academic support because they find it difficult “after being out of school for a long time,” in the opinion of a program director from an Ontario First Nation.

4.5.5. Finding Culturally Competent and Accredited Programs

- Paradoxically, Aboriginals, like all other students in professional health science programs can graduate without sufficient cultural competencies. An Aboriginal person in Manitoba notes: “You can go to university and learn all the clinical skills you need but you come out and you don’t have any of the Aboriginal cultural stuff. It’s really hard for a lot of Aboriginal students because [their education] is all focused on getting the academic part, but there is no spiritual part and Aboriginal people believe in the spirit of the person.”
- A manager from Manitoba shares her frustrations around an Aboriginal counselling program that is offered at a post secondary institution in her region. She feels that this is an excellent program and provides students with the necessary tools to counsel Aboriginal people but the course is not accredited. Consequently, she is not able to hire graduates from the program.

What, then, is the answer to our first question: *How do you attract Aboriginal people to the mental health field, and encourage their success in clinical programs?* The barriers on both fronts are clearly recognized; some are structural, some systemic and some personal. They are also of considerable magnitude. Ways of overcoming many of these barriers are recognized, too, although not necessarily applied extensively, judging by the fact that the barriers are still pervasive. Nonetheless, substantial efforts are being made to attract Aboriginal students into the health sciences, as is evident in specialized programs available in all parts of Ontario.

4.6. *Ensuring Non-Aboriginal Mental Health Providers Are Culturally Competent*

The other side of the cultural competence coin is reflected in the second question: *how do you train non-Aboriginal clinicians to provide culturally competent care?* This is a matter of growing interest and concern. Although cultural competence is not yet widely adopted in educational programs, or as a universal standard of professional practice,²¹⁸ in both spheres it is increasingly seen as essential²¹⁹ and deserving of recognition in the certification and accreditation processes.²²⁰ This is reflected by the number of accreditation bodies or professional associations that already have, or are now establishing standards in this area, along with supportive educational materials.^{221 222 223} To facilitate meeting the new standards, tool kits have been developed,²²⁴ as well as assessment guides for individuals²²⁵ and organizations.²²⁶

These reflect the conceptual models for transcultural care that have emerged; some are relatively simply and elegantly stated,²²⁷ while others give up in comprehension what they gain in comprehensiveness.²²⁸ One model referenced by others is that of Campinha-Bacote; it treats cultural competence as an ongoing process in which the care provider constantly integrates new cultural awareness, knowledge, skills, encounters and desires.²²⁹ Weaver succinctly summarized the knowledge, skills and values or attitudes that are the essence of culturally competent services to Aboriginal people according to Native American helping professionals:

Important areas of knowledge were identified as: (1) culture, (2) diversity, (3) history, and (4) contemporary realities. Important skills included: (1) generic helping skills, (2) containment/listening skills, and (3) culture

specific skills. Important values or attitudes noted were: (1) being open/non-judgmental, (2) valuing diversity, (3) helper wellness, (4) willingness to learn, (5) social justice, and (6) caring.²³⁰

These elements were identified in the context of the United States, but they mirror the observations made in the literature from Canada, Australia and New Zealand, as well as those of other American studies. To address cultural concerns, it is best for clinicians to blend their discipline-based knowledge with ideas drawn from clients, traditional healers and the community at large, gained through meaningful consultation or participatory interaction.^{231 232} For this to happen, however, the providers must appreciate and respect their Aboriginal partners' contributions.²³³ A non-judgemental mindset is the one core attribute that students and practitioners see as key for cultural competence, regardless of discipline.²³⁴ Indeed, the extent of consensus on this point is considered to be striking.²³⁵

Much work remains to be done before professionals have a solid empirical basis on which to found their cross-cultural care.²³⁶ Epidemiological mental health research for Aboriginal populations is under-supported, in part because of difficulties associated with acquiring scientifically valid data.²³⁷ Moreover, the introduction of cultural competence into professional standards is relatively recent, so the affect on actual practice is unknown. For example, in New Zealand the Nursing Council adopted a set of guidelines in 2002 that reflected existing rhetoric within the discipline, but there is no evidence as to their impact yet on outcomes of care.²³⁸ Initial evaluations, however, suggest that the introduction of training standards can produce improvements in the process of care, which by implication, should produce positive outcomes.²³⁹ Training programs in cultural competence are new, however, so the longer term effect on patient care is unknown.²⁴⁰

The literature is replete with discussions about – and recommendations for – achieving cultural competence or, in the words of one observer, ensuring that providers: “know what they need to know.” The following sections summarize the main thrust of the arguments and rationales offered.

4.6.1. Combining Traditional and Western Approaches

Traditional values influence the behaviour and worldview of Aboriginal people in fundamental ways.²⁴¹ In particular, their concepts of health and well being are shaped by beliefs about ecological and spiritual harmony, and the importance of

natural remedies.²⁴² Combining these ideas with western approaches to mental health,²⁴³ is seen as a promising approach to treatment for at least two segments of the Aboriginal population considered at highest risk, young people²⁴⁴ and the elderly. Regarding the latter, a Canadian study cautioned against the use of many conventional cognitive evaluation tools, because their content is not culturally informed and may be irrelevant.²⁴⁵ Even using more appropriate open-ended interviewing techniques does not ensure that non-verbal cues are recognized for their importance.²⁴⁶

The practitioner must be aware of their own belief system and how adherence to it can affect the care they provide.²⁴⁷ For example, nurses working in isolated northern First Nation communities, in most cases outsiders, have to be cognizant of their “other” status while quietly building relationships of trust.²⁴⁸ Reflective self-awareness is seen as an essential foundation for cross-cultural clinical practice.²⁴⁹ ²⁵⁰ Yet, Canadian preparatory programs in the health sciences – even those specifically oriented to northern practice – do not address this issue to any extent.²⁵¹ Instead, the curricula concentrate on developing the clinical skills that will be required in more isolated settings, where a greater range of competencies is expected.²⁵²

Australia currently has several initiatives underway to address specific concerns or areas where cultural, social and clinical knowledge deficits have been identified. For example, the Northern Territory has developed a comprehensive orientation program for physicians about to commence working in remote Aboriginal communities; it covers a wide range of topics from clinical procedures to cultural safety, but also deals with self-care and the delineation between practitioners’ professional roles and personal lives.²⁵³ Of course, such supports need to be sustained once physicians are practicing.²⁵⁴ Service providers in the territory also expressed a lack of confidence in their ability to assess, treat or prevent relapses of mental health conditions in indigenous patients; this uncertainty is being tackled through the creation of care plan training packages and improved relapse prevention activities at health centres in the region.²⁵⁵ Similarly, in Western Australia a distance education program in mental health is available for nurses, allied health and Aboriginal health workers, which has been evaluated positively.²⁵⁶ And in New South Wales, the government is supporting a mentorship program for novice mental health nurses to facilitate their entry into rural practice. ²⁵⁷

4.6.2. Improving Communication Skills

Good communication, in terms of both language familiarity and cross-cultural awareness, is a health care requisite.^{258 259} Aboriginal people in Ontario who are not comfortable communicating in English or French may experience delays or disruptions in their care, for example, through missed appointments, and be less compliant to care regimens that they do not fully understand. This has been found to be the case elsewhere.^{260 261} Reliance on translators from the community or family members may not help, if patients are unwilling to share information they consider private in front of “known” others.²⁶² Language aside, a failure to understand socio-cultural communication differences on the part of the caregiver contributes to dissatisfaction among clients, who in turn exhibit poor adherence to their plans of care and, so, have poorer health outcomes.²⁶³ It also adds to the stress that health care providers’ experience.²⁶⁴

From a practical perspective, good communication skills are an essential part of clinical mental health counselling. A Canadian survey of nurses employed in First Nation communities and hospitals underscored the importance of this, noting mental health as one area where counselling skills could be improved.²⁶⁵ Similarly, an Australian survey found many caregivers working with Aboriginal mental health clients felt inadequately prepared to provide counselling or overseeing medication use.²⁶⁶ Even basic skills like taking a history could be refined, for example, if providers had knowledge of the Aboriginal client’s extended kinship ties or other cultural issues.²⁶⁷ A Canadian study found that the quality of exchanges between physicians and their First Nations patients could be improved if physicians were made aware that communication and trust in physicians was affected by the First Nations client’s previous experiences. Cited as a specific example was the sense that interviews were not of sufficient duration for them to really be “heard.”²⁶⁸

4.6.3. Developing Appropriate Cultural Curricula

As indicated earlier, efforts to achieve cultural competence largely focus on targeted education initiatives, both to prepare individuals entering practice and to provide continuing learning for those already working in the health care field. One consideration in the educational sphere²⁶⁹ or, indeed, in the development of any ameliorative programs or services, is making sure that the intended consumers have a voice in their design.²⁷⁰ Community-level participation increases the likelihood that the initiatives are relevant and, possibly, sustainable.²⁷¹

Given the relative recency of widespread interest in cultural competence, it is not surprising many providers report that no attention was paid to the topic during their initial education.²⁷² Institutions of higher learning acknowledge that this deficit persists in their professional programmes^{273 274} and recognize the value of incorporating the required knowledge.^{275 276} Moreover, cultural competence training must extend across the career path, from novice to expert.²⁷⁷ There are numerous examples of special training initiatives internationally.^{278 279 280 281} A review of program evaluations for 34 such interventions found encouraging results; there was evidence that cultural competence training improves the knowledge, attitudes and skills of health professionals, which meets with positive client feedback.²⁸² But, a recent review specific to mental health care was more guarded, concluding that the evidence with respect to the effectiveness of such training is limited and requires further evaluation.²⁸³

There is a debate within the literature about the level and type of cultural information necessary to adequately prepare people for work in Aboriginal communities. Australia's Queensland Transcultural Mental Health Centre takes the position that detailed knowledge of a particular culture is not necessary in order to provide culturally competent care, as long as a caregiver knows how to work across cultures generally, and has access to information about the cultural group whose members they are treating.²⁸⁴ With reference to psychotherapy, Lo and Fung²⁸⁵ concur that a generic understanding of how to conduct cross-cultural therapeutic encounters is vital, but they also argue that a more profound grasp of a specific client's culture is required for successful therapy. For example, while manifestations of psychopathology can be the same across cultures, standard psychiatric conceptual frameworks may be of limited use in understanding Native Americans' construction of mental health and illness, depending on their assumptions about the relationships between mind, body and spirit.²⁸⁶ Generally, the need to combine generic and culture-group specific knowledge is recognized by most disciplines.²⁸⁷

But there is a danger in practitioners assuming that all members of a broad cultural group share the same beliefs.²⁸⁸ Among Aboriginal peoples, for example, there is considerable variation from one tribal group to the next, and even between generations within a given group, so practitioners have to consider each client's subjective experiences of their particular culture.²⁸⁹ Simplistic, broad generalizations about a whole group can reinforce stereotypes,²⁹⁰ and undermine an appreciation of the socio-political factors that contribute to Aboriginal people's differential access to health services.²⁹¹ Practitioners need to recognize the influence of relational factors, like racism and the political climate of the day.²⁹²

There are also debates among educators and First Nations as to whether Aboriginal content should be threaded throughout a curriculum or presented in the form of separate and distinct learning modules.²⁹³ Whichever strategy is adopted, faculty must be prepared and comfortable delivering the cultural content.^{294 295} In Ontario's nurse practitioner program, Aboriginal case studies that could be used in a flexible manner were developed. However, it was left to the instructors to decide how – and, indeed, whether – they would be introduced in class. Uptake varied, but was quite low overall because most instructors did not feel entirely comfortable with the material or confident in discussing and answering questions about it.²⁹⁶

Those charged with curriculum development in health sciences programs face a particular challenge – trying to fit Aboriginal health, among a number of psychosocial topics, into course loads already crammed with other vital subjects like disease aetiology, diagnosis and treatment.^{297 298} Consequently, cultural content is often covered through didactic offerings rather than in ways that allow skills to be honed by practice and feedback.²⁹⁹ The same principle applies for continuing education; learning that occurs outside a practice context is difficult to sustain and apply.³⁰⁰ Ideally, a portion of the students' training will take place in an Aboriginal setting, so they are aware of the clinical and non-clinical realities.³⁰¹ First hand exposure to the considerable challenges – and great rewards – of practicing in such environments encourages students to consider them as a career destination.³⁰²

4.6.4. Developing Collaborative Professional-Paraprofessional Practice

Despite the compelling reasons for collaboration, between disciplines as well as by professionals and paraprofessionals, all too often health care teams fail to function as *teams*; rather each individual operates within the bounds of their own specialty.³⁰³ This uni-disciplinary phenomenon is not unique to Aboriginal settings, but is common where a shared philosophy and policies supporting integrated mental health services does not exist.^{304 305} Practitioners learn as students to place a high value on their discipline's contributions, which by default may diminish in their minds the knowledge that others possess.³⁰⁶ For instance, individuals from different disciplines see theirs as the one taking the lead role.³⁰⁷ Therefore, it is not surprising that they are often ill prepared to work in interdisciplinary teams.^{308 309} In practice, while they understand their own roles, they do not think that their roles are understood by others.³¹⁰ Nor, all too often, do they appreciate the skills of those from other specialties.^{311 312} In the context of First Nation communities, the lack of appreciation of one-another's roles is the root of many barriers to effective teamwork.³¹³ Writing in

reference to psychiatric care in underserved areas of northern Ontario, DuBois, Nugent and Broder argue that it is important for members of the team to have confidence in one another and to recognize that individuals have “equal but different expertise.”³¹⁴

This lack of role awareness can undermine relations between Aboriginal paraprofessionals and professionals from outside the community, most of whom are non-Aboriginal. Because they do not fully appreciate the scope of paraprofessionals’ job descriptions, for example, nurses in northern First Nations may ask them to act as translators, ignoring the fact that the Mental Health Worker or Community Health Representative has their own clinical and health promotion responsibilities.³¹⁵ Similar complaints are found in Australia.³¹⁶ This was recently characterized as a “pattern of negative collaboration” that is so endemic it threatens implementation of that country’s Mental Health Strategy in rural and remote areas.³¹⁷ Indeed, it has been suggested, just as nation-wide reconciliation over the abuses that occurred during a history of invasion and colonization is needed, reconciliation within the workplace is required between indigenous health workers and their professional colleagues.^{318 319}

4.7. Lessons Learned About Enhancing Workplace Cultural Competence

The experiences of mental health care managers and providers illustrate the points made in the literature. Interviewees in Ontario and other jurisdictions talk about the integration of traditional and western practices, while acknowledging certain issues where cultural specificity is of paramount importance. Discussions centre around the need to balance cultural and clinical competence, learning how to work together, acquiring Aboriginal-specific clinical skills, and, at an organizational level, supporting cultural competence:

4.7.1. Provide Clinical Skills Training for Community Mental Health Workers

- Many of the interviewees believed that there was a need for ongoing clinical skills training for community mental health workers. Front-line providers and managers mentioned several specific areas for

clinical skills improvement, including information about crisis management, medications, and supportive services for individuals with a range of mental health conditions. Staff of Aboriginal heritage who is working in community mental health roles, for example, may have excellent cultural competence, but have not had the opportunity to acquire needed clinical skills. An Ottawa program director reported that at her agency: “We hire sometimes, not based on people bringing skills and training in their field, because there just aren’t many people that have that. However, there are a lot of people that have an interest; they have their own experience, their own understanding, and their own personal qualities that can be developed with training on the job.” At the same time, as a Nova Scotia mental health supervisor commented, agencies have to be aware of “issues of liability” if community workers are not “as well-rounded clinically as they need to be.”

- Given the shortage of workers who have the necessary clinical skills and cultural competence, on-the-job training and employee development strategies are widespread. An administrator from British Columbia prefers to hire Aboriginal staff that have “worked for their band for many years” then support them with educational leaves, tuition reimbursement, and flexible hours to upgrade their clinical skills. A manager from northwestern Ontario uses a comparable approach: “Culturally we are all right but you are not going to find both, so you take what you have and you make up for the rest and train them and send them to conferences, do case conferences and things like that” to enhance their clinical knowledge.
- A Thunder Bay clinic encourages staff members to return to university while maintaining their employment: “If we have someone working in the agency that wants to go back to school, I will bend over backwards to give them flex-time to support them.” The manager believes strongly in the importance of post-secondary education for Aboriginal staff. “I’m not willing to say to my clients, ‘you don’t deserve well educated people to help you.’”

4.7.2. Teach Aboriginal-Specific Clinical Skills

- Both Western mental health practices and Aboriginal healing models need to be taught in post-secondary mental health programs. Imagining what integrated Western-Aboriginal training might look like; a direct care program manager from Parry Sound says the need is for: “some sort of Rosetta stone if you will, that would sort of translate one model into the other.” Mental health professionals also need to learn the cultural bias inherent in certain types of widely-used diagnostic tools. A manager overseeing children’s services from Thunder Bay notes that standard tests are “not adaptive to Native culture.” Applying the same logic, a mental health worker from a Toronto-based program remarks that clinicians can only interpret test results appropriately with Aboriginal clients if they thoroughly understand each client: “You can’t apply that to the Aboriginal population you have to know the patient’s history, so I have to be aware of what I know and who I’m dealing with.”
- All care providers, Aboriginal and Non-Aboriginal alike, need to understand the backgrounds of their clients. A manager of an Alberta hospital said, regarding emergency room care, that staff needed to understand that Aboriginal clients “would typically have their family with them, they might have an elder with them, and other people participating” and to “take the identified patient away from their supports” would go against Aboriginal cultural norms. He added the goal is training staff “about what’s more culturally appropriate to make services more accessible.”
- Additional learning needs included how to manage care for First Nations and Inuit people with status who received care from both federally and provincially-supported services, to avoid breakdowns in continuity of care. As the health adviser for a remote Ontario First Nation reminds, they needed to understand “the communication problems, the reporting, and the background experiences of the counsellors, and also the case management.” Otherwise, community providers “can easily forget somebody that went out for counselling.” Another manager of a northern mental health program said, the need is to learn “how best to support someone and the opportunities to do things in a lot of different ways.”

4.7.3. Develop Culturally Competent Workplace Supports

- Cultural competence policies and workplace training initiatives are essential ingredients in creating and sustaining successful mental health programs for Aboriginal populations. The representative of a mainstream Ontario mental health program describes their commitment to maintaining a culturally competent environment: “We have a policy and we have a diversity statement that recognizes Aboriginals as a very distinct group so it’s educating people within the organization and it’s educating people outside the organization. There’s a lot of trust, honesty, respect and learning from each other.”
- Cultural competence training, however, had to be repeated at regular intervals, to ensure that newly-hired employees were kept fully informed. “We spend a lot of time trying to educate as well ...external agencies and people working in the field and often there is turnover in staff; you do it once and six months later there’s new staff so it’s an ongoing issue” was the experience of an Ontario Aboriginal agency which offered training to mainstream providers. Resources were limited, however, so sometimes there was a mismatch between the workshops available and provider needs. As a mental health worker from northern Ontario said: “You might get a workshop on grief, a workshop on suicide intervention, a workshop on residential abuse ... the same level repeated and repeated and repeated.” He saw benefit in developing additional “workshops on different levels [for example] on post-trauma ... to get improvement in knowledge and skill.”
- Organizations serving rural and remote communities, moreover, sometimes could only access continuing education *via* distance education on the Internet or telehealth networks. Speaking about northern regions in general, a Nunavut program director emphasizes “professional development is one area that’s difficult to access and achieve in the north unless you are motivated to get on the Internet.” Remote First Nations in northern Ontario also offer telehealth case conference sessions for community mental health workers on a regular basis. As well, Ontario’s Métis communities are developing mental health continuing education to be delivered *via* telehealth across the province.

- Some organizations sponsored locally developed and delivered training sessions to enhance cultural competence. Alberta program managers, for example, “[do] basic training on Aboriginal cultural awareness” through a variety of approaches. These include half-day workshops guided by “Aboriginal cultural helpers” where “clinical scenarios [help staff to] identify situations of oppression.” Other health and social service agencies open Aboriginal-led training sessions to the broader community, allowing both Aboriginal and non-Aboriginal providers to benefit. As a frontline provider from northern Ontario emphasizes, non-Aboriginals “need to be trained by First Nation people.”

4.7.4. Offering Community-Specific Cultural Training

- Providing cultural sensitivity training through occasional workshops or in-service training sessions alone was not generally believed to be effective, unless provision is made for follow-up. A respondent from Nova Scotia states: “There needs to be something else because if it is not followed-up with regular contact it can’t influence people’s attitudes.” She adds that cultural sensitivity training is only effective if staff is given opportunities to practice what they have learned through “regular exposure to individuals from other cultures.”
- Some interviewees believe that cultural training should reinforce the message that each First Nations person is unique and each community is different. A coordinator from a northern First Nation community says: “A lot of times professional agencies will just assume that they will be able to understand the culture of other areas, where this isn’t the case. Every individual community is different, everybody has different boundaries a different way of doing things.” A representative of an Ottawa organization notes that cultural training for mental health professionals and paraprofessionals should go beyond the general to include cultural specifics: “Some things might be perceived as mental illness when it really is just the way [Aboriginal people] do things.”

4.8. *Summary*

Aboriginals and non-Aboriginal mental health caregivers locate somewhat differently in relation to the matter of cultural competence. It is assumed, albeit sometimes mistakenly, that the former group have the required knowledge. And, even if they do not know about a given tribal group's traditions, they fully understand the importance of culture as a determinant of health. What they lack, more often, are essential clinical skills. For their part, non-Aboriginal professionals must learn to apply their specialist knowledge within a framework partially constructed from their Aboriginal clients' experiences and cultural expectations. The common link in either case is education.

Recruiting more people of Aboriginal heritage into careers in mental health is generally seen as the ultimate way of fostering more culturally competent care and increasing Aboriginal people's willingness to access services. Ontario's Aboriginal education institutes, community colleges and universities offer training at several levels in the health sciences and related fields; although none focus exclusively on mental health, graduates are prepared to take on various roles in delivering mental health services. A number of barriers stand in the way of student success, however. These include inadequate academic preparation, family commitments, financial hardship, lack of academic supports, discrimination and fear that personal success will lead to rejection from their peers and others in their home communities.

For non-Aboriginal providers cultural competence is increasingly seen as a requisite that should – and probably will – become a constituent part of professional certification and accreditation. There are two aspects of integrating the topic into baccalaureate and continuing education programs: content and structure. Determining what constitutes appropriate content is subject to consultation to understand how traditional beliefs influence the behaviour and worldview of Aboriginal people. It also involves recognizing the pitfalls of stereotyping and the cultural bias of commonly used diagnostic tools. The structural dimension rests largely on how cultural-group specific content is best introduced into curricula already crowded with other essential subjects. Should it be taught as a separate and distinct module or threaded through various courses? Can it be taught in a didactic manner, or must it involve community-based experiences? In pondering both the content and structural dimensions, the message from several people interviewed is particularly cautionary: each Aboriginal person is unique and each community is different.

5. SUMMARY

The available evidence suggests that Aboriginal Canadians experience mental health problems to a significantly greater extent than does the population overall. For example, their reported incidence of depression is twice as high. Youth and young adults are especially at risk, with suicides occurring at up to ten times the national average. While numerous causative factors are suggested in the literature, certain ones are cited as common denominators for various mental health conditions. Poverty and, in some cases, overt racism force many individuals of all ages into marginal life situations that have heavy psychological costs. Moreover, emotionally traumatic residential school experiences continue to haunt those who suffered them first hand and, since they were not exposed to effective models for parenting or family life, their own children and grandchildren. This cumulative mental health burden can be eased only if there are a sufficient number of care providers, with appropriate cultural knowledge and clinical skills, in all settings, whether urban, rural or remote.

The present study was undertaken to find out what health human resources are needed – and what they need to know – to respond to the mental health requirements of Aboriginal residents in Ontario, the home of about twenty per cent of the nation’s First Nation, Métis and Inuit people. It posed eight questions, which were answered by interviews with 55 people in the province, as well as 27 key informants from the other provinces and territories. In addition, an extensive review of the literature revealed what has been found out on each topic, both in Canada and in other countries. Detailed answers are found in the main body of the text. But the following provides a brief summary of the findings on a question-by-question basis:

- 1) *What skills and cultural competencies are required to deliver community mental health programs that cross the spectrum of care to Aboriginal Ontarians?*

Recognizing that those who provide care come from different backgrounds, both Aboriginal and non-Aboriginal, with different levels of preparation in many different disciplines, it is difficult to summarize the array of specific competencies here. It should be sufficient to categorize them broadly and note overarching needs. Some are systemic, others clinical, and still others cultural in nature.

Systemic: Caregivers, particularly those serving status First Nation or Inuit people, have to understand the complex system of overlapping federal and provincial jurisdictional responsibilities that apply, depending on the clients' place of residence, the programs available, and the criteria determining their eligibility. And those dealing with individuals referred from on-reserve primary care clinics to tertiary care settings need to know the mechanics of the process, including the transfer of information in both directions, and options for follow-up care in the communities.

Clinical: Although professionals were thought to require some clinical skills (often tied to culture-specific diagnoses), the emphasis was on the learning needs of paraprofessionals. There are two reasons for this. First, in situations where an indigenous mental health worker is needed immediately, individuals sometimes start to work in paraprofessional roles with little or no formal training. Second, those interviewed reinforced a key message from the literature; that paraprofessional training – albeit adequate perhaps – often is neither standardized nor accredited.

Cultural: For many Aboriginal people, traditional values, beliefs, and practices constitute a major determinant of their mental health. Practitioners need to understand how these factors influence perceptions of mental well-being, patterns of communication, diagnoses and treatment. While this is seen to apply to non-Aboriginal professionals specifically, it colours the care given by Aboriginals as well, particularly when they are working within a tribal context different than their own. Establishing cultural content is challenging, however. There is a great deal of within-group specificity and between-group difference found among First Nations, Métis and Inuit people. Some Aboriginal clients and communities expect that traditional practices should be central to care; others favour integration of traditional and western approaches; while still others want to have the choice of accessing either traditional or western care. But the ability to develop culturally-responsive models of care is limited by program mandates and funding criteria which support either traditional or western approaches, but not both.

2) *Is there a shortage of culturally competent community mental health workers to meet the needs of Aboriginal people in the province? If yes, how does this shortage affect access to mental health services?*

The answer to this question is an unqualified “yes.” Recruiting mental health staff is generally difficult. But finding individuals who are culturally competent is particularly problematic. On one hand, relatively few non-Aboriginals are thought to possess cultural knowledge of sufficient depth to qualify them as *truly* competent. On the other hand, being of Aboriginal heritage is not sufficient qualification, in itself; such individuals may be sensitized to the importance of the issue, but not really

know a specific Aboriginal culture, either their clients or their own. Nonetheless, recruiting more Aboriginal people to mental health practice and, in the case of professionals, encouraging them to work within their own cultural group, is the best answer to this question in the long run.

The shortage of culturally competent practitioners affects care in two ways. First, absent fully informed providers, clients must make do with those available or opt to go without services. Choosing the first alternative sometimes results in inappropriate treatments, miscommunication, patient non-compliance, or client disengagement. And the latter choice, obviously, effectively means a total blockage to access. Second, the shortage of providers – any providers – creates waiting lists, the bane of consumers, whether Aboriginal or not. But interviewees pointed out two responses to waiting lists found among Aboriginal Canadians that they saw as cultural in nature. One is the fact that many Aboriginal people tend to be oriented to the present (and the past), but not the future; forced to wait, they became frustrated and are prone to give up trying to find treatment. The other fact is the interpretation given to waiting lists. Some Aboriginal clients fear such waits really mean they were not being treated fairly; a misunderstanding yes, but one that has to be seen in the light of a history of oppression and discrimination.

- 3) *Is the training available to community mental health workers adequate to meet the clinical and cultural needs of Aboriginal clients? If not, what are the workers' learning needs?*

Ontario's colleges, universities and Aboriginal education and training institutes offer a number of professional and paraprofessional programs in the health sciences which are geared to different interests, levels of preparation and career goals. While none of these focus on Aboriginal mental health specifically, often the topic is part of their curricula. Consequently, graduates are at least partially prepared – the extent depending upon their program of study – when they enter practice; but they must consolidate their knowledge through experience.

For individuals already in practice, access to continuing education can be difficult, especially for those working in isolated locations where there are few distance education options. Interviewees report several ways through which employers attempt to address gaps in staff member's clinical knowledge. For example, health care agencies provide workplace orientations, develop context-specific practice guidelines, and host workshops. Still, substantial learning needs go unmet. Some of those identified link directly to therapeutic interventions, like an awareness of signs and symptoms of impending decompensation or the monitoring of

psychotropic medications. Others relate to the delivery of treatment, such as the mechanics for cross-jurisdictional transfers.

The nature and scope of cultural knowledge needed is vast; ranging from the history of oppression under colonization, through styles of communication, to Aboriginal views of mental well-being. Some are broadly applicable, while others are highly particular to a given tribal group. While the cultural knowledge needed can be ameliorated through education, this poses challenges in itself. How can cultural components be introduced into already crammed curricula in the health sciences? Should it be integrated across the curricula or introduced in separate modules? Is didactic instruction acceptable, or does real learning come only through placements and interaction with Aboriginal people?

- 4) *Is there a lack of cultural sensitivity within mainstream community mental health services that deters Aboriginal clients from seeking and continuing to use these services?*

Study participants confirm published findings indicating that those who work in mainstream mental health services are generally ill-prepared to recognize and respond to the cultural needs of Aboriginal clients. Many health care organizations hire Aboriginal staff to act as interpreters, liaison workers, or spiritual advisors. As useful as they are, however, these resource people can not fully offset any lack of understanding, respect and cultural sensitivity demonstrated by non-Aboriginal providers. When the latter act inappropriately (albeit in most cases unintentionally), it deters an unknown, but possibly significant number of Aboriginal clients from using the services offered.

This is a system-wide issue, found in hospitals, clinics, long-term care homes and with outreach teams; wherever, indeed, Aboriginal clients interact with non-Aboriginal caregivers. It may be seen, for example, in plans of care developed by clinicians which client's cannot adhere to because they fail to reflect their life style or personal preferences and cultural practices. Client non-compliance, in turn, is misunderstood or misinterpreted by the providers, escalating the situation to the point of rupture. Moreover, mainstream programs often create social or physical environments which are not welcoming to individuals of Aboriginal heritage.

- 5) *Is there a need to recruit more Aboriginal workers into the community mental health sector? If yes, what are the barriers to recruiting and retaining them? And what strategies will best promote and sustain the choice of community mental health as a career for Aboriginal people?*

Addressing the shortfall of Aboriginal workers, especially in professional roles, is one of the most pressing needs of Ontario's mental health system. Indeed, managers of health services with an Aboriginal clientele are in almost constant staff-search mode, trying to find fully qualified Aboriginal people to fill the available positions. The major barriers to doing so are subsumed in the phrase "fully qualified." Although Aboriginal people are apt to have sufficient cultural knowledge and even linguistic skills, very few have the clinical qualifications required. This fact is closely linked to the quality of their primary and secondary level education. Moreover, it is difficult to convince those who leave for professional training to return and practice in their own communities (despite the advantage of cultural familiarity they would enjoy). Quite simply, people do not want to go home because they know, and are known by, virtually everyone there. They fear the high expectations, endless demands and ready criticisms awaiting them. It is also difficult to establish appropriate boundaries, or, in other words, to transform personal relationships into professional ones without ruining the underlying bonds of kinship and friendship.

Aboriginal people are inhibited from entering mental health careers by several factors. First, there is a stigma associated with mental health deviations that forms the basis for a general avoidance of the topic. Second, many individuals have unresolved personal issues which they would have to work through before they could help others. Third, the usual western modes of intervention and treatment embody practices that are contrary to traditional Aboriginal practices, at least in the eyes of some. Fourth, on a practical level, Aboriginal people are often inadequately prepared academically to pursue careers in mental health. And, fifth, many lack the family, peer and community encouragement to seek the advanced levels of education required to enter the field. Respondents felt these obstacles might be overcome if Aboriginal organizations and communities focussed on the positive aspects of such a career. Suggested strategies included: building on natural helping skills; promoting positive role models among youth and adults; and fostering awareness through career fairs, job shadowing and apprenticeships.

In the face of the human resource deficit, some organizations are prepared to hire Aboriginal staff with minimum qualifications and then invest heavily in improving their knowledge and skills while they are on-the-job. This practice does raise ethical and liability issues, however. The concern is that these workers may be

caring for clients whose clinical needs are beyond the scope of competence possessed by the workers at the time.

- 6) *Are there barriers experienced by Aboriginal people in accessing and successfully completing College or University training in community mental health? If yes, what are they?*

Once a mental health career has been chosen, Aboriginal learners face a cluster of barriers in accessing and successfully completing college or university training. Some of these are experienced in common. For example, students seldom find their lives reflected in the curricula they study (in other words, something to which they can relate), Aboriginal role models among their teachers, or full acceptance from their non-Aboriginal classmates. Financial hardships also tend to undermine ambitions, no matter whom the students are or where they live. Other factors affect certain segments of the population specifically. Those who return to schools as mature adults must balance their school work with heavy family responsibilities; the latter sometimes overwhelm the former. And students from the north, who usually have to leave their home communities after grade ten, find that their education on-reserve did not prepare them for the more demanding and competitive upper grades at a city high school. Also, they are apt to give in to the temptations of urban life – parties with easy access to alcohol and other recreational drugs.

Colleges and universities have introduced a range of support systems, such as Aboriginal admission schemes, discipline-specific preparatory programs, Aboriginal-content in curricula, and Aboriginal student learning centres. Nonetheless, key informants felt this was an area where more could be done. In particular, it was noted that concerted effort to improve awareness on the part of non-Aboriginal peers and faculty would go some distance in improving the learning environment for First Nations, Métis and Inuit students.

Expanded funding in increased amounts is required. There are multiple areas of need: assistance for non-status First Nations and Métis students, two groups which currently receive no supplements beyond those available to all students in the province; childcare funding to help ensure that students with families can complete their programs; and sufficient educational funding to First Nations and Inuit organizations, so they are not forced to advantage one category of students at the expense of another (e.g. supporting recent high school graduates instead of mature learners), or to cut-off funding before students can finish their studies.

- 7) *What are the federal and provincial governments' roles and responsibilities with respect to the delivery of community mental health programs to Aboriginal peoples in Ontario? What are the implications of any differences in their respective obligations?*

Our study revealed that Aboriginal residents of Ontario, like those in other provinces and territories, have widely differing access to federal and provincial programs, depending on their status, their residence (on- or off-reserve), and their access to general provincial health care services. A range of federally-funded community mental health programs are available to First Nations people with status while they are on-reserve. Off-reserve, federal support is limited to mental health promotion projects open to all First Nations, Métis and Inuit people. Those with status can also access additional federal benefits which cover the costs of medications and travel for mental health assessments and interventions (usually of a short-term crisis nature). Provincially-supported community mental health programs are open to all residents of the province and accessible through the general health care system. The province also delivers Aboriginal-specific mental health programming in partnership with First Nations, Métis and Inuit organizations across Ontario. The specific types of services available, however, vary significantly from one community to the next.

This dual and cross-jurisdiction reality is apt to create problems in certain situations. Providers, for example, experience frustrations trying to navigate the federal and provincial systems when it comes to referrals and benefits for their clients, since each program has its own eligibility requirements and forms to fill out. Coordination of care is especially difficult when status First Nations and Inuit people moved back and forth between their home communities and urban areas. This is because, with the exception of a few integration initiatives, protocols are not in place to guide transfers of care. Interviewees emphasized that closer integration of care between federal and provincial systems is needed to ensure that continuity of care is not compromised.

- 8) *What are the lessons learned from other Canadian provinces and territories regarding the delivery of mental health services to Aboriginal communities? How can these lessons be applied in Ontario?*

Key informants from the other provinces and territories shared the best practices learned through the process of delivering mental health services to Aboriginal residents in their respective jurisdictions. The first, perhaps most fundamental lesson, is the need to incorporate stakeholder consultation into the formation of all major policies and when making significant program decisions. This

involves building – and maintaining – links with Aboriginal communities (not just with their leadership) so that service delivery is continually informed by the views of recipients and providers on the frontlines of care. The process of consultation cannot be a one-way conversation or occur at only one point in time; it has to involve decision-makers, consumers, providers and funders in an on-going dialogue.

A second lesson is the need to achieve stability (through predictable funding and continuing staff) so that there is consistency in the care provided. Aboriginal clients are most likely to turn to programs that are well established and likely to be available on a long-term basis. Also, they will seek out and return to familiar counsellors; when there is continual turnover among staff, clients disengage and become increasingly reluctant to access care. The other side of the consistency equation, of course, is the need to support front-line staff, so they will want to continue working in the same roles. Additional time to connect with clients, reasonable workload expectations and debriefing supports improve worker retention, consistency of care and, ultimately, client satisfaction.

A third lesson is the need for integrated care models, which combine primary care, mental health, addictions, and community wellness services. Although not yet widely available in Canada, integrated approaches are in accord with Aboriginal peoples' preferences for holistic care. They also make good use of scarce human and financial resources, which is especially important in rural and remote communities. However, such models only work well if there are good communications, positive relationships, and effective partnerships among all of the organizations involved.

The final lesson learned is the need for significant commitments to, and investments in Aboriginal mental health education. This need is great and long-term in nature; it can not be satisfied through the short-term, priority funding envelopes commonly resorted to by governments attempting to address pressing problems.

In sum, successful Aboriginal mental health strategies are built on the strengths of Aboriginal communities and the providers who serve them. Best practices emerge when organizations delivering mental health take time to listen to communities, nurture consistency in care, support front-line providers and enhance educational opportunities. Sharing his thoughts on best practices, a British Columbia program director said: "What works most effectively is actually the relationship that develops between individuals responsible for services on the ground in the community." He concludes the need is for "local community relationships on which to build local services."

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Appendix A

Centre for Rural and Northern Health Research
“Community Mental Health Human Resources Issues Pertaining
to Aboriginal Communities”
Interview Questions – Key Informants – Community Sites

The purpose of this study, funded by the Ontario Mental Health Foundation, is to explore the community mental health human resource needs of Aboriginal people who reside in urban, rural or First Nation communities in Ontario. Results obtained from this study will be synthesized into a report summarizing the findings, identifying knowledge gaps and attendant policy implications. As you have been identified as a knowledgeable key informant, we would like to ask you a few questions about relevant programs and policies:

1. Could you describe your organization, its mental health mandate and the Aboriginal client population that it serves?
 - a. Your organization’s services and programs?
 - b. Its mental health mandate?
 - c. The Aboriginal client population and catchment area that it serves?
 - d. Services delivered to clients in rural or northern communities?
2. Could you describe your role in the organization?
 - a. Administrative?
 - b. Case management?
 - c. Front-line service?
 - d. Other role?
3. How are community mental health services provided to Aboriginal clients within your region?
 - a. Community mental health professionals/paraprofessionals?
 - b. Referral to specialist services?
 - c. Referral to community agency?
 - d. Other methods?
4. Is there a shortage of culturally competent community mental health professionals/paraprofessionals to meet the needs of Aboriginal people within your region? (Please explain why or why not.)
 - a. No shortage at the present time
 - b. Shortage at the present time
 - c. Anticipated shortage
 - d. If shortage, how does this shortage affect access to mental health services?

5. Are community mental health professionals/paraprofessionals adequately trained to meet the clinical and cultural needs of Aboriginal clients?
 - a. If adequately trained, what types of specialized clinical and cultural training is offered?
 - b. If not adequately trained, what types of specialized training are needed?
 - c. Other learning needs?
6. Which service-delivery issues might deter Aboriginal clients from seeking and continuing to use mental health services?
 - a. Absence of local community services and support?
 - b. Limited access to regionally-based services and support, including telehealth?
 - c. Lack of cultural sensitivity on the part of care providers?
 - d. Lack of Aboriginal-language services?
 - e. Lack of Aboriginal community mental health workers?
 - f. Other access issues?
7. Is there a need to recruit more Aboriginal professionals/paraprofessionals into the community mental health sector?
 - a. If yes, what are the barriers to recruiting Aboriginal mental health workers?
 - b. If yes, does your province/jurisdiction have any programs in place to recruit and retain Aboriginal mental health workers?
 - c. If yes, what strategies would best promote and sustain the choice of community mental health as a career?
 - d. Related issues?
8. What are the barriers for Aboriginal people succeeding in post-secondary programs that would prepare them for a career as mental health professionals/ paraprofessionals?
 - a. Absence of Aboriginal-specific training programs?
 - b. Lack of Aboriginal role models?
 - c. Absence of specialized access programs for mature Aboriginal students?
 - d. Absence of specialized supports for Aboriginal student families?
 - e. Other barriers?
9. What are the lessons learned in your organization regarding the delivery of community mental health services to Aboriginal communities? How can these lessons be applied elsewhere in Ontario?

Appendix B

Centre for Rural and Northern Health Research
“Community Mental Health Human Resources Issues Pertaining
to Aboriginal Communities”

Key Informant Interview Questions – Provincial/Territorial

The purpose of this study, funded by the Ontario Mental Health Foundation, is to explore the community mental health human resource needs of Aboriginal people who reside in urban, rural or First Nation communities in Ontario. Results obtained from this study will be synthesized into a report summarizing the findings, identifying knowledge gaps and attendant policy implications. As you have been identified as a knowledgeable key informant, we would like to ask you a few questions about relevant programs and policies in your jurisdiction:

1. Could you describe your organization, its mental health mandate and the Aboriginal client population that it serves?
 - a. Your organization’s services and programs?
 - b. Its mental health mandate?
 - c. The client population and catchment area that it serves?
 - d. Services delivered to Aboriginal clients in rural or northern communities?
 - e. Services delivered to Aboriginal clients in urban communities?
2. Could you describe your role in the organization?
 - a. Administrative?
 - b. Program director?
 - c. Policy development/implementation?
 - d. Other role?
3. How are community mental health services provided to Aboriginal clients within your jurisdiction?
 - a. Community mental health professionals/paraprofessionals?
 - b. Referral to specialist services?
 - c. Referral to community agency?
 - d. Other methods?
4. Is there a shortage of culturally competent community mental health professionals/paraprofessionals to meet the needs of Aboriginal people within your province/territory? (Please explain why or why not.)
 - a. No shortage at the present time
 - b. Shortage at the present time
 - c. Anticipated shortage
 - d. If shortage, how does this shortage affect access to mental health services?

5. Are community mental health professionals/paraprofessionals adequately trained to meet the clinical and cultural needs of Aboriginal clients?
 - a. If adequate, what types of specialized clinical and cultural training are offered?
 - b. If not, what types of specialized training is needed?
 - c. Other learning needs?
6. Which service-delivery issues might deter Aboriginal clients from seeking and continuing to use mental health services?
 - a. Absence of local community services and support?
 - b. Limited access to regionally-based services and support, including telehealth?
 - c. Lack of cultural sensitivity on the part of care providers?
 - d. Lack of Aboriginal-language services?
 - e. Lack of Aboriginal community mental health workers?
 - f. Other access issues?
7. Is there a need to recruit more Aboriginal professionals/paraprofessionals into the community mental health sector?
 - a. If yes, what are the barriers to recruiting Aboriginal mental health workers?
 - b. If yes, does your province/jurisdiction have any programs in place to recruit and retain Aboriginal mental health workers?
 - c. If yes, what strategies would best promote and sustain the choice of community mental health as a career?
 - d. Related issues?
8. What are the barriers for Aboriginal people to succeeding in post-secondary programs that would prepare them for a career as mental health professionals/ paraprofessionals?
 - a. Absence of Aboriginal-specific training programs?
 - b. Lack of Aboriginal role models?
 - c. Absence of specialized access programs for mature Aboriginal students?
 - d. Absence of specialized supports for Aboriginal student families?
 - e. Other barriers?
9. What are the lessons learned in your jurisdiction regarding the delivery of community mental health services to Aboriginal communities? How can these lessons be applied in Ontario?

Endnotes

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