

A stylized sunburst graphic in a golden-yellow color, consisting of several vertical lines of varying heights 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: A PRELIMINARY
LITERATURE SCAN**

**BRUCE MINORE
MARGARET BOONE
MARY ELLEN HILL
RYLEE KUZIK
ALEXANDER LYUBECHANSKY**

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FINAL REPORT

Submitted to:

THE ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE
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Aboriginal Health Unit

By:

Bruce Minore, Margaret Boone, Mary Ellen Hill and Rylee Kuzik
Centre for Rural and Northern Health Research
Lakehead University

Alexander Lyubechansky
Northern Ontario Virtual Library Program (NOVL)
Northern Ontario School of Medicine

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TABLE OF CONTENTS

Acknowledgment	ii
Executive Summary	iii
Introduction.....	1
Method	2
Ontario’s Aboriginal Population.....	3
Providing Culturally Competent Care	5
Toward Achieving Cultural Competence	11
Mental Health Team Composition.....	13
Toward Effective Mental Health Teams.....	18
Recruitment and Retention of Community Mental Health Human Resources.....	20
Summary.....	26
References.....	41
Appendix A.....	54

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EXECUTIVE SUMMARY

Aboriginal people have a heavier mental health burden than the majority of Ontario's residents. Moreover, their access to care is often compromised by a lack of culturally appropriate services or, indeed, any services at all. This is largely due to the *insufficiency* of the mental health workforce – both in terms of their number and their preparation. The province recognizes the issue and is committed to developing a comprehensive strategy to insure that there are appropriate and competent health care providers available to meet the needs of its First Nation, Inuit and Métis citizens. To inform their thinking about the topic, the Ministry of Health and Long-Term Care has commissioned a study that will address several interlinked health human resource questions.

As a first step, the present report provides a preliminary review of the literature relevant to four key issues:

- (a) What knowledge is required to provide culturally competent care?
- (b) What personnel constitute the mental health teams serving Aboriginal clients?
- (c) What mix of personnel types is most effective in delivering mental health care to this client population?
- (d) What recruitment and retention strategies are most successful for community mental health team personnel?

National and international information was gathered from several sources. Electronic database search engines were used to identify studies pertaining to the recruitment and retention of community mental health workers to serve Aboriginal clients, culturally

competent training and practice, inter-disciplinary team mix and locus of service (urban, rural and remote). Subscribers of health related listservs were enlisted to help identify the so-called grey literature on these topics – reports, policy and position papers, and non-scientific articles. In addition, websites for key government and non-governmental organizations were searched, as well as those of health professionals’ regulatory bodies across Canada.

Albeit preliminary and constrained by time, the search identified a rich body of literature on each of the issues of interest.

CULTURAL COMPETENCE

Culture is a major determinant of the health of Aboriginal Canadians, in part because of its influence on the care they receive. Hence the importance of a deep understanding on the part of health care providers about the socio-cultural factors that influence Aboriginal clients’ perceptions and decisions regarding their mental health. This mirrors an increasing concern about cultural competence or cultural safety in the care of indigenous people in Australia, New Zealand and the United States. New policies and standards of practice have been adopted or are being developed in a numbers of jurisdictions, but their impact on front-line care has yet to be assessed. Similarly, tools such as cultural competence assessment guides for individuals or organizations are available, although their content is generic rather than cultural group specific.

The literature pays considerable attention to teaching the principles of cultural competence to students in health science professional programs and to individuals already in practice – giving examples of success, but also pointing out challenges. For example, medical schools report difficulty fitting the required information into curricula already packed with science and clinical skills training. Although optimal learning occurs in clinical

settings, cultural content is often relegated to didactic sessions. Continuing education initiatives are also compromised if the learning takes place outside of a clinical context.

MENTAL HEALTH TEAM COMPOSITION

In urban centres Aboriginal clients have access to a full compliment of mental health care providers. But they frequently choose not to use these services because of previous negative experiences in a system largely unprepared to cope with their culture-specific needs. Those who live in rural areas suffer from the general lack of providers now characteristic in rural Canada; there are relatively few programs tailored to suit their unique requirements. However, collaborative interdisciplinary teams that draw from beyond the usual *health* realm – including the police, teachers, social service agency workers and volunteers – are common.

The mental health care teams in many, if not most, Aboriginal communities are constrained by the limited number of workers available. This, of course, is dictated by the size of the community and its relative isolation. Those in northern Ontario, for example, rely on teams in which nurses are the principal primary care providers, supported by visiting physicians or other specialists. Clients must be referred out of the communities for secondary or tertiary care. Paraprofessional mental health workers are central to the provision of Aboriginal mental health services, to some extent in urban centres and more so in rural ones, but especially on-reserve. Recruited locally, they offer cultural knowledge and familiarity with the community, as well as their training as counsellors.

EFFECTIVE MENTAL HEALTH TEAMS

Whatever the mix of care providers, their effectiveness rests on their collective cultural competence – awareness, respect, and sense of self within both a clinical context and

Aboriginal environment. Regrettably, often the role of paraprofessionals is not fully understood, nor is their competence respected by the professional team members, most of who are in the communities only for a short while. An absence of regard for the contributions of those from other disciplines on a team, whether professional or paraprofessional, may be seen in dismissive attitudes toward clients as well. This problem is documented in literature from New Zealand and Australia, as well as here in Canada. Characterized as a “pattern of negative collaboration” in Australia, it could threaten implementation of that country’s mental health strategy in rural and remote areas, where Aborigines are a substantial portion of the population.

Spurred by primary health care reform, Canadian health professional programs are exploring the establishment of more interprofessional educational initiatives. In time this may lead to a breach of the existing disciplinary barriers, which would benefit Aboriginal and non-Aboriginal clients alike. Based on research about the functioning of health care teams in remote Aboriginal communities, several recent Canadian articles argue for including consideration of the paraprofessionals’ role in the education of health professionals.

RECRUITMENT AND RETENTION OF COMMUNITY MENTAL HEALTH HUMAN RESOURCES

While many cities experience periodic gaps in their complement of mental health specialists, there is a chronic shortage in most rural and Aboriginal communities. The problem is compounded by rapid turnover among those who are recruited, which adds to the work load of the few who remain. The contributing factors are well documented – distance, isolation, high disease prevalence, inadequate professional supports, lack of amenities and funding. The literature pays less attention to the adjustment of individuals (and families) to

their surroundings, although difficulties in doing so are known to affect practitioners' decisions to stay or to leave.

Comprehensive recruitment and retention strategies must address professional registration and workplace concerns, as well as develop effective approaches to marketing. But education is the foundation of virtually all coordinated efforts to deal with insufficiencies in health workforces. For example, Canada's Royal Commission on Aboriginal Peoples called for intensive efforts to recruit more Aboriginal people into health science professional programs and some progress is being made in this direction. Similar attempts are occurring in the United States, Australia and New Zealand, premised on the shared belief that having care givers with an Aboriginal heritage will foster culturally competent care and increase patients' willingness to access needed mental health services. Such targeted recruitment is one strategy in common to the rural and remote recruitment/retention strategies recently released in Australia and New Zealand. Generally, programs need to encourage all students' interest in the needs of Aboriginal clients, not only through course content, but by means of clinical learning experiences.

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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 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.

Recognizing their heavy mental health burden, Ontario is committed to improving mental health services for its Aboriginal citizens. To inform the development of a comprehensive approach to this issue, the provincial Ministry of Health and Long-Term Care's Allied Health Human Resources Policy and Planning Unit, together with the Mental Health and Rehabilitation Unit and the Aboriginal Health Unit, requested that a review be done of the literature addressing particular aspects of key health human resource questions. This review will provide a foundation for a larger-scale study entitled *Community Mental Health Human Resources Issues Pertaining to Aboriginal Clients*, which is being funded through a joint ministry initiative with the Ontario Mental Health Foundation.

The full study will involve interviews with practitioners and health administrators serving Aboriginal clients in eight First Nation, rural and urban sites across Ontario, as well as an environmental scan based on an expanded literature review and interviews with government officials and practitioners from all of the other Canadian jurisdictions. A preliminary list of potential interviewees is attached as Appendix A. For purposes of the present preliminary review the overarching questions are:

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?

Within these broader questions, the following review focuses on what the literature tells us about: (a) what knowledge is required to provide culturally competent care; (b) what personnel constitute the mental health teams serving Aboriginal clients; (c) what mix of personnel types is most effective in delivering mental health care to this client population; and (d) what recruitment and retention strategies are most successful for community mental health team personnel.

METHOD

To identify published literature on these issues – health sector and non-health sector, national and international – a search from database inception to February, 2006 was done using the following electronic database search engines: PubMed, Medline, CINAHL, EMBASE, PsycINFO, REHABDATA, CBCA, Social Work Abstracts, AARP Ageline,

ERIC, and Sociofile. Specialised search engines were also be used, including: Scirus, Teoma, Google, and INFOMINE. Studies were selected for inclusion based on their relevance to recruitment and retention of community mental health workers to serve Aboriginal clients, culturally competent training and practice, inter-disciplinary team mix and locus of service (urban, rural and remote). 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 health professionals’ regulatory bodies across Canada. This work was done by a medical librarian based at the Northern Ontario Virtual Library Program (NOVL), with the support of a research assistant from the Centre for Rural and Northern Health Research.

ONTARIO’S ABORIGINAL POPULATION

The last national census, done in 2001, showed that 188,315 Ontario residents identified themselves as being of Aboriginal heritage, whether First Nation, Inuit or Métis.² This number is an underestimation for several reasons. First, seventeen reserves or settlements were not fully enumerated.³ 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.⁴ 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.”⁵ Third, because this population tends to be very mobile within cities, and to be over represented among those who are homeless, an untold number would have been missed in the count.⁶ 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 139 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, our Aboriginal people tend to be younger, with about 46 per cent under 25 years of age.

Although large-scale epidemiological studies establishing the prevalence rates of mental health problems for this population are not available, there is no reason to believe that the highest risk categories would differ from those in other jurisdictions – people who are homeless, incarcerated,⁷ or who have alcohol and drug problems.⁸ A marginalized status, combined with cultural oppression, contributes to mental health deviations for many individuals.⁹ A common root cause, 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.¹⁰ 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.”¹¹ Moreover, community-based counsellors working with victims are themselves vicariously traumatized by their clients’ experiences.¹² In an effort to help eligible claimants cope with their situations, an Indian Residential Schools

Mental Health Support Program has been developed as part of the National Resolution Framework established to redress the harm done at the schools.¹³

PROVIDING CULTURALLY COMPETENT CARE

Culture is recognized as a major determinant in the health of Aboriginal Canadians,¹⁴ in part because of its influence on the care they receive.¹⁵ As for any minority population,¹⁶ culture plays a vital role in their mental health, not only in terms of how it is understood, but how it is responded to.¹⁷ Culture shapes Aboriginal people's perceptions about what constitutes a deviation in mental health,¹⁸ as well as other health beliefs and behaviours. These, 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.¹⁹ It is known that Aboriginal Canadians access care less effectively and that they are more intimidated by the health care system.²⁰ Consequently, a deep understanding of socio-cultural factors affecting the health care system is essential – in both the practice and policy spheres – to overcome the chronic disparities experienced by Aboriginals and other racial minorities.²¹

This need has led, recently,²² to wide-spread calls for the development of what is commonly called *cultural competence*^{23 24 25} or *cultural safety*^{26 27 28} 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.”²⁹ 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.”³⁰ While both systemic characteristics and individual behaviours are encompassed in most definitions,³¹ greater attention is paid to the latter, with an emphasis on interpersonal communications and respect for diversity.³² 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,³³ have yet to be clearly delineated.³⁴

The lack of consensus about terminology is reflected in uncertainty about approaches and their effectiveness.³⁵ However, Branch and Fraser³⁶ 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.

These are grounded, at best, in a lack of knowledge and ethnocentrism among the dominant majority; at worst, they manifest racism or other forms of prejudice.³⁷ 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 wellbeing of the individual.”³⁸ 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.³⁹ 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.⁴⁰

Attitudinal shifts are occurring, however, and these are increasingly reflected in formally stated professional expectations.⁴¹ For example, the importance of cultural competence is recognized in College of Nurses of Ontario practice standard respecting therapeutic nurse-client relationships.⁴² Indeed, the need to comply with new legislative, regulatory, and accreditation mandates is now driving adoption of appropriate programs and practices.⁴³ 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.⁴⁴

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.⁴⁵ With reference to psychotherapy, Lo and Fung⁴⁶ 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.⁴⁷ The need to combine generic and specific knowledge is recognized by most disciplines.⁴⁸ But there is a danger in practitioners

assuming that all members of a broad cultural group share the same beliefs.⁴⁹ 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.⁵⁰ Simplistic, broad generalizations about a whole group can reinforce stereotypes,⁵¹ and undermine an appreciation of the socio-political factors that contribute to Aboriginal people's differential access to health services.⁵² While recruiting practitioners of Aboriginal heritage might ameliorate the extent of cultural misunderstandings, this is not guaranteed.⁵³ Individuals may – or may not – know their own tribe's traditions, but if they opt to practice elsewhere might be unfamiliar with local beliefs and customs, like any outsider.

Traditional values influence the behaviour and worldview of Aboriginal people in fundamental ways.⁵⁴ In particular, their concepts of health and well being are shaped by beliefs about ecological and spiritual harmony, and the importance of natural remedies.⁵⁵ Combining these ideas with western approaches to mental health, is seen as a promising approach to treatment for at least two segments of the Aboriginal population considered at highest risk, young people⁵⁶ 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.⁵⁷ Even using more appropriate open-ended interviewing techniques does not ensure that non-verbal cues are recognized for their importance.⁵⁸ To address such 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.⁵⁹ This approach will help identify the full spectrum of risk factors,⁶⁰ as well as appropriate

interventions.^{61 62} For this to happen, however, the providers must appreciate and respect their Aboriginal partners' contributions.⁶³ A non-judgemental mindset is the one core attribute that students and practitioners see as key for cultural competence, regardless of discipline.⁶⁴ Indeed, the extent of consensus on this point is considered to be striking.⁶⁵

The practitioner must be aware of their own belief system and how adherence to it can affect the care they provide.⁶⁶ 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.⁶⁷ Such reflective, self-awareness is seen as an essential foundation for cross cultural clinical practice.⁶⁸ Yet, Canadian preparatory programs in the health sciences – even those specifically oriented to northern practice – do not address this issue to any extent.⁶⁹ 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.⁷⁰ In a national survey, nurses employed in First Nation communities and hospitals identified mental health as one area where their clinical skills could be improved.⁷¹ Similarly, an Australian survey found many caregivers working with Aboriginal mental health clients felt inadequately prepared to provide counselling or to oversee the safe use of psychotropic medications.⁷² Even basic skills like taking a history could be refined, for example, if they had knowledge of extended kinship ties or other cultural issues.⁷³

Good communication, in terms of both language familiarity and cross-cultural awareness, is a health care requisite.^{74 75} Aboriginal people 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 regimen that they do

not fully understand.⁷⁶ 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.⁷⁷ Language aside, a failure to understand socio-cultural 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.⁷⁸ Exclusion comes in a different form, too. Rapid advances in communication technologies reach poor, isolated Aboriginal communities last; when they arrive, the sensory overload becomes a source of stress.⁷⁹ Health care providers must be prepared to cope with the volatile environment which can result.⁸⁰

Weaver succinctly summarized the knowledge, skills and values or attitudes that are the essence of culturally competent services to Aboriginal people:

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.⁸¹

These were the elements identified by Native American helping professionals 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.

TOWARD ACHIEVING CULTURAL COMPETENCE

Efforts to achieve cultural competence largely focus on targeted education initiatives, both to prepare novices entering practice and to provide continuing learning for those already working in the health care field. One consideration in the educational sphere or, indeed, in the development of any ameliorative programs or services, is making sure that the intended consumers have a voice in their design.⁸² Community-level participation increases the likelihood that the initiatives are relevant and, possibly, sustainable.⁸³

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.⁸⁴ Institutions of higher learning acknowledge that this deficit persists in their professional programmes,⁸⁵ and recognize the value of incorporating the required knowledge.⁸⁶ Moreover, cultural competence training must extend across the career path, from novice to expert.⁸⁷ There are numerous examples of special training initiatives internationally.^{88 89 90 91} A recent review of program evaluations for 34 such interventions found encouraging results; there was strong evidence that cultural competence training improves the knowledge, attitudes and skills of health professionals, which meets with positive client feedback.⁹² There are challenges, however. In medicine, for example, it is difficult to incorporate content on cultural competence into curricula that are already packed with science and clinical skills training.⁹³ Consequently, cultural content is often covered through didactic offerings rather than in ways that allow skills to be honed through practice and feedback.⁹⁴ The same principle applies for continuing education; learning that takes place outside a practice context is difficult to sustain and apply.⁹⁵ In the nursing literature there is also a debate as to whether cultural content should be treated as separate, for example

in a course on transcultural practice, or threaded through out the curriculum.⁹⁶ If the latter, then questions of feasibility arise.⁹⁷ Whichever strategy is adopted, faculty must be prepared and comfortable delivering the cultural content.^{98 99} For this reason, in Australia it has been suggested that culturally and linguistically diverse nurses should be recognized as a valuable and available educational resource.¹⁰⁰

If cultural competence is not yet widely adopted in educational programs, or as a universal standard of professional practice,¹⁰¹ in both spheres it is increasingly seen as critical¹⁰² and deserving of recognition in the certification and accreditation process.¹⁰³ 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.^{104 105 106} To facilitate meeting the new standards, tool kits have been developed,¹⁰⁷ as well as assessment guides for individuals¹⁰⁸ and organizations.¹⁰⁹ These reflect the conceptual models for transcultural care that have emerged; some are relatively simply and elegantly stated,¹¹⁰ while others give up in comprehension what they gain in comprehensiveness.¹¹¹ 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.¹¹²

Still, much work remains to be done before professionals have a solid empirical basis on which to found their cross-cultural care.¹¹³ For example, epidemiological mental health research for Aboriginal populations is under-supported, in part because of difficulties associated with acquiring scientifically valid data.¹¹⁴ 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.¹¹⁵ Similarly, training programs in cultural competence are new, so the longer term effect on patient care is unknown.¹¹⁶

MENTAL HEALTH TEAM COMPOSITION

Any discussion about the composition of the mental health teams 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 generally most appropriate to offer primary mental health care. For example, debates circle around the part that psychiatrists' should play,¹¹⁷ and that of traditional clinical psychiatric nurse specialists in the face of the increasing reliance on generalist nurse practitioners to provide mental health interventions.¹¹⁸ But the primary questions are about access and availability.¹¹⁹

In urban centres, even smaller ones, usually there is a diverse mix of professionals available to Aboriginal clients, as there are to any resident. These include specialist physicians and nurses,¹²⁰ 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 urban centres.¹²¹ However, despite the options potentially available, urban Aboriginals often go untreated.¹²² 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.¹²³

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.¹²⁴ Moreover, the stigma associated with mental health causes clients to ignore conditions, attempting to cope on their own, or to opt for care in a larger centre, if there is one that is sufficiently close to them.¹²⁵ Because of the scarcity of providers, those present tend to adopt team approaches that involve individuals from different disciplines and different agencies. Often a rural mental health team 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 clients in crisis.^{126 127} Clergy¹²⁸ and indigenous healers¹²⁹ are also found. As well, rural outreach teams employ local paraprofessional workers to assist with client identification, support and counselling.^{130 131 132} However, they need adequate supervision and training, as well as help in dealing with emotionally draining clinical encounters.¹³³ Practitioners in underserved rural areas find integrated approaches best because they are easy to manage,¹³⁴ allow more efficient use of resources,¹³⁵ and improve delivery.¹³⁶

We found no literature that considered the composition of mental health teams for Aboriginal people living off-reserve as separate and distinct from the teams serving other rural or, indeed, urban residents. Rather, the Canadian Community Health Survey shows that in a twelve month period spanning 2000/2001, 76.8 per cent of the off-reserve Aboriginal population saw a general practitioner, which is about the same as the non-Aboriginal population, although slightly fewer had a regular doctor. Contacts with other specialists are also comparable, except for dentists, where Aboriginals' utilization is well below that of non-Aboriginals.¹³⁷ Despite the overall similarities, the relative acceptability of the care offered

left needs 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).¹³⁸ 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 counsel from a traditional healer for physical, emotional or mental health issues.¹³⁹ Results from the Aboriginal Peoples Survey (1991), indicated that more than three-quarters of the Aboriginal people living off-reserve obtained health care from a professional, paraprofessional or traditional healer within a given year. For those under fifty-five, the rate of consultations by those off-reserve were a little over 10 per cent higher than among their contemporaries living on-reserve. For those older than fifty-five, the usage rates are more closely comparable: 83.3 per cent on-reserve vs. 86.1 per cent off-reserve.¹⁴⁰ Although this data is now dated, it is the most recent found that considered the off-reserve situation relative to that on-reserve.

The composition of teams serving Aboriginal communities that are geographically separate and distinct varies according to national policies and/or endorsed delivery models. In the United States, for example, the Indian Health Service stipulates that behavioural health teams will be tailored to suit circumstances, but could include psychologists, mental health counsellors, psychiatrists, social workers, substance abuse counsellors, and traditional healers.¹⁴¹ In Australia, while the possible scope of care providers in Aboriginal or Torres Strait Islander communities is as diverse, indigenous mental health workers have a somewhat more defined role.¹⁴² The background of these individuals varies considerably; they come into university-based mental health worker programs sharing their Aboriginal heritage in common, but with differing previous experiences. Some may have been trained as social

workers, for example, while others have had a less formal helping role in their home communities.

In Canada, the nature of the health care team in First Nation communities is dictated by to a considerable extent by community size and location. Northern Ontario provides a good example. Primary mental health is provided by resident nurses and paraprofessionals, such as Mental Health Workers and Community Health Representatives (CHRs). Their services are augmented by regular visits from general physicians from one of the Zone hospitals¹⁴³ and less frequent visits by psychiatrists.¹⁴⁴ Secondary mental health care is provided through the hospitals, Aboriginal controlled counselling services like NODIN in Sioux Lookout,¹⁴⁵ or outside the region. Clients requiring more specialized care are flown to tertiary care facilities located in the larger urban centres of Ontario's mid-north.¹⁴⁶

As in rural communities generally, the notion of the local *team* is inclusive, involving traditional healers, Elders, police officers and teachers, as well as paraprofessionals.¹⁴⁷ But the extent of dependence on paraprofessional mental health workers is significant. The idea was introduced, at least in northwestern Ontario, in the mid-1980s, when psychiatrists from the University of Toronto shifted from providing direct care at the Sioux Lookout Hospital to overseeing the training of indigenous counsellors.¹⁴⁸ The inaugural years were uncertain, with significant concerns about the competence of mental health workers from who so much was expected.¹⁴⁹ Nonetheless, reliance on these local caregivers grew as the region experienced a worsening youth suicide crisis during the 1990s.¹⁵⁰ By the end of the decade, a study of mental health care in the Shibogama First Nations found that the contributions of mental health workers were well recognized by resident nurses. The latter noted, however, that while the familiarity derived from community membership is a strength it can also be a

liability because of concerns about confidentiality.¹⁵¹ But for outside professionals, working with people who know and understand the community and can help them to bridge the cultural gap is a great help.¹⁵²

The actual jobs done by community workers vary considerably from one category of worker to another and, within a category, from one community to the next. The principal types are: community health representatives (CHRs), mental health workers (MHWs) and national native alcohol and addiction program (NNADAP) workers. Community health representatives are especially prepared to do health promotion work out in the community, although many spend much of their time providing primary care or other services at the nursing station. Mental health workers counsel individuals and families, often helping them cope with grieving the loss of a relative through violence. NNADAP workers provide case management for drug and alcohol abusers, arranging referrals to outside agencies for counseling and treatment, or aftercare upon their return.

Preparation for these jobs differs depending on the program and jurisdiction. For example, Nunavut Arctic College offers a 10-month long community health representative certificate program that focuses on health education and promotion, as well as essential clinical and counseling skills. In northwestern Ontario the approach to training has evolved from separate job-linked programs for CHRs, MHWs, and NNADAP workers into two integrated programs that provide cross-cutting skills development. These four semester-long programs, developed by Confederation College in partnership with the Nishnawbe-Aski Nation,¹⁵³ are the Aboriginal Community Services Worker Program (established in 1997) and the Indigenous Wellness and Addictions Prevention program (established in 1999). The former subsumes CHRs as well as other social service workers such as education counselors

and child welfare workers. The latter program incorporates MHWs and NNADAP workers. Adopting more generic, broad-based curricula came about at the behest of First Nations in the region – where it was felt that separate and distinct training resulted in separate and distinct services, instead of the needed cooperation among community workers. It was believed that having individuals who shared knowledge in common, whether their primary role was as MHWs or NNADAP workers, for example, would foster greater collaboration in the field.

An understanding of the staffing compliment necessary in various types of care settings would be facilitated if there were consistent descriptions of the mental health and wellness services available in each. Unfortunately, our search of the literature and web-sites failed to find information that could be considered as standard. Rather the focus is on unique, often “one-off” programs. We have concluded that Ontario specific descriptions should be an added outcome for the *Community Mental Health Human Resources Issues Pertaining to Aboriginal Clients* project.

TOWARD EFFECTIVE MENTAL HEALTH TEAMS

After reviewing the report of Health Canada’s Advisory Group on Suicide Prevention among First Nations youth¹⁵⁴ one might conclude that the characterization of mental health services in the United Kingdom as being “marked by fragmentation, competing priorities, arbitrary divisions of responsibility, inconsistent policy, unpooled resources and unshared boundaries,”¹⁵⁵ is equally apt here. The disarray apparent at the organization level is also manifest on the front lines of care in this country’s Aboriginal communities.¹⁵⁶ Despite the compelling reasons for collaboration and the small number of individuals involved, all too

often health care teams fail to function *as teams*; rather each individual operates within the bounds of their own discipline.¹⁵⁷ This uni-professional phenomenon is not unique to Aboriginal settings, but is common where a shared philosophy about integrating mental health services does not exist.^{158 159} 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.¹⁶⁰ For instance, individuals from different disciplines see theirs as the one taking the lead role.¹⁶¹ Therefore, it is not surprising that they are often ill prepared to work in interdisciplinary teams.^{162 163} In practice, while they understand their own roles, they do not think that their roles are understood by others.¹⁶⁴ Nor, all too often, do they appreciate the skills of those from other disciplines.^{165 166} 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.¹⁶⁷ 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."¹⁶⁸

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 the paraprofessionals' job description, for example, nurses 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.¹⁶⁹ Similar complaints are found in Australia where there is a lack of recognition of the Aboriginal mental health workers' role, and perceived inequities relative to other care providers in the system.¹⁷⁰ This was recently characterized as a "pattern

of negative collaboration” that is so endemic it threatens implementation of Australia’s Mental Health Strategy in rural and remote areas.¹⁷¹

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 urban-based).^{172 173} They may also 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].”¹⁷⁴ Nonetheless, an American study found that community health workers increased access to services and successfully promoted behavioural shifts among ethnic minority women.¹⁷⁵ 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.¹⁷⁶ As yet, no systematic evaluation of Aboriginal paraprofessionals’ role in mental health care has been done in Canada.

RECRUITMENT AND RETENTION OF COMMUNITY MENTAL HEALTH HUMAN RESOURCES

While acknowledging that shortages of certain categories of health professionals, especially physicians, is an emerging issue in cities across Canada,¹⁷⁷ a much larger and persistent problem faces rural^{178 179} and remote¹⁸⁰ parts of the country. The situation is particularly dire in remote Aboriginal communities, where persistent nursing shortages sometimes severely restrict the level of services available.¹⁸¹ Rural¹⁸² and Native¹⁸³ American communities experience similar deficits, as do those in New Zealand¹⁸⁴ and Australia.¹⁸⁵ A study in the United States’ Navajo Area Indian Health Service found that 47

per cent of physicians, nurse practitioners, physician assistants, nurse anaesthetists and midwives planned to leave their employment within three years.¹⁸⁶ In frontier areas of Alaska, another study found that paraprofessionals stay a median of 1186 days, about twice as long as physicians (Mdn = 596 days) and almost three times longer than nurses (Mdn = 408 days); however, such relatively rapid turnover in all three caregiver categories underscores why it is difficult to establish a stable workforce in Native Alaskan communities.¹⁸⁷ In every country investigated there are calls for improved recruitment and retention of appropriate health care providers,^{188 189} although it is also argued that working conditions require equal attention.¹⁹⁰ For instance, the number of vacant or under filled positions adds to the workload of those who stay, compounding the retention problem.¹⁹¹

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), the department of Health Canada responsible for the health of aboriginal people on-reserve, 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.¹⁹² This situation can seriously compromise continuity of care in a system where nurses are the principal primary care providers.¹⁹³

Studies on recruitment into rural nursing mostly focus on organizational factors within hospital settings.^{194 195} With exceptions,¹⁹⁶ less attention has been paid to individuals' adjustment to their surroundings. In comparison, the literature on rural physicians' location choices takes into account both the professional and personal dimensions.^{197 198} A defining characteristic of working as a nurse in Canada's remote Aboriginal communities is the

interplay between one's professional and personal life.¹⁹⁹ In contrast, nurses employed in most settings are able to maintain a high degree of separation between the two. Even those working in rural communities can set limits; although there is some erosion of boundaries since the nurses' clients are also neighbours.²⁰⁰ However, efforts to keep a professional distance when employed in an isolated northern Aboriginal community can negatively affect the community's acceptance of the services offered.²⁰¹

Many of the reasons that both rural and Aboriginal communities in various countries face chronic health human resource shortages are shared in common – distance, isolation, high prevalence of diseases, inadequate professional supports, lack of amenities and funding.^{202 203 204} Spouses who are discontented,²⁰⁵ either because their practitioner partners' heavy professional obligations erode family time,^{206 207} or because there are inadequate employment and educational opportunities available for themselves and their children,^{208 209} contribute to the turnover of staff.

Other factors are unique to Aboriginal communities. Prime among these is the lack of health professionals among their own people. In 1996, 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,²¹⁰ a ten-fold increase. Finally, in 2004, the federal government committed to spending one hundred million dollars over five years to train Aboriginal health professionals.²¹¹ 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.²¹² Canadians are not alone in holding this view. A recent American study asserts that increasing the number of American Indian and Alaska Native mental health professionals would help to overcome the stigma associated

with mental illness which is a major barrier to those in need of treatment.²¹³ However, specialized programs sometimes have difficulty recruiting indigenous students, an experience documented in New Zealand.²¹⁴

Despite the pervasiveness of the recruitment and retention problem or, perhaps, evident by it, definitive solutions have not been found yet. Nonetheless, a number are being attempted. In rural parts of Queensland, Australia, a vast, sparsely populated area of culturally diverse communities, efforts to attract and keep allied health professionals has resulted in the development of an outreach model that incorporates several complementary strategies. Key to the model is the formation of providers into interdisciplinary teams that travel together, spending two or three days in each community on a six week rotation, but with time between spent at their home base. Aircraft cut down on the travel time required. In addition, care providers are given financial supports for childcare and housing, and are assured of opportunities for professional development.²¹⁵ Another Australian initiative, in the central region, has succeeded in stabilizing the nursing workforce. It has three prongs: (1) a comprehensive system of management supports that orient and sustain the nurse in their practice context; (2) appropriate education throughout the period of employment – from a pre-hire package, through a formal six-week orientation, to community-based in-service sessions, along with workshops in Alice Springs, the main town in the region; and (3) a partnership in practice scheme, through which an established pool of rural hospital nurses are used to provide relief to those practicing in more remote communities.²¹⁶ The latter approach to short-term relief has also been suggested in a report to the First Nations and Inuit Health Branch of Health Canada, although not yet acted upon.²¹⁷

The Australian Health Workforce Advisory Committee, after examining the literature and undertaking a stakeholder consultation, identified four key areas which a strategy to recruit/retain rural and remote mental health nurses must address, with several recommendations under each.²¹⁸ Although many of the twenty-three recommendations are country specific, the broad categories – education, registration, workplace and marketing – reflect the usual realms of concern. For example, in New Zealand, it has been suggested that offering foreign trained psychiatrists the opportunity to obtain full specialist registration, if they are prepared to practice in what are termed “provincial” region, would attract new recruits, since uncertainty about their status remains a barrier for immigrants with a medical specialization.²¹⁹ Under the present system they can work temporarily, but it is difficult to obtain permanent registration. The Health Research Council of New Zealand has prepared a set of recommendations for the country’s Mental Health Workforce Development Program; again, some are unique, but others overlap the Australian recommendations.²²⁰

Ontario recently announced an initiative that it is hoped will staff some of the funded, but unfilled primary nurse practitioner positions available in the province, with particular attention to those in Aboriginal and underserved communities. Called the “Grow Your Own Nurse Practitioner” program, it allows agencies that have a position that has been unfilled for a year to apply for government funding to send a registered nurse through the nurse practitioner program, in return for a service commitment of a fixed period. Agencies in any community, including those serving Aboriginal clients, can sponsor a candidate full-time, on the conditions that their studies are completed in one year, with a two year return-of-service agreement. In addition, agencies serving Aboriginal or underserved communities can support a person for two years of study on a part-time basis, but carrying a three year

obligation. In either case, a total of \$110,000 will be committed to cover the persons' salary, tuition and some other educational costs.

Education is the foundation of virtually all recruitment and retention strategies, national or regional. At the student stage, for example, it is suggested that the health disciplines actively court individuals from rural and remote communities in the belief that they are most likely to return home to practice.^{221 222} A major Canadian report on Aboriginal nursing,²²³ calls for increased enrolment at the undergraduate level and in graduate programs; needs to which the country's schools of nursing are trying to respond.²²⁴ In Australia, the National Congress of Aboriginal and Torres Strait Islander Nurses recommended designating places in undergraduate schools of nursing for their people, as well as bridging programs for potential students,²²⁵ similar to those in Canada which give students training in learning skills and core sciences before they enter a nursing program.²²⁶ It is recognized that many Aboriginal learners face a cluster of barriers to successful completion of a program of study in the health sciences: inadequate academic preparation, family commitments, poverty, lack of supports, and fear of community rejection.²²⁷ The last mentioned concern continues for those who graduate, a feeling that their education alienates them from their heritage, making them unwelcome at home.²²⁸ Recognizing such concerns, a Canadian report emphasizes that "learning must flow from the cultural routes from which the learners arise."²²⁹

Beyond targeting certain groups for recruitment, programs can excite interest in rural or Aboriginal practice by giving them critical content and learning experiences. For example, the Committee of Deans of Australian Medical Schools developed a curriculum framework for indigenous health.²³⁰ Ontario's nurse practitioner program also established an Aboriginal component in its program at the outset.²³¹ Ideally, some of the students' training

will take place in a rural or Aboriginal setting. First hand exposure to the considerable challenges – and great rewards – of practicing in such places encourages students to consider them as a career destination.²³² Whatever their form, to be effective recruitment strategies must be founded on ensuring that providers' are aware of the range of clinical and non-clinical realities in rural and remote places.²³³

SUMMARY

Given the limited time available to do this review (about one month), it must be viewed as preliminary in nature. More material will be identified and added to it as part of the environmental scan for the full study. That having been said, the main themes – drawn from the substantial pool of written sources cited – are clear.

Certainly, interest in *culturally competent* practice is an increasing concern in the field of health, with attention being paid to meeting the needs of many minority communities. However, the American, Australian, Canadian and New Zealand literature is replete with discussions on the topic as it pertains to Aboriginal people. In the case of New Zealand, *cultural safety* is the dominant term used – although the notions seem largely interchangeable. The issue is now reflected in formally stated professional standards and efforts to incorporate principles of cultural competence into the curricula of health science professional programs.

However, there is uncertainty about how changing standards or augmenting curricula will ultimately affect practitioners' clinical performance, or be perceived by their minority group clients. Contributing to the lack of clarity is the fact that the elements constituting cultural competence in the care of specific populations, including Aboriginals, have yet to be

established. Nor is there consensus about the best approach to achieve this goal. Nonetheless, efforts are being made to delineate generic and culture group specific knowledge, and to develop compendiums of useful techniques. A number of tool kits have been developed, as well as assessment guides for individuals and organizations. At present, these address generic transcultural knowledge, attitudes and skills. However, for the most part they view acquisition of cultural competence as an ongoing process in which providers integrate new experiences and awareness from cross-cultural encounters with what they learn more formally. This holds out the promise for culture group specificity to be identified more firmly.

The idea of culturally competent practice is closely linked to the issue of health care team composition – both actual and ideal. At present, the nature of the teams serving Aboriginal Canadians is dictated by their place of residence. Those who live in urban centres potentially have access to a full range of providers, although most services are geared to serve the population as a whole, rather than Aboriginals specifically. There is evidence, despite the options open to them, that urban Aboriginals under-utilize the health care system, sometimes because they feel they were discriminated against during previous encounters.

The lack of professional caregivers experienced in rural communities across the country affects everyone, Aboriginal and non-Aboriginal, who live there. Given the general scarcity, there is little by way of specialized programming to meet Aboriginal residents' needs. Similarly, Aboriginal communities face chronic health human resource shortages, especially of nurses – the principal group of primary care providers. In consequence, both rural and Aboriginal communities tend to rely on mental health care teams which recruit members beyond the scope of the health disciplines as normally defined. Elders, traditional

healers, the police, teachers, social service providers and volunteers all may be called upon to help meet community members' psychological, emotional and behavioural needs.

The other group that rural and Aboriginal communities have in common are paid paraprofessionals. In rural communities these individuals are largely seen as extending the role of the professionals; they oversee the implementation of plans of care developed by urban-based professionals, thus allowing people to have professionally guided care while staying at home. The paraprofessionals' role in Aboriginal communities is much more firmly rooted, extensive and recognized. These are individuals who know and are known by their community, undertaking defined health service roles for which they have been specifically prepared; they are now an integral part of health care teams in virtually every Aboriginal community in Canada. Indeed, their presence is a distinguishing characteristic of the system of care. Unfortunately, rapid turnover in the professional providers, often in communities briefly, undermines the role of the paraprofessionals. The "visitors" fail to understand the paraprofessionals role or to develop confidence in their competence.

Despite years of failure, efforts to stabilize the mental health workforce in rural and Aboriginal communities continue unabated. Both Australia and New Zealand have put forward national strategies with detailed recommendations within the domains of education, professional registration, workplace conditions and marketing. On a program level, Ontario recently launched an initiative to increase the number of nurse practitioners, with particular emphasis on filling positions in Aboriginal and other underserved communities. As in each of these cases, education is the common denominator in almost all recruitment and retention initiatives. For example, a report on Aboriginal nursing in Canada emphasized the importance of recruiting more First Nation, Inuit and Métis people into the profession. There

is a widely held belief that expanding the ranks of indigenous people in health care will contribute to greater cultural competence and lessen the service disparities faced by Aboriginal people across the country, whether in a city, rural area, or in one of their own communities.

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APPENDIX A

The following is a preliminary list of the government offices, agencies and organizations at which individuals might be interviewed to fill information gaps apparent from the present review. As specified in the original study proposal, a snowball method of sampling will be used to identify potential respondents in each province, territory and at Health Canada. Since government is the common source of funding for mental health care programs and facilities, the first contacts will be policy and program staff responsible for relevant areas (e.g. mental health care, Aboriginal health) in the respective ministries of health and at First Nations and Inuit Health Branch's five regional offices. Hence the proportionately large number of government offices on this list and the smaller number of direct service agencies and organizations. The latter have yet to be nominated.

Contacts within Ontario

Anishnawbe Mushkiki
Thunder Bay, ON

NorWest Community Health Centres
Thunder Bay, ON

Thunder Bay Indian Friendship Centre
Thunder Bay, ON

Canadian Mental Health Association- Thunder Bay Branch
Thunder Bay, ON

Centre for Addiction and Mental Health- Thunder Bay Community Office
Thunder Bay, ON

Children's Centre
Thunder Bay, ON

Mental Illness Support Network
Thunder Bay, ON

People Advocating for Change through Empowerment, Inc. (PACE)
Thunder Bay, ON

Nodin Counselling Services
Sioux Lookout, ON

Shibogama Health Authority
Sioux Lookout, ON

Community Counselling and Addictions Services
Mental Health Addiction
Sioux Lookout, ON

Community Counselling and Addictions Services
Addictions Treatment Program
Sioux Lookout, ON

Patricia Centre for Children and Youth
Sioux Lookout, ON

Sioux Lookout and Hudson Association for Community Living
Sioux Lookout, ON

Addictions Services Kenora (ASK)
Adult Program
Kenora, ON

Addictions Services Kenora (ASK)
Youth Program
Kenora, ON

Anishinaabeg of Kabapikokawangag Resource Council
Kenora, ON

Changes Recovery Home
Keewatin, ON

Child Development Centre
Kenora, ON

Integrated Services for Northern Children
Kenora, ON

Kenora Area Health Access Centre
Keewatin, ON

Kenora Association for Community Living
Kenora, ON

Kenora Family Connection
Kenora, ON

Kenora-Patricia Child and Family Services
Kenora, ON

Minto Area Parent-Child Resource Centre
Kenora, ON

Ne-Chee Friendship Centre
Kenora, ON

Northwestern Health Unit
Kenora, ON

Women's Place
Kenora, ON

Algonquin Child & Family Services
Parry Sound, ON

The Lighthouse
Parry Sound, ON

West Parry Sound Victim Services (VCARS)
Parry Sound, ON

B'saanibamaadsiwin-Native Mental Health
Parry Sound, ON

Curve Lake First Nation
Curve Lake, ON

Montfort Hospital
Mental Health Program
Ottawa, ON

Wabano Centre for Aboriginal Health
Ottawa, ON

Aboriginal Healing and Wellness
Métis Nation of Ontario
Ottawa, ON

Odawa Native Friendship Centre
Ottawa, ON

Mamidosewin Centre Aboriginal
Ottawa, ON

Canadian Centre of Substance Abuse
Ottawa, ON

Canadian Centre of Elizabeth Fry Societies
Ottawa, ON

Pauktuutit Inuit Women of Canada
Ottawa, ON

Tungasuvvingat Inuit
Ottawa, ON

First Nations Inuit Health Branch
Mental Health and Addictions Division
Indian Residential Schools Mental Health Support Program

First Nations Inuit Health Branch
National Native Alcohol and Drug Abuse Program

Noojimawin Health Authority
Toronto, ON

Contacts outside Ontario

Director
Department of Health
Halifax, NS

Director
Community Mental Health Centre
Department of Health and Wellness Services
Restigouche County, NB

Social Worker
Community Mental Health (Centre)
Government of New Brunswick
Grand Falls, NB

Program Director
Community Mental Health Clinic
Charlottetown, PEI

Director
Health & Community Services, Program Development
Community Programs & Wellness Branch
St. John's, NL

Director
Health & Community Services, Policy Development
Policy & Planning Branch
St. John's, NL

Executive Director
Child & Youth Mental Health Policy & Program Support Branch
Government of British Columbia
Victoria, BC

Manager
Mental Health & Addictions
Government of British Columbia
Victoria, BC

Regional Manager
Mental Health Services
Northern Health Authority
Prince George, BC

Director
Mental Health Services
Peace Country Health Region
Grand Prairie, AB

Director of Mental Health and Addictions Services
Kelsey Trail Health Regional Authority
Melfort, SK

Team Development Coordinator
Heartland Health Regional Health Authority
Rosetown, SK

Program Manager
Adult Community Mental Health
Mental Health Services
Brandon Regional Health Authority
Brandon, MB

Program Manager
Mental Health Services
Assiniboine Regional Health Authority
Brandon, MB

Program Manager/Registered Psychiatric Nurse
Psychosocial Rehabilitation Program
Mental Health Services
Brandon Regional Health Authority
Brandon, MB

Regional Program Director
Mental Health
Winnipeg Regional Health Authority
Winnipeg, MB

Psychiatric Social Worker
Community Mental Health Consultation Team
Mental Health Program
Burntwood Regional Health Authority
Thompson, MB

Mental Health Consultant
Department of Health & Social Services
Yellowknife, NT

Mental Health Worker
Primary Care Clinic
Yellowknife Health & Social Services Authority
Yellowknife, NT

Manager/Registered Chartered Psychologist
Community Counselling Centre
Yellowknife Health & Social Services Authority
Yellowknife, NT

Clinical Manager
Mental Health Services
Community Health Programs,
Health & Social Services
Government of Yukon
Whitehorse, YK

Senior Addictions & Mental Health Counselor
Alcohol & Drug Services
Whitehorse, YK

Youth Outreach Worker
Yukon Family Services Association
Whitehorse, Yukon

A/Coordinator/Community Mental Health Nurse
Mental Health Services
Kivalliq Region
Baker Lake Health Centre
Baker Lake, NU

A/Manager Mental Health & Wellness
Health & Social Services
Government of Nunavut
Taloyoak, NU

Psychiatric Nurse
Department of Health & Social Services
Government of Nunavut
Rankin Islet, Nunavut

Mental Health and Psychiatry Program Coordinator
CLSC Rimouski-Neigette
Rimouski, Quebec

**CENTRE FOR RURAL AND NORTHERN HEALTH RESEARCH
LAKEHEAD UNIVERSITY
HS 1003, 955 OLIVER ROAD
THUNDER BAY, ONTARIO
P7B 5E1**